Australian Government
Australian Institute of Health and Welfare

National palliative care measures

Web report | Last updated: **14 May 2026** | Topic: Palliative care | Media release

About

All people require evidence-based and person-centred care at the end of their lives. However, it is recognised that this care is not equally available to all people across Australia. The National Palliative Care Strategy (2018) (the Strategy) represents the commitment of the Commonwealth, state, and territory governments to ensuring the highest possible level of palliative and end-of-life care is available to all people.

Well-defined measures help to drive improvements in a sector and, when monitored regularly, act as a concise guide for informed decision-making. The national palliative care measures aim to track if 'people affected by life-limiting illnesses get the care they need to live well' aligning with the Strategy's vision. These measures were developed by the Australian Institute of Health and Welfare (AIHW) in alignment with the broad goals of the Strategy. This report provides an update on the progress of these measures.

In 2026 the measures will be updated in two tranches. This release updates measures 1.1, 1.2, 3.2, 4.2b and 5.1a; updates to measures 2.1, 4.1 and 4.2a will be published in late 2026.

Cat. no: HWI 141

Key findings

- Most of the measures indicated that palliative care progressed or remained the same
- From 2018 to 2023 progress was made in timely care for inpatient unstable phases
- Physical wellbeing regressed by 0.5 percentage points between 2018 and 2024
- From 2018 to 2024 full-time equivalent employed palliative medicine physicians and nurses increased

Palliative care measures

The national palliative care measures aim to assess whether “people affected by life-limiting illnesses get the care they need to live well”, aligning with the vision of the National Palliative Care Strategy (2018). These measures were developed by the AIHW and are consistent with the broad goals of the Strategy.

This report provides the second update on the progress of 5 objectives in palliative care:

- effective
- safe
- appropriate
- continuous
- accessible care.

In 2026 the measures will be updated in two tranches. This report release updates measures 1.1, 1.2, 3.2, 4.2b and 5.1a; updates to measures 2.1, 4.1 and 4.2a will be published in late 2026.

To understand more about the development of the measures, please read the Development of the national palliative care measures report.

Development of the National Palliative Care Measures

Resource
PDF 868kB

Objectives

Effective
People with life-limiting illnesses receive effective, high-quality, evidence-based care that minimises pain, discomfort, and mental distress.

Safe
People with life-limiting illnesses receive safe and responsive care that avoids overtreatment, accident and injury.

Appropriate
People with life-limiting illnesses are involved as much as they want to be in planning and decisions about their care and receive the care and die in the place of their choosing. Carers have the information and support they need.

Continuous
People with life-limiting illnesses are provided with well-coordinated, uninterrupted, and timely care across programs, practitioners, and levels over time.

Accessible
Everyone in Australia can access quality palliative care when it is needed, regardless of their geographic location, age, condition, socio-economic needs, cultural and religious background, or languages spoken.

All measures
A list of all 8 measures with the latest available status of each measure

All measures

Table 1 provides an overview of the national palliative care measures. The status of each measure shows if there has been a statistically significant change over time. See the Technical Notes for further information.

Table 1: Overview of the national palliative care measures

Objective area	Measure	Baseline value	Latest value	Status	Latest update
Effective	**1.1 Physical wellbeing** Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention.	71.1% in 2018	70.6% in 2024	 Regress	14 May 2026 Data for physical wellbeing
Effective	**1.2 Psychosocial wellbeing** Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention.	80.2% in 2018	79.6% in 2024	 No change	14 May 2026 Data for psychosocial wellbeing
Effective	**1.3 Evidence-based care** Proportion of specialist palliative care services that met relevant, evidence-based standards.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.
Safe	**2.1 Avoidance of overtreatment** Proportion of people with life limiting illnesses who received potentially non-beneficial treatments at the end of life.	8.9% in 2018	8.3% in 2020	 Progress	23 May 2024 Data for this measure will be updated in late 2026. Data for avoidance of overtreatment
Safe	**2.2 Avoidance of accident and injury** Proportion of people with life limiting illnesses who experienced a potentially preventable accident or injury.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.
Appropriate	**3.1a Collaborative care** Proportion of people with life limiting illnesses who were cared for in their location of preference at the end of life.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.
Appropriate	**3.1b Collaborative care** Proportion of Australians with advance care planning documents.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.
Appropriate	**3.2 Carer wellbeing** Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention.	75.0% in 2018	74.8% in 2024	 No change	14 May 2026 Data for carer wellbeing
Continuous	**4.1 Coordinated care** Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life.	12.9% in 2018	11.9% in 2020	 Progress	23 May 2024 Data for this measure will be updated in late 2026. Data for coordinated care

Continuous	**4.2a Timely care** Proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death.	20.0% in 2018	20.9% in 2020	 Progress	23 May 2024 Data for this measure will be updated in late 2026. Data for timely care
Continuous	**4.2b Timely care** Proportion of inpatient unstable palliative care phases that lasted 3 days or less.	76.1% in 2018	82.3% in 2023	 Progress	14 May 2026 Data for timely care
Accessible	**5.1a Equitable** Number of full-time equivalent employed health practitioners in the specialist palliative care workforce, per 100,000 population.	13.2 FTE per 100,000 in 2018	14.4 FTE per 100,000 in 2024	 Progres	14 May 2026 Data for equitable
Accessible	**5.1b Equitable** Proportion of people in need of palliative care who received palliative care.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.
Accessible	**5.2 Inclusive** Proportion of people accessing palliative care who felt their care was respectful of their cultural beliefs and practices.	. .	. .	 Status not known	Data for this measure will be added when it becomes available.

Status key




Progress The change from baseline to latest available data was statistically significant ($p<0.05$) and moving in the desired direction	**No change** Any change in the measure from baseline to latest available data was not statistically significant ($p<0.05$).	**Regress** The change from baseline to latest available data was statistically significant ($p<0.05$) and moving in the opposite direction to what is desired.	**Status not known** Used when there is not enough data available yet to report on progress.

Effective

Desired outcome: people with life-limiting illnesses receive effective, high-quality, evidence-based care that minimises pain, discomfort, and mental distress.

Data can currently be reported for 2 measures. Work is continuing so that the remaining measure can be reported on in the future.

Measures

Physical wellbeing

In 2024, distress related to pain improved or remained at a low level for 70.6% of palliative care phases.

Psychosocial wellbeing

In 2024, psychological or spiritual problems improved or remained at a low level for 79.6% of palliative care phases.

Evidence-based care

No national data currently available.

Status key

Progress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the desired direction

No change
Any change in the measure from baseline to latest available data was not statistically significant (p<0.05).

Regress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the opposite direction to what is desired.

Status not known
Used when there is not enough data available yet to report on progress.

Physical wellbeing: Measure 1.1

In this section

Measure 1.1

Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention.

This measure is about ensuring that people with life-limiting illnesses receive effective care that minimises avoidable physical discomfort. Physical symptoms change across the illness trajectory, in response this measure looks at improvements across palliative care phases. A palliative care phase is a clinically meaningful period in a patient's condition (stable, unstable, deteriorating, terminal). This measure uses patient-reported data to assess the level of patient distress related to pain.

The desired outcome is that fewer people with life-limiting illnesses experience distress from pain, meaning the measure will increase.

Objective area: Effective **Outcome area:** Physical wellbeing

Baseline value	Latest value	Status
71.1% in 2018	70.6% in 2024	 Regress

About the measure

Table 1.1.1: Measure 1.1 data specifications

	Definition	Data source
Numerator	Number of palliative care phases ending within the reference year with a valid Symptom Assessment Scale (SAS) for 'Distress from Pain' at phase start and end and for which SAS 'Distress from Pain' improved or remained absent/mild.	Palliative Care outcomes Collaboration (PCOC) data
Denominator	Number of palliative care phases ending within the reference year with a valid SAS for 'Distress from Pain' at phase start and end.	PCOC data

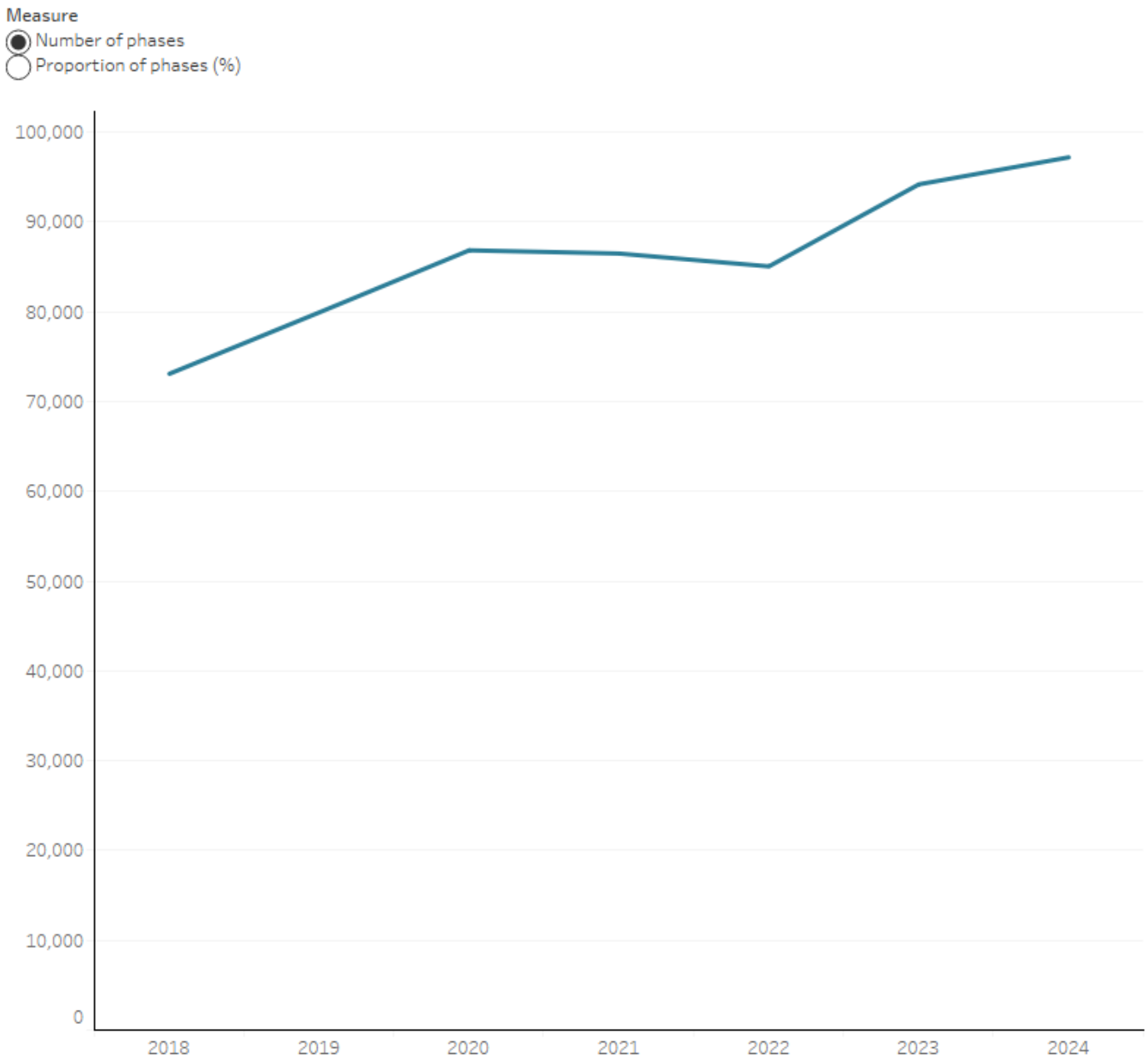
Note, data for this measure only includes a subset of all palliative care delivered in Australia, as there is currently no complete national data on patient outcomes for people with life-limiting illnesses.

For more information see Data dictionary and Data sources.

Trends

In 2018, people with life-limiting illnesses reported that their distress related to pain improved or remained at a low level in 71.1% of palliative care phases (recorded in the PCOC data collection). This has declined slightly over the 6 years to 70.6% in 2024 (Figure 1.1.1). Note, these findings should be interpreted with caution as the number of services participating in PCOC increased between 2018 and 2024.

Figure 1.1.1: Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention, 2018–2024



Source: AIHW. National palliative care measures Table M1.1
https://www.aihw.gov.au/npcm

Characteristics

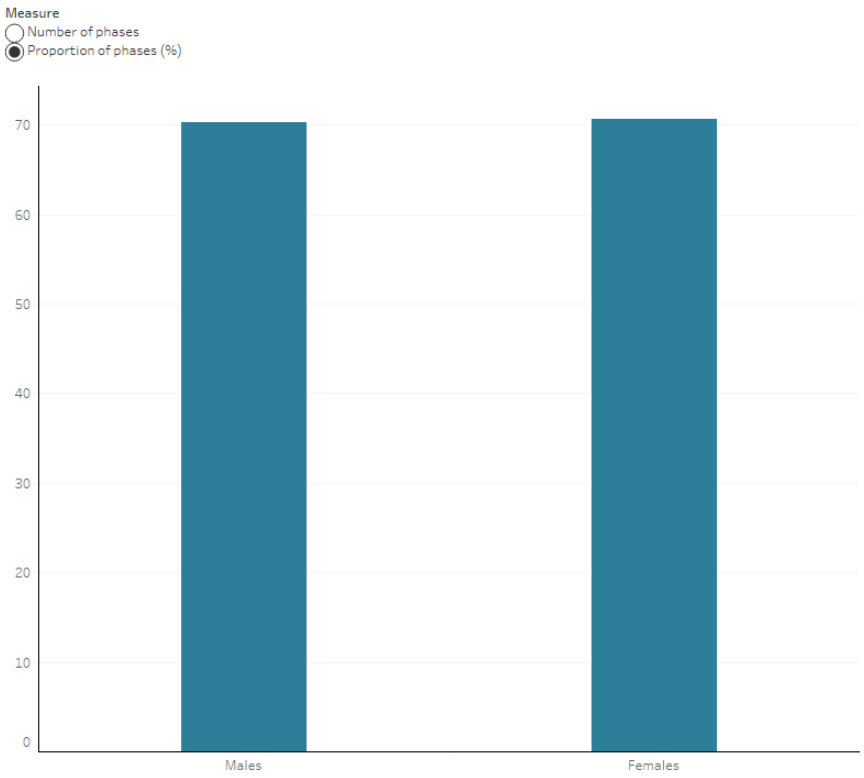
In 2024, the proportion of palliative care phases for which distress related to pain improved or remained at a low level after intervention, varied by some characteristics and not others. Note, these findings should be interpreted with caution as the representativeness of the PCOC data collection across different demographic characteristics is unknown (see Data sources for more information).

Figure 1.1.2 highlights that the proportion of palliative care phases where the distress related to pain improved or remained at a low level over the phase was:

- Similar for males (70.4%) and females (70.8%).
- Steadily increasing with age from age group 45–54 (65.9%) to 85 and over (75.7%). It is important to note that the younger age groups had substantially smaller denominators compared with the older age groups.
- Higher among people with non-cancerous diagnoses (77.6%) than cancer diagnoses (67.8%).
- Similar for people living in areas of varying disadvantage (ranging from 69.4% to 71.3% in areas of most and least disadvantage respectively).
- Highest among people from *Remote* areas (73.1%) and lowest among people from *Inner regional* areas (68.2%).
- Higher among people in inpatient settings (74.6%) than community settings (67.2%).
- Considerably lower for stable phases (61.7%) than for unstable, deteriorating, and terminal phases (ranging from 75.2% to 76.5%).
- Highest for phases where distress from pain was severe at phase start (81.5%) and lowest where distress from pain was moderate at phase start (69.1%).

See Data tables for detailed notes.

Figure 1.1.2: Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention, by selected characteristics, 2024



Source: AIHW. National palliative care measures Table M1.1
https://www.aihw.gov.au/npcm

This interactive bar graph shows phases for which pain improved or remained at a low level after intervention, by selected characteristics in 2024.

Psychosocial wellbeing: Measure 1.2

In this section

Measure 1.2

Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention.

This measure is about ensuring that people with life-limiting illnesses receive effective care that minimises psychological and spiritual distress. People with life-limiting illnesses are likely to experience changing feelings as their illness progresses, so this measure looks at changes across palliative care phases. A palliative care phase is a clinically meaningful period in a patient's condition (stable, unstable, deteriorating, terminal). This measure uses clinician-reported data to assess the severity of problems related to patient psychological or spiritual wellbeing.

The desired outcome is that fewer people with life-limiting illnesses experience psychological or spiritual distress, meaning the measure will increase.

Objective area: Effective **Outcome area:** Psychosocial wellbeing

Baseline value	Latest value	Status
80.2% in 2018	79.6% in 2024	 No change

About the measure

Table 1.2.1: Measure 1.2 data specifications

	Definition	Data source
Numerator	Number of palliative care phases ending within the reference period with a valid Palliative Care Problem Severity Score (PCPSS) for 'Psychological/Spiritual' problems at phase start and end and for which the PCPSS improved or remained absent/mild.	PCOC data
Denominator	Number of palliative care phases ending within the reference year with a valid PCPSS for 'Psychological/Spiritual' problems at start and end of phase.	PCOC data

Note, data for this measure only includes a subset of all palliative care delivered in Australia, as there is currently no complete national data on patient outcomes for people with life-limiting illnesses.

