Australian Government
Australian Institute of Health and Welfare

Palliative care services in Australia

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About

Palliative care aims to prevent and relieve suffering and improve the quality of life of people (adults, children and their families) facing problems associated with life-limiting illness. This report describes the activity and characteristics of people receiving palliative care services in Australia. It includes where palliative care services were delivered, who provided these services, how much was spent, and palliative care outcomes.

Data is updated regularly, and the content keeps growing.

Cat. no: HWI 140

Key findings

- 15,900 people received 78,100 Medicare-subsidised palliative medicine attendance and case conference services in 2024–25
- Pain relief medications accounted for 8 in 10 (80%) of the 1.6 million palliative care-related prescriptions in 2024–25
- There was a 46% increase in palliative care-related hospitalisations between 2015–16 and 2023–24
- There were 1.0 million episode-level non-admitted patient service events for palliative care in 2023–24

Summary

Palliative care services is an Australia's health topic

In this section

- What is palliative care?
- Service activity
- Data availability
- Where do I go for more information?

What is palliative care?

Palliative care is an approach to treatment that improves the quality of life of patients and their families facing a life-limiting illness, as well as reducing the physical and emotional stress of dying (WHO 2020). Palliative care is not limited to any specific condition, can be delivered at any stage of illness, can accompany curative treatments, and can be provided to patients in any health care setting. For further information, see Overview.

Service activity

Since 2015, the AIHW has been reporting on palliative care services, and the people who access these services. This information provides insights on service activity and can be used to inform service planning and delivery of palliative care services.

An overview of the key findings, using the latest available data is provided below. For further information on the definitions used on this page, see Glossary. Note that the data presented in this report and on this page do not capture all palliative care activity in Australia, due to data availability. Further details are provided below in the Data availability section on this page.

Admitted patient palliative care

increase in palliative care-related hospitalisations
from **73,600** in 2015–16 to **107,500** in 2023–24

Over 1 in 2
of the **107,500** palliative care-related hospitalisations ended with the patient dying in hospital in 2023–24

Non-admitted patient palliative care

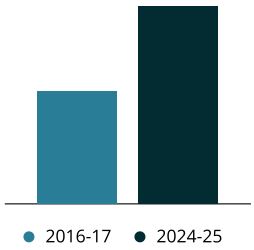
Over 1 in 3
of the **1.0 million** episode-level palliative care service events were referrals from hospital in 2023–24

Medicare-subsidised (MBS) specialist palliative care services

4.9 services per person
78,100 Medicare-subsidised palliative medicine attendance and case conferencing services were provided to 15,900 people in 2024–25

5 in 6
of these services (85% or 66,200) were for attendances in a consulting room or hospital

Palliative care-related prescriptions from the Palliative Care Schedule



72% increase in palliative-care related prescriptions from **908,000** in 2016–17 to **1.6 million** in 2024–25 (increase from 1.8 to 3.2 prescriptions per person)

of the **1.6 million** palliative care-related prescriptions were prescribed by general practitioners

Residential aged care

4,800 people
were appraised as requiring palliative care in 2021–22, accounting for 2.0% of all people in permanent residential aged care

Palliative care workforce

358 palliative medicine physicians and around **3,900** palliative care nurses were employed nationally in 2023

of palliative medicine physicians were employed in a hospital setting in 2023

of palliative care nurses were employed in a hospital setting in 2023

Palliative care outcomes

Of the palliative care episodes reported to the Australian Palliative Care Outcomes Collaboration (PCOC), **92%** commenced within 2 days after patients were ready for palliative care in 2024

of unstable phases (urgent needs) were resolved within 3 days or less

Expenditure on palliative care

In 2023–24, the total cost on admitted patient palliative care was **$666.7 million** and non-admitted patient palliative care was **$218.9 million** for the hospitals reporting data to the Independent Health and Aged Care Pricing Authority (IHACPA)

In 2024–25, **$6.8 million** was paid in benefits for Medicare-subsidised palliative medicine attendance and case conference services, at an average of $430 per patient

In 2024–25, the Australian Government spent **$40.4 million** on palliative care-related medications from the PBS Palliative Care Schedule, at an average of $83 per patient

Data availability

Most national reporting uses single data sources, focussing on individual aspects of specialist palliative care, for example, hospitalisations (admitted and non-admitted patient care), receipt of Medicare-subsidised specialist palliative care services, and use of medicines (from the PBS Palliative Care Schedule). Information is also provided on palliative care outcomes and palliative care workforce.

The data presented on this page and in this report are limited to services provided by palliative care specialists or in specialist palliative care settings. A large volume of palliative care occurs outside of these settings, which is not included in this report, due to data availability (see Box 1).

Box 1: Key data gaps and data improvement activities

Identifying palliative care (including end-of-life care) in existing data collections and health settings remains a key challenge, particularly for care delivered in community, primary care, and residential aged care settings. For example, limited national data are currently available on community-based palliative care services, in particular palliative care services provided by general practitioners and non-palliative care medical specialists. The data on this page focus on specific settings where systems are in place to record palliative care service, in particular specialist palliative care.

The Australian Institute of Health and Welfare (AIHW) is working with palliative care stakeholders to help address data gaps in palliative care reporting. The AIHW, in collaboration with the End-of-Life Care Data Development Working Group, released the *National Palliative Care and End-of-Life Care Information Priorities* (PDF 892KB) report in January 2022. The report outlines an aspirational vision for national palliative care information development over the next decade and articulates priorities aimed at supporting this vision.

The AIHW has also been exploring the use of the National Health Data Hub (NHDH) linked data asset for filling key data gaps in palliative care. In 2025, AIHW released analysis of Specialist palliative care use for older people receiving aged care using NHDH data to understand differences in palliative care use. The Palliative care and health service use for people with life-limiting conditions report released in May 2024, was the first national study to provide insights on need, receipt, and unmet need of specialist palliative care across multiple settings of care and in combination with other health services. These types of analysis were previously not possible using single data collections.

Where do I go for more information?

For more information on palliative care services, see:

- National Palliative Care Measures
- Department of Health, Disability and Ageing – Palliative care
- Palliative Care Australia
- Medicare Benefits Schedule (MBS Online)
- Pharmaceutical Benefits Scheme
- Palliative Care Outcomes Collaboration

For more on this topic, see Palliative care.

References

WHO (World Health Organization) (2020) *Global atlas of palliative care (2nd edition)*, WHO website, accessed 07 March 2025.

Overview

The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-threatening illness. It aims to prevent and relieve suffering through early identification, assessment, and treatment of pain and other physical, psychosocial and spiritual issues. Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (WHO 2020).

In 2014, the World Health Assembly unanimously passed a resolution to strengthen palliative care as a component of comprehensive care throughout the life course (WHA 2014). In the same year, the WHO and the Worldwide Palliative Care Alliance released the Global Atlas of Palliative Care at the End of Life – a tool to advocate for including palliative care in the global, regional and national health agendas (WHO 2014). The second edition was released in 2020, and is designed to support countries to develop palliative care policies and services that integrate palliative care into their health systems (WHO 2020). The WHO regard palliative care as a human right in high demand, with an estimated 26 million people needing end-of-life care each year (WHO 2020).

Palliative care in Australia

In Australia, and many other parts of the world, the demand for palliative care services is increasing due to the ageing of the population and increases in the prevalence of cancer and other chronic diseases that accompany ageing (WHO 2014).

Historically, it was assumed that palliative care would commence only once all treatment aimed at 'curing' people had finished or only when a person was dying. Now, it is well-accepted that there is benefit in providing palliative care in association with disease-modifying therapies that aim to prolong life. It is also recognised that many people with life-limiting illnesses are not 'cured', but continue to live with these illnesses for many years (PCA 2018).

Palliative care is now provided in almost all settings where health care is provided, including neonatal units, paediatric services, general practices, acute hospitals, residential and community aged care services, and generalist community services. A distinction is commonly made between care provided in hospitals (including hospices or dedicated palliative care wards) and care provided in the community (such as in the patient's home or in residential aged care facilities).

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 (PCA 2018). Specialist palliative care services operate from a variety of settings, including specialist inpatient consulting services, specialist inpatient settings, hospices and community-based specialist services (Department of Health 2019).

The exact model of care provision differs across Australia, with each state and territory having specified an approach to providing palliative care-related services (Senate Community Affairs References Committee 2012). The states and territories have different approaches to planning and delivering publicly funded services, different local service delivery practices and differently structured health-care systems. They also have varying demographic and remoteness profiles, and varying demands for particular types of services.

Palliative care strategies

Over the last decade, there has been various strategic initiatives to guide improvements in the provision of palliative care services, such as the National Palliative Care Strategy and Implementation Plan and the Royal Commission into Aged Care Quality and Safety.

Better palliative care data will assist policy makers, palliative care providers, researchers and the general public to better understand the amount and nature of palliative care activity in the Australian health-care sector. Reliable, accurate and comprehensive data about health-care services can improve the quality of care and lead to better health outcomes through:

- highlighting areas in need of more or different types of services
- highlighting inequalities and inequities in access to and outcomes of care
- helping to assess the uptake of guidelines and evidence-based practices and to evaluate the effects these practices have on patient outcomes, as well as other consequences
- helping to detect barriers to and facilitators of the uptake of best-practice patterns of care
- helping to understand trends in the use of pharmaceutical medicines in palliative care to inform policy and research
- helping to recognise changes in practice and consequent changes in outcomes
- informing evidence-based policy and strategy decisions
- providing practitioners with information and the ability to make appropriate decisions and to provide high-quality care (AIHW 2008).

A strategic plan to improve national information on palliative care and end-of-life care, titled the National Palliative Care and End-of-Life Care Information Priorities [PDF 892KB], has been developed by the Palliative Care and End-of-Life Care Data Development Working Group. This provides the foundation priorities for better national data into the future.

National Palliative Care Strategy

Australian Governments have committed to addressing the palliative care needs of Australians through the *National Palliative Care Strategy 2018 (the Strategy)* (Department of Health 2019). This version of the Strategy builds on the work of the first National Palliative Care Strategy, published in 2000, and the second version published in 2010.

The Strategy was produced following a 2016 evaluation of the 2010 Strategy and involved extensive consultation with the Australian Government and state and territory health departments, carers, consumer and service providers peak bodies, clinicians and a range of service providers and other key organisations involved in palliative care.

The purpose of the Strategy is to guide improvement of palliative care across Australia and provide a shared direction. The Strategy represents a commitment of all Australian governments to ensure the highest possible level of palliative care is available to all people who need it (Department of Health 2019). The *Implementation Plan for the National Palliative Care Strategy 2018* was released in October 2020, to support governments' reporting on the progress of implementing the Strategy.

The Strategy outlines a number of priority goals, including robust data collection, monitoring and reporting, which aim to meet the identified demand for high-quality palliative care services across Australia. These goals encompass building and enhancing the capacity of all relevant sectors to provide quality, appropriate and effective palliative care to all Australians who need it.

For national palliative care initiatives and programs, see the initiatives and programs listed on the Australian Government Department of Health and Aged Care website.

State and territory strategies and frameworks

In addition to the Strategy and the palliative care initiatives and programs, each state and territory has a range of initiatives in place to improve the delivery of palliative care services. For example, some jurisdictions have overarching frameworks or strategies to guide service improvement, such as the:

- *New South Wales End of Life and Palliative Care Framework 2019–2024*
- *Victoria's end of life and palliative care framework*
- *South Australia's Palliative Care Strategic Framework 2022–2027* [PDF 7.5MB]
- *Queensland Health Palliative and End-of-Life Care Strategy* [PDF 16MB]
- *Palliative Care Tasmania Strategic Plan 2024–2027*
- *Western Australia End-of-Life and Palliative Care Strategy 2018–2028* [PDF 1.46MB]

Royal Commission into Aged Care Quality and Safety

The Australian Government established the Royal Commission into Aged Care Quality and Safety in October 2018, which received various submissions on palliative care within the aged care sector. The Commission's report was published in March 2021 (*Royal Commission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect*). Key recommendations from the report for palliative care included compulsory palliative care training for aged care workers, comprehensive sector funding specifically including palliative care and end-of-life care, a review of the Aged Care Quality Standards to regulate high quality palliative care in residential aged care, access to multidisciplinary outreach services, and a new Aged Care Act that includes the right to access palliative care and end-of-life care.

The Australian Government formally responded to the Royal Commission's recommendations in May 2021 (*Australian Government response to the final report of the Royal Commission into Aged Care Quality and Safety*), committing to a range of reforms which are now at various stages of implementation. Progress with the range of reforms as assessed by the Inspector-General of Aged Care is included in the *2024 progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety*.

References

PCA (Palliative Care Australia) (2018) *Palliative Care Service Development Guidelines*, PCA, accessed 22 April 2025.

Department of Health (2019) *National Palliative Care Strategy 2018*, Department of Health, Australian Government, accessed 22 April 2025.

Senate Community Affairs References Committee (2012) *Palliative care in Australia. Report to the Senate, Australian Government,* Senate Community Affairs References Committee.

World Health Assembly (WHA) (2014) Strengthening of palliative care as a component of comprehensive care throughout the life course, Sixty-seventh World Health Assembly, Geneva, 22 April 2025.

WHO (World Health Organization) (2014) *Global Atlas of Palliative Care at the End of Life*, WHO.

WHO (2020) *Global Atlas of Palliative Care at the End of Life, 2nd Ed 2020*, WHO.

Admitted patient palliative care

This chapter provides information related to palliative care-related hospitalisations and explores the distribution and characteristics of these hospitalisations between 2015–16 to 2023–24. Further information about how palliative care-related hospitalisations are identified through admitted patient care is provided in Box 1 and the Data source.

The information in this chapter was last updated in October 2025.

Box 1: Identifying palliative care in admitted patient care data

This chapter only covers care for admitted patients, who undergo a formal admission process in public or private hospitals to receive treatment and/or care. It focuses on Palliative care-related hospitalisations where palliative care was provided during all or part of the episode of care. These hospitalisations are divided into 2 groups depending on how they are identified in the hospital data:

- primary palliative care hospitalisations: hospitalisations with a recorded care type of palliative care, and
- other palliative care hospitalisations: hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

For more information, see Data source.

Key points

In 2023–24, among the 107,500 palliative care-related hospitalisations:

- 57,800 were for primary palliative care and 49,700 for other palliative care, equating to 21 and 18 per 10,000 population, respectively
- nearly 3 in 5 (59%) hospitalisations were for people aged 75 and over with a median admission age of 77
- the average length of stay was nearly double the length of stay for hospitalisations for all reasons – 11 days compared to 5.6 days
- 1 in 2 (48%) primary palliative care hospitalisations had a principal diagnosis of cancer compared with 30% for other palliative care hospitalisations
- more than half (55%) of hospitalisations ended with the patient dying in hospital, with this more prevalent for primary than other palliative care hospitalisations (69% and 40%, respectively).

Between 2015–16 and 2023–24, palliative care-related hospitalisations increased at an annual rate of 4.9%, double that of hospitalisations for all reasons (2.3%).

Socio-demographic and regional characteristics

In 2023–24 there were 12.6 million hospitalisations across Australia, of which 107,500 were palliative care-related hospitalisations (Table 1 in PCSiA 2025 in Data tables: PCSiA 2025 Admitted patient palliative care).

Of all palliative-care related hospitalisations, over half (54% or 57,800) were primary palliative care hospitalisations (21 per 10,000 population) and 49,700 (46%) were other palliative care hospitalisations (18 per 10,000 population). Most palliative care-related hospitalisations occurred in public hospitals (85%), compared with 59% for hospitalisations for all reasons (Table 13).

Among the 107,500 palliative care-related hospitalisations (Figure 1):

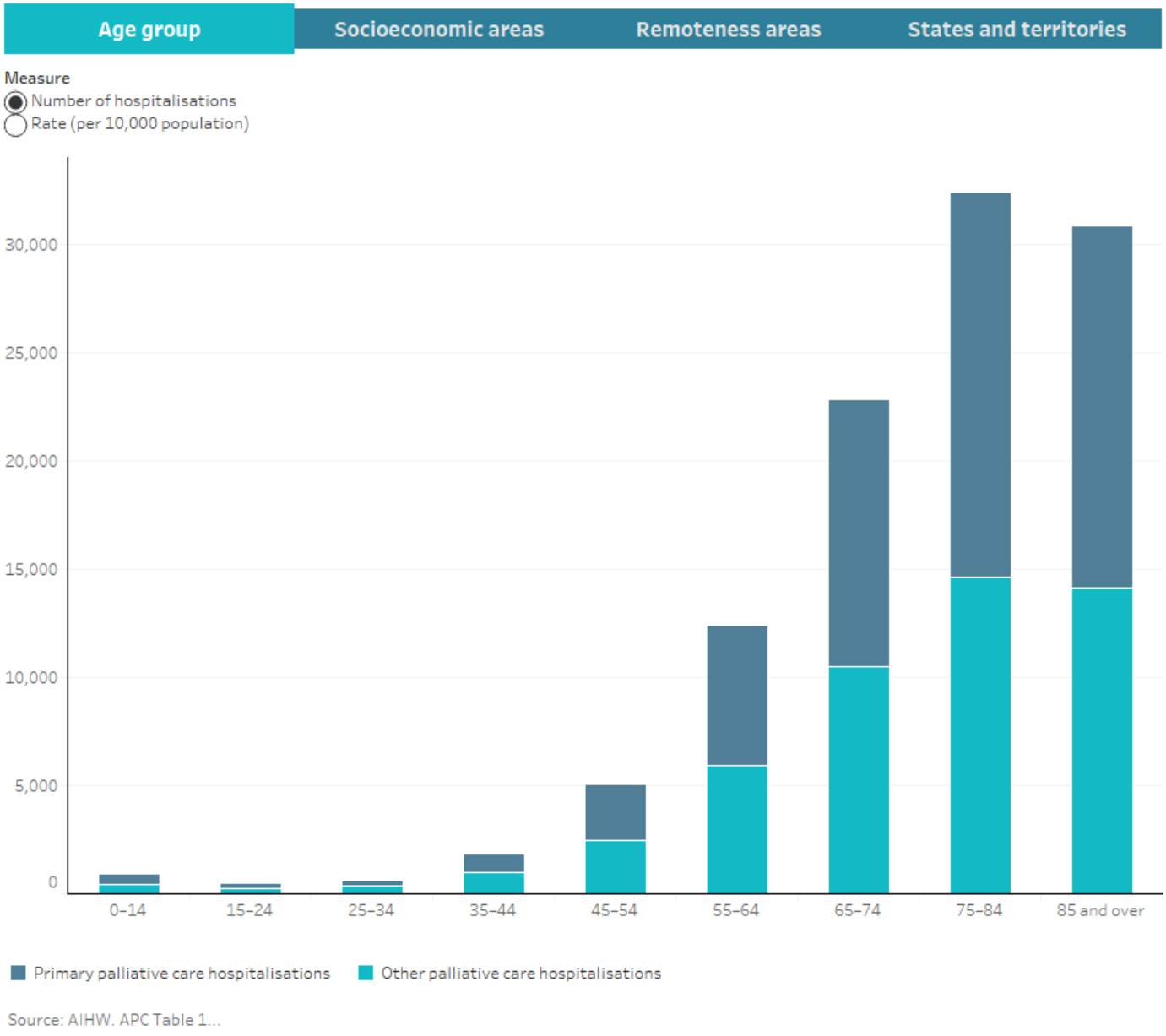
- Almost 3 in 5 (59%) were provided to people aged 75 and over and less than 1 in 10 (8.4%) were for people aged under 55.
- The median age at admission was 77 years, which was considerably older than for hospitalisations for all reasons (61 years).
- 3,100 (2.9%) were provided to Aboriginal and Torres Strait Islander (First Nations) people, most of which occurred in public hospitals (95%; Table 2) – a higher proportion than for other Australians (85%).
- Rates of palliative care-related hospitalisations in public hospitals increased as socioeconomic disadvantage increased (from 25 to 44 per 10,000 population, for people living in the highest compared to the lowest socioeconomically disadvantaged areas). Conversely, rates in private hospitals decreased with greater socioeconomic disadvantage (from 9.2 to 3.7 per 10,000 population). These patterns are also observed in hospitalisations for all reasons (Table 3).

As highlighted in Figure 1, there were **regional variations** in palliative care-related hospitalisations. In public hospitals, the rates of palliative care-related hospitalisations for people living in *Outer* and *Inner regional* areas (both 42 per 10,000 population) were higher than in *Major cities* and *Remote and very remote* areas (31 and 34 per 10,000 population, respectively). A different pattern was observed in private hospitals, with palliative-care related hospitalisations decreasing with increasing remoteness (from 6.2 in *Major cities* to 1.5 per 10,000 in *Remote and very remote* areas).

Figure 1 also highlights variations across the states and territories. Information on palliative care-related hospitalisations at the Primary Health Networks (PHN) level are included in Table 6 and the PHN palliative care services information chapter.

Note, that regional differences in palliative care-related hospitalisations may be influenced by variations in hospital admission policies, practices, and service types.

Figure 1: Distribution of palliative care-related hospitalisations, by demographic characteristics, 2023–24



Source: AIHW. APC Table 1...

Characteristics of palliative care-related hospitalisations

Primary reason for hospitalisation

In 2023–24 (Figure 2):

- Cancer was the most common principal diagnosis recorded for palliative care-related hospitalisations (40%) – almost 1 in 2 (48%) for primary palliative care hospitalisations and almost 1 in 3 (30%) for other palliative care hospitalisations.
- Secondary site cancer (cancer of an unknown or ill-defined primary site) was the most common cancer diagnosis (8.7% for primary palliative care and 9.5% for other palliative care hospitalisations), followed by lung cancer (7.6% and 3.7%, respectively).
- The most frequently recorded non-cancer principal diagnosis was cerebrovascular disease (4.6%) and septicaemia (3.5%) for primary palliative care, and influenza and pneumonia (4.9%) and other ill-defined causes (4.7%) for other palliative care hospitalisations.

Average length of stay

In 2023–24 (Figure 2), the average length of stay for palliative care-related overnight hospitalisations was:

- 11 days, nearly double the stay for overnight hospitalisations for all reasons (5.6 days)
- longer in private hospitals (14 days) than in public hospitals (10 days). In contrast overnight hospitalisations for all reasons was slightly longer in public hospitals than in private hospitals (5.8 and 5.1 days, respectively).

Status at discharge

In 2023–24 (Figure 2):

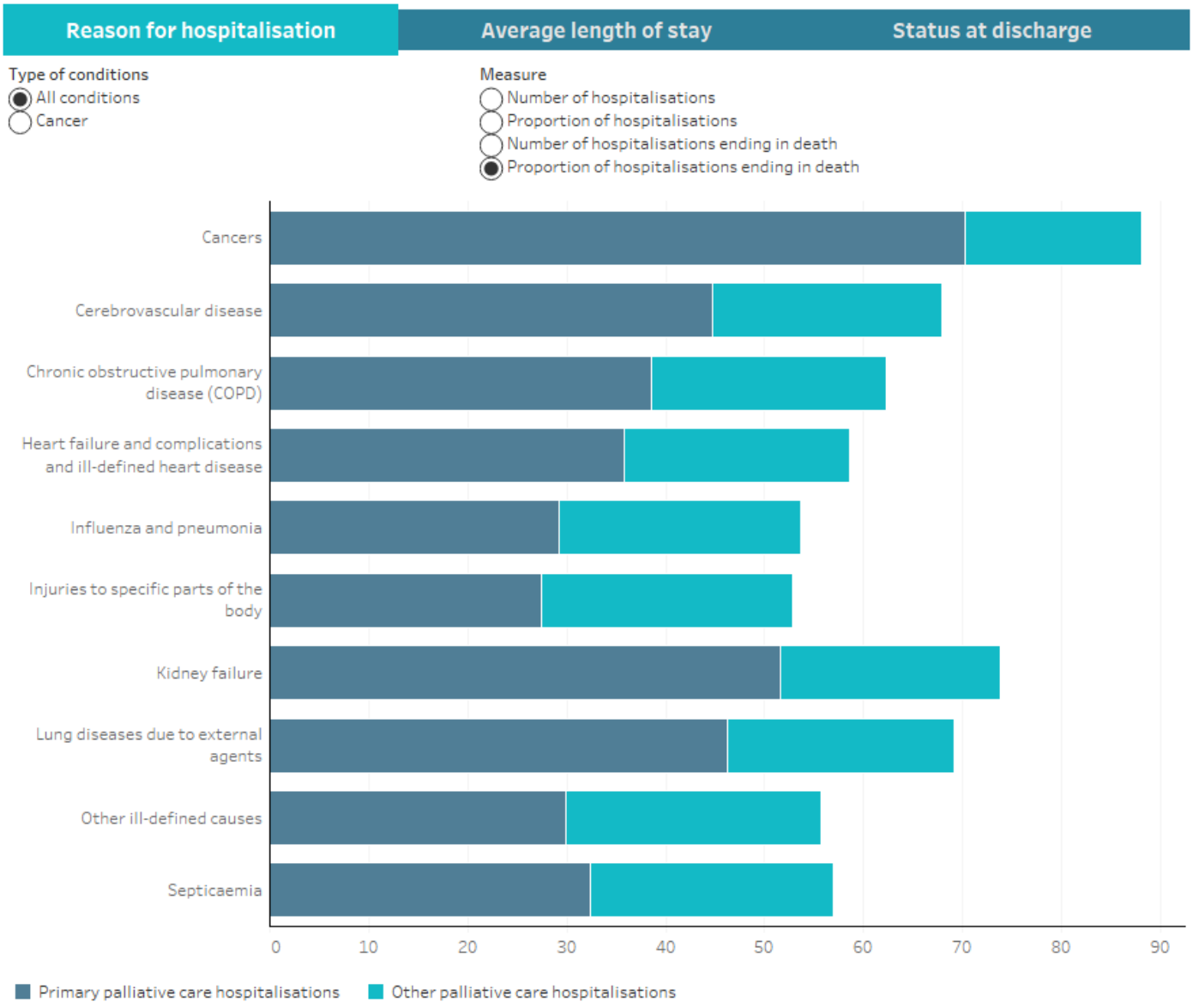
- Over half (55%) of palliative care-related hospitalisations ended in the patient dying in hospital – 69% for primary palliative care and 40% for other palliative care.
- Discharge to usual residence was the next most common status at discharge (26%) –21% for primary palliative care and 32% for other palliative care hospitalisations.