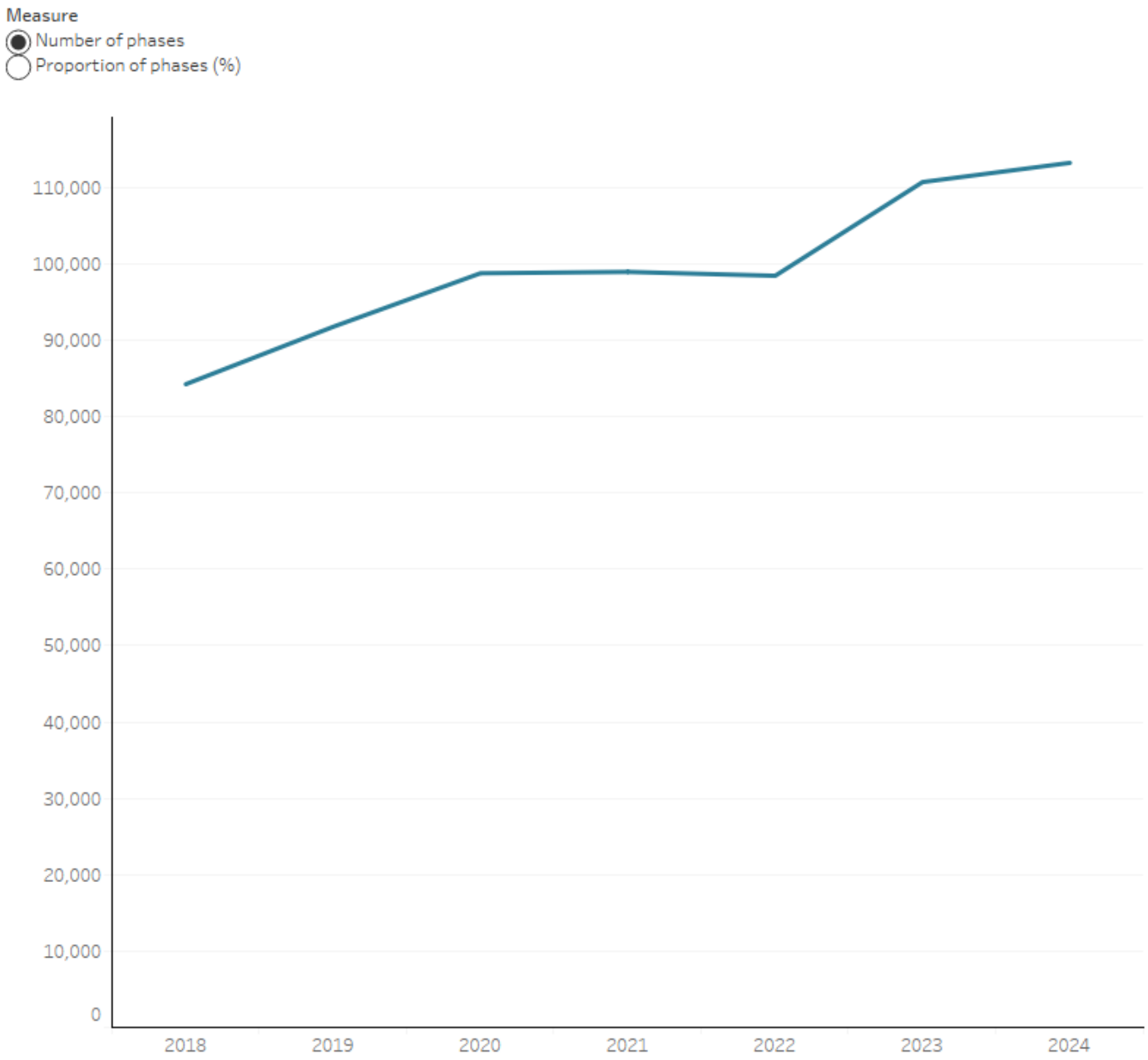
See Data dictionary and Data sources for more information.

Trends

In 2018, people with life-limiting illnesses experienced improved or maintained low levels of psychological or spiritual problems in 80.2% of palliative care phases (recorded in the PCOC data collection). This proportion was similar in 2024 at 79.6%, up from previous decreases that occurred over the COVID-19 pandemic.

Note, these findings should be interpreted with caution as the number of services participating in PCOC increased between 2018 and 2024 (see Data sources for more information).

Figure 1.2.1: Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention, 2018–2024



Source: AIHW. National palliative care measures Table M1.2
https://www.aihw.gov.au/npcm

Characteristics

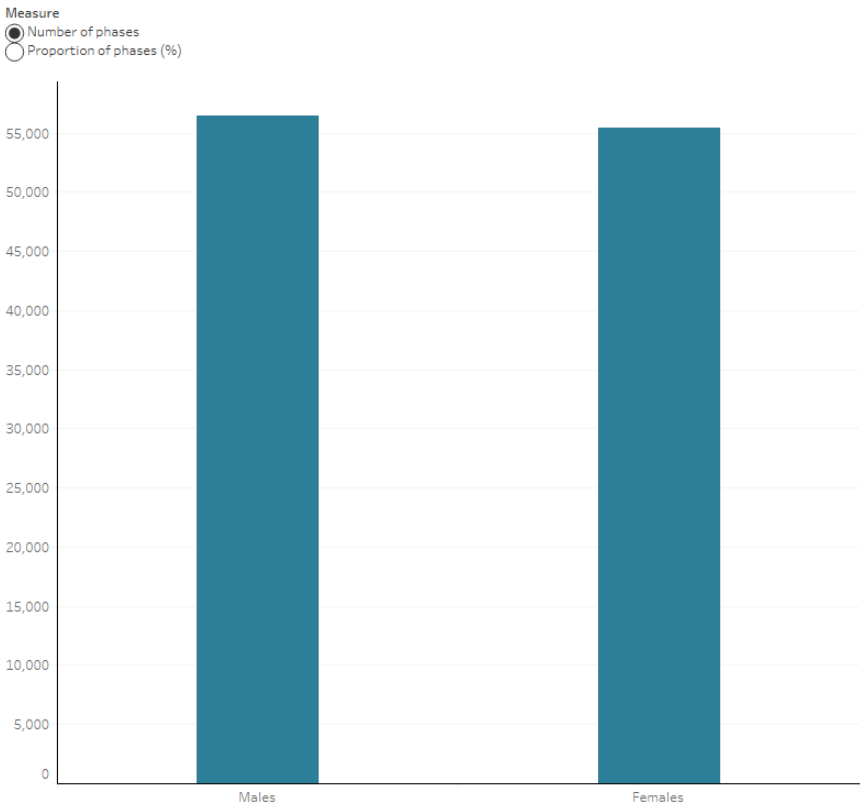
In 2024, the proportion of palliative care phases for which psychological or spiritual problems improved or remained at a low level after intervention, varied by some characteristics and not others. Note, these findings should be interpreted with caution as the representativeness of the PCOC data collection by different demographic characteristics is unknown (see Data sources for more information).

Figure 1.2.2 highlights that the proportion of palliative care phases for which psychological or spiritual problems improved or remained at a low level over the phase was:

- Similar for males and females (both 79.6%).
- Steadily increasing with age from age group 45–54 (75.8%) to 85 and over (84.7%). It is important to note that the younger age groups had substantially smaller denominators compared with the older age groups.
- Higher among people with non-cancerous diagnoses (83.2%) than cancer diagnoses (78.0%).
- Similar for people living in areas of varying disadvantage (ranging from 78.5% to 80.1%).
- Similar for people from varying remoteness areas (ranging from 77.5% to 81.4%), except for *Very remote* areas (72.9%).
- Higher among people in inpatient settings (83.6%) than community settings (75.6%).
- Highest for terminal phases (84.2%) and lowest for stable phases (73.9%).
- Highest for phases where psychological or spiritual problems were mild at phase start (89.2%) and lowest where psychological or spiritual problems were moderate at phase start (63.6%).

See Data tables for detailed notes.

Figure 1.2.2: Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention, by selected characteristics, 2024



Source: AIHW. National palliative care measures Table M1.2
https://www.aihw.gov.au/national-palliative-care-measures..

This interactive bar graph shows the phases for which psychological wellbeing improved or remained at a low level after intervention, by selected characteristics in 2024.

Safe

Desired outcome: people with life-limiting illnesses receive safe and responsive care that avoids overtreatment, accident, and injury.

Data can currently be reported for one measure. Work is continuing so that the remaining measure can be reported on in the future.

Measures

Avoidance of overtreatment

8.3% of people with life-limiting illnesses received a potentially non-beneficial treatment at the end of life in 2020

Avoidance of accident and injury

No national data currently available.

Status key

Progress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the desired direction.

No Change
Any change in the measure from baseline to latest available data was not statistically significant (p<0.05).

Regress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the opposite direction to what is desired.

Status not known
Used when there is not enough data available yet to report on progress.

Avoidance of overtreatment: Measure 2.1

In this section

Measure 2.1

Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life.

This measure is about understanding whether people with life-limiting illnesses are receiving treatments that could potentially undermine quality of life at the end of their lives. It is important to note that the data used for this measure do not capture the nuance at the time of treatment such as the intentions of care, the patient's functional status, or patient/family preferences. Further, it can be difficult for treating clinicians to accurately predict life expectancy, in particular, knowing that it might be the person's last 30 days of life. Given these uncertainties, this measure is likely to include some treatments that were in fact appropriate at the time of treatment.

Note, data for this measure are not available for Western Australia and Northern Territory. This means the counts presented here underestimate national totals and the influence on proportions is unknown.

The desired outcome is that people with life-limiting illnesses who receive potentially non-beneficial treatments at the end of life is low, meaning the measure will decrease.

Objective area: Safe **Outcome area:** Avoidance of overtreatment

Baseline value	Latest value	Status
8.9% in 2018	8.3% in 2020	 Progress

About the measure

Table 2.1.1: Measure 2.1 specifications

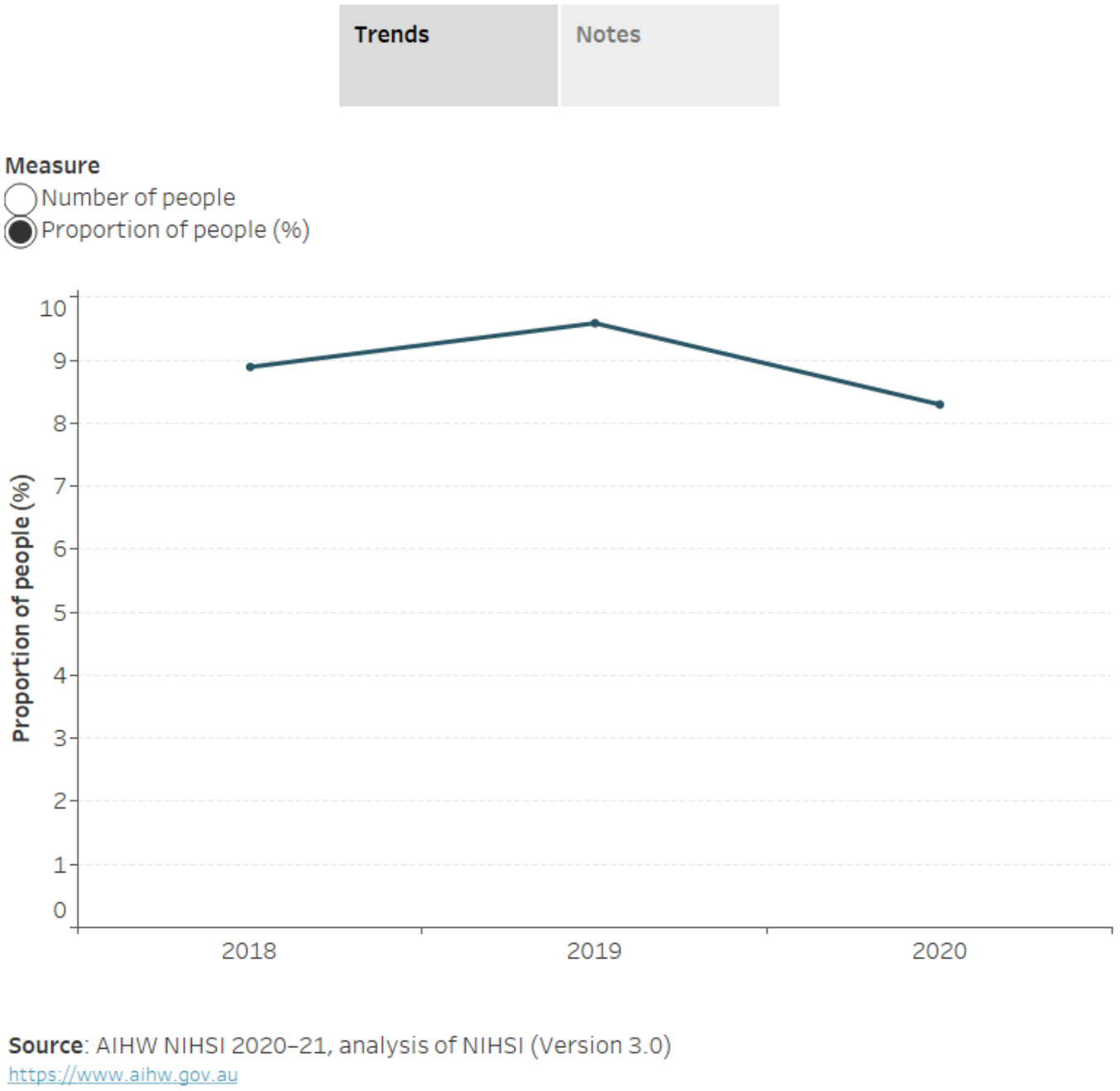
	Definition	Data source
Numerator	Number of people with life-limiting illnesses who died within the reference year and had at least one record of receiving a potentially non-beneficial treatment as a public hospital inpatient at the end of life. Treatments include cardiopulmonary resuscitation, intravenous feeding, mechanical ventilation, or initiation of chemotherapy or dialysis in the last 30 days of life, or receipt of chemotherapy in the last 15 days of life.	NHDH (formerly NIHSI) 2020–21
Denominator	Number of people with life-limiting illnesses who died within the reference year.	NHDH (formerly NIHSI) 2020–21

See Data dictionary and Data sources for more information.

Trends

In 2018, among people with life-limiting illnesses whose death was registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory, 8.9% received at least one potentially non-beneficial treatment at the end of their life. This increased to 9.6% in 2019 before decreasing to 8.3% in 2020 (Figure 2.1.1).

Figure 2.1.1: Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life, 2018-2020



Characteristics

Figure 2.1.2 highlights that the proportion of people with life-limiting illnesses who received at least one potentially non-beneficial treatment at the end of life, and whose death was registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory in 2020, varied by these characteristics:

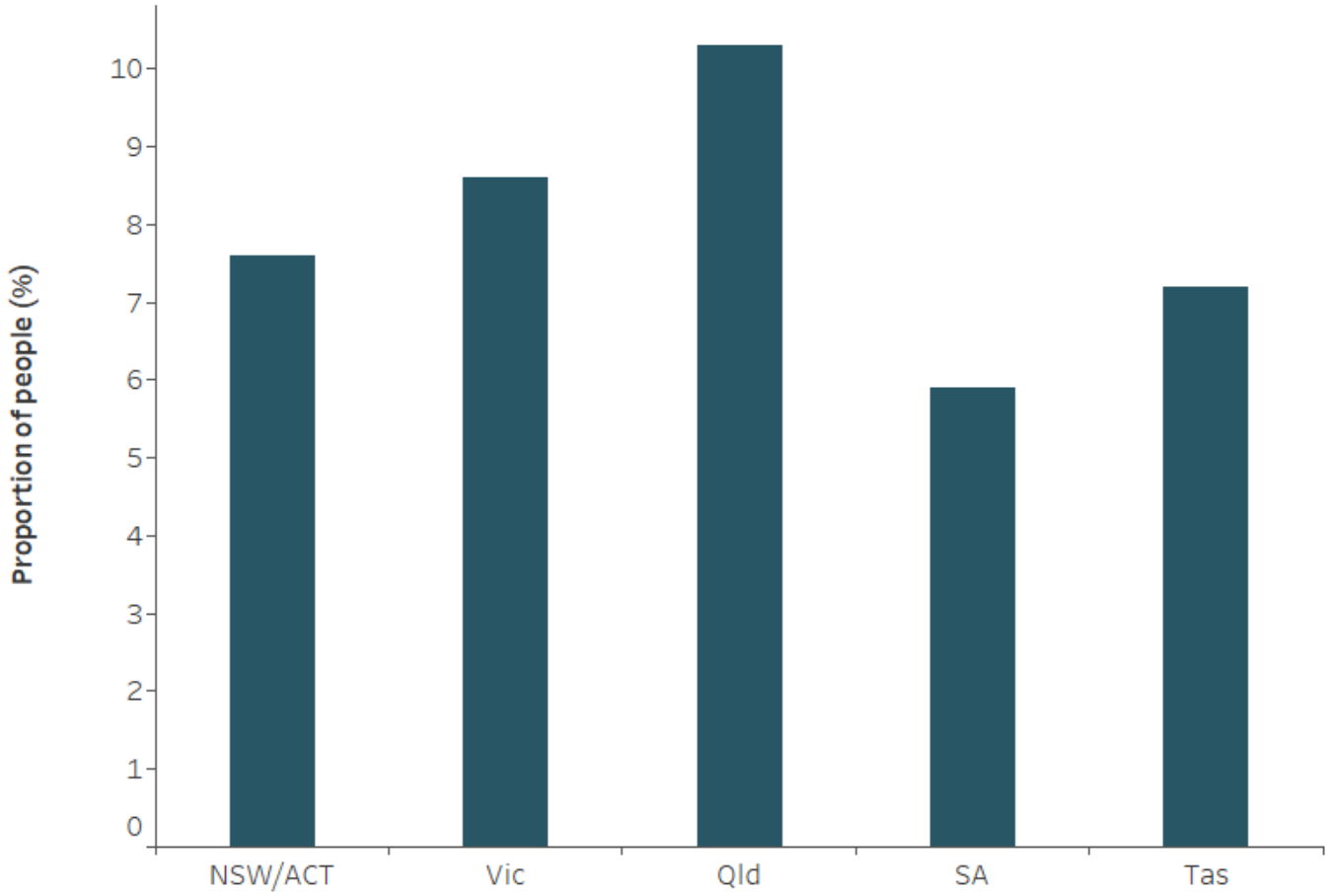
- The lowest proportion was in South Australia, where 5.9% of people with life-limiting illnesses received a potentially non-beneficial treatment at the end of life. Differences between states and territories should be interpreted with caution as modes of service delivery, definitions, and data recording practices differ across states and territories.
- There was little difference in the proportion between Australians from all *Regional* and *remote areas* (combined) (8.4%) and Australians from *Major cities* (8.2%).
  Note: Western Australia and Northern Territory are not included in these data so disaggregation by remoteness area should be interpreted with caution (for more information see Data sources).
- A higher proportion of males (9.6%) received a potentially non-beneficial treatment at the end of life when compared with females (6.9%).
- The proportion decreased as age increased – 25.2% of children (0–14 years) and 28.1% of those aged 15–24 received a potentially non-beneficial treatment at the end of life, compared with 3.0% of people aged 85 and over.
- The proportion increased with increasing disadvantage – 6.5% of people who lived in the areas of least disadvantage received a potentially non-beneficial treatment at the end of life, compared with 9.5% of people living in areas of most disadvantage.
- The proportion varied considerably by cause of death – the highest proportion was among people with liver diseases (20.0%) and the lowest proportion was for people with dementia/ Alzheimer's disease/ senility (1.2%).

Figure 2.1.2: Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life, by selected characteristics, 2020

State/Territory	Remoteness area	Sex	Age group	Socioeconomic area	C ..

Measure

- ○ Number of people
- ● Proportion of people (%)



Source: AIHW NIHSI 2020–21, analysis of NIHSI (Version 3.0)
https://www.aihw.gov.au

Appropriate

Desired outcome: people with life-limiting illnesses are involved as much as they want to be in planning and decisions about their care and receive the care and die in the place of their choosing. Carers have the information and support they need.

Data can currently be reported for one measure. Work is continuing so that the remaining measure can be reported on in the future.

Measures

Collaborative care

No national data currently available.

Carer wellbeing

In 2024, family/carer problems improved or remained at a low level for 74.8% of palliative care phases.

Status key

Progress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the desired direction

No change
Any change in the measure from baseline to latest available data was not statistically significant (p<0.05).

Regress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the opposite direction to what is desired.

Status not known
Used when there is not enough data available yet to report on progress.

Carer wellbeing: Measure 3.2

In this section

Measure 3.2

Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention.

This measure is about ensuring that the carers of people with life-limiting illnesses get the support they need. Carers need support to help them provide care in a manner that also promotes their own health, wellbeing, and personal aspirations.

The only national data currently available to describe carers' experience is through the experience of the person with a life-limiting illness. This may not accurately reflect how well supported a carer feels.

The desired outcome for this measure is that more carers have the support they need, meaning the measure will increase.

Objective area: Appropriate **Outcome area:** Carer wellbeing

Baseline value	Latest value	Status
75.0% in 2018	74.8% in 2024	 No change

About the measure

Table 3.2.1: Measure 3.2 specifications

	Definition	Data source
Numerator	Number of palliative care phases ending within the reference year with a valid Palliative Care Problem Severity Score (PCPSS) for 'Family/Carer' problems at phase start and end and for which the PCPSS for 'Family/Carer' problems improved or remained absent/mild.	PCOC data
Denominator	Number of palliative care phases ending within the reference year with a valid PCPSS for 'Family/Carer' problems at phase start and end.	PCOC data

Note, there is currently no complete national data on outcomes for people with life-limiting illnesses and their carers. Data for this measure is from the Palliative Care Outcomes Collaboration (PCOC) data collection which only includes a subset of all palliative care delivered in Australia.

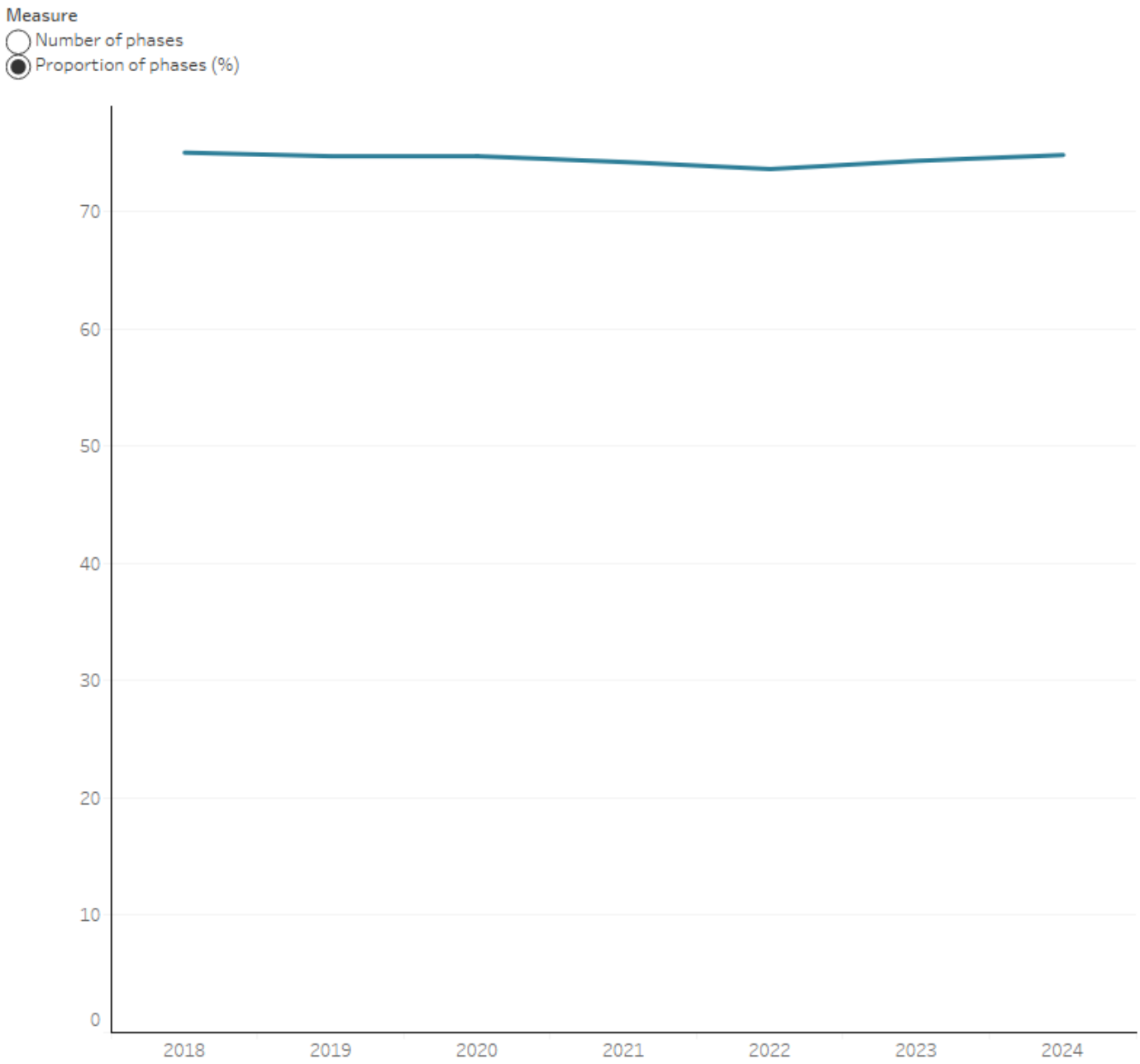
See Data dictionary and Data sources for more information.

Trends

In 2018, people with life-limiting illnesses experienced improved or maintained low levels of family or carer problems in 75.0% of palliative care phases. This measure remained similar over the following 6 years (74.8% in 2024), noting a slight decrease during the COVID-19 pandemic.

Note, these findings should be interpreted with caution as the number of services participating in PCOC increased between 2018 and 2024 (see Data sources for more information).

Figure 3.2.1: Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention, 2018-2024



Source: AIHW. National palliative care measures Table M3.2
https://www.aihw.gov.au/npcm

Characteristics

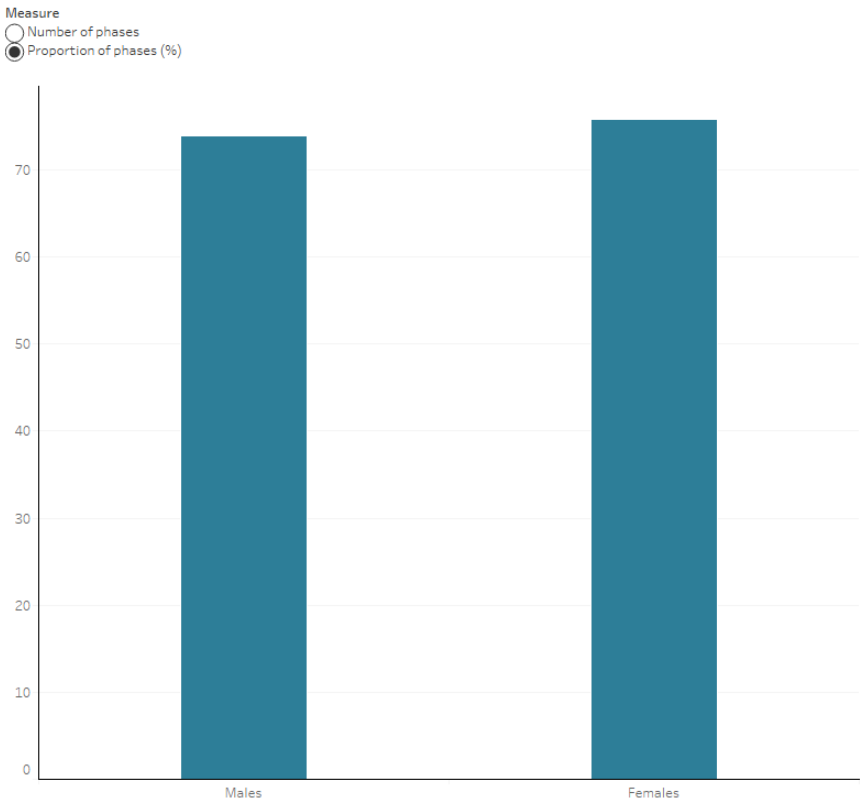
In 2024, the proportion of palliative care phases for which family or carer problems improved or remained at a low level after intervention, varied by some characteristics and not others. Note, these findings should be interpreted with caution as the representativeness of the PCOC data collection across different demographic characteristics is unknown (see Data sources for more information).

Figure 3.2.2 highlights that the proportion of palliative care phases for which family or carer problems improved or remained at a low level over the phase was:

- Slightly lower for males (73.9%) when compared with females (75.8%).
- Generally increasing with age from 68.5% for those aged 0–14 to 77.1% for those aged 85 and over. It is important to note that the younger age groups had substantially smaller denominators compared with the older age groups.
- Higher among people with non-cancerous diagnoses (77.1%) than cancer diagnoses (73.7%).
- Similar for people living in areas of varying disadvantage (ranging from 74.1% to 75.9%).
- Highest among people from *Remote* areas (77.6%) and lowest among those from *Very remote* areas (68.8%).
- Higher among people in inpatient settings (79.7%) than community settings (70.1%).
- Highest for unstable phases (77.4%) and lowest for stable phases (71.8%).
- Highest for phases where family or carer problems were mild at phase start (85.2%) and lowest where family or carer problems were moderate at phase start (55.7%).

See Data tables for more detailed notes.

Figure 3.2.2: Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention, by selected characteristics, 2024



Source: AIHW. National palliative care measures Table M3.2
https://www.aihw.gov.au/npcm

This interactive bar graph shows the phases for which family/carer problems improved or maintained low levels after intervention, by selected characteristics in 2024.

Continuous

Desired outcome: people with life-limiting illnesses are provided with well-coordinated, uninterrupted, and timely care across programs, practitioners, and levels over time.

Data are currently available for all 3 measures.

Measures

Coordinated care

In 2020, 11.9% of people with life-limiting illnesses had a potentially preventable hospitalisation in their last 3 months of life.

Timely care

In 2020, 20.9% of people who received specialist palliative care first received it at least 3 months before they died.

Timely care

In 2023, 82.2% of inpatient unstable palliative care phases lasted 3 days or less.

Status key

Progress
The change from baseline to latest available data was statistically significant ($p<0.05$) and moving in the desired direction

No change
Any change in the measure from baseline to latest available data was not statistically significant ($p<0.05$).

Regress
The change from baseline to latest available data was statistically significant ($p<0.05$) and moving in the opposite direction to what is desired.

Status not known
Used when there is not enough data available yet to report on progress.

Coordinated care: Measure 4.1

In this section

Measure 4.1

Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life.

This measure is about ensuring that people with life-limiting illnesses receive well-coordinated multidisciplinary care at the end of life. A potentially preventable hospitalisation is indicative of a lack of early disease management and/or preventive health intervention typically delivered in primary and community-based care. There are many factors that can contribute to this including patient choice, a lack of at-home support, and/or barriers to accessing primary and community care such as geographical remoteness, affordability, or opening hours.

Note, data for this measure are not available for Western Australia and Northern Territory. This means the counts presented here underestimate national totals and the influence on proportions is unknown.

The desired outcome is that fewer people with life-limiting illnesses are hospitalised for a potentially preventable reason in their last 3 months of life, meaning the measure will decrease.

Objective area: Continuous **Outcome area:** Coordinated care

Baseline value	Latest value	Status
12.9% in 2018	11.9% in 2020	 Progress

About the measure

Table 4.1.1: Measure 4.1 specification

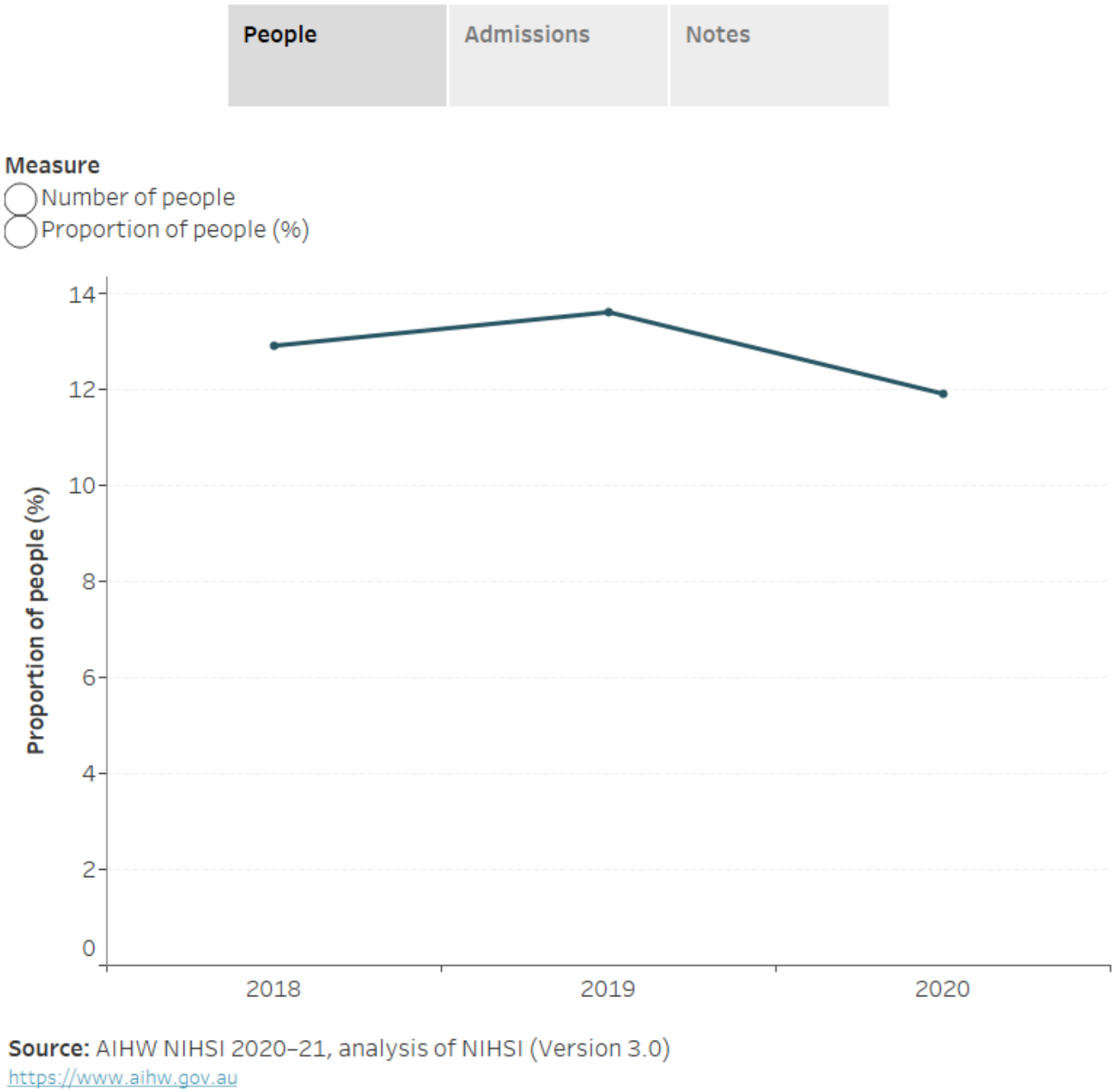
	Definition	Data source
Numerator	Number of people with life-limiting illnesses with at least one potentially preventable hospitalisation in a public hospital in the last 3 months (0 to 90 days) of life within the reference year. This includes vaccine-preventable conditions, acute conditions, and chronic conditions.	NHDH (formerly NIHSI) 2020–21
Denominator	Number of people with life-limiting illnesses who died within the reference year.	NHDH (formerly NIHSI) 2020–21

See Data dictionary and Data sources for more information.