In 2023–24, of the 89,300 patients who died in hospital (Table 8):

- 2 in 3 (67%, or 59,500) received palliative care during their final hospitalisation – 45% for primary palliative care and 22% for other palliative care
- patients with a principal diagnosis of cancer were more likely to receive palliative care during the last hospitalisations than patients with non-cancer diagnoses – 88% of cancer patients compared with 58% of non-cancer patients respectively.

These results are consistent with a 2024 AIHW report which highlighted that over 2 in 3 people receiving specialist palliative care were an admitted patient at the time of death. This may reflect greater referrals to initiation of specialist palliative care as inpatients in the last days of life (median of 9 days before death).

Figure 2: Characteristics of palliative care-related hospitalisations, 2023–24



Source: AIHW. APC Table 7 and Table 8.
https://www.aihw.gov.au/pcsia

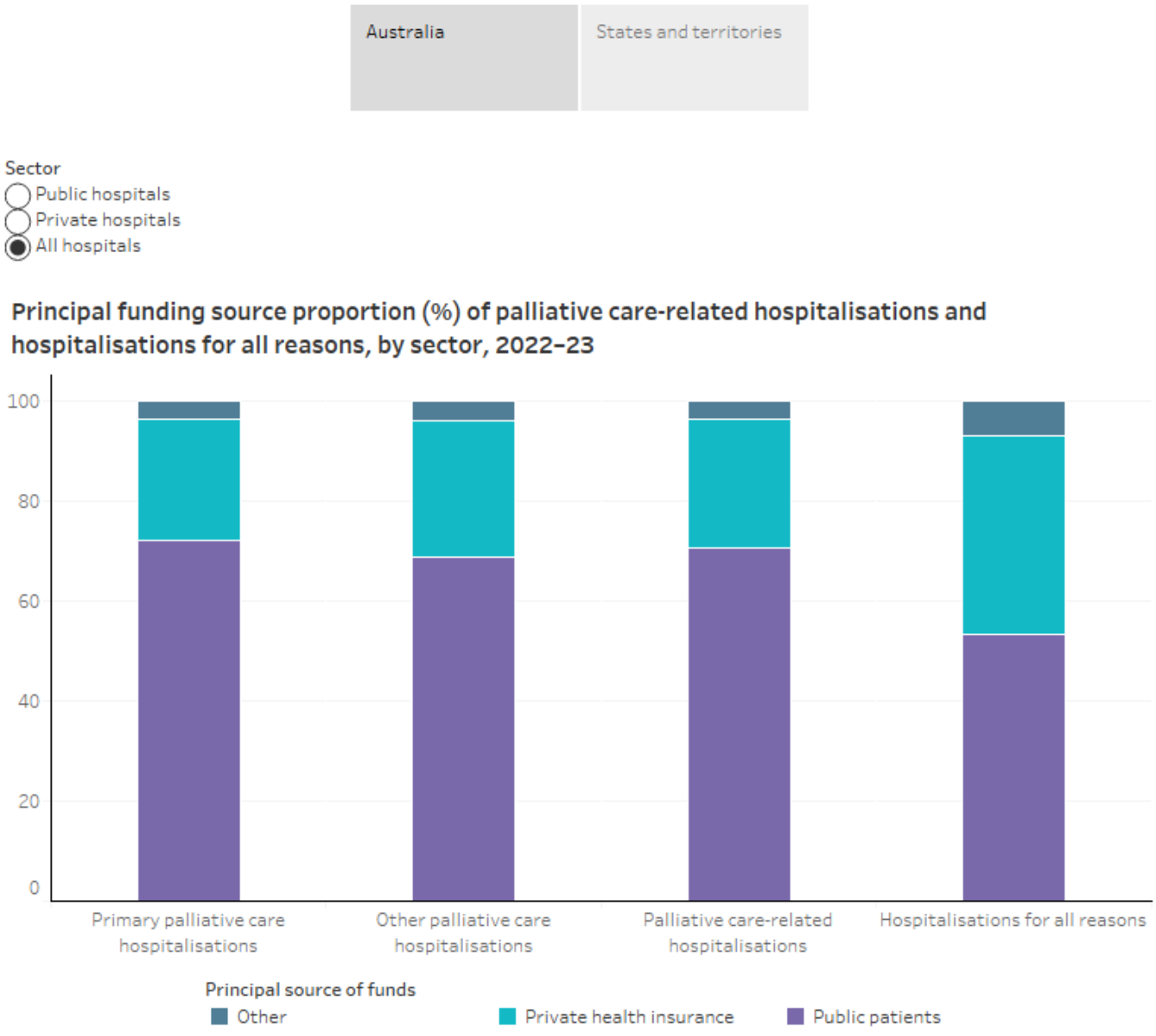
Principal funding source

Public and private hospitals both receive funding from the Australian Government, state and territory governments, private health insurance funds and out-of-pocket payments to cover the costs for hospital admitted patient episodes. However, funds vary across the sectors, reflecting the types of patients they treat, the services they provide, and the administrative arrangements (AIHW 2021).

In 2022–23 (Figure 4):

- In public hospitals, the proportion of public patient funding for palliative care-related hospitalisations (80%) was lower compared to all hospitalisations (86%). In contrast, private health insurance accounted for higher funding for palliative care-related hospitalisations (17%) compared to all hospitalisations (11%).
- In private hospitals, private health insurance was the principal funding source for 76% of palliative care-related hospitalisations, lower than all hospitalisations (81%). Meanwhile, the proportion of public patient funding for palliative care-related hospitalisations (16%) was higher than for all hospitalisations (6.1%).

Figure 4: Principal funding source for palliative care-related hospitalisations, by sector, 2022–23



Note: Other includes self-funded, workers compensation, motor vehicle third party personal claim, Department of Veteran's Affairs and other.
Source: AIHW. APC Table 11.
https://www.aihw.gov.au/pcsia

References

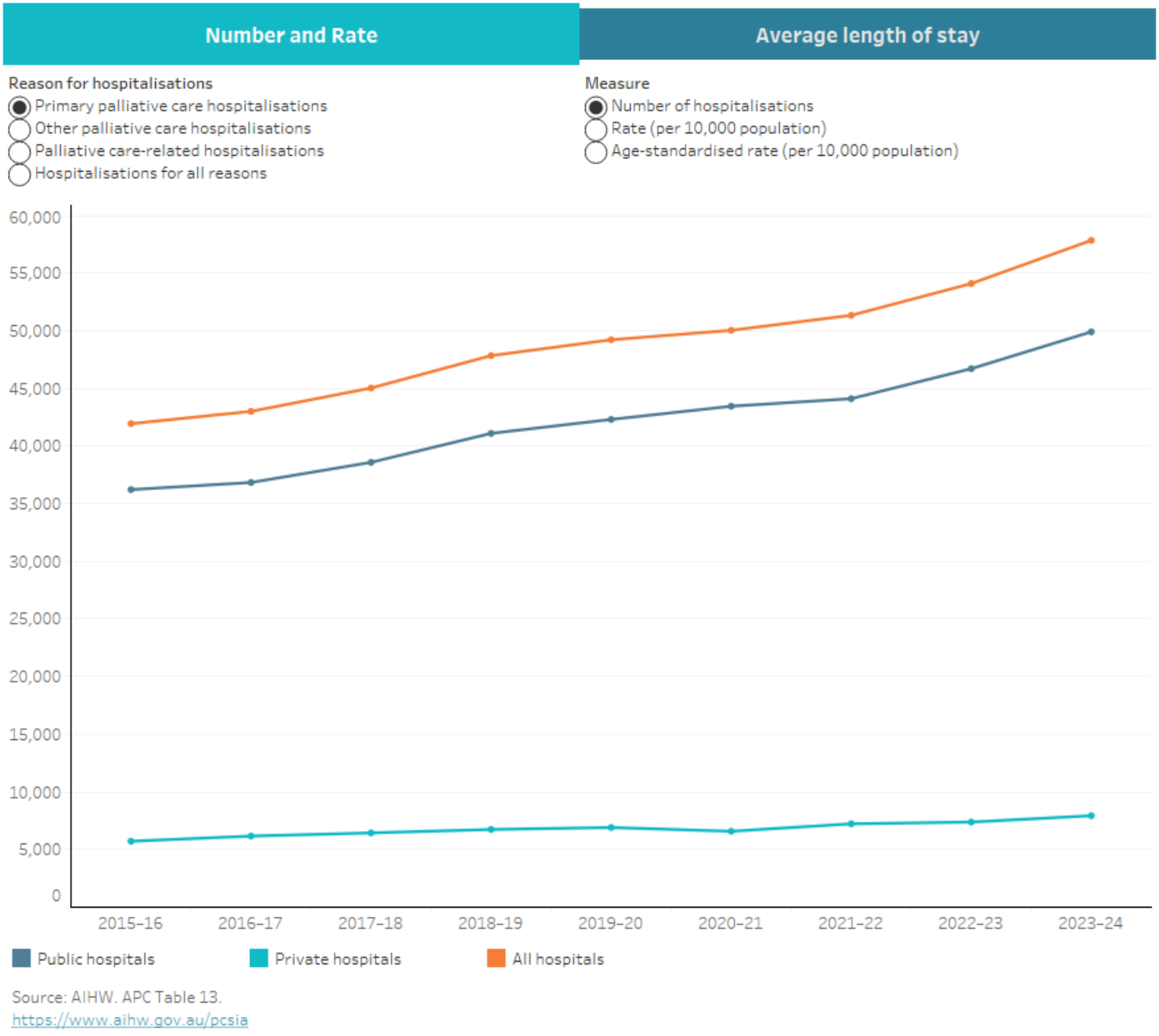
AIHW (Australian Institute of Health and Welfare) (2021) *Health expenditure Australia 2019–20*, AIHW, Australian Government, accessed 10 July 2024.

Trends

Between 2015–16 and 2023–24, the number of palliative care-related hospitalisations increased by 46% (from 73,600 to 107,500), or from 31 to 40 hospitalisations per 10,000 population (Figure 3). This increase in hospitalisation rates was considerably smaller when adjusting for changes in the population age structure over this period (from 26 to 30 per 10,000), suggesting this increase is partly due to Australia's ageing population.

Compared with hospitalisations for all reasons, the growth in palliative care-related hospitalisations has increased at twice the rate – average annual increase of 4.9% compared with 2.3% for hospitalisations for all reasons between 2015–16 and 2023–24.

Figure 3: Trends in palliative care-related hospitalisations, 2015–16 to 2023–24



Source: AIHW. APC Table 13.
https://www.aihw.gov.au/pcsia

Data source

National Hospital Morbidity Database

Data on admitted patient palliative care are sourced from the National Hospital Morbidity Database (NHMD). This annual collection is compiled and maintained by the Australian Institute of Health and Welfare (AIHW), using data supplied by state and territory health authorities. Information from almost all hospitals in Australia is included in the database: from public acute and public psychiatric hospitals, private acute and psychiatric hospitals, and from private free-standing day hospital facilities (AIHW 2023). The latest available data at the date of publication of this report was 2023–24. A complete Data Quality Statement – NHMD 2023–24 (PDF 580KB) is available online.

Episode-based data

The NHMD is episode-based, with the term 'hospitalisation' used to refer to an episode of admitted patient care; individual patients may have multiple hospitalisations ending in discharge, transfer, or statistical discharge with a change in care type and ultimately death. Thus, a single patient may have two or more hospitalisations during any one hospital stay. Since each record within the NHMD is based on an episode of care, the hospitalisation count is a count of episodes, not persons. In cases of more than one care type, length of stay refers to the length of the episode of care, not the total duration of the patient's hospital stays.

Identifying palliative care-related hospitalisations

The admitted patient palliative care section in this report describes and quantifies admitted patient hospitalisations for which palliative care was provided. Two NHMD data items – 'care type' and 'diagnosis' – capture information indicating that palliative care has been provided to a patient. The AIHW has previously explored how these two data items can be used to identify palliative care-related hospitalisations in *Identifying palliative care separations in admitted patient data: technical paper* (AIHW 2011).

Coding 'palliative care' as a care type

A care type is assigned for each admitted patient hospitalisation and describes the overall nature of a clinical service provided to the patient. Only one type of care can be assigned at a time. Where the primary clinical purpose or treatment goal for the patient changes, the change in care type leads to a statistical discharge and a corresponding statistical admission. This means that a person can have multiple hospitalisations recorded for a single stay in hospital.

Prior to 1 July 2013, the care type of 'palliative care' was defined as:

'Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional, and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family.'

It includes care provided:

- in a palliative care unit
- in a designated palliative care program
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

From 1 July 2013, the care type of 'palliative care' was defined as:

'Care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.'

Palliative care is always:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Palliative care excludes care which meets the definition of mental health care.

Changes in the definitions for the care type of 'palliative care' should be considered when interpreting changes over time. The impact of these changes is likely to be minimal given the data included in this report is from 1 July 2015 onwards.

Coding 'palliative care' as a diagnosis

In addition to the information on the provision of palliative care collected via the care type data item, information on palliative care is also recorded in the NHMD under the diagnosis data items. In Australian hospitals, a principal diagnosis is assigned during each hospitalisation. One or more additional diagnoses may also be assigned. The principal diagnosis is 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care' (AIHW 2025b; ACCD 2016). An additional diagnosis is 'a condition or complaint that either co-exists with the principal diagnosis or arises during the episode of care'. Such diagnoses provide information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care (AIHW 2025b; ACCD 2016).

The classification used nationally to assign diagnosis codes is the ICD-10-AM (see Classifications in Technical notes). The specific ICD-10-AM has been updated, with the ninth edition used for 2015–16 and 2016–17 data, the tenth edition used for 2017–18 and 2018–19 data, the eleventh edition used for 2019–20 to 2021–22 data, and the twelfth edition used for 2022–23 data onwards. Further details about each edition, including the differences between editions, can be found in Resources page in IHACPA website. One of the codes in the classification – Z51.5 – is 'palliative care'. While diagnosis codes

usually describe a condition such as a disease, injury, or poisoning, they can also be used in certain instances to indicate the specific care or service provided for a current condition or other reasons for hospitalisation (AIHW 2025). This is the case when a diagnosis code of 'palliative care' is recorded during a hospitalisation.

Starting with the 9th edition of the ICD-10-AM, a specific coding standard ('2116') was created and applied to the recording of 'palliative care' as a diagnosis (ACCD 2015). The classification instruction clarified that 'palliative care' (Z51.5) should only be assigned where there is documented evidence that the patient has been provided with palliative care and that it may be assigned independent of the admitted patient care type. Prior to the ICD-10-AM 9th Edition, standard '0224' was used for coding 'palliative care', where 'palliative care' (Z51.5) must be assigned as an additional diagnosis only, to indicate that the episode of care involved care by a palliative care team. Note, if Z51.5 is reported as a principal diagnosis, the hospitalisation is still counted in this reporting. Therefore, palliative care-related hospitalisations prior to 2015 are not directly comparable with data after 2015.

In 2023–24, there were about 107,500 hospitalisations identified as providing some form of palliative care, regardless of the care type assigned. These hospitalisations are identified by either the assignment of the ICD-10-AM principal or additional diagnosis code of 'palliative care' (Z51.5), or by the assignment of the care type of 'palliative care', or both.

From 2015–16, there was a notable increase in hospitalisations with an additional diagnosis code of 'palliative care', while hospitalisations assigned with a care type of 'palliative care' appeared to increase in a more stable fashion when compared with previous years. This change coincided with the changes mentioned before in the ICD-10-AM coding standard for palliative care that explicitly stated: 'palliative care may be assigned independent of the admitted patient care type'. Therefore, the historical data should be interpreted with caution when interpreting changes over time.

There are evident jurisdictional differences in the level of congruence between the coding of care type and diagnosis items for palliative care patients. For all states and territories, there were some episodes that had only a care type of 'palliative care' or a diagnosis code of 'palliative care' (AIHW 2025b).

Reporting palliative care-related hospitalisations

At its March 2011 meeting, the Australian Health Ministers Advisory Committee's (AHMAC) Palliative Care Working Group endorsed the use of both care type and diagnosis information to identify those hospitalisations for which palliative care was a component of the care provided. Since then, the total number of these hospitalisations was reported to show the widest possible view of the palliative care related activity within admitted patient care. However, this made it difficult to identify specialist palliative care, and thus difficult to reconcile data reported in Palliative care services in Australia with other palliative care data, such as the Palliative Care Outcomes Collaboration (PCOC) data reported in the Palliative care outcomes section of this report.

In view of this, at its November 2019 meeting, AHMAC's new Palliative Care and End-of-life Care Data Development Working Group endorsed the change to separately report on care type and diagnosis information to identify palliative care-related hospitalisations. Therefore, from 2020 onwards, the statistics presented in Palliative care services in Australia distinguish between hospitalisations with a care type of 'palliative care' and those only with a diagnosis of 'palliative care' (Z51.5) but the care type was not recorded as 'palliative care'.

Between 2020 and 2023, the AIHW considered the most appropriate wording for describing hospitalisations for palliative care. From 2023:

- 'primary palliative care hospitalisation' is used to refer to hospitalisations with a recorded care type of 'palliative care'. Between 2020 and 2022, this was referred to as 'palliative care hospitalisation'
- 'other palliative care hospitalisation' is used to refer to a recorded diagnosis of 'palliative care' (Z51.5) but the care type is not recorded as 'palliative care'. Between 2020 and 2022, this was referred to as 'other end-of-life care hospitalisation'. As end-of-life care is generally defined as people who are likely to die within 12 months, this term was changed in 2023 to capture the broader concept of palliative care.

Coverage

For each of the years considered in this report, the coverage of the NHMD has been very good. For example, in 2023–24, coverage for the NHMD was high – data from all public hospitals were included (AIHW 2025b). Most private hospitals also provided data, the exceptions being the private free-standing day hospital facilities and two overnight private hospitals in the Australian Capital Territory. Note that the data for private hospitals and all hospitals (public and private combined) in Tasmania, the Australian Capital Territory and the Northern Territory were not published for confidentiality reasons.

Hospitals may be re-categorised as public or private between or within years (see Local Hospital Networks/Public hospital establishments National Minimum Data Set (NMDS) 2023-24 for further information). This should be considered when comparing data by sector over time.

Data on state/territory of hospitalisation should be interpreted with caution because of cross-border flows of patients. This is particularly the case for the Australian Capital Territory. In 2023–24,17% of hospitalisations in the Australian Capital Territory public hospitals were for patients who lived in New South Wales.

The AIHW *Indigenous identification in hospital separations data: quality report* assessed the quality of Indigenous status identification in Australian public hospitalisations. The results of this study indicated that data for all jurisdictions should be used in any hospital analyses of Aboriginal and Torres Strait Islander (First Nations) people and that the 'true' number of First Nations people was close to 9% higher than the number indicated in hospital records (AIHW 2013). This should be considered when interpreting the hospital data by Indigenous status. Note, no adjustment has been applied to the counts in the hospital data by Indigenous status in this report.

Standard admitted patient care data exclusions

As per the standard AIHW practice when analysing admitted patient data in the NHMD, the data presented in this report exclude those records for which the 'Care type' data item was reported as newborn (unqualified days only), hospital boarder or organ procurement (posthumous).

Further information

Comprehensive hospital statistics from the NHMD are released by the AIHW on an annual basis in Admitted patients (AIHW 2025a) and further information about the NHMD can be obtained from those publications. Metadata information for the Admitted Patient Care and Local Hospital Networks/Public Hospital Establishments NMDS, that are the basis for the AIHW National Hospital Databases, are published in the AIHW's online metadata registry – METEOR and the *National Health Data Dictionary: version16.2*.

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Non-admitted patient palliative care

In this report, non-admitted patient service event refers to care (treatment or consultation) provided in the public hospital system without hospital admission (non-admitted patient). This chapter focuses on palliative care-related service events in 2023–24, highlighting their distribution and characteristics.

Due to changes in the scope of non-admitted care data collections, time series comparisons are not included. Details on how these palliative care-related service events are identified are provided in Box 1 and the Data source.

Palliative and end-of-life care is increasingly delivered outside inpatient settings. This chapter helps address a key gap in community-based services, as identified in the *Palliative Care and End-of-Life Care Information Priorities* [PDF 892KB].

This chapter was last updated in October 2025.

Palliative Care and End-of-Life Care Information Priorities [PDF 892KB]

Identifying palliative care in non-admitted patient care data

People with life-limiting illnesses may receive care in various hospital settings, including wards, emergency departments, and outpatient clinics. This chapter focuses on outpatient care for non-admitted patients, who are not formally admitted and receive care through public hospitals, Local Hospital Networks, or other state-managed services listed under the *National Health Reform Agreement (2011).*

In this report, palliative care-related service events are where the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness and must contain a recorded therapeutic or clinical content that result in a dated entry in the patient's medical record. These non-admitted patient service events are grouped into three categories based on how they are identified in the data:

- Primary palliative care service events: care type of palliative care; includes medical consultations, allied health or clinical nurse specialist interventions, and treatments such as chemotherapy or radiation therapy.
- Medical consultations for palliative care: Tier 2 non-admitted service type as palliative care in medical consultations. These consultations can be categorised as palliative, rehabilitation, or other care by care type.
- Allied health and/or clinical nurse specialist interventions for palliative care: Tier 2 non-admitted service type as palliative care in allied health and/or clinical nurse specialist interventions. These interventions can be categorised as palliative or rehabilitation care by care type.

Note: there is no palliative care class in non-admitted services classified under procedures or diagnostic services. Palliative care service events can be identified as palliative care by care type, by Tier 2 clinics type, or both.

This chapter presents episode-level data on palliative care non-admitted patient service events, sourced from the National Non-admitted Patient Database (NNAP(el)D), which is part of the broader Non-admitted Patient Care Data Collections.

For more details, see Data source.

Key points

In 2023–24, among the 1.0 million palliative care-related service events recorded at episode-level:

- almost 3 in 4 (74%) were for people aged 65 and over
- over 1 in 3 referrals were from hospitals (24% was from the same hospital where service was provided and 13% from other hospitals) and almost 1 in 5 from medical consultations (12% from general practice and 7.1% from specialist practice)
- almost 3 in 4 (72%) were delivered off the hospital campus of the healthcare provider and 1 in 4 (25%) were delivered on the hospital campus of the health care provider.

Socio-demographic and regional characteristics

In 2023–24, there were 40.9 million non-admitted patient care service events reported at episode-level across Australia (AIHW 2025), of which 1.0 million were palliative care-related service events (Table 1 in Data tables: PCSiA 2025 non-admitted patient palliative care).

Of these palliative care-related service events (Figure 1):

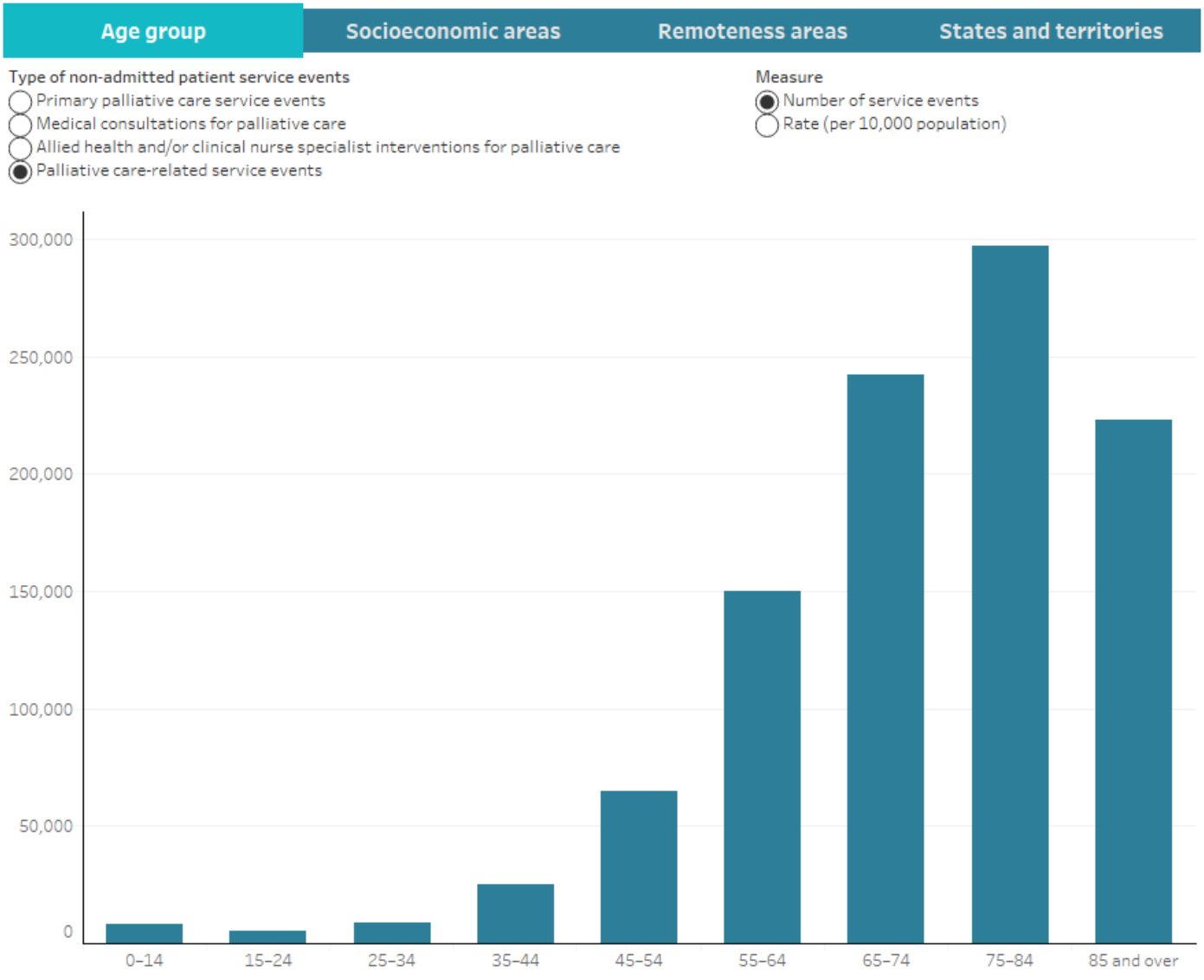
- primary palliative care services events (identified by care type) accounted for 97% of all events – 997,000 or 370 per 10,000 population. Only 2.7% of palliative care services events were identified solely by Tier 2 clinic type (see Box 1 for further details)
- almost 3 in 4 (74%) were provided to people aged 65 and over, 15% to people aged 55-64, and 11% for people aged under 55. The median age at the time of receiving the service was 75 years
- 30,900 (3%) were provided to Aboriginal and Torres Strait Islander (First Nations) people, equating to 303 service events per 10,000 population
- the rate of service events were higher for people living in areas of most socioeconomically disadvantaged - 425 service events per 10,000 population for people compared to 290 service events per 10,000 for people living in the least socioeconomically disadvantaged areas, respectively.

As highlighted in Figure 1, there were **regional variations** in palliative care-related service events. For example, the rate of palliative care-related service events was higher in *Inner regional* (475 per 10,000) and *Outer regional* (451 per 10,000) areas than *Major cities* (316 per 10,000) and *Remote and very remote* areas (395 per 10,000).

Figure 1 also highlights variations by states and territories. Information on palliative care service events at the Primary Health Networks (PHN) level are included in Table 2 and in the PHN palliative care services information chapter.

Note, that regional differences in palliative care service events may be influenced by variations in admission policies, practices, service types and the scope of hospitals across jurisdictions.

Figure 1: Distribution of palliative care-related service events, by socio-demographic and regional characteristics, 2023-24



Source: AIHW. NAP Table 1.
https://www.aihw.gov.au/pcsia

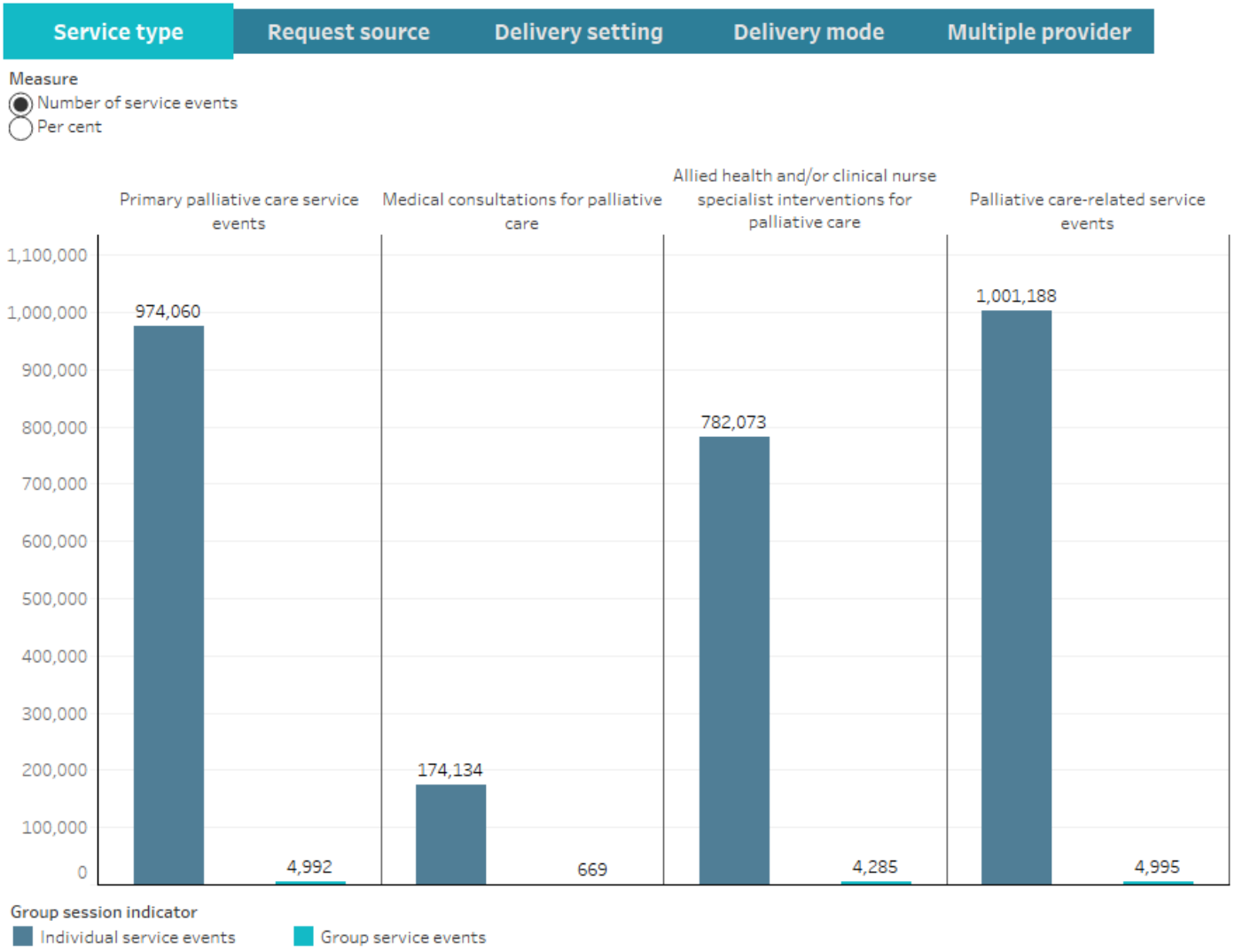
Characteristics of palliative care-related service events

In 2023–24, among the 1.0 million episode-level palliative care-related service events (Figure 2):

- over 1 in 3 referrals were from hospitals (24% was from the same hospital where service was provided and 13% from other hospitals) and almost 1 in 5 from medical consultations (12% from general practice, 7.1% from specialist practice)
- almost 3 in 4 (72%) were delivered off the hospital campus of the health care provider, and 1 in 4 (25%) were delivered on the hospital campus of the health care provider
- almost half were delivered by telephone (49%) or in person (46%).

Details on service events, including whether they were delivered to individuals or involved multiple health care providers, as well as information on funding sources, are available in Tables 3–4.

Figure 2: Characteristics of palliative care-related service events, 2023–24



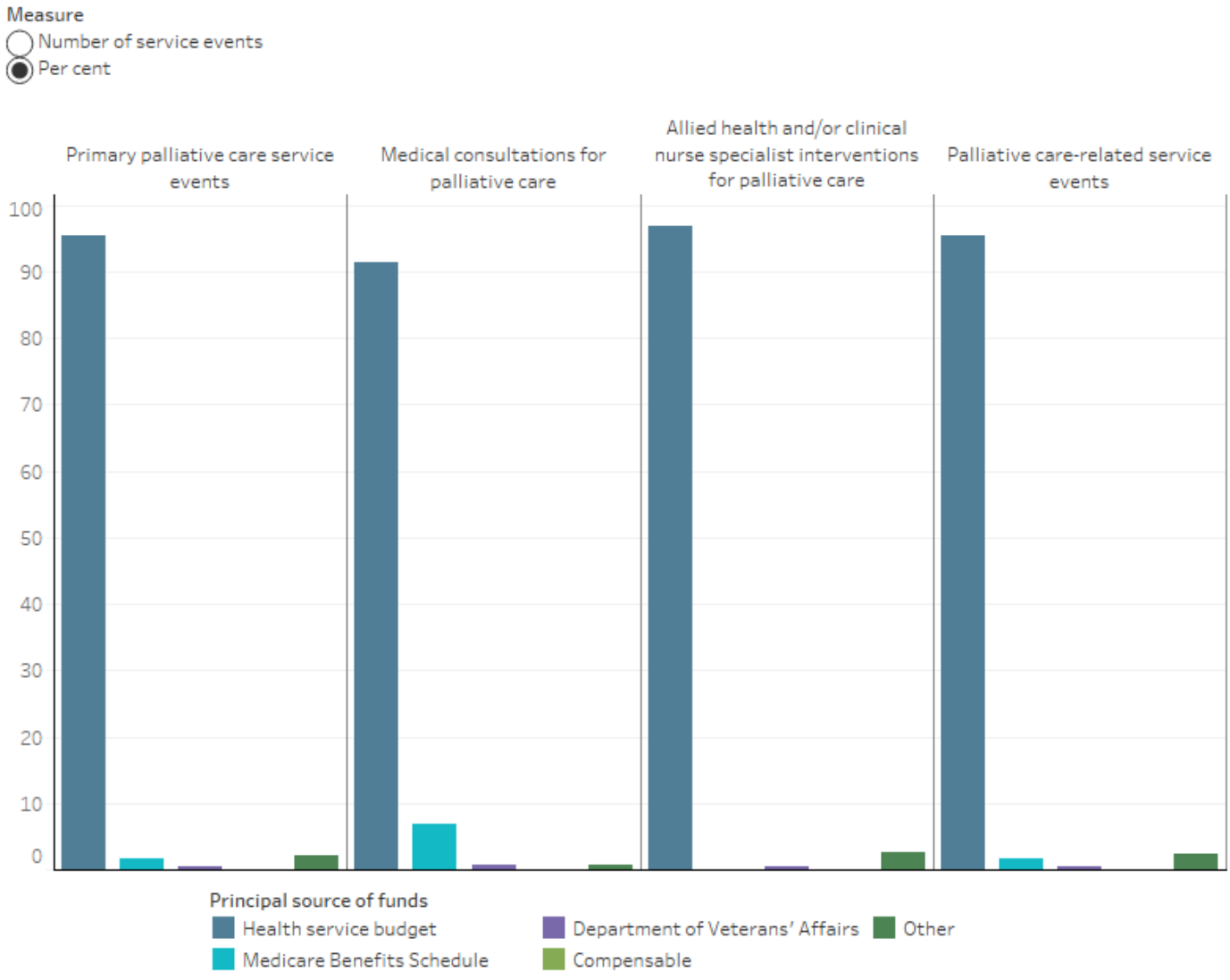
Note: The per cent of 'Service type' may not sum to 100% for each category of non-admitted patient service events for palliative care, as the data on records with the 'Service request source' as 'Unknown' are not presented in the figure.
Source and notes: AIHW. NAP Table 3.
https://www.aihw.gov.au/pcsia

Principal funding source

Of the 882,000 episode-level palliative care-related service events in 2022–23 (Figure 4):

- 96% were funded through the health service budget, and 1.7% were funded under the Medicare Benefits Schedule
- 6.9% of medical consultations for palliative care were funded under the Medicare Benefits Schedule – this proportion was higher than allied health and/or clinical nurse specialist interventions for palliative care, and primary palliative care service events (0.1% and 1.7%, respectively).

Figure 4: Principal funding source of palliative care-related service events, 2022–23



Notes
1. Health service budget includes Health service budget not covered elsewhere, due to eligibility for Reciprocal Health Care Agreement, and no charge raised due to hospital decision.
2. Compensable includes Worker's compensation, Motor vehicle third party personal claim or Other compensation.
3. Other includes Department of Defence, Correctional facilities, Other hospital or public authority (contracted care), Private health insurance, Self-funded, Other funding source, or Not known.
Source: AIHW. NAP Table 4.
https://www.aihw.gov.au/pcsia

Data source

Non-admitted Patient Care Data Collections

Data on non-admitted patient palliative care are sourced from the Non-admitted Patient Care Data Collections, which includes information on non-admitted patient service events provided by public hospitals, Local Hospital Networks, and other public hospital services, managed by state or territory health authorities in Australia. The latest available data at the date of publication of this report is 2023–24. A complete Non-admitted patient care data collections: Data Quality Statements 2023–24 [PDF 403KB] is available online.

The Non-admitted Patient Care Data Collections include both aggregated clinic-level and episode-level details, providing insights into outpatient clinic activities, individual and group service events, and the various funding sources of these services. This report only includes the episode-level data for palliative care-related service events, which is based on data in the National Non-admitted Patient Database (NNAP(el)D). The NNAP(el)D is collected under the Non-admitted patient National Best Endeavours Data Set (NAP NBEDS) and includes information on:

- type of outpatient clinic
- type of care provided
- selected patient characteristics
- selected characteristics for the services events, such as service request source, delivery mode and setting
- funding source of service events.

Note that for NNAP(el)D, counts represent each service event, not each patient. Therefore, patients who receive more than one non-admitted patient service event in the reporting period will have more than one record in the NNAP(el)D.

The scope of NAP NBEDS is non-admitted patient service events involving non-admitted patients provided by:

- public hospitals
- Local Hospital Networks
- other public hospital services that are managed by a state or territory health authority and are included in the General list of in-scope public hospital services, which have been developed under the *National Health Reform Agreement (2011)*.

The scope of NAP NBEDS excludes:

- non-admitted services provided to admitted patients and emergency department patients
- the community mental health care services
- the service events which are delivered as non-clinical care (such as home-based care).

The Tier 2 Non-Admitted Services Classification (Tier 2) categorises a hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service. Tier 2 is classified to one of the groups below based on the predominant nature of the service provided:

- Procedures: used to capture clinics where health care professionals provide procedural based health services. These may include COVID-19 vaccination, treatment chemotherapy, radiation therapy, renal dialysis and so on.
- Medical consultation services: used to capture clinics where the nature of the medical consultation means it is typically provided by a medical practitioner, a nurse practitioner or an endorsed midwife practitioner. In medical clinics, it is assumed that there may also be input from allied health personnel and/or clinical nurse specialists. These services include COVID-19 response, pain management, general practice and primary care, paediatric medicine and surgery, and so on.
- Diagnostic services: used to capture clinics that provide diagnostic services as inputs to the health care services of other non-admitted clinics. The services include COVID-19 response diagnostics, Medical Resonance Imaging (MRI), Computerised Tomography (CT), mammography screening, clinical measurement and so on.
- Allied health or clinical nurse specialist intervention services: used to capture clinics where there are allied health personnel and/or clinical nurse specialists providing the majority of services in a clinic. The services include COVID-19 response, aged care assessment, primary health care, rehabilitation, social work and so on.

A full list of services in each Tier 2 class in the reporting period can be found in the Tier 2 National Index 2023-24.

Patient episodes are then allocated to classes based on the predominant specialisation, which may be formed around the clinician, patient condition, patient population group or type of care.

Identifying non-admitted patient palliative care

Two data items – 'care type' and 'Tier 2 Outpatient Clinic type' – capture information indicating palliative care has been provided to a patient.

Coding 'palliative care' as a 'care type'

A 'care type' is recorded in the NNAP(el) database and assigned for each non-admitted patient service event. It describes the type of care provided at a non-admitted patient service event. As such, a patient can be counted as multiple non-admitted patient service events in one day, provided that every visit meets each of the criteria in the service event definition.

In this report, the 'care type' recorded as 'palliative care' (primary palliative care service events) refers to non-admitted patient care with a recorded care type of palliative care. These services may include medical consultations for palliative care, developmental disabilities, general medicine, medical and radiation oncology; allied health and/or clinical nurse specialist interventions for palliative care, nutrition/dietetics, Geriatric Evaluation and Management (GEM) and oncology; and treatment chemotherapy, treatment radiation therapy, minor surgical and minor medical procedures.

Coding ‘palliative care’ as a ‘Tier 2 Outpatient Clinic type’

In addition to the information on the provision of palliative care collected via the ‘care type’ item, information on palliative care is also recorded in the NNAPC(agg)D and NNAP(el) database under ‘Tier 2 Outpatient Clinic Type’. Tier 2 categorises hospital’s non-admitted services into classes based on the clinician and the service provided (IHACPA 2023).

In this report, the Tier 2 Non-Admitted Services Definitions Manual 2023–24 was used to identify services related to palliative care, including:

- Medical consultations for palliative care (coded as 20.13 for palliative care): non-admitted patient care with a recorded Tier 2 as palliative care in medical consultations. These consultations can be categorised as palliative care, rehabilitation care or other care by care type.
- Allied health and/or clinical nurse specialist interventions for palliative care (coded as 40.35 for palliative care): non-admitted patient care recorded as Tier 2 palliative care in allied health and/or clinical nurse specialist interventions. These interventions can be categorised as palliative care or rehabilitation care by care type.

For more information, see IHACPA website.

Coverage

Each year the collection increasingly reports on episode-level data, however, not all data suppliers are able to report data in this format. In 2023–24, 90% of non-admitted patient service events were recorded at the episode-level. The data presented in this report therefore is likely to underestimate the counts of all non-admitted patient service events for palliative-care delivered in Australia. There are variations among states and territories in admission practices and the types of services provided for non-admitted patients through hospitals (AIHW 2017). This must be considered when interpreting non-admitted patient data.

Note that due to the evolving scope of the non-admitted patient care data collections, reporting on time series data are not recommended (AIHW 2025b).

Further information

Comprehensive hospital statistics from the Non-admitted Patient Care Data Collections, including further information about these collections, are released by AIHW on an annual basis in Non-admitted patients (AIHW 2025a). Metadata information for the Non-admitted Patient Care data for the reporting period is published in the AIHW’s online metadata registry – Non-admitted patient care aggregate NBEDS 2024-25 and Non-admitted patient NBEDS 2024-25.

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AIHW (2025b) *Non-admitted patient care 2023–24 Appendix information [PDF 402KB]*, AIHW, Australian Government, accessed 21 August 2025.

IHACPA (Independent Health and Aged Care Pricing Authority) (2023) *Tier 2 Non-Admitted Services Compendium 2023–24*, IHACPA, Australian Government, accessed 21 August 2025.

Medicare-subsidised palliative medicine attendance and case conference services

This chapter provides information related to Medicare-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians or specialists and the characteristics of people who received them over the period 2015–16 to 2024–25. Further information about how these services are identified through the Medicare Benefits Schedule (MBS) data is provided in Box 1 and the Data source.

The information in this chapter was last updated in May 2026.

Box 1: Identifying palliative care services in MBS data

The data presented in this chapter relate only to palliative medicine attendances/consultations and case conferencing services that are both provided by palliative medicine physicians/specialists and are claimed under specialist palliative care MBS item numbers. For more information, see Data source.

Note that palliative medicine physicians and specialists may, at times, use other MBS items when attending to palliative care patients and that other health professionals also attend to terminally ill patients and provide palliative care. Unless otherwise stated, these items are not included in the data here, as they are not claimed specifically as a palliative care-related service and cannot be identified in the MBS data.

Key points

In 2024–25, for Medicare-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists:

- 15,900 people received these services (58.4 people per 100,000 population)
- 78,100 services were provided, at an average of 4.9 services per person
- 5 in 6 services (85% or 66,200) were for attendances in a consulting room or hospital, 3.6% (2,800) were for attendances in other settings and 11.6% (9,100) were for case conference services.

The number of Medicare-subsidised palliative medicine attendance and case conference services has declined from a peak of 90,600 services in 2018–19 to 78,100 services in 2024-25, with an average annual decrease of 2.4% over five years. This was broadly consistent with the pattern observed for the number of people receiving these services over the same period.

Socio-demographic and regional characteristics

In 2024–25, there were 78,100 Medicare-subsidised palliative medicine attendance and/or case conference services provided to 15,900 people (58.4 people per 100,000 population), an average of 4.9 services per person.

For these services (Figure SER 1):

- Almost 4 in 5 (78%) of the people receiving services were aged 65 and over, including 25% for people aged 85 years and over.
- The number of services per person was similar for all age groups between 25–84 (4.3–5.6 services per person) and considerably lower for people aged under 25 years (1.3 services per person).
- More than 5 in 6 services (85% or 66,200) were for attendances in a consulting room or hospital, 3.6% (2,800) were for attendances in other settings (such as in a person's place of residence) and 12% (9,100) were for case conferences.

As highlighted in Figure SER 1, there were regional variations in the number of people receiving these services. For example, people living in *Major cities* were almost 5 times as likely to receive these services as people living in *Remote and very remote* areas (63 and 13 per 100,000 population, respectively). It should be noted that the vast majority of employed palliative medicine physicians and nurses work in *Major cities*. For further details, see Palliative care workforce. Figure SER 1 also shows state and territory variations in palliative medicine attendance and/or case conference services.

Information on Medicare-subsidised palliative medicine attendance and/or case conference services at the Primary Health Network (PHN) level are included in Table 2 and the PHN palliative care services information chapter.