Trends

In 2018, among people with life-limiting illnesses whose death was registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory, 12.9% were hospitalised for a potentially preventable reason in their last 3 months of life. This decreased to 11.9% in 2020 (Figure 4.1.1).

Figure 4.1.1: Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life, 2018-2020



Characteristics

Among people with life-limiting illnesses in 2020, almost two-thirds (65.8%) of potentially preventable hospitalisations lasted for 3 days or more. Most potentially preventable hospitalisations (69.9%) were for chronic conditions.

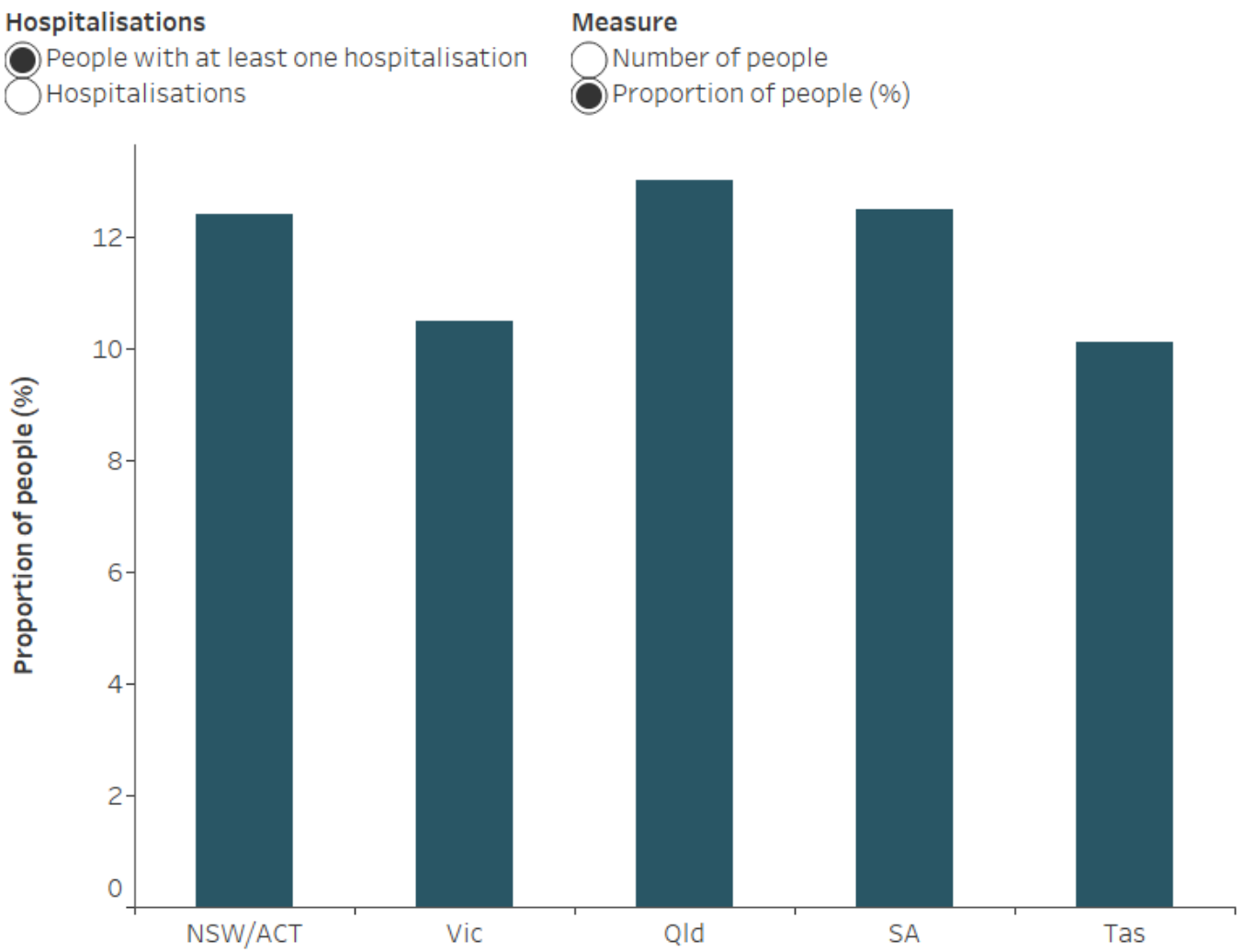
Figure 4.1.2 highlights that the proportion of people with life-limiting illnesses who had a potentially preventable hospitalisation in their last 3 months of life, and whose death was registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory in 2020 varied by these characteristics:

- The lowest proportions were in Tasmania, where 10.1% of people with life-limiting illnesses were hospitalised for a potentially preventable reason in their last 3 months of life, and in Victoria (10.5%). Differences between states and territories should be interpreted with caution as modes of service delivery, definitions, and data recording practices differ across states and territories.
- The proportion increased with increasing remoteness – *Major cities* had the lowest proportion (11.5%) and *Remote* and *very remote* (combined) had the highest proportion (18.3%).
  Note, Western Australia and Northern Territory are not included in these data so disaggregation by remoteness area should be interpreted with caution (see Data sources for more information).
- A slightly higher proportion of males (12.5%) were hospitalised for a potentially preventable reason in their last 3 months of life when compared with females (11.3%).
- The proportion generally increased as age increased – 7.7% of people aged 25-34 years were hospitalised for a potentially preventable reason in their last 3 months of life, compared with 13.5% of people aged 75-84 (although slightly lower for those 85 or over at 11.0%).
- The proportion increased with increasing disadvantage – 8.6% of people who lived in the highest socioeconomic areas were hospitalised for a potentially preventable reason in their last 3 months of life, compared with 14.4% of people living in the lowest socioeconomic areas.

- The proportion varied considerably by cause of death – the highest proportion was among people with respiratory diseases (31.5%) and the lowest proportion was for people with neurodegenerative diseases (4.6%).

Figure 4.1.2: Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life, by selected characteristics, 2020

State/Territory	Remoteness area	Sex	Age group	Socioeconomic area	C. .



Source: AIHW NIHSI 2020–21, analysis of NIHSI (Version 3.0)
https://www.aihw.gov.au

Timely care: Measure 4.2a

In this section

Measure 4.2a

Proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death.

This measure is about ensuring that people with life-limiting illnesses receive palliative care in a timely manner. Data are not currently available on all palliative care delivered in Australia, so this measure focuses on those people who received "specialist" palliative care. However, many people with a life-limiting illness can be well managed by primary and community care providers and may not require specialist palliative care services.

Note, data for this measure are not available for Western Australia and Northern Territory. This means the counts presented here underestimate national totals and the influence on proportions is unknown.

The desired outcome is that more people with life-limiting illnesses receive timely palliative care, meaning the measure will increase.

Objective area: Continuous **Outcome area:** Timely care

Baseline value	Latest value	Status
20.0% in 2018	20.9% in 2020	 Progress

About the measure

Table 4.2.1: Specifications for the proportion of people who first received specialist palliative care at least 3 months before death

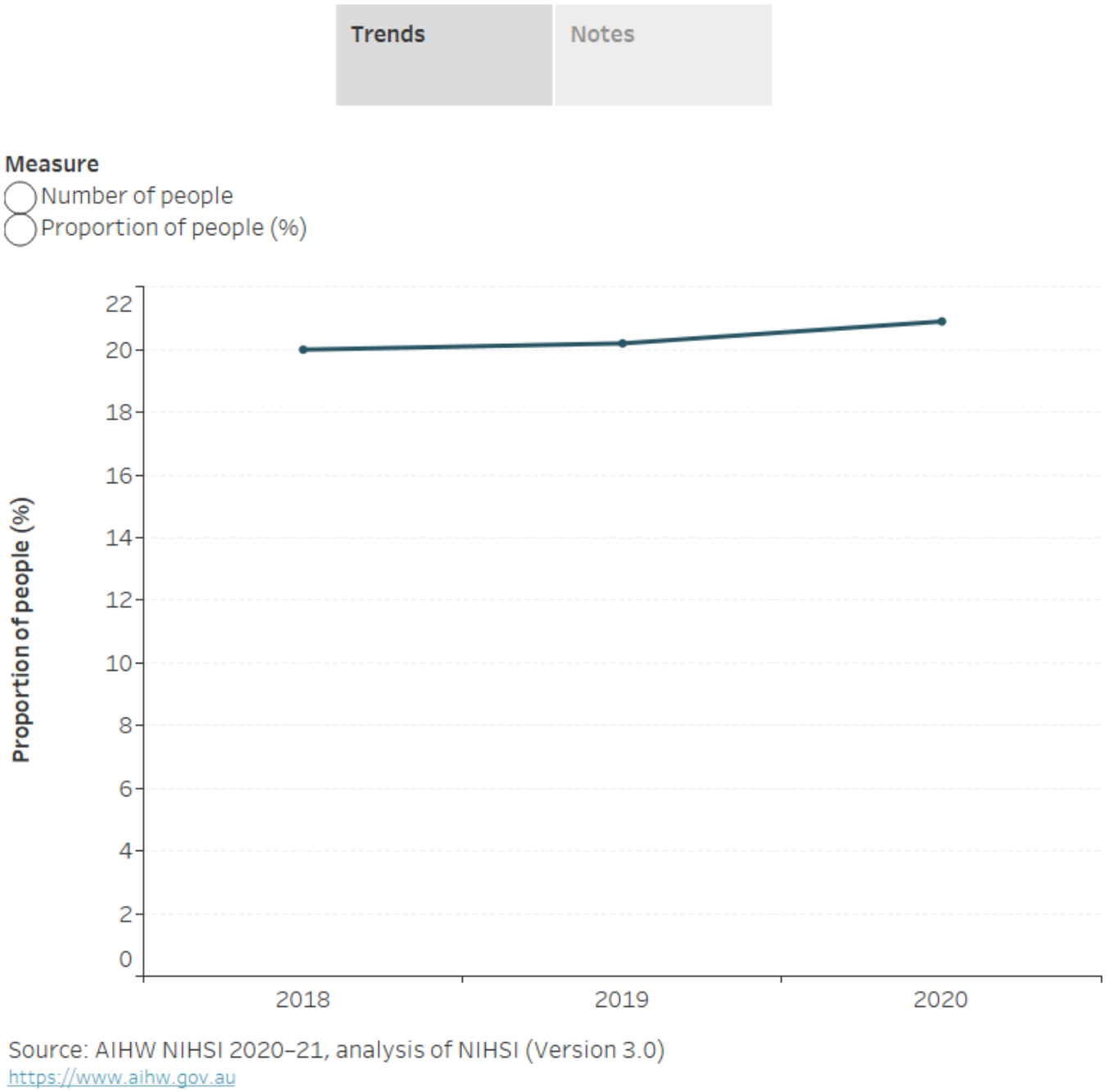
	Definition	Data source
Numerator	Number of people who died from a predictable death within the reference year and first received a specialist palliative care service (inpatient hospital care, outpatient hospital clinic services, and/or Medicare-subsidised consultations with palliative medicine specialist/physician) at least 3 months (91 to 365 days) before death.	NHDH (formerly NIHSI) 2020–21
Denominator	Number of people who died from a predictable death within the reference year and received a specialist palliative care service within their last year of life (0 to 365 days before death).	NHDH (formerly NIHSI) 2020–21

See Data dictionary and Data sources for more information.

Trends

In 2018, among those whose death was registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory and who received specialist palliative care in their last year of life, 20.0% first received it at least 3 months before they died. This increased to 20.9% in 2020 (Figure 4.2.1).

Figure 4.2.1: Proportion of people who first received specialist palliative care at least 3 months before death, 2018-2020



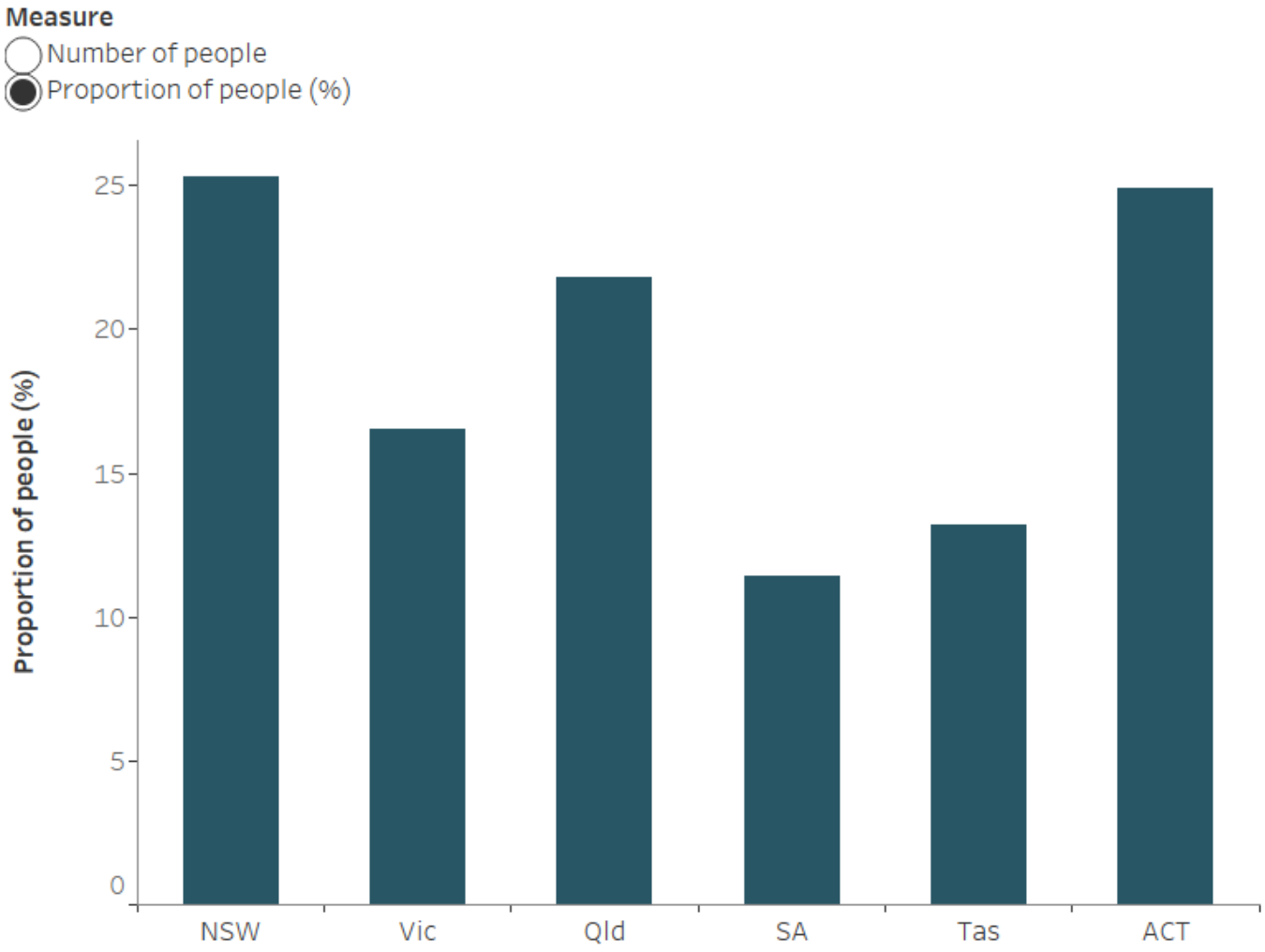
Characteristics

Figure 4.2.2 presents the proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death. This proportion varied by a range of characteristics:

- The highest proportion was in New South Wales and the Australian Capital Territory, where 1 in 4 (25.3% and 24.9% respectively) people who received specialist palliative care first received it at least 3 months before they died. Differences between states and territories should be interpreted with caution as modes of service delivery, definitions, and data recording practices differ across states and territories.
- The proportion decreased as remoteness increased – *Major cities* had the highest proportion (22.5%) and *Remote and very remote* (combined) had the lowest proportion (15.6%). Note, Western Australia and Northern Territory are not included in these data so disaggregation by remoteness area should be interpreted with caution (see Data sources for more information).
- A slightly smaller proportion of males (20.7%) who received specialist palliative care, first received it at least 3 months before they died, compared with females (21.1%).
- The proportion decreased as age increased – almost half (47.7%) of all children (0–14 years) who received specialist palliative care first received it at least 3 months before they died, compared with 1 in 7 (14.9%) people aged 85 and over.
- The proportion decreased as disadvantage increased – 25.8% of people who lived in the highest socioeconomic areas and received specialist palliative care, first received it at least 3 months before death, compared with 18.9% of people living in the lowest (and 17.9% in the second lowest) socioeconomic areas.
- The proportion varied considerably by cause of death - the highest proportion was among people with neurodegenerative diseases (31.6%) and the lowest proportion was for people with cerebrovascular diseases including stroke (4.9%).

Figure 4.2.2: Proportion of people who first received specialist palliative care at least 3 months before death, by selected characteristics, 2020

State/Territory	Remoteness area	Sex	Age group	Socioeconomic area	S. .



Source: AIHW NIHSI 2020–21, analysis of NIHSI (Version 3.0)
https://www.aihw.gov.au

Timely care: Measure 4.2b

In this section

Measure 4.2b

Proportion of inpatient unstable palliative care phases that lasted 3 days or less.

This measure is about ensuring that people with life-limiting illnesses receive palliative care in a timely manner. An unstable phase is where an urgent change is required in the care approach. Patient and/or family choices may delay the time it takes to stabilise a person in this phase.

Note, due to data availability only inpatient settings are captured.

The desired outcome is that more unstable palliative care phases last 3 days or less, meaning the measure will increase.

Objective area: Continuous **Outcome area:** Timely care

Baseline value	Latest value	Status
76.1% in 2018	82.2% in 2023	 Progress

About the measure

This measure only captures the palliative care unstable phase records of those patients who have received inpatient palliative care.

There may be some circumstances in which it is not possible to stabilise a patient in an unstable palliative care phase within 3 days due to patient and/or family choice.