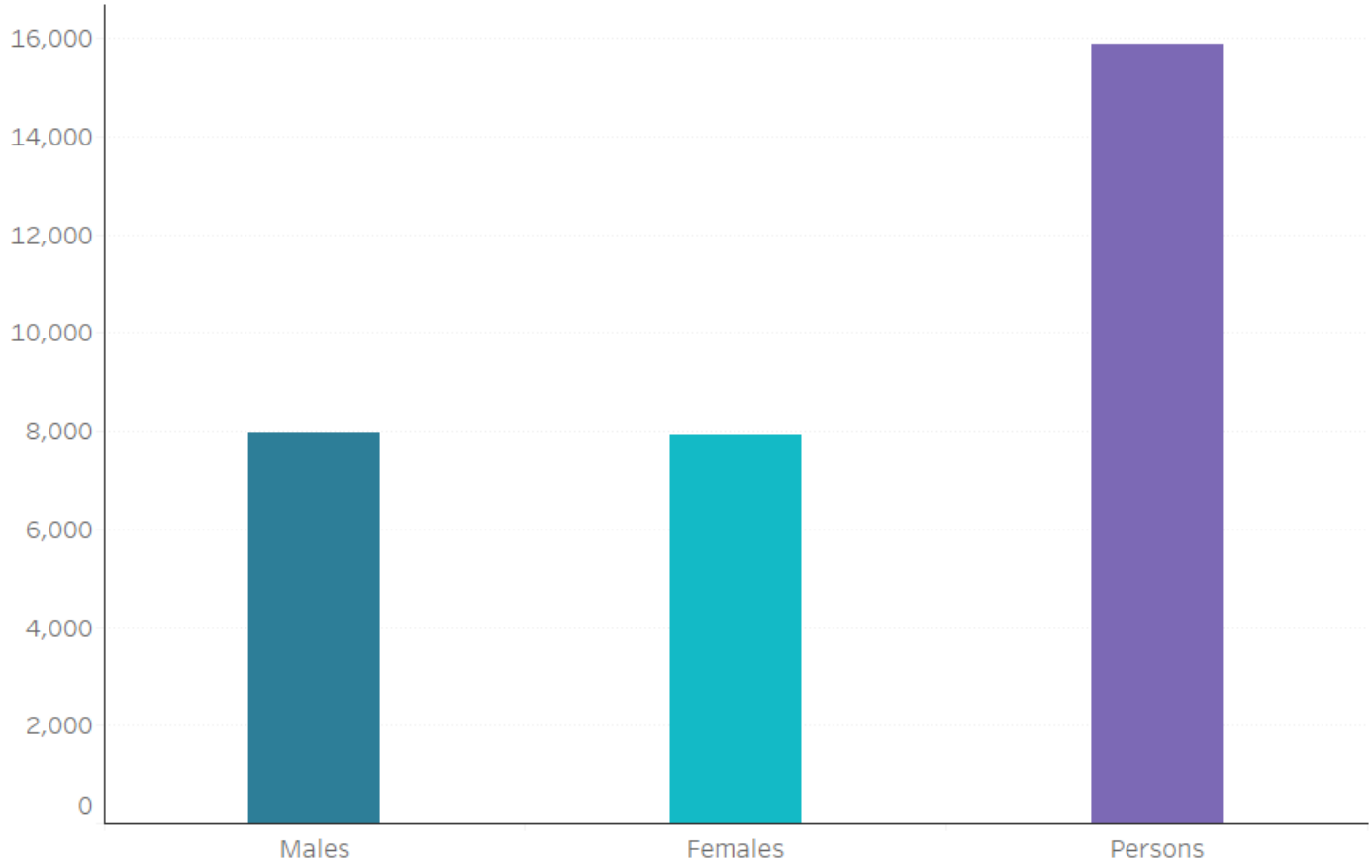
Figure SER 1: Medicare-subsidised palliative medicine attendance and case conference services and people receiving them, 2024–25

Sex | Age group | Service type | States/territories | Remoteness areas

Select measure

- (●) Number of people
- ( ) Number of services
- ( ) Rate of people (per 100,000 population)
- ( ) Rate of services (per 100,000 population)
- ( ) Services per person

Figure SER 1.1: Medicare-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists and people receiving them, by sex, 2024–25



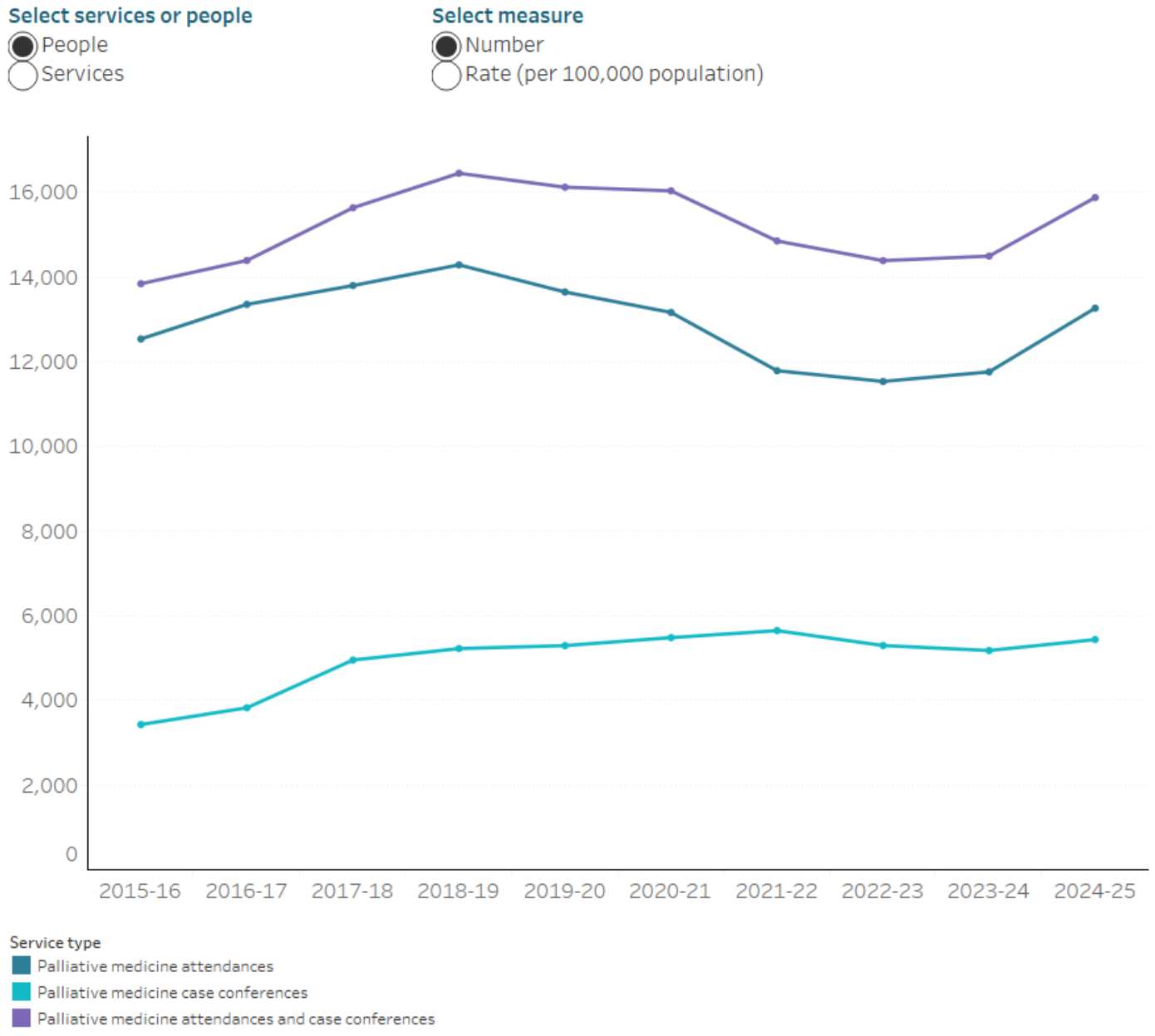
Source and notes: AIHW. Medicare-subsidised palliative medicine attendance and case conference services Table 1.
https://www.aihw.gov.au/pcsia

Trends

There was a slight increase in the number of Medicare-subsidised palliative care medicine attendance and case conference services from 70,400 in 2023–24 to 78,100 in 2024–25, after several years of decline from a peak of 90,600 services in 2018-19. Despite this increase, the overall trend since 2018–19 still reflects an average annual decrease (2.4% per year). Conversely, for the number of people receiving these services, the trend since 2018-19 reflects an average annual increase of 0.6% per year.

A different pattern is observed for all services from palliative medicine specialists/physicians, which has been increasing steadily from 123,400 to 149,700 between 2018–19 and 2024–25 (average annual increase of 3.3%). These diverging patterns have resulted in declines in the proportion of attendance services from palliative medicine specialists/physicians that were claimed under palliative medicine attendances and case conferences from 74% to 52%. This may suggest that palliative medicine specialists/physicians are increasingly using other MBS items when attending to palliative care patients.

Figure SER 2: Trends in Medicare-subsidised palliative medicine attendance and case conference services and people receiving them, 2015–16 to 2024–25



Source and notes: AIHW. Medicare-subsidised palliative medicine attendance and case conference services Table 6.
https://www.aihw.gov.au/pcsia

Data source

Medicare Benefits Schedule data

The Medicare Benefits Schedule (MBS) is part of Australia's public health insurance scheme. Through the MBS, the Australian Government subsidises the costs of a broad range of health services. The MBS subsidies pay all or part of the costs of these services, dependent on factors such as patient eligibility, the type of service and choices by health practitioners regarding the fees they charge for their services. MBS benefits are claimable only for services rendered by an appropriate health practitioner and which are listed on the MBS.

Services Australia collects administrative data in processing claims for benefits under the MBS and provides this information to the Australian Government Department of Health, Disability and Ageing. The item numbers and benefits paid by Services Australia are determined based on the MBS, as listed in MBS Online.

The data presented in this report relate to services provided on a 'fee-for-service' basis for which MBS benefits were paid, and only for palliative medicine attendances and case conferencing services that are both provided by palliative medicine physicians or specialists, and are claimed under specialist palliative care MBS item numbers.

Patients who are referred to specialists or physicians in palliative medicine usually have:

- intermediate and fluctuating needs that might result in unplanned use of hospital and other services, and/or
- complex and persistent needs (physical, social, emotional, or spiritual) that are not effectively managed through established protocols (PCA 2018).

Information is also provided on the settings where the attendances were provided – in hospital or consulting room, or in other settings, such as attendance at a person's place of residence, including home, residential aged care or institution (see Table SER 1). For case conferencing, it refers to community case conference and discharge case conference (see Table SER 2).

Table SER 1: MBS items for palliative medicine attendances provided by palliative medicine physicians or specialists in this report

MBS item	MBS group and subgroup	MBS item number
Attendance in a consulting room or hospital, initial brief video conference	Group A24	3003*
Attendance in a consulting room or hospital, initial visit	Group A24	3005
Attendance in a consulting room or hospital, subsequent visit, minor, after initial attendance	Group A24	3014
Attendance in a consulting room or hospital, subsequent visit, other than a minor attendance	Group A24	3010
Attendance in a consulting room or hospital, video conference	Group A24	3015*
Attendance in a place other than consulting rooms or hospital, initial visit	Group A24	3018
Attendance in a place other than consulting rooms or hospital, subsequent visit	Group A24	3023
Attendance in a place other than consulting rooms or hospital, subsequent visit, minor, after initial attendance	Group A24	3028

* Items 3003 and 3015 ceased on 31 December 2021, with telehealth services now claimed against relevant item numbers in Group A40.

Note: Refer to the Medicare Benefits Schedule Book July 2024 edition for full item descriptions (pages 308–309) and further information relating to MBS items for palliative care (pages 118–119).

Table SER 2: **MBS items for palliative medicine case conferences provided by palliative medicine physicians or specialists in this report**

MBS item	MBS group and subgroup	MBS item number
Organise and coordinate a community case conference 15–<30 minutes	Group A24	3032
Organise and coordinate a community case conference 30–<45 minutes	Group A24	3040
Organise and coordinate a community case conference >=45 minutes	Group A24	3044
Participate in a community case conference 15–<30 minutes	Group A24	3051
Participate in a community case conference 30–<45 minutes	Group A24	3055
Participate in a community case conference >=45 minutes	Group A24	3062
Organise and coordinate a discharge case conference 15–<30 minutes	Group A24	3069
Organise and coordinate a discharge case conference 30–<45 minutes	Group A24	3074
Organise and coordinate a discharge case conference >=45 minutes	Group A24	3078
Participate in a discharge case conference 15–<30 minutes	Group A24	3083

Participate in a discharge case conference 30–<45 minutes	Group A24	3088
Participate in a discharge case conference >=45 minutes	Group A24	3093

Note: Refer to the Medicare Benefits Schedule Book July 2024 edition for full item descriptions (pages 309–311) and further information relating to MBS items for palliative care (pages 118–119).

Palliative care physicians and specialists may at times use other MBS item numbers when attending to palliative care patients. These items are not included in the data in this report, as they are not claimed specifically as a palliative care-related service under the MBS. Further, other medical practitioners (general practitioners and medical specialists) and health professionals also attend to terminally ill patients and provide palliative care, without the service being eligible to be claimed specifically as a palliative care-related service under the MBS. In other words, the reported number of patients who receive a palliative care-related service under the MBS is a known underestimate of total palliative care activity. Further, the data does not include referred attendances by palliative medicine physicians or specialists to public inpatients or public outpatients of hospitals and services funded from the Department of Veterans' Affairs National Treatment Account.

It should be noted that a patient may access more than one type of these specific MBS items provided by palliative medicine physicians or specialists during the reporting period and that each service is counted separately in this report.

The MBS data presented in this report (2024–25 and trend data) are based on the date the service was provided rather than the date of service processing, as this more accurately reflects the date a service occurred. This only includes services that were processed on or before 30 Nov 2025. Note that in reports released prior to 2022, the data was based on the date the service was processed by Services Australia and as a result, the data presented since 2022 releases are not comparable with previous releases.

References

PCA (Palliative Care Australia) (2018) *Palliative Care Service Development Guidelines*, PCA website, accessed 21 February 2025.

Palliative care-related medications

This chapter provides information related to palliative care-related prescriptions from Palliative Care Schedule under Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) and the characteristics of people who received them over the period 2016–17 to 2024–25.

Note that the data presented on this page do not include all medications prescribed for palliative care purposes, due to data availability (see Box 1). Further information about how these prescriptions are identified through the PBS and RPBS is provided in the Data source.

The information in this chapter was last updated in May 2026.

Box 1: Identifying palliative care-related medications in PBS data

The data presented in this chapter relate primarily to medications listed on the PBS Palliative Care Schedule (referred to as palliative care-related prescriptions). This does not capture all medications prescribed for palliative care purposes, as some palliative care medicines (for example, morphine) are prescribed from the General Schedule. Further, the PBS and RPBS data do not capture over the counter medicines, medicines supplied to public hospital inpatients, and private prescriptions.

Information is also presented on medications prescribed by palliative medicine specialists from all schedules and are therefore likely to include prescriptions prescribed for both palliative care and non-palliative care reasons.

See Data source for further information.

Key points

In 2024–25:

- there were 1.6 million palliative care-related prescriptions provided to 488,000 people, equating to 3.2 prescriptions per person
- 8 in 10 (80% or 1.2 million) palliative care-related prescriptions were for pain relief
- general practitioners prescribed 89% of palliative care-related prescriptions, with 4 in 5 (82%) of these being for pain relief.

Between 2016–17 and 2024–25, the average annual change in palliative care-related prescriptions was 7.0% (908,000 to 1.6 million). Meanwhile, the number of people dispensed palliative care-related prescriptions declined by -0.2% per year (495,000 to 488,000). Consistent with these patterns, the number of prescriptions per person increased from 1.8 to 3.2 over this period.

Socio-demographic and regional characteristics

In 2024–25, 1.6 million palliative care-related prescriptions were dispensed to 488,000 people (1.8% of the population), an average of 3.2 prescriptions per person.

For these palliative care-related prescriptions (Figure MED 1):

- more females than males received prescriptions (273,000 females and 215,000 males). Females also had a higher average number of prescriptions per person than males (3.3 prescriptions per female and 3.1 per male).
- 3 in 5 (60%) prescriptions were dispensed to people aged 65 and over, with the number of prescriptions per person also highest for this age group – around 3.5 prescriptions per person compared with 2.2 prescriptions per person for people aged less than 45 years.

As highlighted in Figure MED 1, there were regional variations in the number of people receiving these prescriptions. For example, people living in *Inner regional* and *Outer regional* areas were more likely to be dispensed palliative care-related prescriptions (about 2.4%) than people in other areas (1.6% in *Major cities* and 1.3% in *Remote and Very remote* areas). Note that medicines distributed through Remote Area Aboriginal Health Services are not included in these data.

Figure MED 1 also shows variations across state and territory in palliative-care related prescriptions rates per 100,000 population ranging from 8431.7 per 100,000 population in Tasmania to 2,275.4 per 100,000 population in the Northern Territory.

Further information on palliative care-related prescriptions at the Primary Health Network (PHN) level are included in Table 2 in the Data tables for Palliative care-related medications.

Figure MED 1: Prescriptions and people receiving them from PBS Palliative Care Schedule, 2024–25

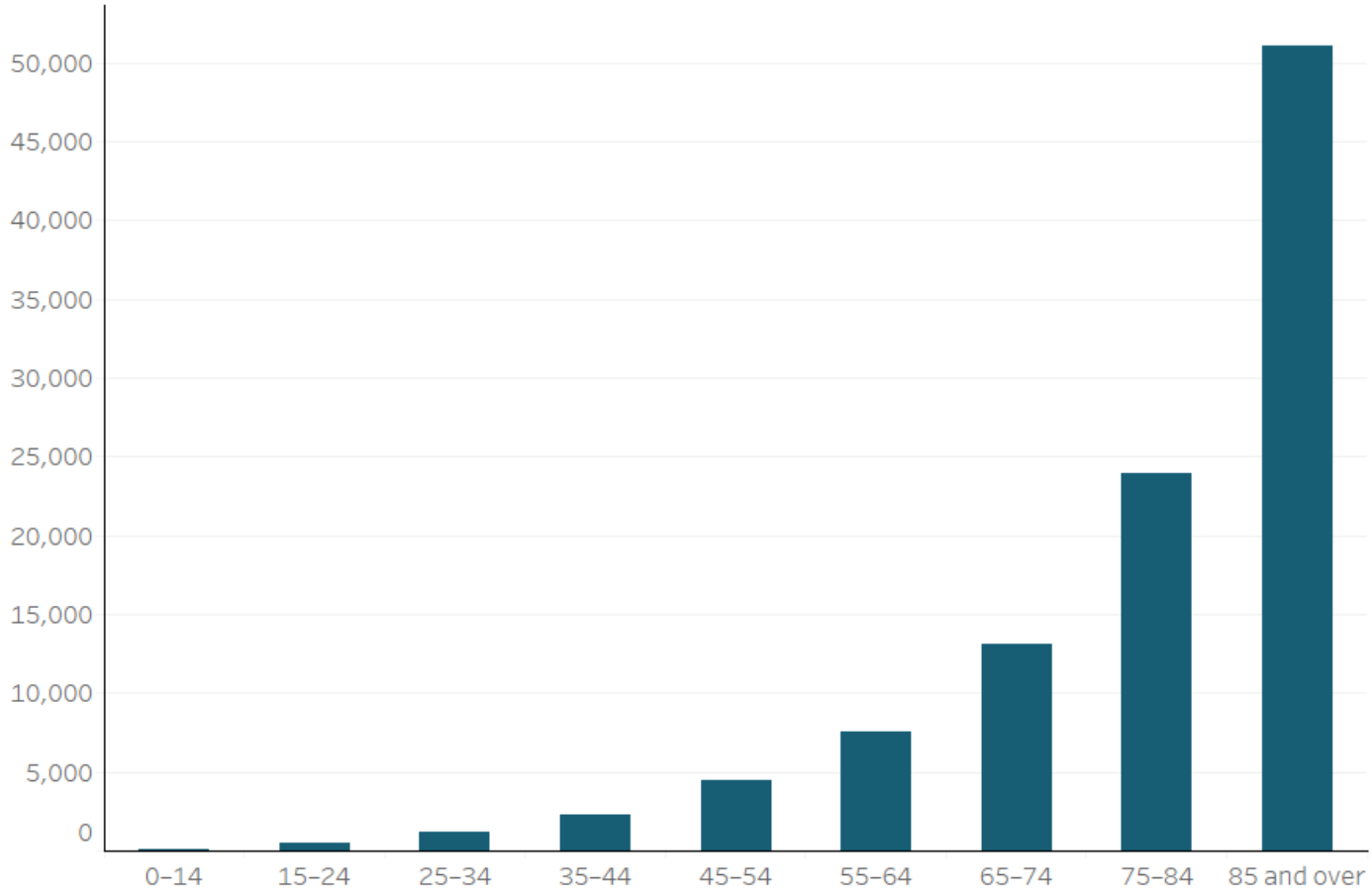
Select characteristics

- ○ Sex
- ◉ Age group
- ○ States and territories
- ○ Remoteness areas

Select measure

- ○ Number of people
- ○ Number of prescriptions
- ○ Prescriptions per person
- ○ Rate of people (per 100,000 population)
- ◉ Rate of prescriptions (per 100,000 population)

Figure MED 1.1: Prescriptions from PBS Palliative Care Schedule and people receiving them, by age group, 2024–25



Source and notes: AIHW. Palliative care-related medications Table 1.
https://www.aihw.gov.au/pcsia

Medication groups and people prescribing these prescriptions

In 2024–25, of the 1.6 million palliative care-related prescriptions dispensed (Figure MED 2):

- 8 in 10 (80%) were for pain relief – equating to 1.2 million prescriptions or 3.1 prescriptions per person. The next most common medication groups were gastrointestinal symptoms and neurological symptoms (8.9% and 9.0% respectively), followed by psychological symptoms (1.5%) and respiratory symptoms (1.0%).
- General practitioners (GPs) prescribed the majority (89%) of palliative care-related prescriptions, while palliative medicine specialists prescribed 1.3% of medications. The remainder (10%) were prescribed by other clinicians (including medical specialists from other disciplines and nurse practitioners).
- GPs were more likely than palliative medicine specialists to prescribe medications for pain relief (82% compared with 70%, respectively). Palliative medicine specialists were more likely than GPs to prescribe medications for other symptoms – almost twice as likely to prescribe medications for gastrointestinal symptoms (14% compared to 8.5%) and over 4 times as likely for psychological symptoms (6.0% compared to 1.3%).

For further details on these prescriptions, see Table MED 1 in Data source.

Pain relief medications

Pain management is an integral component of quality palliative care. Pain-relieving medications are often used in conjunction with other strategies. It can be due to a life-limiting illness, its treatment, debility or comorbid illnesses.

For further information, see Therapeutic Guidelines: Palliative Care.

In 2024–25, of the 1.2 million pain relief prescriptions, *opioids* and *other analgesics and antipyretics* were the two common types (38% and 44%, respectively), followed by *non-steroidal anti-inflammatory and antirheumatic* products (19%; Figure MED 2).

Most pain relief prescriptions were initial scripts (66% of the 1.2 million prescriptions), with *opioid* prescriptions more likely to be initial scripts (84%) than *non-steroidal anti-inflammatory and antirheumatic (54%) and other analgesics and antipyretics (57%)* products (Table 6 in Data tables for Palliative care-related medications).

Note that some pain relief medicines can be bought 'over the counter', which means that people do not need a prescription from the doctor to access them. These medications are not included in this report.

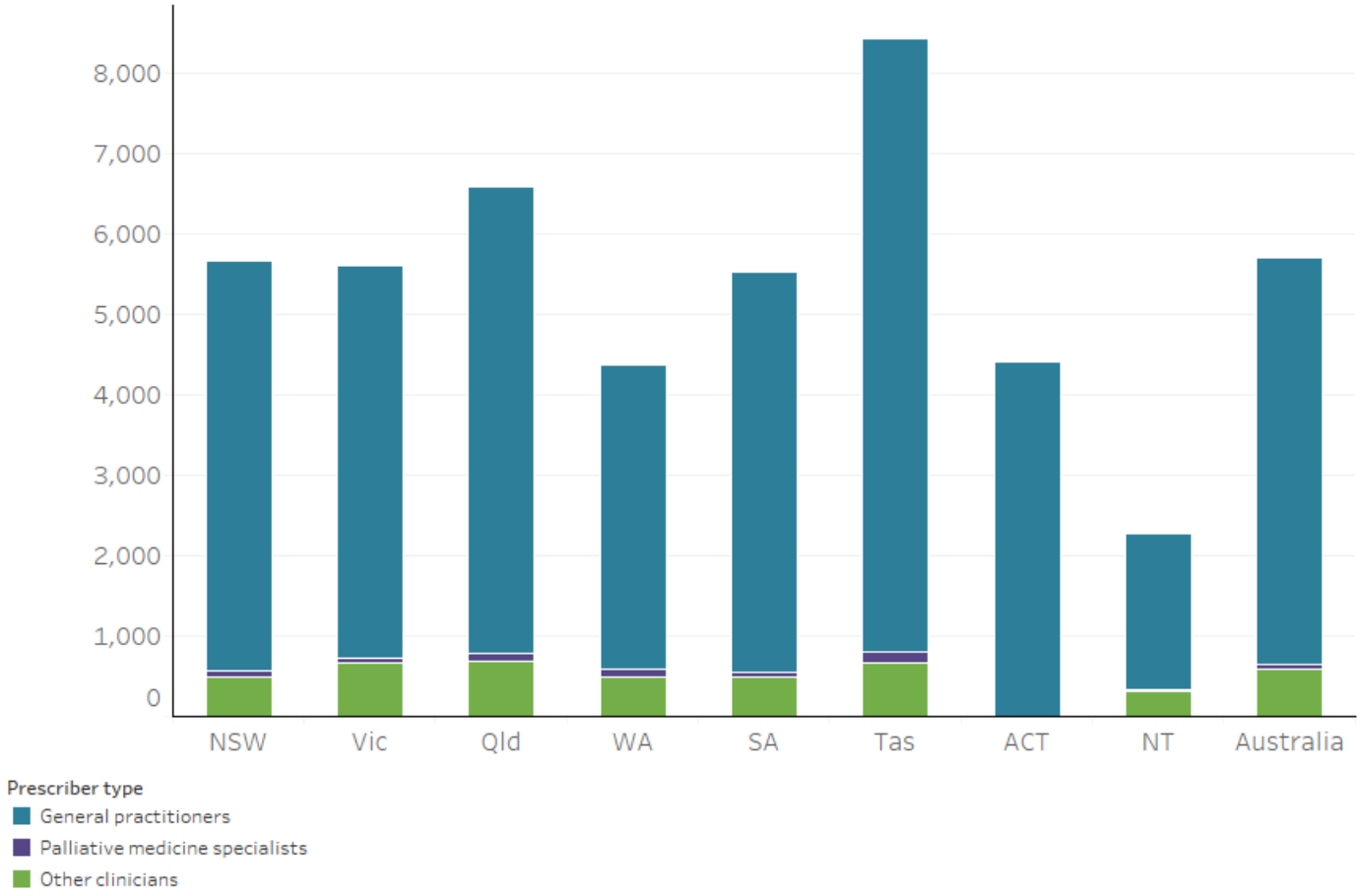
For further details on the coverage and scope of PBS and RPBS, see Data source.

Figure MED 2: Prescriptions from PBS Palliative Care Schedule, by prescriber type, 2024–25

Prescriber type | Medication by prescriber | Medication group | Pain relief medication

Select measure
- ○ Number of prescriptions
- ○ Per cent
- ● Rate (per 100,000 population)

Figure MED 2.1: Prescriptions from PBS Palliative Care Schedule, by prescriber type and states and territories, 2024–25



Note: 'Other clinicians' includes medical specialists from other disciplines, and nurse practitioners.
Source and notes: AIHW. Palliative care-related medications Table 5.
https://www.aihw.gov.au/pcsia

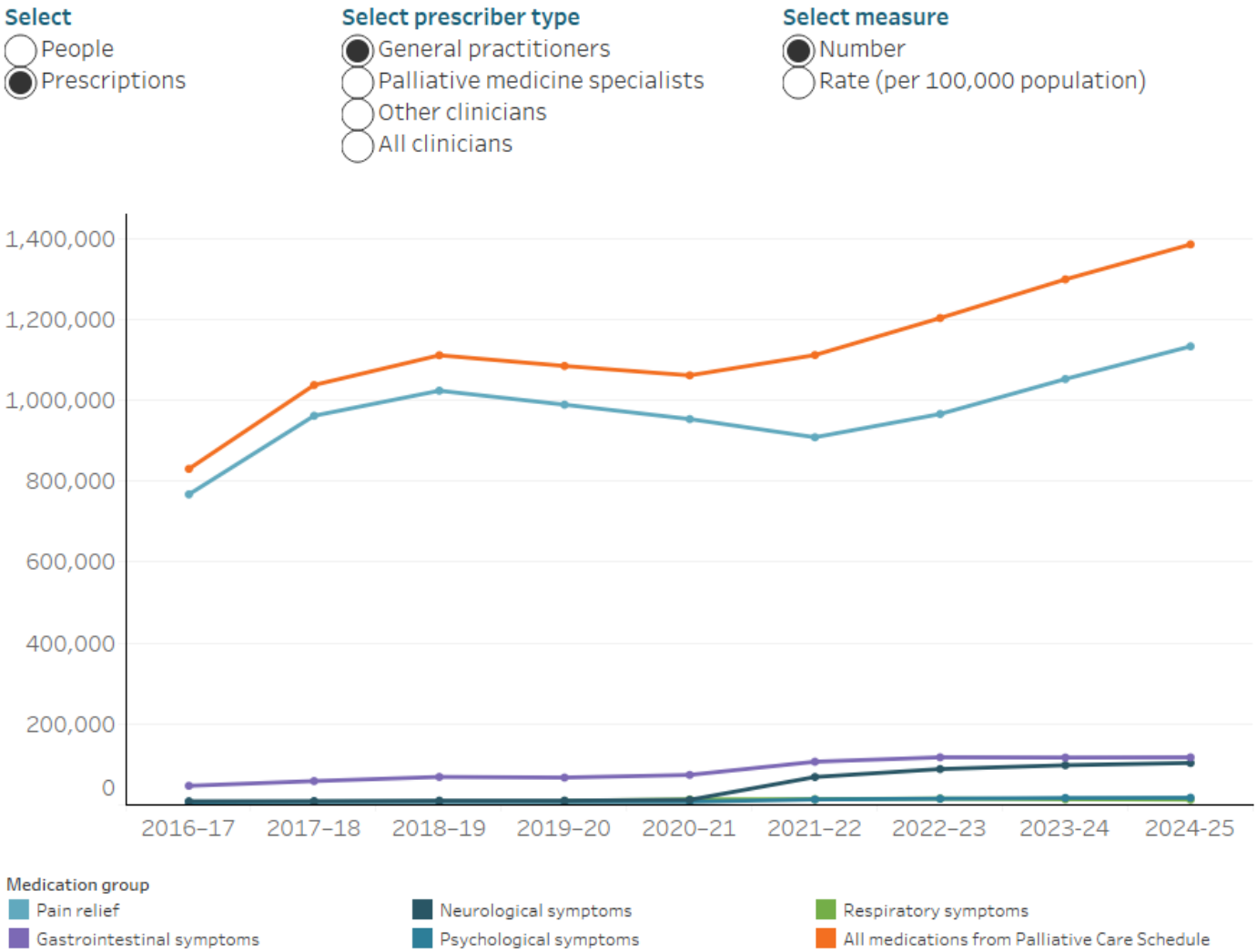
Trends

Between 2016–17 and 2024–25, the number of palliative care-related prescriptions increased overall by 72%, rising from 908,000 to 1.6 million, except for a decline in 2020–21. However, the number of people dispensed palliative care-related prescriptions slightly declined from 495,000 to 488,000 (1.4% decline). Consistent with these patterns, the number of prescriptions per person increased from 1.8 to 3.2 over the same period (Figure MED 3).

A similar increasing trend was also observed for prescriptions dispensed by GPs, palliative medicine specialists and other clinicians. However, in the year to 2021–22 there was a steep increase in the number of prescriptions dispensed – nearly tripling from 6,400 to 17,900 for palliative care specialists. This compares with a more modest increase for prescriptions from GPs (4.7% increase) and other clinicians (29% increase) between 2020–21 and 2021–22.

The sharp rise in palliative care-related prescriptions from palliative medicine specialists reflects a combination of policy changes, health care system adjustments, and shifts in prescribing practices. New medication listings to the PBS Palliative Care Schedule from June 2021 for gastrointestinal, psychological, and neurological symptoms, resulted in an increase in prescriptions related to these medication groups (for further details see 2023 edition of this report in Archived content).

Figure MED 3: Trends in prescriptions from PBS Palliative Care Schedule and people receiving them, 2016–17 to 2024–25



Notes:
1. 'Other clinicians' includes medical specialists from other disciplines, and nurse practitioners.
2. The data for prescriptions of respiratory symptoms and people receiving them are available from 2019-20.
Source and notes: AIHW. Palliative care-related medications Table 9.
https://www.aihw.gov.au/pcsia

Data source

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

Services Australia collects administrative data while processing prescriptions dispensed under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data and provides these data to the Australian Government Department of Health, Disability and Ageing.

Through the PBS and RPBS data, the Australian Government subsidises the cost of pharmaceutical products listed on the Schedule of Pharmaceutical Benefits. In 2004, the Australian Government introduced Pharmaceutical Benefits for Palliative Care, referred to as the PBS Palliative Care Schedule. The PBS Palliative Care Schedule, which lists medication items available for palliative care, was established as a separate schedule, complementing the General Schedule to improve access to essential and affordable medications for patients receiving palliative care.

Only the medications listed on the PBS Palliative Care Schedule (referred to as palliative care-related prescriptions) and the medications prescribed by palliative medicine specialists are included in this report.

Palliative care patients who access medications listed on the PBS Palliative Care Schedule can also access medications listed on the General Schedules, for example morphine. The same medications may be listed on the PBS Palliative Care Schedule and the General Schedule, however, medications on the PBS Palliative Care Schedule may be listed with larger quantities and/or more script repeats, making them more suitable for use in palliative care (Department of Health, Disability and Ageing 2016a). This may reduce patient co-payment costs and decrease the frequency of doctor consultations for ongoing symptom management.

Given the overlap in medication items listed on the different schedules, and because the PBS Palliative Care Schedule is intended to complement the General Schedule, it is likely that some medicines prescribed for palliative care are prescribed from the General Schedule. These prescriptions are not included in the count of palliative care-related prescriptions in this report. In addition, medications prescribed for palliative care purposes in some other instances are not included in this report as well, since PBS and RPBS data do not capture over the counter medicines, medicines supplied to public hospital inpatients, and private prescriptions. For example, if a medicine is not listed under the PBS Schedule for a specific indication, but it has market authorisation by the Therapeutic Goods Administration for sale, it would not be included.

Palliative care prescriptions can also be identified through the prescriber. Palliative medicine specialists may prescribe medicines for a range of reasons, some of which may be for palliative care, and may prescribe from different schedules. This report includes information on medications prescribed by palliative medicine specialists from all schedules (Table 8 in Data tables for Palliative care-related medications), and are therefore likely to include prescriptions prescribed for both palliative care and non-palliative care reasons.

The PBS and RPBS data presented in this report (2024–25 and trend data) are based on the date of supply, which is when the prescription was dispensed to the patient. The report includes all prescriptions supplied during 2024-25 financial year that were processed on or before 30 November 2025.

Types of palliative care-related prescriptions

Previously, this report has defined types of palliative care-related medicines by categories based on the Anatomical Therapeutic Chemical (ATC) classification system (WHO 2022). Since 2022, this report has used an updated method to report types of palliative care-related prescriptions, with the categories based on the Palliative Care publication of the Australian Therapeutic Guidelines (Therapeutic Guidelines Limited 2021). Therefore, the medication types (at the ATC level 2) in editions before 2022 are not directly comparable with the 'medication group' in this report.

Table MED 1 lists the medication items from the PBS Palliative Care Schedule with their corresponding medication groups and ATC codes at levels 2, 3 and 5. Note that most of these medicines are listed in multiple areas in PBS and RPBS, and are not specific to the Palliative Care Schedule. In this report, data extracted using ATC codes for medication groups was filtered by program type (Palliative Care Schedule) to report on all palliative care-related prescriptions.

Table MED 1: PBS Palliative Care Schedule medicines according to medication group

Medication group	ATC level 2	ATC level 3	ATC level 5	Medication name/s
Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AB01	Indomethacin
Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AE01	Ibuprofen
Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AE02	Naproxen
Pain relief	Analgesics	Opioids	N02AA01	Morphine (excluding PBS items 11760Y and 11761B)
Pain relief	Analgesics	Opioids	N02AA03	Hydromorphone
Pain relief	Analgesics	Opioids	N02AA05	Oxycodone
Pain relief	Analgesics	Opioids	N02AA55	Oxycodone + Naloxone

Pain relief	Analgesics	Opioids	N02AB03	Fentanyl
Pain relief	Analgesics	Opioids	N02AE01	Buprenorphine
Pain relief	Analgesics	Opioids	N02AC	Methadone
Pain relief	Analgesics	Other analgesics and antipyretics	N02BE01	Paracetamol
Gastrointestinal symptoms	Stomatological preparations	Stomatological preparations	A01AD02	Benzydamine
Gastrointestinal symptoms	Drugs for functional gastrointestinal disorders	Propulsives	A03FA01	Metoclopramide
Gastrointestinal symptoms	Drugs for functional gastrointestinal disorders	Belladonna and derivatives, plain	A03BB01	Hyoscine butylbromide (aka butylscopolamine)*
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AB02, A06AG02	Bisacodyl
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AC53	Rhamnus Frangula + Sterculia
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AD15	Macrogol – 3350
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AD15	Macrogol – 3350 + Sodium Chloride + Bicarbonate + Potassium Chloride
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AG20	Citric Acid + Lauryl Sulfoacetate Sodium + Sorbitol
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AH01	Methylnaltrexone
Neurological symptoms	Antiepileptics	Antiepileptics	N03AE01	Clonazepam
Respiratory symptoms (Chronic breathlessness)	Analgesics	Opioids	N02AA01	Morphine (PBS items 11760Y and 11761B only)**
Psychological symptoms	Psycholeptics	Antipsychotics	N05AD01	Haloperidol
Psychological symptoms	Psycholeptics	Hypnotics and Sedatives	N05CD07	Temazepam
Psychological symptoms	Psycholeptics	Hypnotics and Sedatives	N05CD02	Nitrazepam
Psychological symptoms	Psycholeptics	Anxiolytics	N05BA01	Diazepam
Psychological symptoms	Psycholeptics	Anxiolytics	N05BA04	Oxazepam

*Hyoscine Butylbromide can also be used to manage respiratory secretions.

**These PBS items are listed on the PBS as Restricted Benefit which can only be prescribed for specific therapeutic uses.

Relevant changes to the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme over time

Reporting of 'subsidised' and 'under co-payment' prescription data

Under the PBS and RPBS, the Australian Government sets a maximum 'patient co-payment' amount that people pay towards the cost of their medicines.

- If a prescription is priced over the co-payment threshold, it is considered as 'over co-payment' or a 'subsidised prescription', the Australian Government pays pharmacies the difference between a consumer's co-payment and the PBS price of a medicine, as listed on the Schedule of Pharmaceutical Benefits.
- If a prescription is priced below the co-payment threshold, it is classified as an 'under co-payment prescription', the consumer pays the total cost, and the government does not contribute.

The maximum co-payment a patient pays depends on their level of entitlement, which is determined by the patient's concessional status and whether they have qualified for the PBS safety net. Current and historical co-payments can be found on the PBS website.

Since 2022, this report combines under co-payment and subsidised data in most tables. An additional table by patient beneficiaries shows the palliative care data by co-payment type in a single table for 2024–25 (Table 4 in Data tables for Palliative care-related medications), rather than including this split in every table.

Changes to restriction levels on the Palliative Care Schedule

On 1 June 2016, as part of the Post-market Review of Authority Required PBS Listings, changes were made to items listed on the Palliative Care Schedule. The restrictions for a number of Palliative Care Schedule items were changed and some medications were added or deleted. The restriction level of certain Palliative Care Schedule items, specifically those in the 'pain relief' and 'gastrointestinal symptoms' categories, were changed, in many cases from 'Authority Required (STREAMLINED)' to 'Restricted Benefit', reducing the level of restriction. Certain versions of medications were delisted due to initial and continuing treatment restrictions being simplified and merged under a single item code.

It should also be noted that data from 2016–17 onwards are not comparable with previous years, given the above-mentioned changes to the PBS restriction level from June 2016 and new listings of medications in the PBS Palliative Care Schedule (Department of Health, Disability and Ageing 2016b).

References

Department of Health, Disabilty and Ageing (2016a) *Access to medicines for palliative care on the PBS*, Department of Health, Disability and Ageing, Australian Government, accessed 20 February 2025.

Department of Health, Disability and Ageing (2016b) *Schedule of Pharmaceutical Benefits: Summary of Changes. Effective 1 January 2016*, Department of Health, Disability and Ageing, Australian Government, accessed 10 February 2025.

Department of Health, Disability and Ageing (2011) *Pharmaceutical Benefits Scheme Collection of Under Co-payment Data*, Department of Health and Ageing, Australian Government, accessed 10 February 2025.

Therapeutic Guidelines Limited (2021) *Therapeutic Guidelines: Palliative Care*, Therapeutic Guidelines Limited website, accessed 4 March 2025.

WHO (World Health Organization) (2022) *ATC Structure and principles*, WHO website, accessed 18 January 2023.

Palliative care for people living in residential aged care

On this page:

In 2021–22, people in permanent residential aged care (PRAC) with an Aged Care Funding Instrument (ACFI) appraisal indicating need for palliative care accounted for 2.0% (4,800) of all people (246,000), 3.5% (2,400) of all new admissions (69,100), and 6.0% (4,300) of all exits (72,100) from permanent residential aged care. This section provides information on the characteristics of admissions, exits and people using permanent residential aged care, including comparison between those appraised as requiring palliative care and those not appraised as requiring palliative care based on ACFI.

Note that there is limited data on the need for and receipt of palliative care among people accessing home-based and residential aged care services. Available data is based on those in permanent residential aged care appraised as requiring end-of-life palliative care and for whom a claim was submitted. Information on actual service provision and that palliative care maybe required for a longer period (not just end-of-life care) is a considerable gap in the national data. See below and the Data sources section for further information on the residential aged care data presented in this report.

The information in this section was last updated in May 2023.

Aged care service provision and context for interpreting residential aged care data

Australia's government-funded aged care system offers a continuum of care under 3 main types of service:

- Home support (Commonwealth Home Support Programme), which provides entry-level services focused on supporting individuals to undertake tasks of daily living to enable them to be more independent at home and in the community.
- Home care (Home Care Packages Program), a more comprehensive package of home-based support for older people with complex care needs to enable them to live independently in their own homes, which includes 4 levels of packages from basic care needs (level 1) to high care needs (level 4).
- Residential aged care, which provides support and accommodation for people who have been assessed as needing higher levels of care than can be provided in the home, and the option for 24-hour nursing care. Residential care is provided on either a permanent, or a temporary (respite) basis.

From March 2018 to September 2022, the Aged Care Funding Instrument (ACFI) was a tool for assessing the care needs of people entering and living in permanent residential aged care. The tool is used to allocate government funding to residential aged care service providers based on the needs of the people in their care, regardless of the actual care planning or care provided by the service to the assessed individual. The ACFI is not a comprehensive assessment; it is focused on factors that affect the cost of care. Consequently, the capture of information on a person's care needs, including health conditions and need for assistance with activities of daily living, may be affected by their relevance to the cost of care and the number of available fields on the form. For more information about the ACFI, refer to the ACFI User Guide (Department of Health and Aged Care 2017).

Funding for palliative care under the ACFI is provided specifically for 'end-of-life' care, which takes place during the last days or week of a care recipient's life, where ongoing care will involve very intensive clinical nursing and/or complex pain management in the residential care setting (Department of Health and Aged Care 2017). From 1 October 2022, a new care funding model (Australian National Aged Care Classification, AN-ACC) has replaced the ACFI, which includes 13 variable funding classes that reflect the different care needs of residents in each class. There is a palliative care class for people near end-of-life – this allows frail residents with a life-expectancy of less than 3 months, with an approved palliative care plan, to enter a facility without an AN-ACC assessment.

The number of people needing and receiving palliative care services in community and residential aged care is a key data gap. Available data is based on those in permanent residential aged care appraised as requiring end-of-life palliative care and for whom a claim was submitted, rather than whether they actually received the services. Analysis by the AIHW has indicated that palliative care service delivery for people living in residential aged care may be higher than that captured through ACFI appraisals, based on how many people receive some form palliative care in their last year of life before dying in residential aged care (AIHW 2021).

In practice, it is possible to receive palliative care in residential aged care without having received an ACFI appraisal indicating the need for end-of-life palliative care. Also note that the data available cannot confirm the extent or nature of palliative care actually provided for those who were funded for palliative care under the ACFI.

Data in this report is based on ACFI appraisals, between 1 July 2021 to 30 June 2022, including trend data from 2017–18. For more information on the data used in this report, refer to the Data sources section.

Key points

In 2021–22, among people in permanent residential aged care (PRAC) with an ACFI appraisal indicating need for palliative care – accounted for 2.0% (4,800) of all people in PRAC, 3.5% (2,400) of all new admissions to PRAC, and 6.0% (4,300) of all exits from PRAC:

- almost 3 in 5 (59%) were aged 85 years and over
- 1 in 5 (21%) had cancer listed as the first condition on their appraisal, compared with 3.7% for those not appraised as requiring palliative care
- 1 in 2 (50%) exited PRAC within 8 weeks of admission, compared with 7.9% for those not appraised as requiring palliative care
- death was the most common reason for exit from PRAC – 95% compared with 85% for those not appraised as requiring palliative care.

Between 2017–18 and 2021–22, the number of people in PRAC (including those appraised as requiring palliative care) has remained relatively stable; however, the number of new admissions to PRAC has decreased over the same period – by 11% from 2,700 to 2,400 for those appraised as requiring palliative care and by 3.7% from 69,200 to 66,600 for those not appraised as requiring palliative care.

Who was appraised as requiring palliative care?

In 2021–22, there were 4,800 people and 2,400 new admissions for people appraised as requiring palliative care in PRAC (2.0% of all people and 3.5% of all new admissions). Among people using PRAC with an ACFI appraisal indicating need for palliative care (Table AC.1 in Data tables: PCSiA 2023 Palliative care for people living in residential aged care and Figure AC.1):

- More were women (55%) than men – 2,600 compared with 2,200. However, as a proportion of all people in PRAC, men were 1.5 times as likely to be appraised as requiring palliative care as women (2.5% and 1.7%, respectively).
- Almost 4 in 5 (78%) were aged 80 years and over, same as the proportion for those not appraised as requiring palliative care.
- 2 in 3 (69%) were born in Australia, similar to the proportion for those not appraised as requiring palliative care (66%).
- Most were living in *Major cities* (61%) and *Inner regional areas* (30%), however as a proportion of the population living in these regional areas, those living in *Inner regional areas* had the highest rate – 31 per 100,000 population compared with 16 and 19 per 100,000 population for those living in *Major cities* and *Outer regional areas.* This is consistent with the pattern observed for those not appraised as requiring palliative care.
- Rates varied across the states and territories – Tasmania had the highest population rate (31 per 100,000 population) and Northern Territory the lowest (3.6 per 100,000). For those not appraised as requiring palliative care, South Australia had the highest rate (1,200 per 100,000) and Northern Territory the lowest (250 per 100,000).

Context for interpreting palliative care data from the Aged Care Funding Instrument

Cancer diagnosis more likely in those appraised than not appraised as requiring palliative care in permanent residential aged care

During the ACFI appraisal process, information is recorded on relevant mental and behavioural diagnoses and up to 3 other medical diagnoses relevant to a person's care needs, based on information collected in 2 diagnostic sections – Mental and Behavioural Diagnosis and Medical Diagnosis (includes any disease or disorder, excluding the mental and behavioural disorders recorded in the ACFI Mental and Behavioural Diagnosis checklist). Data in this report refers to the first listed condition only (see Data sources for further information). Furthermore, conditions recorded on the ACFI are not necessarily related to palliative care status but do provide insights on the types of medical conditions at the time of admission to permanent residential aged care (PRAC).

In 2021–22, 1 in 5 (21%) people appraised as requiring palliative care had cancer listed as their first condition on their Medical Diagnosis appraisal compared with 3.7% for those not appraised as requiring palliative care.

For diseases other than cancer, circulatory system disease was the most common medical condition (21%), followed by musculoskeletal (11%) for those appraised as requiring palliative care, based on Medical Diagnosis. However, for those not appraised as requiring palliative care, musculoskeletal conditions were the most common (21%), followed by circulatory system disease (20%; see Table AC.2).

For the first listed condition on the Mental and Behavioural Diagnosis, dementia (including Alzheimer's disease) was the most common for all people in PRAC (46% for people requiring palliative care and 51% for people not requiring palliative care).

It should be noted that identifying mental health conditions and dementia in older people can be difficult. For example, conditions such as dementia and depression are often under-diagnosed and under-treated in PRAC. In addition, many mental health conditions share similar symptoms, which can present additional challenges in making a diagnosis. Additional information is available from AIHW publications Dementia in Australia (AIHW 2022) and Depression in residential aged care 2008–2012 (AIHW 2013). Further, it should be noted that the ACFI is focused on components of the person's care needs that affect the cost of care, rather than providing a comprehensive, diagnostic assessment (see above for further details).

Figure AC.1: Characteristics of people using permanent residential aged care, 2021–22

https://tableau.aihw.gov.au/t/Staging/views/HWI128_AgedCare_25052023/FigureAC_1

How long did people stay and how was care completed?