Table 4.2.2: Specifications for the proportion of unstable palliative care phases that lasted 3 days or less

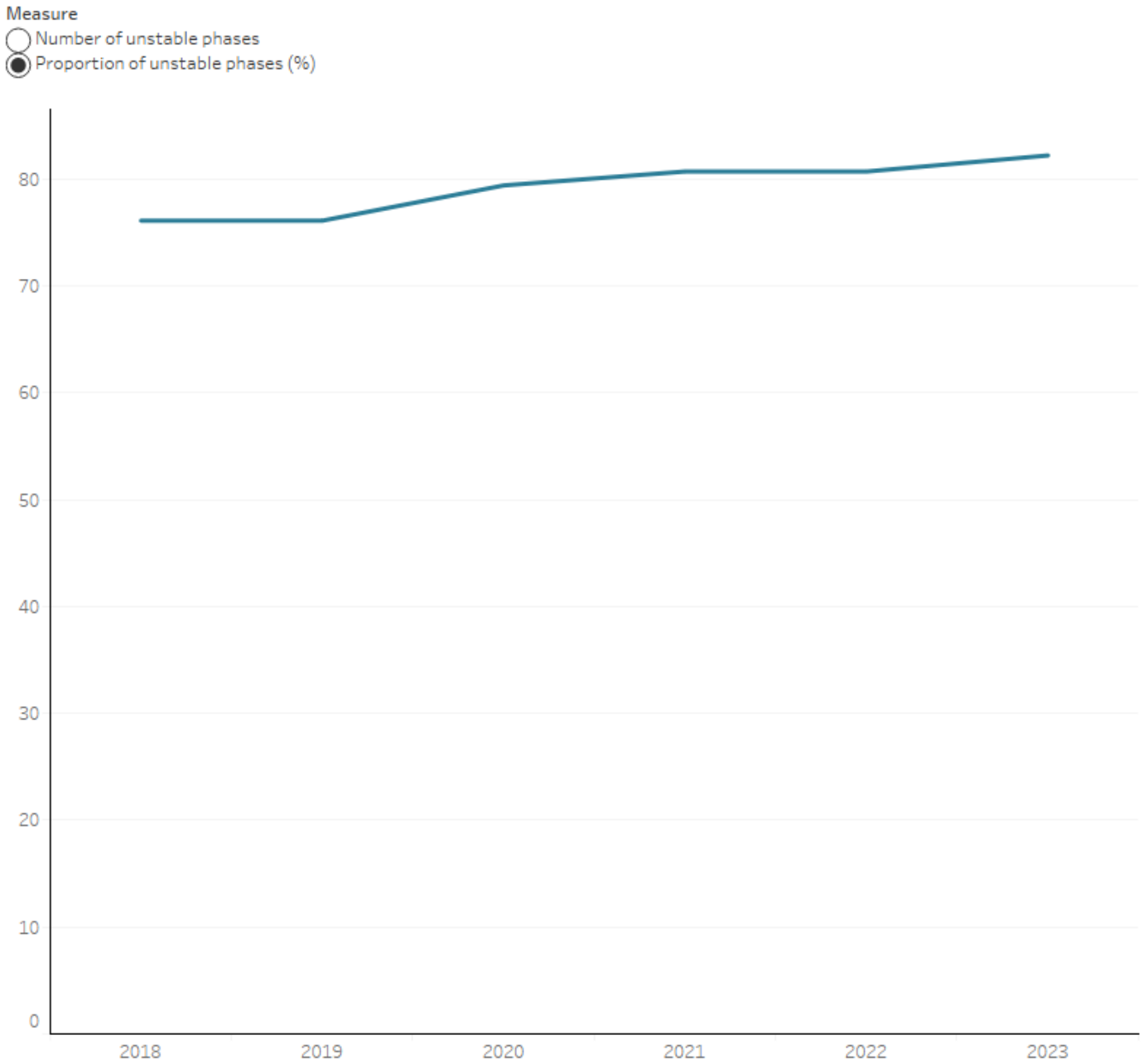
	Definition	Data source
Numerator	Number of inpatient unstable palliative care phases lasting for 3 days or less within the reference year.	ASNAHC NBEDS
Denominator	Number of inpatient unstable palliative care phases within the reference year.	ASNAHC NBEDS

See Data dictionary and Data sources for more information.

Trends

In 2018, 76.1% of inpatient unstable palliative care phases lasted 3 days or less. This increased to 82.2% in 2023 (Figure 4.2.3).

Figure 4.2.3: Proportion of inpatient unstable palliative care phases that lasted 3 days or less, 2018-2023



Source: AIHW. National palliative care measures Table M4.2
https://www.aihw.gov.au/npcm

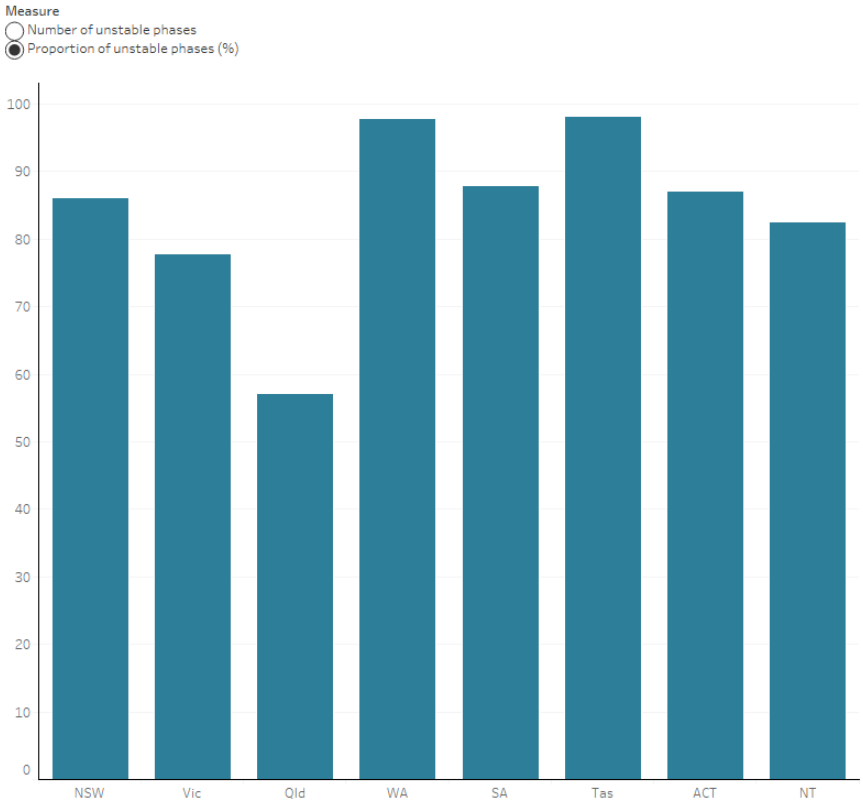
Characteristics

Figure 4.2.4 shows that the proportion of inpatient unstable palliative care phases that lasted 3 days or less in 2023 varied by these characteristics:

- Proportions varied by state and territory, ranging between 98.2% in Tasmania to 57.2% in Queensland.
- The proportion was lowest in *Remote and very remote* areas (76.1%) and highest in *Major cities* (83.6%).
- People aged 15–24 years recorded the lowest proportion (73.1%), while those aged 25–34 years recorded the highest (88.0%). The remaining age groups were relatively consistent, with proportions of approximately 82%. It is important to note that the younger age groups (under 35 years) had substantially smaller denominators compared with the older age groups.
- The proportion increases as socioeconomic disadvantage decreased (from 80% to 83% for people living in the most compared to the least socioeconomically disadvantaged areas.
- The proportion was lower for Aboriginal and Torres Strait Islander (First Nations) people (79.3%) than for non-indigenous Australians (82.5%).
- Between 2021 and 2023 there was a decrease in the proportion of First Nations people who had inpatient unstable palliative care phases that lasted 3 days of less (from 83% to 79%) (AIHW 2024).

See Data table for detailed notes.

Figure 4.2.4: Proportion of inpatient unstable palliative care phases that lasted 3 days or less, by selected characteristics, 2023



Source: AIHW. National palliative care measures Table M4.2
https://www.aihw.gov.au/npcm

This interactive bar graph shows the proportion of unstable palliative care phases that lasted 3 days or less, by selected characteristics in 2023.

References

Australian Institute of Health and Welfare (2024) National Palliative Care Measures report, Data table 4.2b, viewed 23 March 2026

Accessible

Desired outcome: everyone in Australia can access quality palliative care when it is needed, regardless of their geographic location, age, condition, socio-economic needs, cultural and religious background, or languages spoken.

Data can currently be reported for one measure. Work is continuing so that the remaining measures can be reported on in the future.

Measures

Equitable

In 2024, there were 14.4 full-time equivalent employed health practitioners in the specialist palliative care workforce, per 100,000 population.

Inclusive

No national data currently available.

Status key

Progress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the desired direction

No change
Any change in the measure from baseline to latest available data was not statistically significant (p<0.05).

Regress
The change from baseline to latest available data was statistically significant (p<0.05) and moving in the opposite direction to what is desired.

Status not known
Used when there is not enough data available yet to report on progress.

Equitable: Measure 5.1a

In this section

Measure 5.1a

Number of full-time equivalent employed health practitioners in the specialist palliative care workforce, per 100,000 population.

This measure is about ensuring that people in need of palliative care receive it. Currently, it is not possible to measure this directly and so a proxy measure is reported, which focuses on the number of practitioners in the specialist palliative care workforce. This proxy measure was chosen because achieving a functional and sustainable palliative care workforce is necessary to ensuring the needs of those requiring specialist palliative care are met.

Due to data availability only the specialist palliative care workforce is captured. However, it is recognised that not all people with life-limiting illnesses receive specialist palliative care, and that the palliative care workforce is made up of a broad range of professionals. General practitioners, pharmacists, other medical specialists, and allied health professionals form an integral part of the palliative care workforce. Adequate training of these professionals is essential to ensuring palliative care is accessible to all. Existing national data sources are not currently able to capture the extent of palliative care services provided by these health professionals, nor their access to palliative care-specific training.

The desired outcome is an increase in the number of specialist palliative care practitioners per 100,000 population.

Objective area: Accessible **Outcome area:** Equitable

Baseline value	Latest value	Status
13.2 FTE per 100,000 in 2018	14.4 FTE per 100,000 in 2024	 Progress

About the measure

Table 5.1.1: Number of health practitioners in specialist palliative care workforce, per 100,000 population specifications

	Definition	Data source
Numerator	Number of full-time equivalent (FTE) employed palliative medicine physicians and palliative care nurses in the reference year.	National Health Workforce Dataset
Denominator	Number of people in the Australian Estimated Resident Population in the reference year.	ABS Estimated Residential Population

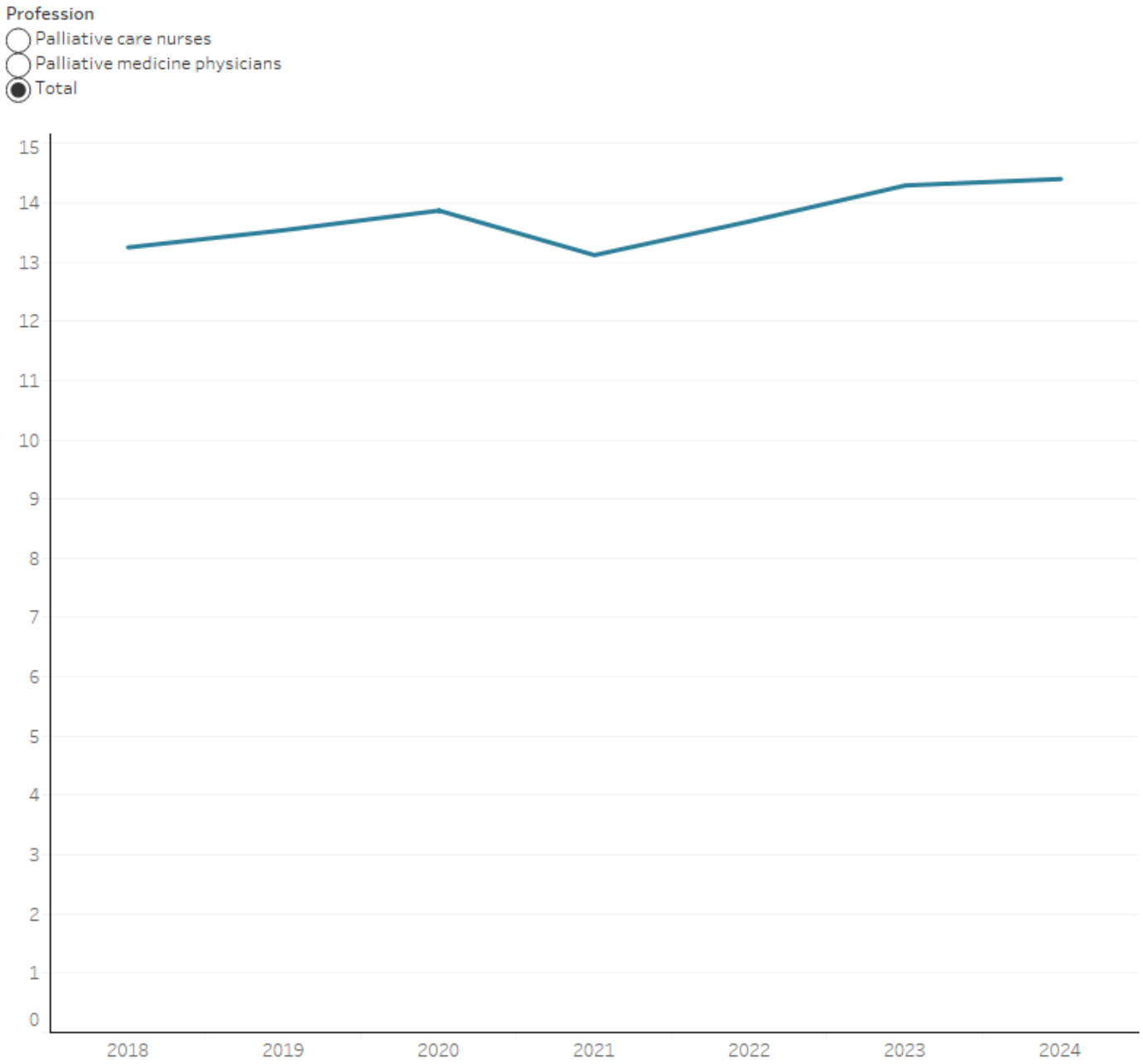
See Data dictionary and Data sources for more information.

Trends

In 2018, there was 1.0 palliative medicine physician and 12.2 palliative care nurses per 100,000 population (Figure 5.1.2). In 2024, there was an increase to 1.3 palliative medicine physicians per 100,000 population, while the rate of palliative care nurses remained similar to 2018 results (13.1 palliative care nurses per 100,000 population).

These rates should be interpreted with caution, as they do not capture the non-specialist palliative care workforce, or physician and nurses that have multiple roles but did not list palliative care as their primary role.

Fig 5.1.2 Number of health practitioners in specialist palliative care workforce per 100,000 population, 2018-2024



Source: AIHW. National palliative care measures Table M5.1
https://www.aihw.gov.au/npcm

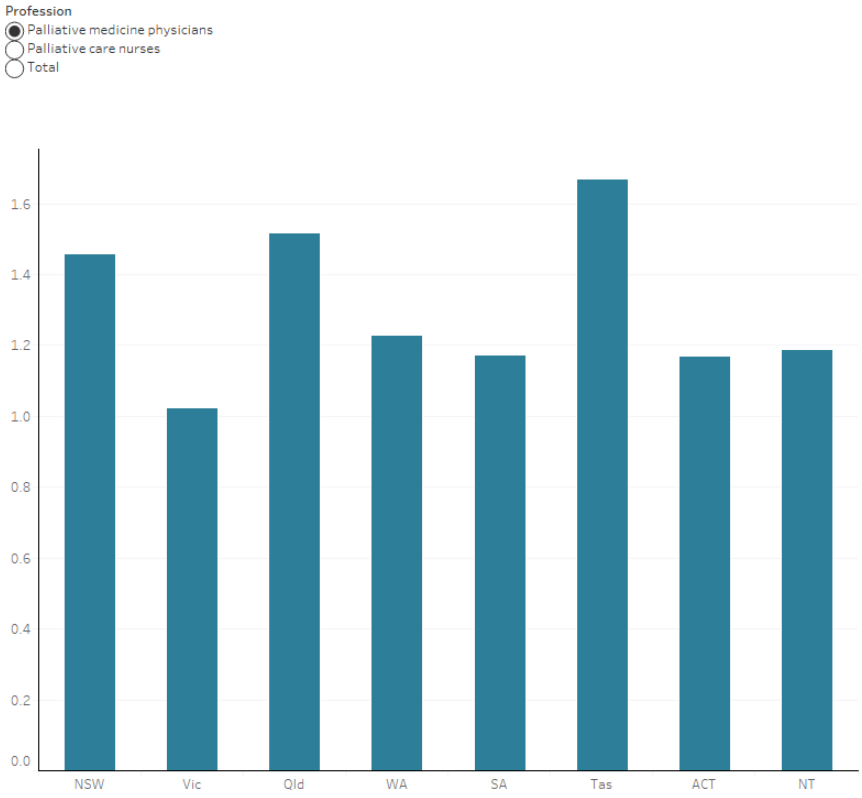
Characteristics

The rate of employed palliative medicine physicians and palliative care nurses in 2024 varied by a range of characteristics:

- The rates of palliative medicine physicians and palliative care nurses varied across states and territories from 19.2 FTE per 100,000 population in Tasmania to 13.3 FTE per 100,000 population in Western Australia.
- Rates of palliative care medicine physicians decreased as remoteness increased – *Major cities* (1.5 FTE per 100,000 population) had the highest rate and *Remote and very remote* areas combined had the lowest rate (0.0 FTE per 100,000 population).
- Between 2022 and 2024 the rate of palliative care nurses in *Remote and very remote* areas combined increased from 5.4 FTE per 100,000 population to 9.0 FTE per 100,000 population.
- The highest rate of palliative care nurses was in *Inner regional* areas (15.3 FTE per 100,000 population).
- Both palliative medicine physicians and nurses were most commonly working in hospital settings (1.0 FTE per 100,000 population and 6.5 FTE per 100,000 population respectively).
- Palliative care nurses were more likely to be working in community health care services than palliative medicine physicians (3.5 FTE per 100,000 population and 0.1 FTE per 100,000 respectively).