In 2021–22, among people using PRAC with an ACFI appraisal indicating need for palliative care:

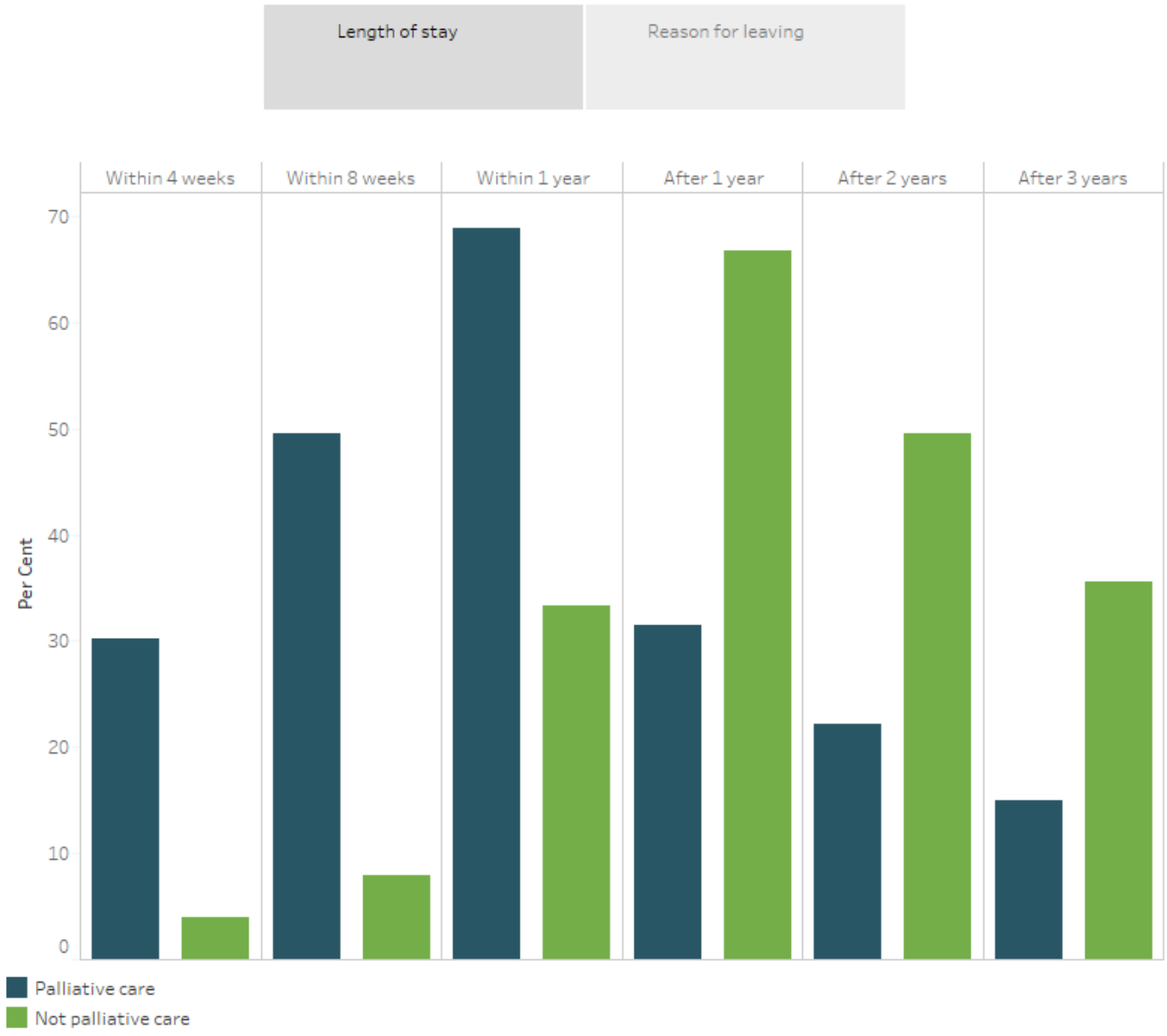
- 1 in 2 (50%) exited PRAC within 8 weeks of admission (including 30% within 4 weeks), 69% within one year, and 22% after 2 years. For those not appraised as requiring palliative care, 2 in 3 (67%) exited after 1 year – 31% within 1–3 years and 36% after 3 years, while 7.9% exited within 8 weeks (Figure AC.2).

The shorter stays for people appraised as requiring palliative care are consistent with the purpose of the funding for palliative care under ACFI that is provided specifically for 'end-of-life' care (see Aged care service provision and context for interpreting residential aged care data above for further details).

In 2021–22:

- Death was the most common reason for exit from PRAC – 95% and 85% of exits for those appraised as requiring palliative care and for those not appraised as requiring palliative care, respectively. Further, return to the community and to other residential care was far more common among those not appraised as requiring palliative care (3.7% and 7.8% of exits, respectively) than those appraised as requiring palliative care (0.6% and 2.2% of exits, respectively; see Figure AC.2).
- Over 1 in 4 people in PRAC required hospital leave from PRAC – 29% and 27%, respectively for those appraised as requiring palliative care and for those not appraised as requiring palliative care (see Table AC.5).

Figure AC.2: Exits from permanent residential aged care, 2020–21



Source: AIHW. Table AC.3.
http://www.aihw.gov.au/pcsia

Have there been changes over time?

Overall, the number of people appraised as requiring palliative care using PRAC in 2021–22 was relatively similar to 2017–18, driven by large annual fluctuations over the preceding 5 years, as shown in Figure AC.3. In contrast, the number of people using PRAC not appraised as requiring palliative care generally increased slightly each year (2% increase overall between 2017–18 and 2021–22).

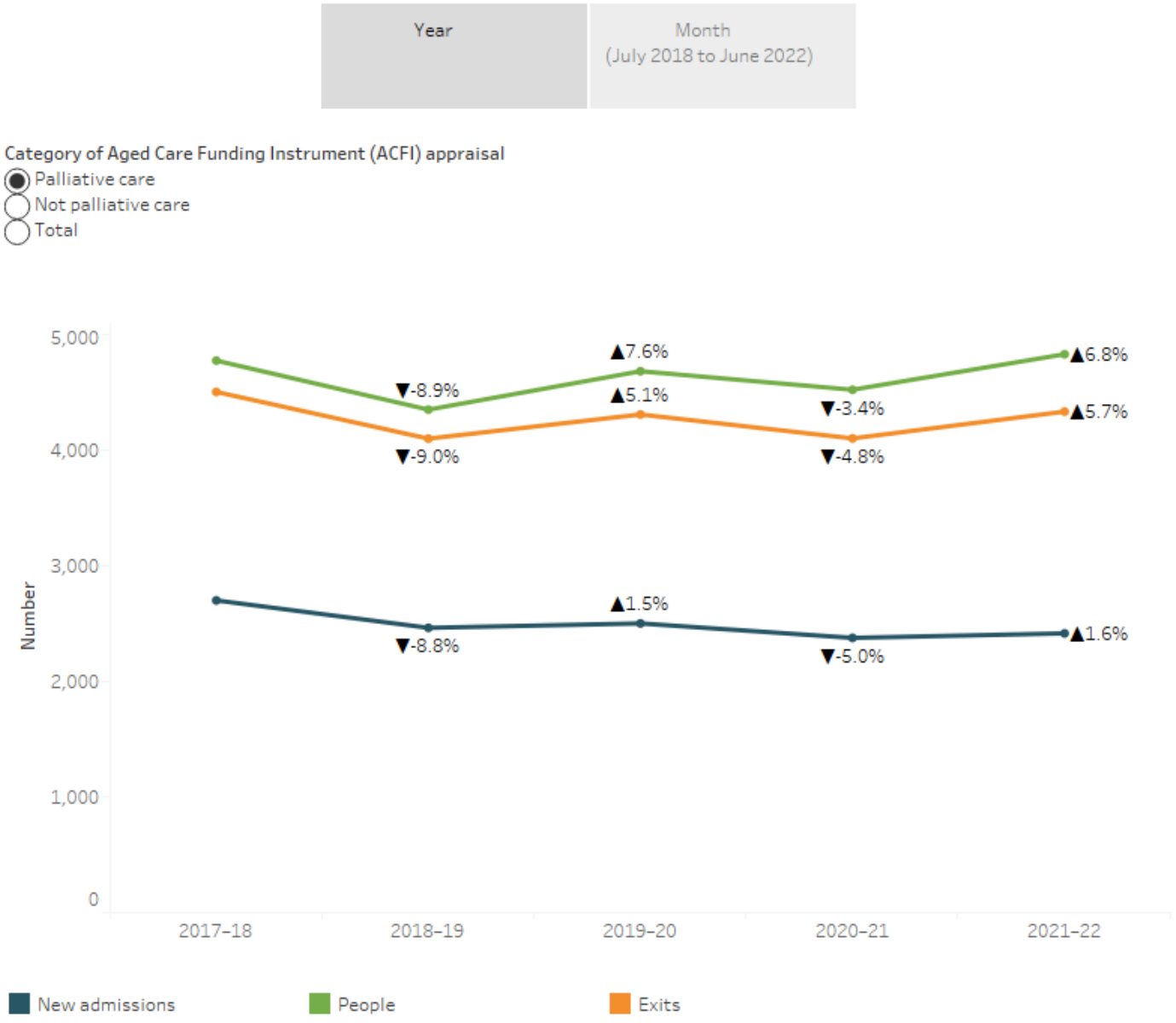
The number of new admissions to PRAC appraised as requiring palliative care also experienced some fluctuations over this period, but overall declined by 11% between 2017–18 and 2021–22. This rate of decline was steeper than for those not appraised as requiring palliative care (overall decline of 3.7% over this same period).

Between 2019–20 and 2020–21, there was a decline in the number of people and new admissions to PRAC for people assessed as requiring palliative care (by 3.4% and 5.0%, respectively), and a subsequent increase in the following 12 months (by 6.8% and 1.6%, respectively).

These patterns likely reflect the introduction and easing of public health measures introduced to manage the spread of the COVID-19 pandemic during 2020 and 2022. In particular, the various falls in new admissions and rises in exists coincided with lockdowns and the tightening and easing of restrictions in response to the waves of the COVID-19 and new strains of the coronavirus. For example, compared with corresponding months in 2018–19, the number of new admissions to PRAC for people assessed as requiring palliative care fell by 19% in May 2020, 25% in October 2020, 21% in October 2021 and 17% in January 2022 but increased by 20% in March 2022 – similar to the patterns observed for new admissions to PRAC for people not assessed as needing palliative care. Exits from PRAC for those appraised as requiring palliative care also followed a similar pattern – 28% higher in April 2020, 22% higher in May 2020, and 15–18% higher in September 2020, May 2021, September 2021, December 2021, and May 2022 (compared with corresponding months in 2018–19). This report did not explore the reasons for these PRAC exits (such as death or to another setting).

These fluctuations in new admissions and exists may reflect a number of factors that not related to the COVID-19 pandemic (see 2022 edition of this report for further details on the impacts of COVID pandemic). Further, ACFI reviews were undertaken from the Department of Health's offices since 2020 to minimise COVID19 transmission risks.

Figure AC.3: Trend in new admissions, exits and people using permanent residential aged care, 2017–18 to 2021–22



Source: AIHW. Table AC.6.
http://www.aihw.gov.au/pcsia

Data sources

National Aged Care Data Clearinghouse

Data on palliative care in permanent residential aged care (PRAC) are sourced from the AIHW's National Aged Care Data Clearinghouse (NACDC) that includes data on all recipients of government-funded aged care from 1997 onwards, including prior activity data for those in care in 1997. The holdings mostly relate to government-funded aged care programs operating under the *Aged Care Act 1997* and include data on Aged Care Funding Instrument (ACFI) appraisals, which were used to determine Australian Government subsidies for permanent aged care residents from March 2008 to September 2022. These data have been used for the analyses presented in this report.

The ACFI is a tool used to determine Australian government subsidies for permanent aged care residents, based on a person's need for care across 3 care domains:

- activities of daily living
- cognition and behaviour
- complex health care (Department of Health and Aged Care 2017).

ACFI appraisals include:

- relevant mental and behavioural diagnoses outlined in the ACFI User Guide Mental and Behavioural disorders Checklist;
- up to 3 other medical diagnoses relevant to a resident's care needs;
- 5 questions relating to a resident's assessed care needs with regard to activities of daily living: nutrition, mobility, personal hygiene, toileting, and continence;
- 5 questions relating to a resident's cognition and behaviour: cognitive skills, wandering, verbal behaviour, physical behaviour, and depression;
- 2 questions relating to the need for assistance with the use of medication and ongoing complex health care procedures and activities; with the need for palliative care being covered by these questions (Department of Health and Aged Care 2017).

Responses to ACFI questions are rated on a scale of A to D and are used to determine the level of care a person needs. While mental health or behavioural diagnoses, along with other medical diagnoses, can be recorded, the ACFI is not designed to be a comprehensive assessment tool.

Note that in this report, only the first listed mental and behavioural diagnoses and first listed other medical diagnosis are included in the analysis.

Note that the ACFI is primarily focused on components of the resident's care needs that affect the cost of care. Consequently, the capture of information on a person's care needs, including health conditions and need for assistance with activities of daily living, may be affected by their relevance to the cost of care and the number of available fields on the form.

Funding for palliative care under the ACFI is provided specifically for 'end-of-life' care, which takes place during the last days or week of a care recipient's life (Department of Health and Aged Care 2017). Permanent residents who have been appraised as requiring palliative care under the ACFI are included in the 'palliative care' group described in this report. It should be noted that if a resident is already on the maximum ACFI Complex Health Care claim, services may not claim for palliative care, as it is not possible to increase the subsidy payable in this situation. For more information about the ACFI, refer to the ACFI User Guide(Department of Health and Aged Care 2017).

The method used to derive the number of permanent aged care residents in this report (any point during the reporting period) differs from the approach used in other reporting, such as through the AIHW GEN aged care data website (that commonly counts people as at 30 June in each year). This approach has been taken as people appraised as requiring palliative care tend to stay in PRAC for short periods of time.

Data presented in this report may differ from those published elsewhere due to differences in the preparation and analysis of the source data.

Key concepts

Table 1: Key concepts in this chapter

Key concept	Description
ACFI diagnosis	The ACFI consists of 12 questions about a person's assessed care needs, and two diagnostic sections: Mental and Behavioural Diagnosis and Medical Diagnosis. Medical diagnosis includes any disease or disorder, excluding the mental and behavioural disorders recorded in the ACFI Mental and Behavioural Diagnosis checklist. See the Aged Care Funding Instrument User Guide for a complete list of Mental and Behavioural Disorders. During the ACFI appraisal process, information is recorded on up to 3 mental and behavioural diagnoses and up to 3 other medical diagnoses relevant to a person's care needs. Data in this report refers to the first listed conditions only – first listed mental and behavioural disorder and first listed other medical condition.
Exit from PRAC	An exit from PRAC occurs when a person who is a permanent resident stops receiving care from a particular PRAC service. The reasons for exit may include death, admission to hospital (excluding where the person is on hospital leave), return to community (such as to family or home), move to another residential aged care facility.
Hospital leave	A short-term stay in hospital of at least one night, which does not involve permanent discharge from permanent residential aged care.
Palliative care in permanent residential aged care	In this report, palliative care in permanent residential aged care (PRAC) is based on Aged Care Funding Instrument (ACFI) appraisals. Funding for palliative care under the ACFI is provided specifically for 'end-of-life' care, which takes place during the last days or week of a care recipient's life, and where ongoing care will involve very intense clinical nursing and/or complex pain management in the residential care setting.
Permanent admission	An admission to a permanent residential aged care service. This captures both new entries and transfers between services.

Permanent resident	A person who is receiving long-term care in a permanent residential aged care (PRAC) service.

References

AIHW (Australian Institute of Health and Welfare) (2013) *Depression in residential aged care 2008–2012*, Canberra: AIHW, Australian Government, accessed 20 January 2023.

AIHW (2021) *Interfaces between the aged care and health systems in Australia – where do older Australians die?* Canberra: AIHW, Australian Government, accessed 15 January 2023.

AIHW (2022) *Dementia in Australia*, Canberra: AIHW, Australian Government, accessed 25 January 2023.

Department of Health and Aged Care (2017) *Aged Care Funding Instrument (ACFI): User Guide,* Canberra: Department of Health, Australian Government, accessed 27 January 2023.

Palliative care outcomes

This chapter provides information related to characteristics and outcomes for people receiving palliative care from the services participating in Australian Palliative Care Outcomes Collaboration (PCOC) program over the period 2014 to 2024.

Note, as participation in PCOC is voluntary, not all services participate in PCOC. The data presented in this chapter therefore describe a subset of all palliative care delivered in Australia. Further information on PCOC is provided in Data source.

The information in this chapter was last updated in October 2025.

Key points

In 2024, 202 services participated in the PCOC program, delivering palliative care services to 72,400 patients.

Of the 95,500 palliative care episodes recorded in PCOC:

- almost 3 in 4 (75%) ended within 30 days, with most ending within 2 weeks (60%)
- over 9 in 10 (92%) commenced within 2 days after patients were ready for palliative care.

Of the 211,000 palliative care phases (reflecting the type of care required by patients) recorded in PCOC:

- almost 9 in 10 (86%) unstable palliative care phases were resolved within 3 days
- nearly 9 in 10 patients maintained an absent/mild pain throughout the phase (89% for pain severity, 88% for distress from pain), and around 3 in 5 improved from moderate/severe to absent/mild pain by phase end (61% for pain severity, 58% for distress from pain).

Overview of patients, episodes of care and phases

Palliative care patient

PCOC defines a patient as a person for whom a palliative care service accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.

In 2024, among the 72,400 patients receiving palliative care from the 202 services participating in PCOC:

- 3 in 5 (61%) had a diagnosis of cancer (Figure 1)
- 1 in 2 (50%) died – of these 70% died in hospital, 17% at home, and 12% in residential aged care.

Of the 35,900 patients that died in 2024, the median number of days from referral to death was 6 days, with referrals on average occurring much earlier for patients in community than inpatient settings (20 compared with 4.0 days). Earlier referrals were also observed for people with malignant compared with non-malignant diagnosis in both inpatient (median of 6 vs 2 days) and community settings (27 and 14 days, respectively).

For further details on the characteristics of these patients, see Tables 1-3, 11 in Data tables: PCSiA 2025 Palliative care outcomes.

Palliative care episodes

A palliative care episode is a period of contact between a patient and a service provider where palliative care is provided in a single setting (inpatient or community setting).

A patient may have multiple palliative care episodes over the reference period if a patient's care needs change, they no longer require palliative care, or they change settings. For example, if a patient receives care at home and then transitions to care in a hospital, this would be reflected as 2 separate episodes.

Palliative care episodes, as used in this report, include both open episodes (those without an episode end date in the reporting period), and closed episodes (those with an episode end date in the reporting period), unless otherwise specified.

In 2024, there were 95,500 palliative care episodes recorded in PCOC, equating to an average of 1.3 palliative care episodes per patient.

Among these palliative care episodes:

- the median age at episode start was 77 years
- 55% of referrals were from public hospitals, including 17% from medical team and 10% from palliative care oncology team. A further, 10% of referrals were from private hospitals (over half of which (5.7%) were from palliative care or oncology team), and 15% from general practitioners and community palliative care services (7.4% and 7.8%, respectively) (Figure 1).

There were 85,600 episodes that ended (closed palliative care episodes) in 2024. Among these closed palliative care episodes (Figure 1 and Table 7):

- 3 in 4 (75%) ended within 30 days, with most ending within 2 weeks (60%).
- Inpatient episodes were generally shorter than community episodes, with a median duration (elapsed days) of 4 days compared to 23 days. This is driven by inpatient episodes 3 times as likely as community episodes to end within 2 days (35% and 10%, respectively).
- Over 1 in 2 (54%) inpatient episodes ended with the patient dying compared to 26% for community episodes. The most common reason for community episodes ending was the patient being admitted into inpatient care, accounting for 1 in 2 (52%) episodes.

Palliative care phases

There are four palliative care phase levels included in PCOC:

- stable phase: patient problems and symptoms are adequately controlled by an established plan of care
- unstable phase: an urgent change in the plan of care or emergency treatment is required
- deteriorating phase: the care plan is addressing anticipated needs but requires periodic review
- terminal phase: death is likely within days.

Note that palliative care phases are not necessarily sequential. A patient may transition back and forth between phases; therefore, it is likely that a patient will have more than one phase within an episode.

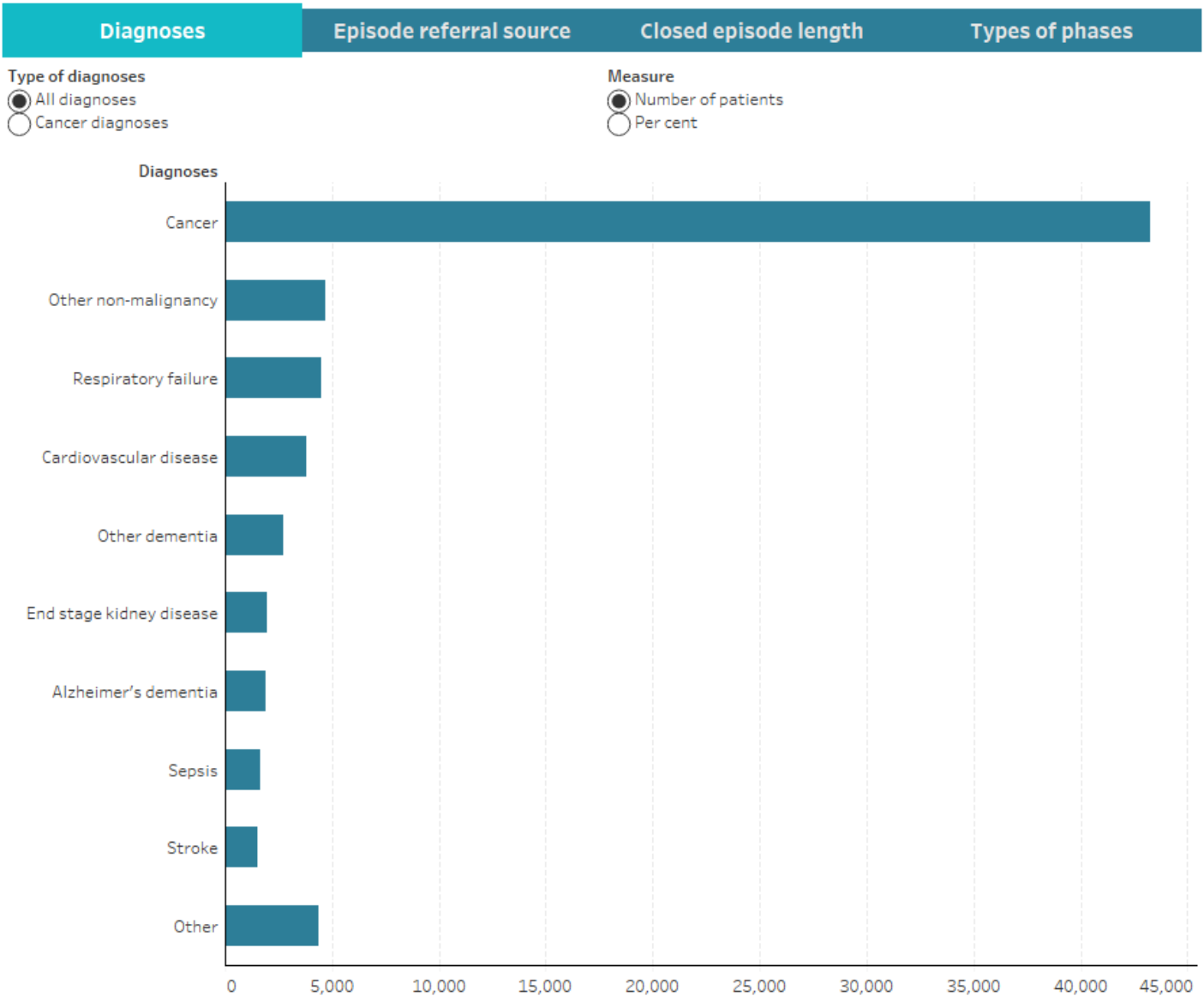
See Data source.

In 2024, there were 211,000 palliative care phases recorded in PCOC – 104,500 in inpatient settings and 106,500 in community settings. On average, patients had 2.4 phases per closed episode (2.2 for inpatient settings and 2.5 for community settings), and 2.9 phases per patient (Table 1).

Among these palliative care phases:

- 2 in 5 (42%) were deteriorating phases, almost 1 in 3 (32%) were stable phases, followed by terminal (15%) and unstable (11%), with the proportion of deteriorating or terminal phases higher in inpatient settings (62%) than community settings (53%) (Figure 1).
- Overall, the average length of phase was 3 times as long in community than inpatient settings (11.1 days compared to 3.6 days, respectively), especially for stable phases (23 compared to 5.7 days) and deteriorating phases (15 compared to 4.7 days, respectively).
- Patients in an unstable palliative care phase were more likely to rate their symptoms (using symptom assessment scale (SAS)) as moderate or severe at phase start than patients in any other phase. In contrast, patients in stable or terminal phases were more likely to report absent/mild symptoms at phase start (Table 10 and Figure 1).

Figure 1: Overview of patients, episodes of care and phases in services participating in PCOC, 2024



Source: AIHW. PCOC Table 3.
https://www.aihw.gov.au/pcsia

Palliative care outcome measures

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national program that uses standardised validated clinical assessment tools to benchmark and measure palliative care outcomes. The development and implementation of these outcome measures and associated benchmarks helps improve patient and carer outcomes and drives improvements in the quality of palliative care.

Palliative care outcome measures and benchmarks

In 2024, the 95,500 palliative care episodes and 211,000 palliative care phases recorded in PCOC revealed:

- In over 9 in 10 (92%) episodes, care commenced within 2 days of the patient being ready for palliative care – 97% in inpatient settings and 87% in community settings.
- Almost 9 in 10 (86%) unstable phases lasted for 3 days or less – 90% in inpatient setting and 81% in community settings.
- Almost 9 in 10 palliative care phases that began with absent/mild symptoms remained in that range by the end of the phase – 88–89% for pain severity, distress related to pain, fatigue, and family/carer problems. For distress related to breathing problems a higher proportion remained in the absent/mild phase (94%).
- When symptoms started as moderate/severe, improvement to absent/mild at phase end was less frequent, especially for fatigue (50%), breathing problems (52%), and family/carer problems (54%).

Case-mix adjusted outcomes measure the changes in symptoms relative to the national average. It allows services to compare the changes in symptoms and problem scores for 'like' patients (patients in the same phase who started with the same level of symptoms).

In 2024, the data on 95,500 palliative care episodes and 211,000 palliative care phases recorded in PCOC revealed the following key findings on palliative care outcomes (Figure 2):

- In over 9 in 10 (92%) episodes, care commenced within 2 days of the patient being ready for palliative care – 97% in inpatient settings and 87% in community settings.
- Almost 9 in 10 (86%) unstable phases lasted for 3 days or less – 90% in inpatient setting and 81% in community settings.
- Almost 9 in 10 palliative care phases that began with absent/mild symptoms remained in that range by the end of the phase – 88–89% for pain severity, distress related to pain, fatigue, and family/carer problems. For distress related to breathing problems a higher proportion remained in the absent/mild phase (94%).
- When symptoms started as moderate/severe, improvement to absent/mild at phase end was less frequent, especially for fatigue (50%), breathing problems (52%), and family/carer problems (54%).

Case-mix adjusted outcomes measure the changes in symptoms relative to the national average. It allows services to compare the changes in symptoms and problem scores for 'like' patients (patients in the same phase who started with the same level of symptoms).

Palliative care case-mix adjusted outcome measures and benchmarks

Case-mix adjusted outcomes is calculated by measuring the mean change in symptoms on both Palliative Care Problem Severity Score (PCPSS) and PCOC Symptom Assessment Scale (PCOC SAS), after adjusting for both phase and the symptom score at the start of each phase.

The PCOC palliative care case-mix adjusted outcome measures include eight symptoms/problems:

- Four clinical reported problem severity using PCPSS, including pain, other symptoms, family/care problems and psychological/spiritual problems.
- Four patient reported symptom distress using PCOC SAS, including pain, nausea, breathing problems and bowel problems.

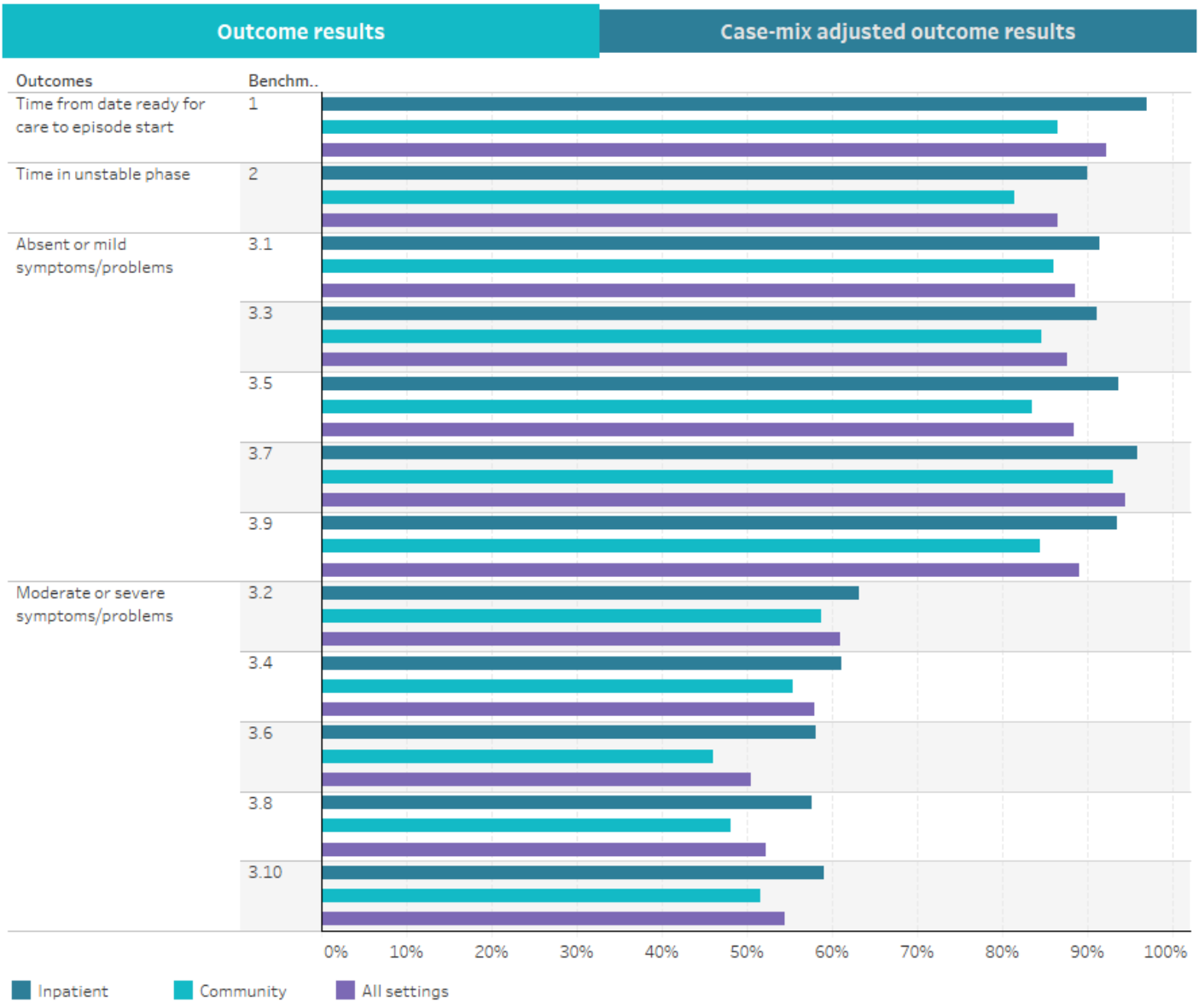
A case-mix adjusted score is calculated by comparing the change in symptoms/problems to patients at baseline national average level (January to June 2014). A positive score indicates that a service is performing above the baseline national average, and a negative score indicates that it is below the baseline national average.

A full description on each of case-mix adjusted outcome measures and benchmarks reported is included in Data source.

In 2024 (Figure 2):

- On average, services in all settings (inpatient and community settings combined) and in inpatient settings were performing above the baseline national average on all 8 case-mix adjusted outcome measures.
- In community settings, most services performed above the national baseline, with only two case-mix adjusted outcome measures (clinician-reported pain severity and patient-reported distress from pain), falling below the average.

Figure 2: Palliative care outcome results in the services participating in PCOC, 2024



Source: AIHW. PCOC Table 9.
https://www.aihw.gov.au/pcsia

Trends

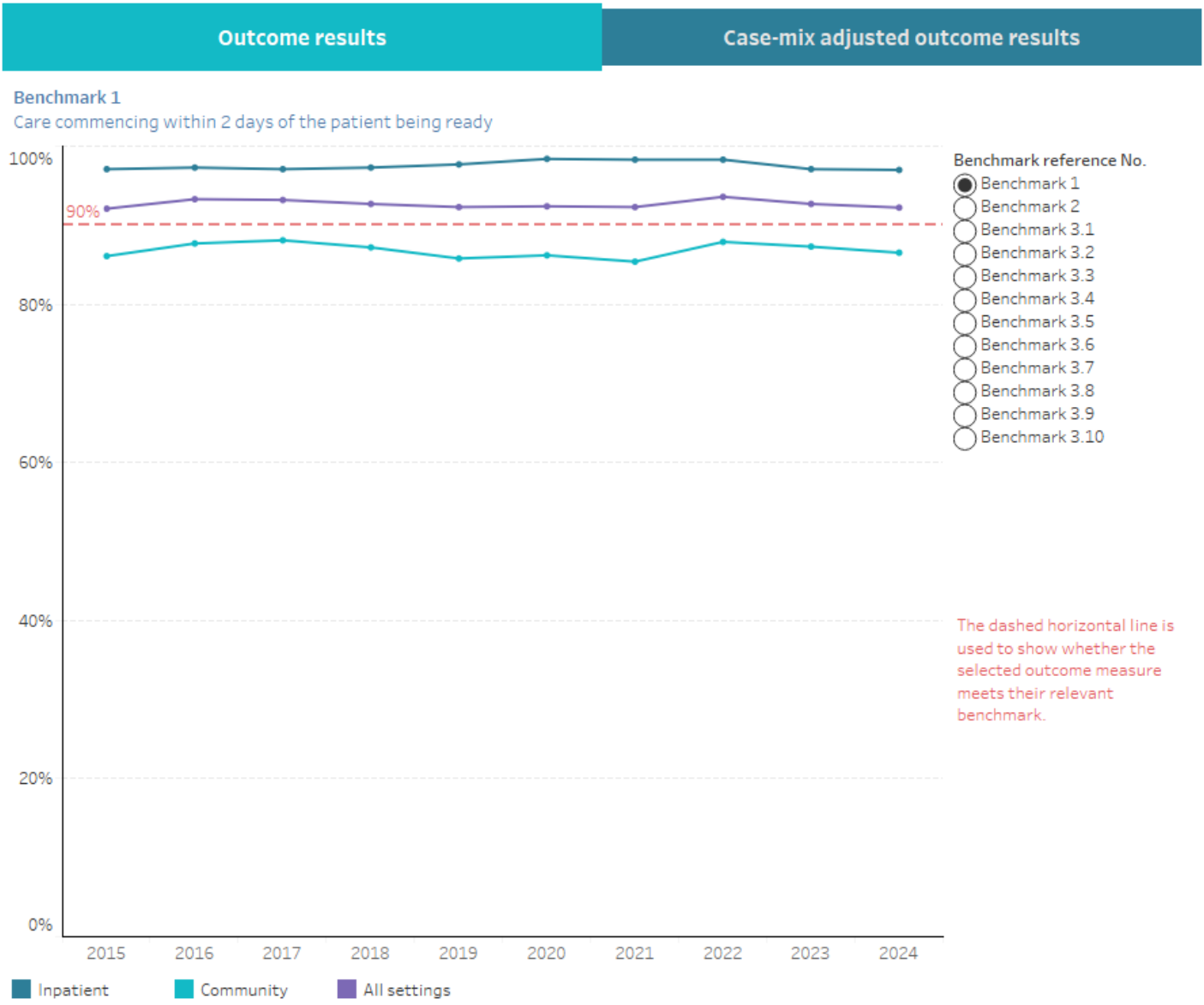
Between 2015 and 2024, the number of palliative care services participating in PCOC nearly doubled from 104 to 202 services, with a similar rate of growth observed for patients (from 36,300 to 72,400) and episodes of care (48,300 to 95,500). The growth in palliative care phases was not as steep (from 114,500 to 211,000) (Figure 3).

Between 2015 and 2024, most outcome measures remained relatively stable over this period, with some notable exceptions (Figure 3):

- patients remaining with absent/mild symptoms at the end of the phase for distress from fatigue increased rapidly between 2015-2017 (from 76% to 84%), and has since continued to increase slowly, reaching 88% in 2024
- patients moving from moderate/severe to absent/mild symptoms at the end of the phase has increased for: distress from fatigue (from 33% to 50%; benchmark 3.6), breathing problems (from 39% to 52%; benchmark 3.8) and family/care problems (from 42% to 54%; benchmark 3.10).

Note that comparisons of outcome measures over time should be interpreted with caution, as these outcome measures may be affected by compositional changes in the population. For example, changes in the services participating in PCOC over the same period.

Figure 3: Trends in palliative care services, patients, episodes, phases, and outcome results in PCOC-participating services, 2015–2024



Source: AIHW. PCOC Table 9.
https://www.aihw.gov.au/pcsia

Data source

Palliative Care Outcomes Collaboration

The Australian Palliative Care Outcomes Collaboration (PCOC), established in 2005, is a national palliative care outcomes quality improvement program. It includes information on patient demographics, clinical setting information and uses the standardised validated clinical PCOC assessment tools to benchmark and measure outcomes in palliative care, including:

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

The PCOC data are provided by each participating palliative care service, using a standardised data submission process (a *PCOC Version 3.0 Dataset Data Dictionary and Technical Guideline* (PDF 762KB) is made to assist with this process). This process also involves standardised data quality checks and assurance procedures, which are completed by clinical, quality improvement and data experts. For further information, see *Palliative Care Outcomes Collaboration Dataset 2023: Data Quality Statement* (PDF 299KB).

The PCOC data are captured at 3 levels – the patient-level, episode-level, and phase-level.

- Patient-level information describes demographics such as sex, Indigenous status, preferred language and country of birth, and the place in which the patient died.
- Episode-level information describes the setting of palliative care service provision. It also includes information relating to the facility or organisation that has referred the patient, and how an episode starts and ends.
- Phase-level information describes the clinical condition of the patient during the episode. This information is derived from five clinical tools. These tools include measures that examine palliative care phase, the patient's functional status and performance status, symptom burden as assessed by examining symptom severity and distress, including pain and other common symptoms, the patient's psychological/spiritual problems, and family/carer issues.

Information provided in this report is categorised into 2 broad settings of care:

- inpatient – admissions to hospital or hospice
- community – occurring in the patient's 'home'. For example, this may be in their private residence or aged care.

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. However, not all services participate in PCOC. The data presented in this report therefore describes a subset of all palliative care delivered in Australia.

Data using Version 1 of the PCOC dataset were collected between January 2006 and January 2007. Version 2 of the dataset was enacted from July 2007, and Version 3 was implemented in July 2012. For more information, see *PCOC Version 3.0 Dataset Data Dictionary and Technical Guideline* (PDF 762KB).

The national information presented in this chapter reflect all palliative care services that submitted data for the 1 January 2014 to 31 December 2023 period. A full list of the services that contributed data to this report can be found on the Palliative Care Outcomes Collaboration website.

Outcome measures and benchmarks

In 2009, PCOC and participating services, developed and implemented a set of national outcome measures and associated benchmarks to drive service innovation and allow participating services to compare their service nationally. The most recent update was released in 2015, which included the addition of 6 measures to Benchmark 3 relating to fatigue, breathing problems and family/carer problems. More information can be found on the PCOC Research & data webpage.

Further detail on the definition and measurement of each outcome measure and associated benchmark are provided in the following.

Outcome measure 1: Time from date ready for care to episode start

Measures the time (in days) between the date the patient is ready to receive care and the actual start date of the episode of palliative care by the service. This is measured for all episodes of care and across all settings of care.

To meet Benchmark 1, 90% of episodes of care must commence on the day of, or the day following, the date ready for care.

This measure replaced 'Time from referral to first contact for the episode' in July 2013 in consultation with participating services.

Outcome measure 2: Time in unstable phase

Measures the number of days the patient spent in an unstable phase. An unstable phase alerts clinical staff to the need for urgent or emergency intervention requiring an associated change in the existing care plan. Once assigned, and with the new care plan in place, the clinical team monitor for improvements in the patient and/or family/carer condition. Improvement can be demonstrated through observation and clinical assessments (reducing symptom distress and problem severity scores). With signs of improvement, the new care plan demonstrates its effectiveness and thus, the patient/family/carer can be moved out of the unstable phase into another relevant phase. However, at any time a patient is identified as dying within days (clinical indicators), the phase is immediately changed to terminal phase.

For services to meet Benchmark 2, 90% of unstable phases must last for 3 days or less.

Outcome measure 3: Change in symptoms/problems

Symptoms and problems for Benchmark 3 include the items of pain severity, distress related to pain, distress caused by fatigue, distress caused by breathing problems, and family/carer problems.

Symptoms and problems are measured at the start and end of a phase, and although symptoms and problems can be measured throughout the phase, an outcome is defined as the change from the beginning and at the end of the phase. It follows that phase records must have valid start and end scores to be included.

Two of the five PCOC clinical assessment tools are used to measure these patient and family symptoms and problems: the patient-rated PCOC Symptom Assessment Scale (PCOC SAS) and the clinician-rated Palliative Care Problem Severity Score (PCPSS).

A positive outcome for a patient is to have the symptom/problem in the absent to mild range at the end of a phase (for example, when the type of phase changes or the person is discharged from the service).

There are 2 benchmarks for each symptom/problem. The first benchmark is that at least 90% of phases that start with patients experiencing absent/mild symptoms (or problems) remain absent/mild at the end of the phase. This is reflective of anticipatory care. The second benchmark is that at least 60% of phases that start with patients experiencing moderate/severe symptoms (or problems) reduce to an absent/mild level by the end of the phase. This is reflective of responsive care.

Outcome measures 3.1–3.4: Pain

Pain management is acknowledged as 'core business' of palliative care services; hence, measuring patient pain is considered to be a vitally important outcome for palliative care services. The PCPSS measures pain severity rated by the clinician, used in Benchmarks 3.1 and 3.2, and the PCOC SAS measures patient-rated distress from pain, used in Benchmarks 3.3 and 3.4.

Outcome measure 3.5–3.6: Fatigue

Fatigue is the most common symptom in palliative care patients who have advanced cancer or other serious and/or life-threatening illnesses. The PCOC SAS is used for Benchmarks 3.5 and 3.6.

Outcome measure 3.7–3.8: Breathing problems

Breathing problems is a common symptom reported by patients receiving palliative care. The PCOC SAS is used to measure patient distress related to this symptom. This is used for Benchmarks 3.7 and 3.8.

Outcome measure 3.9–3.10: Family/carer problems

The PCPSS family/carer domain measures problems associated with a patient's condition or palliative care needs. The clinician reports on the severity of the problems of their family/carer. This is used for Benchmarks 3.9 and 3.10.

Outcome measure 4: Change in symptoms relative to the national average

Case-mix adjusted outcomes measure is used to compare the changes in symptoms relative to the national average. This measure allows services to compare the changes in symptoms and problem scores for 'like' patients (patients in the same phase who started with the same level of symptoms). It is calculated by measuring the mean change in symptoms on both Palliative Care Problem Severity Score (PCPSS) and PCOC Symptom Assessment Scale (PCOC SAS), after adjusting for both phase and the symptom score at the start of each phase.

The PCOC palliative care case-mix adjusted outcome measures include eight symptoms/problems:

- Four clinical reported problem severity using PCPSS, including pain, other symptoms, family/care problems and psychological/spiritual problems.
- Four patient reported symptom distress using PCOC SAS, including pain, nausea, breathing problems and bowel problems.

The baseline national average has been calculated based on the period January to June 2014. Each service is measured against this baseline national average for each 6-month reporting period. This allows each service to measure any change in their symptom management over time. A positive score indicates that a service is performing above the baseline national average and a negative score indicates that it is below the baseline national average.

For further details on each of the PCOC outcome measures and benchmarks, refer to *PCOC Guide to National Outcome Measures and Benchmarks* (PDF 733KB).

Palliative care workforce

This chapter provides information related to the employed workforce of palliative medicine physicians and palliative care nurses over the period 2013 to 2023.

Note, this chapter only includes information on physicians and nurses, as these professionals can be specifically identified as palliative care providers in National Health Workforce Dataset (NHWDS) through Health Workforce Data Tool (HWDT). As a result, the information included in this chapter does not represent the entire palliative care workforce. Further information on how health care providers are identified through NHWDS and HWDT is provided in Data source.

The information in this chapter was last updated in October 2025.

Key points

In 2023, there were 358 palliative medicine physicians (335 full-time equivalent) and around 3,900 palliative care nurses (3,500 full-time equivalent) employed in Australia – equating to 1.3 and 13 FTEs per 100,000 population, respectively.

Of these:

- about 2 in 3 (64%) employed palliative medicine physicians and 9 in 10 (92%) employed palliative care nurses were women
- over 4 in 5 (85%) employed palliative medicine physicians and almost 3 in 4 (71%) employed palliative care nurses worked in *Major cities*
- 3 in 4 (75%) employed palliative medicine physicians and 1 in 2 (49%) employed palliative care nurses worked in a hospital setting.

Between 2013 and 2023, the number of employed palliative medicine physicians grew at a much steeper rate than palliative care nurses – physicians increased from 183 to 358 or 5.0% annual growth in the FTE rate (from 0.8 to 1.3 per 100,000); nurses increased from 3,300 to 3,900 or 0.8% annual growth in the FTE rate (from 12 to 13 FTE per 100,000).

Characteristics

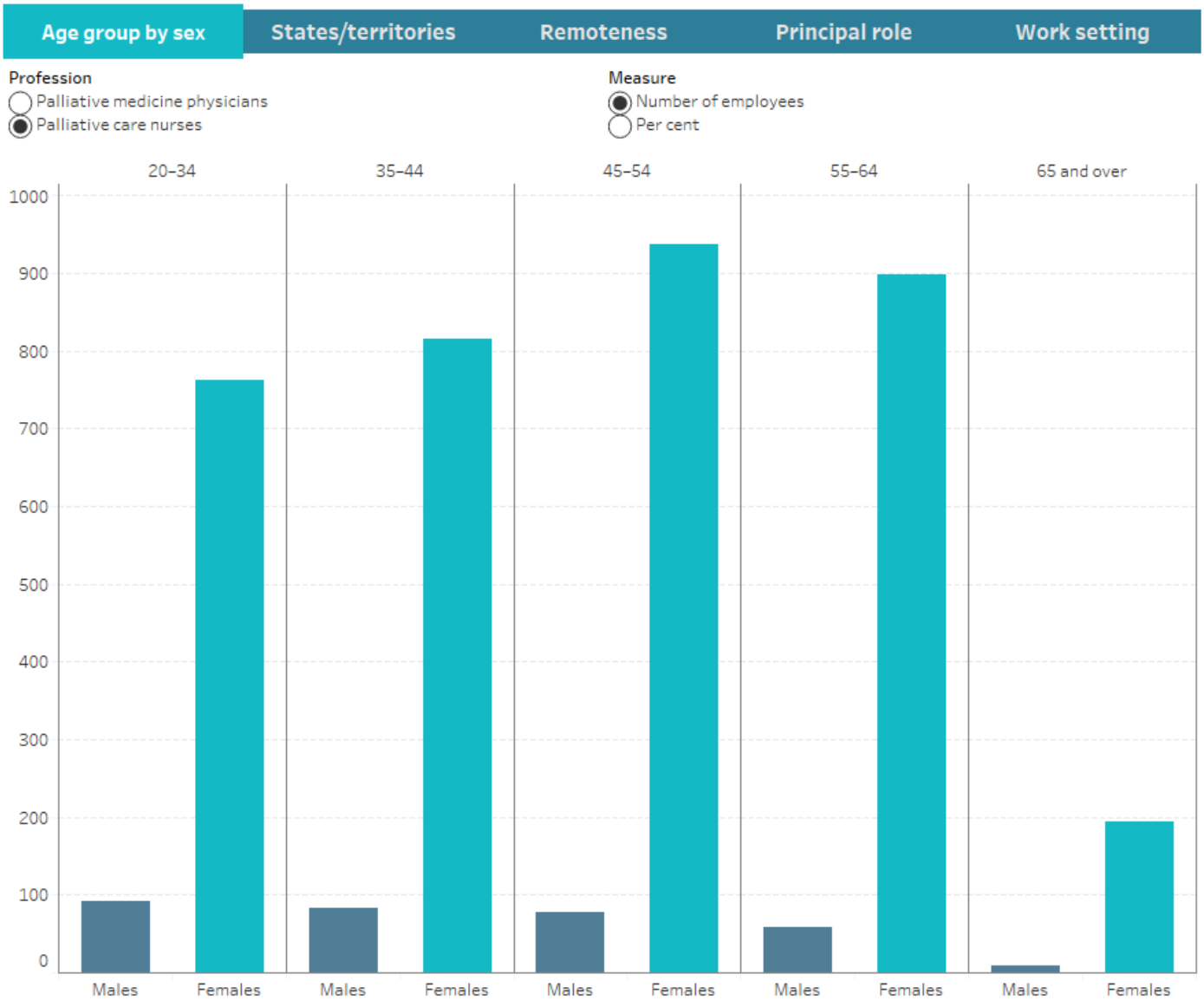
In 2023, there were 358 palliative medicine physicians (335 full-time equivalent (FTE)) and around 3,900 palliative care nurses (3,500 FTE) employed in Australia, accounting for 0.8% of all employed specialist medical practitioners and 1.0% of all employed nurses and midwives.