See Data table for detailed notes.

Fig 5.1.3 Number of health practitioners in specialist palliative care workforce per 100,000 population by characteristics, 2024



Source: AIHW. National palliative care measures Table M5.1
https://www.aihw.gov.au/npcm

This interactive bar graph shows the number of health practitioners in specialist palliative care workforce, by selected characteristics in 2024.

Data dictionary

The national palliative care measures aim to track if "people affected by life-limiting illnesses get the care they need to live well", aligning with the vision of the National Palliative Care Strategy (2018). These measures were developed by the AIHW and are consistent with the broad goals of the Strategy. While the measures have been developed to maximise use of existing data, data are not currently available for 6 of the 14 measures. Further, proxy measures have been used where currently available data do not allow for outcomes to be measured directly. For each of the 8 measures with available data, this data dictionary provides information about:

- **Attributes** – such as who the data are about (the population) and how the reported statistic was calculated (numerator, denominator, computation description)
- **Notes** – to help understand what is reported
- **Data source** – where the data came from.

Progress is reported by testing for differences in the baseline and latest data for each measure:

- **Baseline data** are the information that is available closest to the start of the Strategy (2018)
- **Latest data** are the most recent information available for each measure (in most cases with a 2–3-year lag from when measures were released due to data availability).

Objectives	Outcome area	Measure
1. Effective	Physical wellbeing	1.1 Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention.
1. Effective	Psychosocial wellbeing	1.2 Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention.
2. Safe	Psychosocial wellbeing	2.1 Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life.
3. Appropriate	Carer wellbeing	3.2 Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention.
3. Appropriate	Coordinated care	4.1 Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life.
4. Continuous	Timely care	4.2a Proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death.
4. Continuous	Timely care	4.2b Proportion of inpatient unstable palliative care phases that lasted 3 days or less.
5. Accessible	Equitable	5.1a Number of full-time equivalent employed health practitioners in specialist palliative workforce, per 100,000 population.

Measure 1.1

Objective area
Effective

Outcome area
Physical wellbeing

Measure
Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention.

Population
People who received a service from a palliative care service provider participating in the Palliative Care Outcomes Collaboration (PCOC).

Numerator
Number of palliative care phases ending within the reference year with a valid Symptom Assessment Scale (SAS) for 'Distress from Pain' at phase start and end and for which SAS 'Distress from Pain' improved or remained absent/mild.

Denominator
Number of palliative care phases ending within the reference year with a valid SAS for 'Distress from Pain' at phase start and end.

Computation
(Numerator ÷ Denominator) x 100

Disaggregation
Age group, Sex, Socioeconomic area, Remoteness area, Diagnosis, Setting, Phase type, Problem severity at phase start. See Data sources for more information on these data items.

Source
Palliative Care Outcomes Collaboration (PCOC) data collection.

Definitions
Symptom Assessment Scale (SAS) – a patient (or proxy) rated tool that assesses the level of distress using a numerical rating scale from 0 – no distress to 10 – worst possible distress for 7 key symptoms (insomnia, appetite problems, nausea, bowel problems, breathing problems, fatigue, and pain). Only SAS 'Distress from Pain' is used in analyses. SAS are grouped according to the categories: absent (0), mild (1-3), moderate (4-7) and severe (8-10) (Daveson et al. 2021).
Table 1.1.2 shows that a symptom is considered to have improved over the phase if there was at least a one-point change between phase start and end. A symptom is considered to have remained at a low level if the symptom at phase start was between 0 and 3 and did not increase.

Table 1.1.2: SAS improvement in measure 1.1 numerator

Severity at phase start	Score at phase start	Score at phase end
Absent	0	0
Mild	1	≤ 1
Mild	2	≤ 2
Mild	3	≤ 3
Moderate	4	≤ 3
Moderate	5	≤ 4
Moderate	6	≤ 5
Moderate	7	≤ 6
Severe	8	≤ 7
Severe	9	≤ 8
Severe	10	≤ 9

Notes
1. There is currently no complete national data on patient outcomes for people with life-limiting illnesses. However, part of the picture is available from the PCOC data collection. Participation in PCOC is voluntary and contribution to the collection is sought from all palliative care service providers in public and private health sectors, across all regions, and across inpatient and community settings. Not all services participate in PCOC and so the data used for this measure only includes a subset of all palliative care delivered in Australia. Most services participating in PCOC are specialist palliative care services. See Data sources and the PCOC 2024 Data Quality Statement for more information.
2. State and territory disaggregation has not been included for this measure. Further work is required to better understand the coverage of the PCOC data collection across different jurisdictions.
3. All phases without a valid start and end SAS for 'Distress from Pain' were excluded. SAS assessments are not performed at death. Most terminal phases end in death.
4. A small number of PCOC services do not collect SAS.

See Data table for detailed notes.

References

Daveson BA, Allingham SF, Clapham S, Johnson CE, Currow DC, Yates P, Eagar K (2021) 'The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs', *PLOS ONE,* 16(3): e0247250, doi.org/10.1371/journal.pone.0247250

Measure 1.2

Objective area
Effective

Outcome area
Psychosocial wellbeing

Measure
Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention.

Population
People who received a service from a palliative care service provider participating in the Palliative Care Outcomes Collaboration (PCOC).

Numerator
Number of palliative care phases ending within the reference period with a valid Palliative Care Problem Severity Score (PCPSS) for 'Psychological/Spiritual' problems at phase start and end and for which the PCPSS improved or remained absent/mild.

Denominator
Number of palliative care phases ending within the reference year with a valid PCPSS for 'Psychological/ Spiritual' problems at start and end of phase.

Computation
(Numerator ÷ Denominator) x 100

Disaggregation
Age group, Sex, Socioeconomic area, Remoteness area, Diagnosis, Setting, Phase type, Problem severity at phase start. See Data sources for more information on these items.

Source
Palliative Care Outcomes Collaboration (PCOC) data collection.

Definitions
Palliative Care Problem Severity Score (PCPSS) – a clinician rated screening tool to assess the overall severity of problems within four key palliative care domains including the patient's psychological or spiritual wellbeing. The scores are 0 – absent, 1 – mild, 2 – moderate and 3 – severe (Masso et al. 2016).
Table 1.2.2 shows a symptom is considered to have improved over the phase if there was at least a one-point change between phase start and end. A symptom is considered to have remained at a low level if the symptom at phase start was between 0 and 1 and did not increase.

Table 1.2.2: PCPSS improvement in measure 1.2 numerator

Severity at phase start	Score at phase start	Score at phase end
Absent	0	0
Mild	1	≤ 1
Moderate	2	≤ 1
Severe	3	≤ 2

Notes
1. There is currently no complete national data on patient outcomes for the psychological or spiritual distress of people with life-limiting illnesses. However, part of the picture is available from the PCOC data collection. Participation in PCOC is voluntary and contribution to the collection is sought from all palliative care service providers in public and private health sectors, across all regions, and across inpatient and community settings. Not all services participate in PCOC and so the data used for this measure only includes a subset of all palliative care delivered in Australia. Most services participating in PCOC are specialist palliative care services. See Data sources and the PCOC 2024 Data Quality Statement for more information.
2. State and territory disaggregation has not been included for this measure. Further work is required to better understand the coverage of the PCOC data collection across different jurisdictions.
3. All phases without a valid start and end PCPSS for 'Psychological/Spiritual' problems were excluded. PCPSS assessments are not performed at death. Most terminal phases end in death.

See Data table for detailed notes.

References

Masso M, Allingham SF, Johnson CE, Pidgeon T, Yates P, Currow D, Eagar K. Palliative Care Problem Severity Score: Reliability and acceptability in a national study. Palliat Med. 2016 May;30(5):479-85. doi:10.1177/0269216315613904.

Measure 2.1

Objective area
Safe

Outcome area
Avoidance of overtreatment

Measure
Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life.

Population
People with life-limiting illnesses who died within the reference year.

Numerator
Number of people with life-limiting illnesses who died within the reference year and had at least one record of receiving a potentially non-beneficial treatment as an inpatient of a public hospital at the end of life. This includes cardiopulmonary resuscitation, intravenous feeding, mechanical ventilation, or initiation of chemotherapy or dialysis in the last 30 days of life (0 to 29 days inclusive), or receipt of chemotherapy in the last 15 days of life (0 to 14 days inclusive).

Denominator
Number of people with life-limiting illnesses who died within the reference year.

Computation
(Numerator ÷ Denominator) x 100

Disaggregation
State/Territory, Age, Sex, Socioeconomic area, Remoteness area, Cause of death, Potentially non-beneficial treatment. For more information see Data sources.

Source
AIHW National Integrated Health Service Information (NIHSI) linked data asset.

Definitions
People with life-limiting illnesses – all people who died in the reference year and had an underlying cause of death amenable to palliative care based on Murtagh et al. (2013)) as shown in Table 2.1.2.

Table 2.1.2: Causes of death amenable to palliative care based on Murtagh et al. (2013)

Cause of death	ICD-10 codes
Neoplasm (excludes benign neoplasms)	C00-C97
Heart disease	I00-I52
Cerebrovascular disease	I60-I69
Renal disease	N17, N18, N28
Liver disease	K70-K77
Respiratory disease	J06-J18, J20-J22, J40-J47, J96
Neurodegenerative disease	G10, G20, G35, G122, G903, G231
Alzheimer's disease	F01, F03
Dementia	G30
Senility	R54
HIV/AIDS	B20-B24

Potentially non-beneficial treatment – A treatment or intervention that is unlikely to prolong life or provide comfort at the end of life including the following treatments from the Australian Classification of Health Interventions Code:

Table 2.1.3: Non-beneficial treatment by Australian Classification of Health Intervention Codes

Non-beneficial treatment	Block description	Block extension	Block ext. description
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96196-00	Intra-arterial
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96197-00	Intramuscular

Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96198-00	Intrathecal
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96199-00	Intravenous
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96200-00	Subcutaneous
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96201-00	Intracavitary
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96202-00	Enteral
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96203-00	Oral
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96205-00	Other
Chemotherapy (receipt in the last 15 days of life or initiation in the last 30 days of life	Administration of pharmacological agent, antineoplastic agent	96209-00	Loading of drug delivery device, antineoplastic agent
Cardiopulmonary resuscitation (in the last 30 days of life)	Therapeutic interventions on cardiovascular system	92052-00	Cardiopulmonary resuscitation
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96196-07	Intra-arterial
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96197-07	Intramuscular
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96198-07	Intrathecal
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96199-07	Intravenous
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96200-07	Subcutaneous
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96201-07	Intracavitary
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96202-07	Enteral
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96203-07	Oral
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96205-07	Other
Artificial nutrition (in the last 30 days of life)	Administration of pharmacological agent, nutritional substance	96209-07	Loading of drug delivery device, nutritional substance

Mechanical ventilation (in the last 30 days of life)	Management of continuous ventilatory support	13882-00	24 hours or less
Mechanical ventilation (in the last 30 days of life)	Management of continuous ventilatory support	13882-01	More than 24 but less than 96 hours
Mechanical ventilation (in the last 30 days of life)	Management of continuous ventilatory support	13882-02	96 hours or more
Mechanical ventilation (in the last 30 days of life)	Management of non-invasive ventilatory support	92209-00	24 hours or less
Mechanical ventilation (in the last 30 days of life)	Management of non-invasive ventilatory support	92209-01	More than 24 but less than 96 hours
Mechanical ventilation (in the last 30 days of life)	Management of non-invasive ventilatory support	92209-02	96 hours or more
Dialysis (initiation in the last 30 days of life)	Peritoneal dialysis	13100-06	Peritoneal dialysis, short term
Dialysis (initiation in the last 30 days of life)	Peritoneal dialysis	13100-07	Intermittent peritoneal dialysis, long term
Dialysis (initiation in the last 30 days of life)	Peritoneal dialysis	13100-08	Continuous peritoneal dialysis, long term
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-00	Haemodialysis
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-01	Intermittent haemofiltration
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-02	Continuous haemofiltration
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-03	Intermittent haemodiafiltration
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-04	Continuous haemodiafiltration
Dialysis (initiation in the last 30 days of life)	Haemodialysis	13100-05	Haemoperfusion

Notes

1. Identifying overtreatment using administrative data is challenging as the data do not capture the nuance at the time of treating, such as treatment appropriateness, care intent, life expectancy, patient functionality, patient and family preferences, and physician-patient interactions. Furthermore, end of life trajectories are inherently uncertain. It can be very difficult for clinicians to predict time to death, and they may not know that a treatment is non-beneficial at the time of treating. Given the uncertainty of the circumstances at the time of treating and the social and ethical pressures that exist, a certain level of potentially non-beneficial treatments will likely always be present but reducing their occurrence should be an aim of improving the quality of palliative care in Australia.
2. There is currently no complete national data on receipt of potentially non-beneficial treatments for people with life-limiting illnesses. The NIHSI linked data asset is the only available national data that identifies inpatient procedures and cause-specific outcomes. However, this data collection does not present a complete picture of health service use, as it excludes hospital data from Western Australia and the Northern Territory, and all private hospitals nationally for this analysis, for the reference period. It omits services received by patients in specialised palliative care units in private hospitals/ facilities. For more information see Data sources.

References

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Measure 3.2

Objective area
Appropriate

Outcome area
Carer wellbeing

Measure
Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention.

Population
People who received a service from a palliative care service provider participating in the Palliative Care Outcomes Collaboration (PCOC).

Numerator
Number of palliative care phases ending within the reference year with a valid **Palliative Care Problem Severity Score (PCPSS)** for 'Family/Carer' problems at phase start and end and for which the PCPSS for 'Family/Carer' problems improved or remained absent/mild.

Denominator
Number of palliative care phases ending within the reference year with a valid PCPSS for 'Family/Carer' problems at phase start and end.

Computation
(Numerator ÷ Denominator) x 100

Disaggregation
Age group, Sex, Socioeconomic area, Remoteness area, Diagnosis, Setting, Phase type, Problem severity at phase start. See Data sources for more information on these items.

Source
Palliative Care Outcomes Collaboration (PCOC) data collection.

Definitions
Palliative Care Problem Severity Score (PCPSS) – a clinician rated screening tool to assess the overall severity of problems within four key palliative care domains. This includes family/carer problems associated with a patient's condition or palliative care needs. Written, verbal, or observational information may be used by the clinician to assess severity. The scores are 0 – absent, 1 – mild, 2 – moderate and 3 – severe (Masso et al. 2016). Table 3.2.2 shows that a symptom is considered to have improved over the phase if there was at least a one-point change between phase start and end. A symptom is considered to have remained at a low level if the symptom at phase start was between 0 and 1 and did not increase

Table 3.2.2: PCPSS improvement in measure 3.2 numerator

Severity at phase start	Score at phase start	Score at phase end
Absent	0	0
Mild	1	≤ 1
Moderate	2	≤ 1
Severe	3	≤ 2

Notes
1. Available data do not allow the described measure to be tracked. Currently an alternative measure is reported. This measure describes carers' experiences through the experience of the person with life-limiting illness and may not accurately reflect how well supported a carer feels.
2. There is currently no complete national data on carer problems. However, part of the picture is available from the PCOC data collection. Participation in PCOC is voluntary and contribution to the collection is sought from all palliative care service providers in public and private health sectors, across all regions, and across inpatient and community settings. Not all services participate in PCOC and so the data used for this measure only includes a subset of all palliative care delivered in Australia. Most services participating in PCOC are specialist palliative care services. See Data sources and the PCOC 2024 Data Quality Statement for more information.
3. State and territory disaggregation has not been included for this measure. Further work is required to better understand the coverage of the PCOC data collection across different jurisdictions.
4. All phases without a valid start and end PCPSS for 'Family/Carer' problems were excluded. PCPSS assessments are not performed at death.

See Data table for detailed notes.

Reference

Masso M, Allingham SF, Johnson CE, Pidgeon T, Yates P, Currow D, Eagar K. Palliative Care Problem Severity Score: Reliability and acceptability in a national study. Palliat Med. 2016 May;30(5):479-85. doi:10.1177/0269216315613904.

Measure 4.1

Objective area
Continuous
Outcome area
Coordinated care
Measure
Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life.
Population
People with life-limiting illnesses who died within the reference year.
Numerator
Number of people with life-limiting illnesses with at least one potentially preventable hospitalisation in a public hospital in the last 3 months of life (0-90 days). Namely, an admission within the reference year for any of the following three condition groups:
a. acute conditions (cellulitis, convulsions and epilepsy, dental conditions, ENT infections, gangrene, pelvic inflammatory disease, perforated/ bleeding ulcer, pneumonia, UTI)
b. chronic conditions (angina, asthma, bronchiectasis, congestive cardiac failure, COPD, diabetes complications, hypertension, iron deficiency anaemia, nutritional deficiencies, rheumatic heart disease)
c. vaccine-preventable conditions (pneumonia, influenza, other).
Denominator
Number of people with life-limiting illnesses who died within the reference year.
Computation
(Numerator ÷ Denominator) x 100
Disaggregation
State/Territory, Age, Sex, Socioeconomic area, Remoteness area, Hospitalisation condition group, Cause of death, Length of stay. See Data sources for more information on these items.
Source
AIHW National Health Data Hub (NHDH) formerly known as National Integrated Health Service Information (NIHSI) linked data asset.
Definitions
People with life-limiting illnesses– all people who died in the reference year and had an underlying cause of death amenable to palliative care based on Murtagh et al. (2013) as shown in Table 4.1.2.

Table 4.1.2: Causes of death amenable to palliative care based on Murtagh et al. (2013)

Cause of death	ICD-10 codes
Neoplasm (excludes benign neoplasms)	C00-C97
Heart disease	I00-I52
Cerebrovascular disease	I60-I69
Renal disease	N17, N18, N28
Liver disease	K70-K77
Respiratory disease	J06-J18, J20-J22, J40-J47, J96
Neurodegenerative disease	G10, G20, G35, G122, G903, G231
Alzheimer's disease	F01, F03
Dementia	G30
Senility	R54
HIV/AIDS	B20-B24

Potentially preventable hospitalisation– an admission to hospital for a condition where the hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management usually delivered in primary care and community-based care settings including:

Table 4.1.3: Definition of preventable hospitalisation by ICD-10 codes

Category	ICD-10	Additional requirements
Acute		
Chronic		
Cellulitis	L02, L03, L04, L08, L88, L98.0, L98.3	As principal diagnosis, AND if the record has: a. No procedures whatever OR b. All procedures for the record are within the blocks [1820] to [2016] OR c. The record has only one procedure and that procedure is one of 30216-00[1604], 30216-01[1604], 30216-02[1604], 30676-00[1659], 30676-02[1659], 30223-01[1606], 30223-02[1606], 30064-00[1605], 90660-00[1602], 90661-00[1608], 96230-00[1659].
Convulsions and epilepsy	G40, G41, R56	As principal diagnosis.
Dental conditions	K02 – K06, K08, K09.8, K09.9, K12, K13, K14.0	As principal diagnosis.
Ear, nose, and throat infections	H66, J02, J03, J06, J31.2	As principal diagnosis.
Gangrene	R02	In any diagnosis.
Gangrene	I70.24, E09.52	As principal diagnosis.
Pelvic inflammatory disease	N70, N73, N74	As principal diagnosis.
Perforated or bleeding ulcer	K25.0, K25.1, K25.2, K25.4, K25.5, K25.6, K26.0, K26.1, K26.2, K26.4, K26.5, K26.6, K27.0, K27.1, K27.2, K27.4, K27.5, K27.6, K28.0, K28.1, K28.2, K28.4, K28.5, K28.6	As principal diagnosis.
Pneumonia (not vaccine-preventable)	J15.3, J15.4, J15.7, J16.0	In any diagnosis. Exclude people under 2 months.
Urinary tract infections	N10, N11, N12, N13.6, N15.1, N15.9, N28.9, N39.0, N39.9	As principal diagnosis.
Angina	I20, I24.0, I24.8, I24.9	As principal diagnosis. Exclude cases according to the list of procedures excluded from the Congestive cardiac failure category.
Asthma	J45, J46	As principal diagnosis. Exclude children aged less than 4 years.
Bronchiectasis	J47	As principal diagnosis.
	J20	As principal diagnosis. Only with additional diagnosis of J47.
Congestive cardiac failure	I50, I11.0, J81	As principal diagnosis. Exclude cases with the following cardiac procedure codes: Blocks [572], [600]–[606], [608]–[650], [653]–[657], [660]–[664], [666], [669]–[682], [684]–[691], [693], [705]–[707], [717] and codes 33172-00[715], 33827-01[733], 34800-00[726], 35412-00[11], 38721-01[733], 90217-02[734], 90215-02[732].
Chronic obstructive pulmonary disease (COPD)	J20	As principal diagnosis. Only with additional diagnoses of J41, J42, J43, J44.
	J41, J42, J43, J44	As principal diagnosis.
Diabetes complications	E10.0–E10.9, E11.0–E11.9, E13.0–E13.9, E14.0–E14.9	As principal diagnosis.
Hypertension	I10, I11.9	As principal diagnosis. Exclude cases with procedure codes according to the list of procedures excluded from the Congestive cardiac failure category.
Iron deficiency anaemia	D50.1, D50.8, D50.9	As principal diagnosis.
Nutritional deficiencies	E40, E41, E42, E43, E55.0	As principal diagnosis.
Rheumatic heart diseases	I00, I01, I02, I05, I06, I07, I08, I09	As principal diagnosis.
Vaccine-preventable conditions		

Other vaccine-preventable conditions including but not limited to measles, rubella, hepatitis B, diphtheria, etc.	A08.0, A35, A36, A37, A80, B01, B05, B06, B16.1, B16.9, B18.0, B18.1, B26, G00.0	In any diagnosis.
Pneumonia and influenza (vaccine-preventable)	J10, J11, J13, J14	In any diagnosis. Exclude people under 2 months.

Notes

1. There are many factors that can contribute to a lack of individualised preventative health interventions that may lead to a potentially preventable hospitalisation. This can include patient choice, a lack of at-home support, and/or barriers to accessing primary and community care such as geographical remoteness, affordability, and/or opening hours. As such, a certain level of potentially preventable hospitalisations will likely always be present. Reducing their occurrence should be an aim of improving the quality of palliative care in Australia.
2. There is currently no complete national data on potentially preventable hospitalisations for people with life-limiting illnesses. The NIHSI linked data asset is the only available national data that identifies inpatient procedures and cause-specific outcomes. However, this data collection does not present a complete picture of health service use, as it excludes hospital data from Western Australia and the Northern Territory, and all private hospitals nationally for this analysis, for the reference period. It omits services received by patients in specialised palliative care units in private hospitals/facilities. See Data sources for more information.

References

AIHW (Australian Institute of Health and Welfare) (2022) 'National Healthcare Agreement: PI 18-Selected potentially preventable hospitalisations', *2022*, *METEOR Metadata Online Registry*, accessed 30 January 2024.

Murtagh FE, Bausewein C, Verne J, Groeneveld EI, Kaloki YE, and Higginson IJ (2013). 'How many people need palliative care? A study developing and comparing methods for population-based estimates', *Palliative Medicine*, doi:10.1177/0269216313489367.

Measure 4.2a

Objective area
Continuous
Outcome area
Timely care
Measure
Proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death.
Population
People who received specialist palliative care services in the last year of life and died from a predictable death within the reference year.
Numerator
Number of people who died from a predictable death within the reference year and first received a specialist palliative care service (inpatient hospital care, outpatient hospital clinic services, and/or Medicare-subsidised consultations with palliative medicine specialist/physician) at least 3 months (91 to 365 days) before death.
Denominator
Number of people who died from a predictable death within the reference year and received a specialist palliative care service (inpatient hospital care, outpatient hospital clinic services, and/or Medicare-subsidised consultations with palliative medicine specialist/physician) within their last year of life (0 to 365 days before death).
Computation
(Numerator ÷ Denominator) x 100
Disaggregation
State/territory, Age, Sex, Socioeconomic area, Remoteness Area, Cause of death, Service type (inpatient, outpatient, Medicare-subsidised). See Data sources for more information on these items.
Source
AIHW National Health Data Hub formerly known as National Integrated Health Service Information (NIHSI) linked data asset.
Definitions
Predictable death – all causes of death excluding sudden deaths where the underlying cause of death:

- occurs during pregnancy, childbirth, or the puerperium (ICD-10-AM O00-O99)
- originates during the perinatal period (ICD-10-AM P00-P96)
- results from injury, poisoning and certain other external causes (ICD-10-AM S00-T98)
- or results from external causes of morbidity and mortality (V01-Y98) (Rosenwax et al. 2005).

Specialist palliative care services – are comprised of multidisciplinary teams with specialised skills, competencies, experience, and training to deliver care to people where the palliative needs are complex and persistent. This includes:

- **inpatient hospital care** where palliative care was a component of the care provided during all or part of the episode. Includes care type of palliative care, or diagnosis of palliative care (Z51.5) for care type other than palliative care.
- **out-patient hospital clinic services** for palliative care medical consultation, usually delivered by a palliative medicine specialist or medical practitioner providing palliative care (outpatient clinic type tier 2: 20.13).
- **Medicare-subsidised consultations** with palliative medicine specialist/physician (all MBS services where the service provider code is '043' or '077').

Notes

1. Not all people with life-limiting illnesses require specialist palliative care. A sustainable, quality, and accessible palliative care system is one that is integrated into primary health care, community, and home-based care, as well as supportive of informal carers such as family and community volunteers.
2. The Rosenwax (2005) definition of the 'Maximal Estimate' of a potential palliative care population was used to identify people who died from a 'predictable death'.
3. There is currently no complete national data on receipt of specialist palliative care. The NIHSI linked data asset is the only available national data that identifies services across settings and cause-specific outcomes. However, this data collection does not present a complete picture of health service use, as it excludes hospital data from Western Australia and the Northern Territory, and all private hospitals nationally for this analysis. It omits services received by patients in specialised palliative care units in private hospitals/facilities. Further, the scope of the data asset does not include all settings in which specialist palliative care services may be delivered, such as in community health settings or by allied health professionals (for example, care provided in the home, or by ambulance, disability, or aged care services) that are not captured through Medicare-subsidised claim items. See Data sources for more information.

References

Rosenwax L, McNamara B, Blackmore A, Holman C (2005) 'Estimating the size of a potential palliative care population', Palliative Medicine, 19(7):556-562, doi:10.1191/0269216305pm1067oa.

Measure 4.2b

Objective area
Continuous
Outcome area
Timely care
Measure
Proportion of inpatient unstable palliative care phases that lasted 3 days or less.
Population
People who received inpatient palliative care within the reference year.
Numerator
Number of inpatient unstable palliative care phases lasting for 3 days or less within the reference year.
Denominator
Number of inpatient unstable palliative care phases within the reference year.
Computation
(Numerator ÷ Denominator) x 100
Disaggregation
Age, Sex, Indigenous status, State/territory, Socioeconomic area, and Remoteness Area. See Data sources for more information on these items.
Source
Admitted subacute and non-acute hospital care NBEDS 2022–23
Definitions
Unstable palliative care phase lasting for 3 days or less – includes all unstable phases for which the time between the unstable phase start date and the unstable phase end date is equal to or less than 3 days. An unstable phase start date is defined as the date an urgent change to the care plan or emergency treatment is required. A new plan of care or emergency treatment is initiated and reviewed for effectiveness. The end of the unstable phase is when the care plan is working to resolve or improve problems and no further changes to the care plan are required, or when the patient's death is likely to occur within a matter of days (as this signals that the patient has moved into a terminal phase). The date this occurs would be defined as the unstable phase end date. Unstable phases in which the start date and end date were not recorded were excluded.
The recording of **inpatient palliative care phases** (including phase type 2, "unstable") is coded and defined by METEOR 681029
Start-date
An unstable phase start date is defined as the date an urgent change to the care plan or emergency treatment is required. A new plan of care or emergency treatment is initiated and reviewed for effectiveness.
End-date
An unstable phase end date is:

- When the care plan is working to resolve or improve problems and no further changes to the care plan are required,
- or when the patient's death is likely to occur within a matter of days (as this signals that the patient has moved into a terminal phase).

Notes

1. The measure only captures those people who have received inpatient palliative care.
2. There may be some circumstances in which it is not possible to stabilise a person in an unstable palliative care phase within 3 days due to patient and/or family choice.
3. We recommend caution in the interpretation of state and territory differences. Jurisdictions may differ in their modes of service delivery and some types of palliative care may not be well represented in the available data. Further, states and territories may differ in their definitions of services or phases, and some residents may have cross-border treatment.

See Data table for detailed notes.

Measure 5.1a

Objective area
Accessible
Outcome area
Equitable
Measure
Number of full-time equivalent employed health practitioners in the specialist palliative care workforce, per 100,000 population.
Population
Australian Estimated Resident Population
Numerator
Number of full-time equivalent (FTE) employed palliative medicine physicians and palliative care nurses in the reference year.
Denominator
Number of people in the Australian Estimated Resident Population in the reference year.
Computation
(Numerator ÷ Denominator) x 100,000
Disaggregation
Practitioner (physician, nurse), State/territory, Remoteness area, Work setting. See Data sources for more information.
Source
National Health Workforce Dataset
Definitions
Full-time equivalent (FTE) – A full-time (FTE=1.0) standard working week is defined as 40 hours for medical practitioners and as 38 hours for nurses. The FTE number is calculated by:

FTE number = Total hours worked by workforce ÷ Standard working week for each profession.
Employed – employed in Australia and excluding those who are registered in the profession but are retired from regular work, working outside the profession, working in the profession but on extended leave of 3 months or more, only engaged in unpaid/ volunteer work or working outside Australia.
Estimated Resident Population – is the official Australian population estimate published by the ABS and includes all people who usually reside in Australia (regardless of nationality, citizenship or visa status). To calculate ERP between Censuses, the ABS uses administrative data to estimate flows of population change (births, deaths, and migration) which it adds to the stock population estimate.
Notes
1. Due to a lack of available data, this is a proxy measure as it does not directly measure if people in need of palliative care are able to access it. However, achieving a functional and sustainable palliative care workforce is necessary to ensuring the needs of those requiring specialist palliative care are met.
2. This measure only considers the specialist palliative care workforce and will not measure changes in the non-specialist palliative care workforce. The palliative care workforce is made up of a broad range of professional groups, each playing a unique role in supporting people with life-limiting illnesses to receive comprehensive, patient-centred care. It is recognised that general practitioners, other medical specialists, social workers, occupational therapists, physiotherapists, and other allied health professionals form an integral part of the palliative care workforce. However, existing national data sources are not able to accurately capture the extent of palliative care services provided by these health professionals.
3. Nurse practitioners whose principal job area is palliative care cannot be identified from the National Health Workforce Dataset and so are not included in this measure.

See Data table for detailed notes.

Data sources

The reported data come from a lot of different sources. Some information is collected by Australian, state and territory government departments and agencies as part of the services they provide. Other information is collected through clinical assessment tools.

This section includes information for each data source including:

- Collection frequency – how often the data are collected
- Description of the data source – what/who is included in the source data
- Measures reported – which palliative care measures the source data will be reported against
- Disaggregation categories – what type of categories will be reported on from the source data.

The measures are sourced from the following data sources:

- Palliative Care Outcomes Collaboration (PCOC)
- National Health Data Hub (NHDH) – formerly the National Integrated Health Services Information (NIHSI) analytical asset
- National Health Workforce Data Set (NHWDS)
- Admitted subacute and non-acute hospital care National Best Endeavours Data Set (ASNAHC NBEDS).

National Health Data Hub

Collection frequency

Annual

The National Health Data Hub, formerly known as National Integrated Health Services Information (NIHSI) Version 3.0 was used to populate the measures. This version contains data from 2010–11 up to and including 2020–21 and was available for analysis approximately 2 years after the end of the reference period.

Baseline data

1 January – 31 December 2018

Latest data

1 January – 31 December 2020

Description of data source

The NHDH, managed under the custodianship of the AIHW, is an enduring linked data asset that brings together state/territory hospitals data with national health administrative datasets using probabilistic linkage. Participation in and contribution to the NHDH by states and territories is voluntary.

NIHSI V3.0 included data from various sources:

- the National Death Index (NDI)
- Hospital admitted patient care (APC) services in all public hospitals for participating states and territories (excludes NT and WA) and private hospital data from Qld only (for 2019–2021)
- Hospital emergency department (ED) services in public hospitals for all participating states and territories (excludes NT and WA)
- Outpatient non-admitted patient (NAP) services in public hospitals for all participating states and territories (excludes SA, NT, and WA)
- Medicare Benefits Schedule (MBS)
- Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)
- Residential Aged Care (RAC) – includes permanent residential aged care and/or respite care.

The NHDH can be used to inform health service planning, for monitoring and evaluation purposes and policy development for Australians. It includes records of services provided to people who are usual residents of Australia. It may capture some people who live in Australia but are not eligible for Medicare (for example, international students, visitors to Australia from countries with reciprocal health-care agreements). As such, both under coverage and over coverage of different groups within the Australian resident population need to be considered in the analysis and interpretation of the NHDH.

Measures reported

2.1 Proportion of people with life-limiting illnesses who received potentially non-beneficial treatments at the end of life.
4.1 Proportion of people with life-limiting illnesses with a potentially preventable hospitalisation in their last 3 months of life.
4.2a Proportion of people who received specialist palliative care in the last year of life with first receipt at least 3 months before death.

Age group

Refers to person's age at death according to the NDI.

Disaggregation categories (years): 0–14, 15–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85 or over.

Sex

The sex at death according to the categories 'Male', 'Female', 'Indeterminate', and 'Not stated/inadequately described', as per the NDI. Only individuals with sex recorded as 'Male' or 'Female' in the NDI were included in analyses.
Disaggregation categories: Males, Females.

State/territory

The unique state/territory in which a person's death was registered according to the NDI. This is not necessarily the state/territory where a service was received nor necessarily the state/territory of usual residence. Differences in health service delivery or data recording may warrant caution in the interpretation of outcomes disaggregated by state/territory. Only deaths registered in New South Wales, Victoria, Queensland, South Australia, Tasmania, or the Australian Capital Territory were included in the analyses as no hospital data were available for the Northern Territory and Western Australia.
Disaggregation categories: New South Wales, Victoria, Queensland, South Australia, Tasmania, and the Australian Capital Territory.

Remoteness area

The Remoteness Area (RA) of a person's usual residence at the time of death as per the NDI based on Statistical Area Level 2 (SA2). The Australian Statistical Geography Standard (ASGS) 2016 was used to assign RAs for all people whose death was registered prior to 2021 and ASGS 2021 was used for people whose death was registered in 2021. Where more than one RA category was associated with a specific SA2, the RA category accounting for the highest proportion by area was assigned to that SA2.
Disaggregation categories: *Major cities*, *Inner regional*, *Outer regional*, and *Remote* and v*ery remote* (combined).
Source: Australian Bureau of Statistics (ABS) (METEOR Identifier 697105)

Socioeconomic area

The socioeconomic area of a person's usual residence at the time of death as per the NDI based on Statistical Area Level 2 and according to the ABS Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD). ABS SEIFA 2016 was used to assign SEIFA IRSD quintiles for all people whose death was registered prior to 2021 and SEIFA 2021 was used for people whose death was registered in 2021.
Disaggregation categories: SEIFA IRSD quintiles (1–5 or lowest/most disadvantaged to highest/least disadvantaged socioeconomic area).
Source: Australian Bureau of Statistics (METEOR Identifier 695778).

Cause of death

Based on the underlying cause of death according to the NDI.

Disaggregation categories: Malignant neoplasm (C00–C97), Heart disease (I00–I52), Cerebrovascular disease (I60–I69), Renal disease (N17, N18, N28), Liver disease (K70–K77), Respiratory disease and HIV/AIDS (J06-J18, J20-J22, J40-J47, J96, B20-B24), Neurodegenerative disease (G10, G20, G35, G122, G903, G231), Dementia/Alzheimer's disease/Senility (G30, F01, F03, R54).

Potentially non-beneficial treatment/intervention

Based on any record from the hospitals data in the reference period. No hospital data from the private hospital sector were accessed.
Disaggregation categories: chemotherapy, cardiopulmonary resuscitation, intravenous feeding, mechanical ventilation, dialysis, blood transfusion.
See Data dictionary for more information.

Hospitalisation condition group (for potentially preventable hospitalisation)

Based on any record from the hospitals data in the reference period. No hospital data from the private hospital sector were accessed.

Each potentially preventable hospitalisation admission is associated with at least 1 of the specified condition-groups (acute, chronic and/or vaccine-preventable). If an admission was associated with more than 1 condition-group, it was assigned to a single condition-group according to the following highest-to-lowest priority order, acute > chronic > vaccine-preventable, to allow unambiguous categorisation in the 'Hospitalisation condition group' analysis.

Disaggregation categories: Acute conditions, Chronic conditions, Vaccine-preventable conditions.

See Data dictionary for more information.

Length of stay

The total length of stay of an inpatient measured in days. This is the length of time between the hospital admission date and separation date, minus any leave days.
Disaggregation categories: Same-day admission, 1–2 days, 3 or more days.

Reference

AIHW (2020-21) National Health Data Hub, aihw.gov.au, accessed 14 April 2026.

National Health Workforce Dataset

Collection frequency

Annual

The National Health Workforce Dataset (NHWDS) holds data from April 2011 up to and including 2024.

Baseline data

1 January – 31 December 2018

Latest data

1 January – 31 December 2024

Description of data source

Data from the Australian Health Practitioner Agency (APHRA) together with data from a workforce survey that is voluntarily completed at the time of registration, forms the National Health Workforce Dataset (NHWDS).

Data in the NHWDS is used to provide nationally consistent workforce estimates. It provides information on demographic and employment information for registered health professionals in the following professions: Nurse, Midwife, Chiropractor, Dental practitioner, Medical practitioner, Osteopath, Pharmacist, Physiotherapist, Podiatrist, Occupational therapist, Medical radiation practitioner, Chinese medicine practitioner and Aboriginal and Torres Strait Islander health practitioner. However, only physicians and nurses specialising in palliative care can currently be identified as palliative care providers using the Department of Health and Aged Care's Health Workforce Data Tool (HWDT).

The palliative care workforce is made up of a broad range of professional groups, each playing a unique role in supporting people with a life limiting illness to receive comprehensive, patient-centred care. It is recognised that general practitioners, other medical specialists, social workers, occupational therapists, physiotherapists, and other allied health professionals form an integral part of the palliative care workforce. However, existing national data sources are not able to accurately capture the extent of palliative care services provided by these health professionals, nor their access to palliative care-specific training.

Measures reported

5.1a Number of full-time equivalent employed health practitioners in specialist palliative workforce, per 100,000 population.

Palliative medicine physician

Refers to practitioners whose main speciality is palliative care. They must be a Fellow of the Royal Australasian College of Physicians (RACP), or a Fellow of the Australasian Chapter of Palliative Medicine (AChPM), or both. Palliative medicine physicians are required to have completed 3 years of training in either a paediatric or adult setting under the supervision of a palliative medicine physician. Successful trainees gain the qualification of Fellow of RACP/ Fellowship of the AChPM and are accredited to practice as a palliative medicine physician in Australia or New Zealand. Medical practitioners may also complete a 6-month Clinical Diploma in Palliative Medicine, but this qualification does not result in specialist accreditation. Practitioners who practice palliative care as a second or third speciality are not considered palliative medicine physicians.

Palliative care nurse

Refers to nurses whose principal job area is palliative care. The classification of nurses in Australia varies with the type of training they have undertaken. Nurse practitioners, registered nurses and enrolled nurses need to complete a variety of short or more comprehensive courses (including a postgraduate certificate or master's degree) to work in the field of palliative care, and postgraduate qualifications are generally required for nurses working in specialist palliative care services.

State/Territory

The state or territory of the principal workplace of the professional.
Disaggregation categories: New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania, Australian Capital Territory, and the Northern Territory.

Remoteness area

The Remoteness Area of the principal workplace of the professional according to the Australian Statistical Geography Standard 2021.
Disaggregation categories: *Major cities*, *Inner regional*, *Outer regional*, *Remote* and v*ery remote* (combined).

Work setting

The type of work setting of the principal workplace of the professional.
Disaggregation categories: Hospital, Hospice, Community health care service, Outpatient service, Solo private practice, Residential health or aged care facility, Tertiary education facility, other government department or agency, other or unspecified.

Admitted subacute and non-acute hospital care National Best Endeavours Dataset

Collection frequency

Annual

The Admitted subacute and non-acute hospital care National Best Endeavours Dataset (ASNAHC NBEDS) holds data from July 1993–94 up to and including 2022–23.

Baseline data

1 January – 31 December 2018

Latest data

1 January – 31 December 2023

Description of data source

The ASNAHC NBEDS is comprised of information about care provided to subacute and non-acute admitted public and private patients in activity based funded hospitals.

The scope of the NBEDS is:

- Same-day and overnight admitted subacute and non-acute care episodes
- Admitted public patients provided on a contracted basis by private hospitals
- Admitted patients in rehabilitation care, palliative care, geriatric evaluation and management, psychogeriatric and maintenance care treated in the hospital-in-the-home.

For palliative care type episodes, data elements for each change in phase of care is reported.

Measures reported

4.2b Proportion of inpatient unstable palliative care phases that lasted 3 days or less.

Age group

The age of the patient at the time of treating.

Disaggregation categories: 0–14, 15–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85 or over.

Sex

The sex of the patient according to the categories 'Male', 'Female', 'Intersex or Intermediate' and 'Not Stated/ Inadequately described'. Only individuals with sex recorded as 'Male' or 'Female' were included in analyses.
Disaggregation categories: Males, Females.
Source: Australian Bureau of Statistics (METEOR Identifier 635126)

Indigenous status

Whether a person identifies as being of Aboriginal or Torres Strait Islander origin (based on Indigenous status standard question).
Disaggregation categories: First Nations, non-Indigenous.
Source: METEOR identifier 602543.

State/territory

The state or territory of the usual place of residence of the patient.
Disaggregation categories: New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania, Australian Capital Territory, and the Northern Territory.

Remoteness area

The Remoteness Area of a person's usual residence based on Statistical Area Level 2 and according to the Australian Statistical Geography Standard 2016.
Disaggregation categories: *Major cities*, *Inner regional*, *Outer regional*, and *Remote* and v*ery remote* (combined).
Source: Australian Bureau of Statistics (ABS) (METEOR Identifier 697105)

Socioeconomic area

The socioeconomic area of a person's usual residence based on Statistical Area Level 2 and according to the ABS Socio-economic Indexes for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD).
Disaggregation categories: SEIFA IRSD quintiles (1–5 or most disadvantaged to least disadvantaged socioeconomic area).
Source: Australian Bureau of Statistics (METEOR Identifier 695778).

Palliative Care Outcomes Collaboration Dataset

Collection frequency

Biannual

Palliative care services participating in Palliative Care Outcomes Collaborative (PCOC) submit data at the following times:

- January – February (for the previous July – December reporting period).
- July – August (for the January – June reporting period).

Baseline data

1 January – 31 December 2018

Latest data

1 January – 31 December 2024

Description of data source

PCOC, established in 2005, is a national palliative care outcomes quality improvement program. The program uses standardised validated clinical assessment tools to benchmark and measure outcomes in palliative care, including pain and symptom control, and timely access to services when they are needed to drive quality improvements.

Description of data source

PCOC, established in 2005, is a national palliative care outcomes quality improvement program. The program uses standardised validated clinical assessment tools to benchmark and measure outcomes in palliative care, including pain and symptom control, and timely access to services when they are needed to drive quality improvements.

The PCOC data collection includes patient demographics, clinical setting information, and patient outcomes collected via the 5 assessment tools:

- Palliative Care Phase
- Palliative Care Problem Severity score
- Symptom Assessment Scale (SAS)
- Australia-modified Karnofsky Performance Status (AKPS)
- Scale Resource Utilisation Groups - Activities of Daily Living (RUG-ADL)

Data collected from July 2012 are based on PCOC Version 3.0. See the PCOC Data Dictionary and Technical Guidelines for more information.

Participation in PCOC is voluntary and open to all palliative care service providers across Australia. Representation is sought from public and private health sectors, rural and metropolitan areas, and inpatient and community settings. However, not all services participate in PCOC and so the data only capture a subset of all palliative care delivered in Australia. A total of 185 services reported data to PCOC in 2024, and work is ongoing to expand this number. Most services that report data to PCOC are specialist palliative care services. See the PCOC 2024 Data Quality Statement for more information.

Variations in definitions/terminology due to differing funding models across jurisdictions may also impact on the comparability and interpretability of the data at the state, territory, and national level. As a result, no disaggregation by state and territory are presented for the measures using PCOC data in the 2026 release.

Measures reported

1.1 Proportion of palliative care phases for people with life-limiting illnesses for which the distress related to pain improved or remained at a low level after intervention.

1.2 Proportion of palliative care phases for people with life-limiting illnesses for which psychological or spiritual problems improved or remained at a low level after intervention.

3.2 Proportion of palliative care phases for people with life-limiting illnesses for which family or carer problems improved or remained at a low level after intervention.

Age group

Patient age as at episode start date derived from the date of birth of the patient.

Disaggregation categories: 0–14, 15–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85 or over.
Source: National Health Data Dictionary (METEOR Identifier 287007)

Sex

The sex of the patient according to the categories 'Male', 'Female', 'Indeterminate', and 'Not stated/ inadequately described'.
Disaggregation categories: Males, Females, Not stated/ inadequately described/ intersex.
Source: National Health Data Dictionary (METEOR Identifier 287316).

Remoteness area

The postcode of usual residence of the patient is used to derive remoteness area based on the Australian Statistical Geography Standard 2021.
Disaggregation categories: *Major cities*, *Inner regional*, *Outer regional*, *Remote*, *Very remote*.
Source: Australian Bureau of Statistics (METEOR Identifier 747271)

Diagnosis

The principal life-limiting illness responsible for the patient requiring palliative care.
Disaggregation categories: 31 PCOC diagnostic groups.
Source: PCOC Data dictionary V3.0

Socioeconomic area

The postcode of usual residence of the patient is used to derive socioeconomic area. Socioeconomic areas are based on the ABS Index of Relative Socioeconomic Disadvantage (IRSD), 2021.
Disaggregation categories: SEIFA IRSD quintiles (1–5 or lowest/ most disadvantaged to highest/ least disadvantaged socioeconomic area).

Source: Australian Bureau of Statistics (METEOR Identifier 762080)

Setting

The broad setting in which care was delivered. This includes inpatient settings which refers to admissions to hospital or hospice, and community settings which refers to care occurring in the patient's 'home'. For example, this may be in their private residence or residential aged care. See PCOC reports for the latest list of inpatient and community services.

Disaggregation categories: Inpatient, Community.

Source: PCOC Data dictionary V3.0

Phase type

A clinically meaningful period in a patient's condition. The palliative care phase is determined by a holistic clinical assessment, which considers the needs of the patients and their family and carers. The 5 palliative care phases are stable, unstable, deteriorating, terminal and bereavement. A patient may move back and forth between phases (except bereavement).

Stable: patient problems and symptoms are adequately controlled by an established plan of care, and:

- further interventions to maintain symptom control and quality of life have been planned, and
- family/carer situation is relatively stable, and no new issues are apparent.

Unstable: an urgent change in the plan of care or emergency treatment is required because:

- patient experiences a new problem that was not anticipated in the existing plan of care, and/or
- patient experiences a rapid increase in severity of a current problem, and/or
- family/carer circumstances change suddenly impacting on patient care.

Deteriorating: the care plan is addressing anticipated needs but requires periodic review because the:

- patients overall functional status is declining, and/or
- patient experiences a gradual worsening of existing problem, and/or
- patient experiences a new but anticipated problem, and/or
- family/carers experience gradual worsening distress that impacts on the patient care.

Terminal: death is likely within days.

Bereavement: the patient has died and bereavement support provided to family/carers is documented in the deceased patient's clinical record (Masso et al. 2015).

Disaggregation categories: Stable, Unstable, Deteriorating, Terminal.

Source: PCOC Data dictionary V3.0.

Severity at phase start

Severity of distress related to 7 key symptoms recorded via the Symptom Assessment Scale (SAS) tool, and/or severity of problems assessed via the Palliative Care Problem Severity Score (PCPSS) at phase start.

Disaggregation categories: Absent, Mild, Moderate, Severe.

Source: PCOC Data dictionary V3.0.

References

Masso M, Allingham SF, Banfield M, Johnson CE, Pidgeon T, Yates P et al (2015) 'Palliative Care Phase: inter-rater reliability and acceptability in a national study', *Palliative Medicine*, 29(1): 22–30.

Technical notes

This section describes the classification systems and methodology used in the *National Palliative Care Measures* web report. More detailed information is available under Data dictionary and Data sources, and in the accompanying data tables.

National Health Data Hub (NHDH)

The National Health Data Hub (NHDH), formerly the National Integrated Health Services Information (NIHSI), is a major national health data linkage system for health and welfare research and analysis. It comprises de-identified and enduring health and welfare data from state and territory, Commonwealth and non-government data sources.

Access granted to the NHDH data does not constitute endorsement by the data custodians of the methodology used or related findings.

For more information on the NHDH, see National Health Data Hub.

International Statistical Classification of Diseases and Related Health Problems

The International Statistical Classification of Diseases and Related Health Problems (ICD), which was developed by the World Health Organization (WHO), is the international standard for coding morbidity and mortality statistics. It was designed to promote international comparability in collecting, processing, classifying and presenting these statistics. The ICD is periodically reviewed to reflect changes in clinical and research settings (WHO 2022).

The version currently used in Australia to code causes of death, ICD-10 (WHO 1992), was endorsed in May 1990 and officially came into use in WHO member states from 1994. The 11th revision of the ICD-10 was released in June 2018. Further information on the ICD is available from the WHO website.

ICD-10-AM

Admitted patient care data in the NHDH are drawn from the National Hospital Morbidity Database (NHMD). Diagnosis, procedure and external cause hospital data for 2023–24 were reported to the NHMD by all states and territories using the 11th edition of the Australian Modification of ICD-10, referred to as the ICD-10-AM. ICD-10-AM, is based on ICD-10 (NCCH 2013). ICD-10 was modified for the Australian setting by the National Centre for Classification in Health (NCCH) to make it more relevant to Australian clinical practice. Compatibility with ICD-10 at the higher levels (that is, up to 4-character codes) of the classification has been maintained. ICD-10-AM has been used to classify diagnoses in admitted patient hospital records in all Australian states and territories since 1999–2000 (AIHW 2000).

The ICD-10-AM disease classification is hierarchical; a small number of summary disease chapters are divided into a large number of more specific disease groupings (represented by 3-character codes). Most of the 3-character disease groupings can be divided into an even larger number of very specific disease categories represented by 4- character and 5-character codes (see Measures 2.1, 4.1 and 4.2a in the Data Dictionary).

Methodology for reporting on the progress of measures over time

To determine the ‘progress status’ of each measure, statistical testing was used to understand if the measure had significantly changed over time. Weighted linear regression was used to test the direction and statistical significance ($p<0.05$) of the change in each measure from baseline to the latest available data. Statistical testing was performed on summary data only for measures 1.1, 1.2, 3.2, 4.2b and 5.1a.

The 'Status key' for the relevant icon in the report can be summarised as follows:

- **Progress**: The change in the measure from baseline to latest available data was statistically significant ($p<0.05$) and moving in the desired direction.
- **Nochange**: Any change in the measure from baseline to latest available data was not statistically significant ($p<0.05$).
- **Regress**: The change in the measure from baseline to latest available data was statistically significant ($p<0.05$) and moving in the opposite direction to what is desired.
- **Status not yet known**: Insufficient data currently available.

References

AIHW (Australian Institute of Health and Welfare) (2000) Australian hospital statistics 1998–99, AIHW, Australian Government, accessed 29 August 2023.

NCCH (National Centre for Classifications in Health) (2013) International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification, eighth edition. Sydney: NCCH.

WHO (World Health Organisation) (1992) International Statistical Classification of Diseases and Related Health Problems, tenth revision. Vol. 1. Geneva: WHO.

WHO (2022) International Classification of Diseases (ICD), WHO website, accessed 11 February 2023.

Notes

14/05/2026 – The catalogue number was changed from HSE 254 to HWI 141.

Australian Government
Australian Institute of Health and Welfare

Data

Data tables: National palliative care measures (May 2026)

Data

XLSX 182kB

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