Among these employed palliative medicine physicians and palliative care nurses (Figure 1):

- almost 2 in 3 (64%) palliative medicine physicians were women, higher than the proportion of all employed specialist medical practitioners (39%)
- 9 in 10 (92%) palliative care nurses were women, slightly higher than the proportion among all employed nurses and midwives (88%)
- the rate of palliative care nurses total FTE per 100,000 was highest in inner regionals areas (14.8 per 100,000 population) and lowest in very remote areas (3.7 per 100,000 population), while the total FTE rate for all employed nurses and midwives showed a more even distribution across remoteness areas
- palliative medicine physicians follow a similar distribution to all employed specialist medical practitioners with higher rates in major cities (1.5 and 202.1 FTE per 100,000 population, respectively) compared to regional areas
- more than half of palliative medicine physicians and palliative care nurses worked in a hospital setting (75% and 49%, respectively) and the majority were principally employed as clinicians (92% and 93%, respectively)
- over 4 in 5 (84%) palliative care nurses were registered nurses only and 13% were enrolled nurses only.

In addition, according to data from the Medical Board of Australia Registrant, there were 7 paediatric palliative medicine physicians in Australia over the period 01 October 2023 to 31 December 2023, accounting for 0.2% of all physicians with a primary speciality of paediatrics and child health (3,600) over this period. This rate has not changed since 2017 (MBA 2025).

Figure 1: Characteristics of employed palliative medicine physicians and palliative care nurses, 2023



Source: AIHW. Workforce Table 1.
https://www.aihw.gov.au/pcsia

References

MBA (Medical Board Ahrpa) (2025) *Medical Board of Australia - Statistics*, MBA statistics, accessed 26 August 2025.

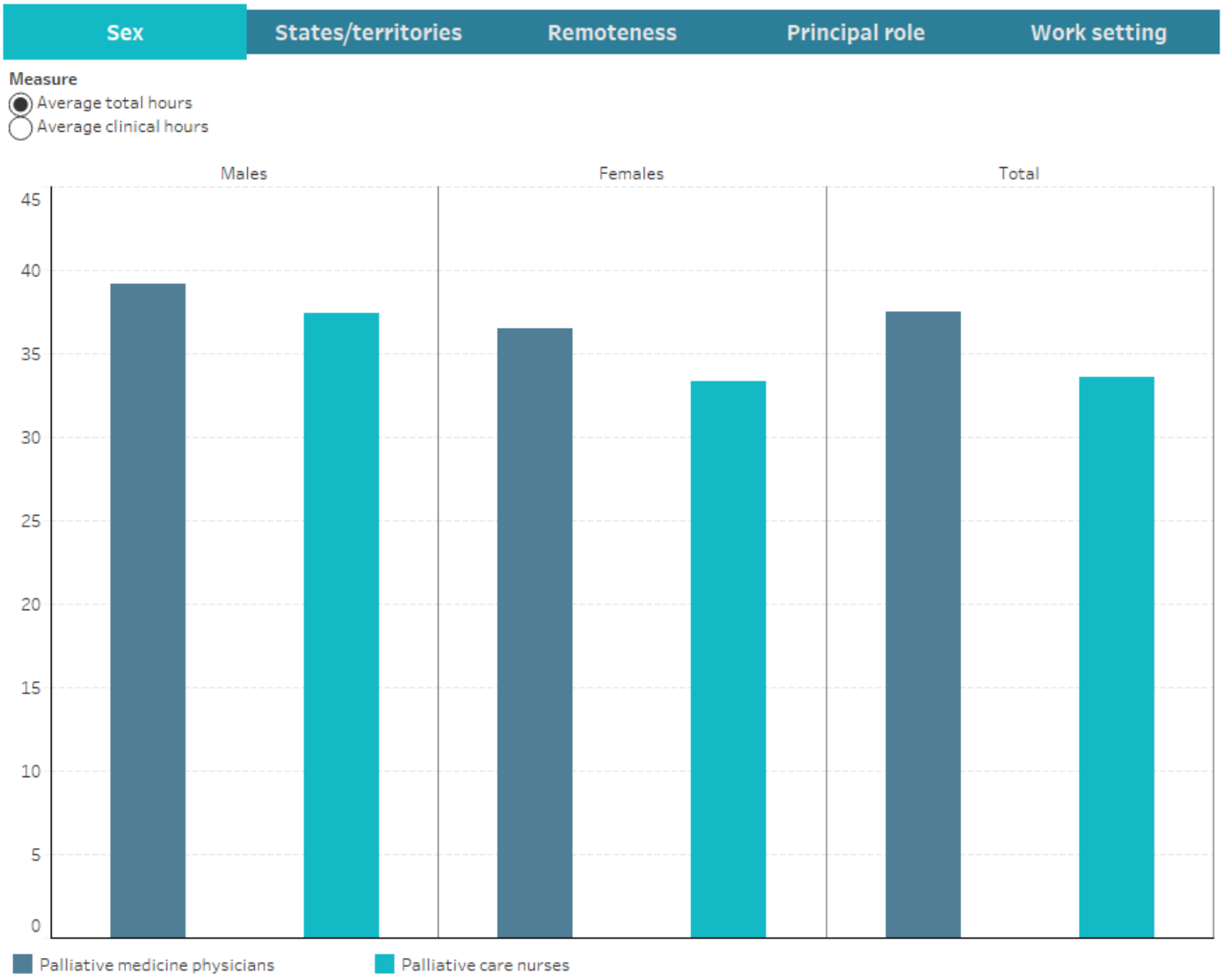
Working hours

In 2023, among employed palliative medicine physicians and palliative care nurses (Figure 2), on average:

- palliative medicine physicians worked less hours than all employed specialist medical practitioners (an average 38 total hours per week compared to 41 hours), this same pattern was observed for clinical hours as well (29 and 35 hours per week, respectively)
- palliative care nurses, worked similar total and clinical hours as all employed nurses and midwives (an average of 34 total hours and 31 clinical hours)
- males worked slightly longer hours than females both for palliative medicine physicians (an average of 39 versus 36.5 total hours) and palliative care nurses (37 versus 33 total hours), consistent with the pattern observed for all employed specialist medical practitioners and all employed nurses and midwives
- total hours worked increased with remoteness for palliative medicine physicians, rising from 37 total hours in *Major cities* to 40 total hours in *Outer regional* areas. The pattern amongst palliative care nurses was less clear, with no consistent trend observed across remoteness areas.

Figure 2 provides further details on working hours by work setting and principal role.

Figure 2: Average hours worked per week by employed palliative medicine physicians and palliative care nurses, 2023



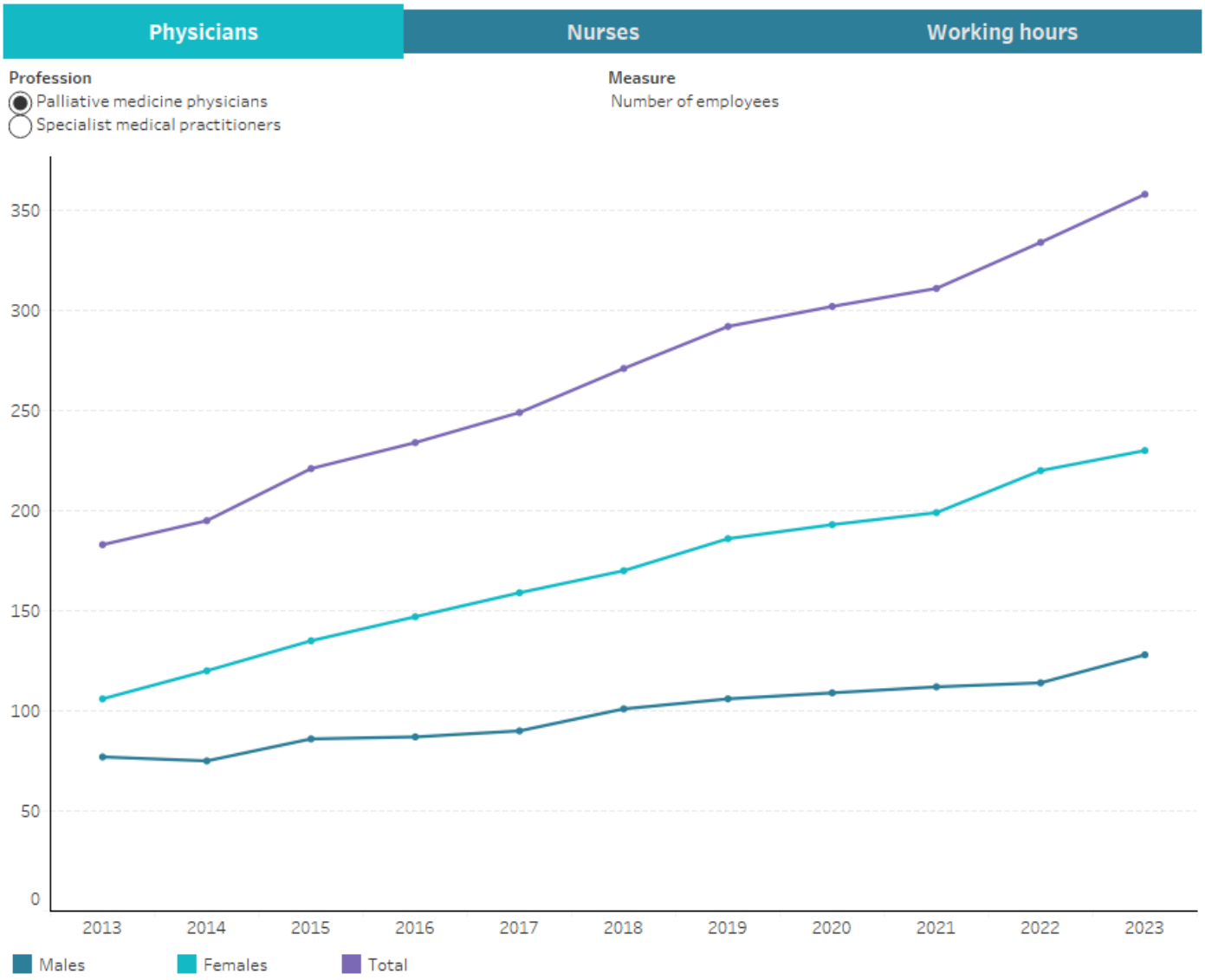
Note: The statistics for 'Total' have been calculated based on data of sex in 'Males' and 'Females'.
Source: AIHW. Workforce Table 2.
https://www.aihw.gov.au/pcsia

Trends

Between 2013 and 2023 (Figure 3):

- The number of palliative medicine physicians almost doubled from 183 to 358 (5.2% annually), outpacing the rise for all specialist medical practitioners (4.7% annually). The number of palliative care nurses increased from 3,300 to 3,900 (1.9% annually), slightly slower than that for all employed nurses and midwives (2.9% annually).
- Annual growth in total FTE rates per 100,000 population was higher for palliative medicine physicians (5.0% annually, increasing from 0.8 to 1.3 FTE) compared to all specialist medical practitioners (2.6% increase annually). In contrast, palliative care nurses saw a modest increase of 0.8% annually in the FTE rate (from 12 to 13 per 100,000), which was slower than the 1.5% annual increase for all nurses and midwives.
- The proportion of palliative medicine physicians who were male has decreased slightly (from 42% to 36%), indicating a gradual shift in gender representation. In contrast, the proportion of male palliative care nurses has remained consistently low at just 10%. These trends are also reflected among all employed specialist medical practitioners and all employed nurses and midwives.

Figure 3: Trends in employed palliative medicine physicians and palliative care nurses, 2013–2023



Note: The statistics for 'Total' do not include instances where sex was unknown/not stated.
Source: AIHW. Workforce Table 7.
https://www.aihw.gov.au/pcsia

Data source

National Health Workforce Data Set

The Workforce Surveys are administered to all health practitioners registered by the Australian Health Practitioner Regulation Agency (AHPRA) and are included as part of the registration renewal process. The workforce surveys are voluntary. The respective surveys are used to provide nationally consistent workforce estimates. They provide data not readily available from other sources, such as on the type of work done by, and job setting of, health practitioners; the number of hours worked in a clinical or non-clinical role, and in total; and the number of years worked in, and intended to remain in, the health workforce. The surveys also provide information on those registered health practitioners who are not undertaking clinical work or who are not employed. The information from the workforce surveys, combined with some National Registration and Accreditation Scheme (NRAS) registration data items, comprises the National Health Workforce Dataset (NHWDS).

Details of medical practitioners, nurses, and allied health practitioners registered with AHPRA are available for public access through the Department of Health, Disability and Ageing's Health Workforce Data Tool (HWDT). The numbers in this report reflect those extracted using HWDT as of 1 July 2025 Workforce for each profession is defined as those employed in Australia in the profession as one who:

- reported (the week before the survey) practising in Australia (including practitioners on leave for less than 3 months), or
- was involved with work that is principally concerned with their health discipline (including non-clinical roles – for example education, research, and administration).

Physicians and nurses specialising in palliative care

This report examines registered medical practitioners and nurses, as these professionals can be identified using the HWDT as specialist palliative care providers. In Australia, both doctors and nurses usually complete specialised training in addition to their medical or nursing degrees to work in palliative care.

Medical specialists must have completed post-graduate specialist training to become a palliative medicine physician. Palliative medicine physicians are required to have completed 3 years of full-time equivalent training in either a paediatric or adult setting under the supervision of a palliative medicine physician. Successful trainees gain the qualification of Fellow of the Royal Australasian College of Physicians (FRACP) / Fellowship of the Australasian Chapter of Palliative Medicine (FAChPM) 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 (RACP 2020).

The classification of nurses in Australia varies with the type of training that has been undertaken (see Department of Health, Disability and Aged Care for more information). Nurse practitioners, registered nurses and enrolled nurses need to complete a variety of short or more comprehensive courses (including postgraduate certificates and Master's degrees) to work in the field of palliative care, and postgraduate qualifications are generally required for nurses working in specialist palliative care services. While data on nurse practitioners are included in NHWDS and have been reported in Factsheets for Nursing and Midwifery, nurse practitioners are not identified in the HWDT and are therefore not included in this section. Further, in the HWDT nurses and midwives are grouped together under professions, hence the comparison of palliative care nurses is to all nurses and midwives in this chapter.

In the HWDT, employed palliative medicine physicians only include practitioners whose main speciality is palliative care. Employed palliative care nurses include only nurses whose principal job area is palliative care. This excludes those practitioners who:

- practice palliative care as a second or third speciality
- are registered in the profession but are retired from regular work
- work outside the profession
- work in the profession but are on extended leave of 3 months or more
- are only engaged in unpaid/volunteer work or
- work outside Australia.

It should be noted that 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 do not accurately capture the extent of palliative care services provided by these health professionals.

The full-time equivalent (FTE) is defined in this report as the number of standard-hour workloads worked by employed health professionals. The FTE is calculated by multiplying the number of employed professionals in a specific category by the average total hours worked by employed people in that category and dividing by the number of hours in a standard working week. The standard working week, equivalent to 1 FTE, is based on working 38 hours per week for all practitioners except for medical practitioners, where it is defined as 40 hours. In this report, the FTE for palliative care nurses is therefore based on working 38 hours per week and for palliative medicine physicians 40 hours per week.

Past and present surveys have different collection and estimation methodologies, questionnaire designs and response rates. As a result, caution should be taken in comparing historical data from the AIHW Medical Labour Force Surveys prior to 2010 with data from the NHWDS. Also, there may be differences between the data presented here and that published elsewhere due to different calculation or estimation methodologies or extraction dates. Additionally, the HWDT uses a randomisation technique to confidentialise small numbers. This can result in differences between the column sum and total and small variations in numbers from one data extract to another.

Further information regarding the Medical practitioner workforce and Nursing and midwifery workforce surveys is available from the Department of Health, Disability and Aged Care Health Workforce Data website.

Reference

RACP (Royal Australian College of Physicians) (2020) *Training pathways*, RACP website, accessed 22 August 2025.

PHN palliative care services information

In this section

Introduction

The Primary Health Network (PHN) data exploration tool provides information on palliative care services, and the people who access these services, at the PHN level. These data will enhance previously published data on palliative care services by including additional disaggregations, compiled into a regional interactive data exploration tool at the PHN-level. This more granular view of palliative service utilisation aims to increase our understanding of receipt of palliative care services at the PHN level.

This tool includes information on palliative care related hospitalisations (admitted and non-admitted patient care), receipt of Medicare-subsidised specialist palliative care services and palliative-care related medications (from the PBS Palliative Care Schedule).

More detailed information and analysis for the data included in the PHN data exploration tool is available in the relevant sections of the Palliative Care Services in Australia report:

- Admitted patient palliative care
- Non-admitted patient palliative care
- Medicare-subsidised palliative medicine attendance and case conference services
- Palliative care-related medications

Note that the data on this page do not include receipt of all palliative care services, due to data availability. These data gaps are described in further detail in the above-mentioned chapters of this report.

Table 1 includes high-level definitions for commonly used terms in the tool.

The data in this tool was last updated October 2025.

For further information on the definitions, data, and data sources used on this page, see Glossary and Technical specifications and General information within the Data tables: PCSiA October 2025 PHN palliative care services data.

How to use the data exploration tool

Instructions

Select a PHN from the ‘Select a PHN’ drop-down menu to filter data for that PHN specifically.

Use the ‘Filter by State/Territory’ drop-down menu to filter PHNs for a specific state/territory.

Use the navigation bar across the top to view more detailed information related to Admitted palliative care hospitalisations, Non-admitted palliative care service events, MBS-subsidised palliative medicine attendances and case conference services, and PBS palliative care-related medications.

Use the ‘Select measure’ filter to change the value type displayed in the charts.

Hover over chart components to see more information.

Use the ‘Show PHN map’ button to view your selected PHN in comparison to surrounding PHNs on a heatmap.

Note that data are not available for all disaggregations due to small counts and/or to preserve data confidentiality. In these cases, the charts will have missing bars.

Accessing data

See Data to download the PHN level data used in this tool, including further details on definitions and data sources.

PHN data exploration tool

PHN palliative care services dashboard

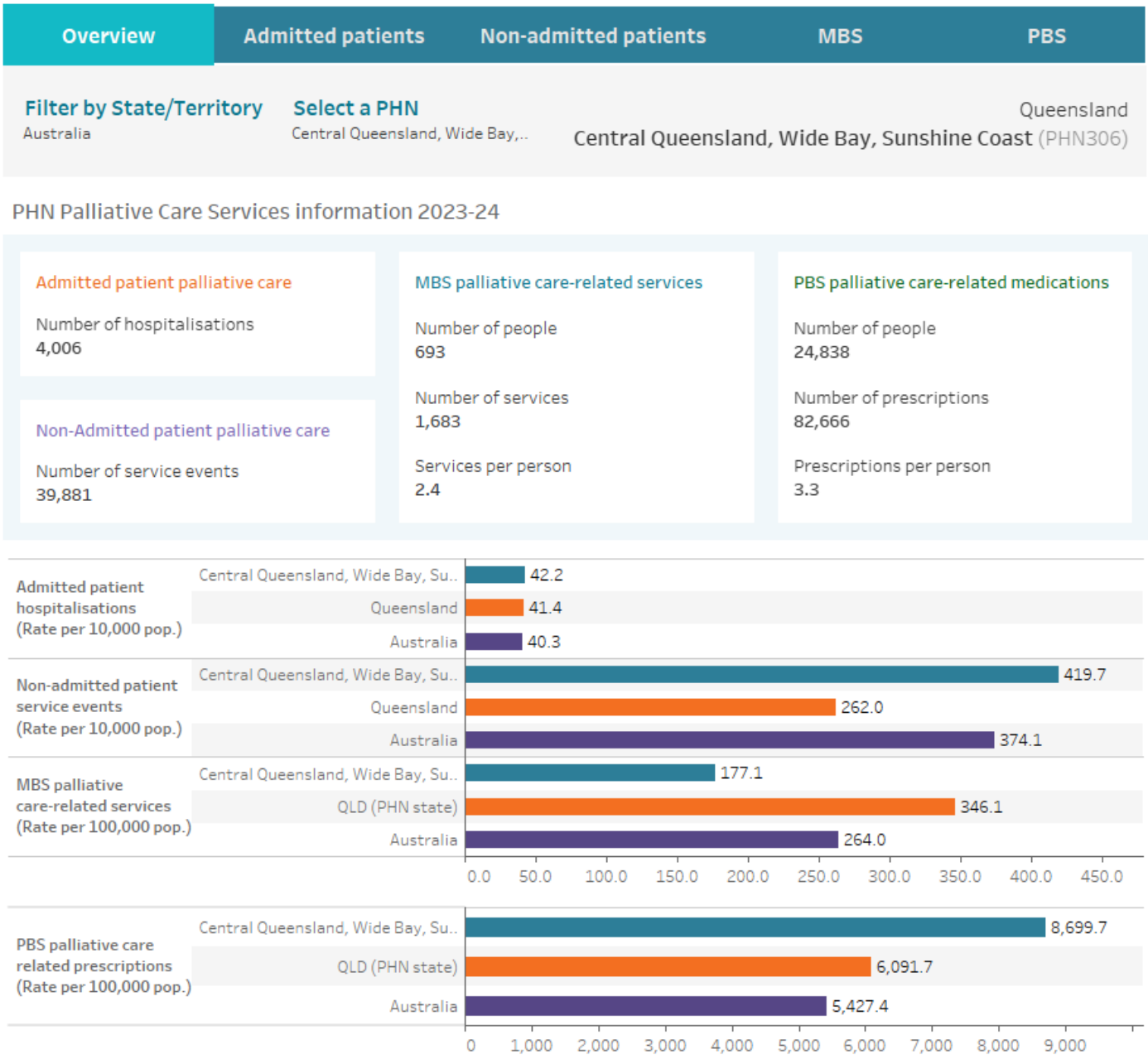


Table 1: Key terms

Key concepts	Description
MBS-subsidised palliative medicine attendance and case conference services	Services provided by palliative medicine physicians or specialists and are claimed under specialist palliative care MBS item numbers. For more information, see Data source.
Palliative care-related hospitalisation	A hospitalisation where palliative care was a component of the admitted patient care provided during all or part of the episode. These hospitalisations can be divided into 2 groups: • primary palliative care hospitalisations: hospitalisations with a recorded care type of palliative care, and • other palliative care hospitalisations: hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care. For more information, see Data source.

Primary palliative care service event	A non-admitted patient service event with a recorded care type of palliative care, where the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. These services are often associated with an emergency or admitted patient episode for which diagnostic or follow-up care is required without requiring hospital admission. For more information, see Data source.
Principal diagnosis	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, episode of residential care or attendance at a health care establishment. See METEOR identifier: 746665.
Palliative care-related prescriptions	Palliative care-related prescriptions are defined as medications listed in Palliative Care Schedule under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS). It is a count of medications dispensed, rather than a count of prescriptions written by clinicians. For more information, see Data source.
Primary Health Network (PHN)	Primary Health Network area of usual residence is based on the geographical region in which a person usually resides (provided as Statistical Area level 2 for most jurisdictions) defined as a Primary Health Network 2023. Your local Primary Health Network | Australian Government Department of Health and Aged Care
Socioeconomic area	Socioeconomic areas are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD). The IRSD has been used in these reports to indicate socioeconomic position for five groups (quintiles) – from the most disadvantaged (worst off or lowest socioeconomic area) to the least disadvantaged (best off or highest socioeconomic area). It is important to note that the IRSD reflects the overall or average socioeconomic position of the population of an area; it does not show how individuals living in the same area might differ from each other in their socioeconomic position.
PHN state	The state value displayed in the tool is calculated by summing all PHNs within the state. It excludes individuals and services where the PHN information was unknown. Therefore, it may not align with previously published state-level data.

Expenditure on palliative care

This chapter provides information related to expenditure on palliative care, sourced from the National Hospital Cost Data Collection (NHCDC), Medicare Benefits Schedule (MBS), and Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS).

Note that the expenditure reported in this chapter does not include all palliative care expenditure due to data availability. Further information about how expenditure on palliative care is identified through these available data sets is provided in Data sources.

The information in this chapter was last updated in May 2026.

Key points

Hospital expenditure:

- In 2023–24, 313 of 772 public hospitals reported admitted patient palliative care data to the Independent Health and Aged Care Pricing Authority (IHACPA), with a total hospital cost of $666.7 million on admitted palliative care. This represents 16% of all subacute care costs.
- In 2023–24, 229 public hospitals reported non-admitted patient palliative care data to the IHACPA, with a total hospital cost of $218.9 million on non-admitted palliative care.

Medicare-subsidised services and prescription medicines:

- In 2024–25, the benefits paid for Medicare-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists was $6.8 million, at an average of $430 per patient.
- In 2024–25, the Australian Government spent $40.4 million on palliative care-related medications from the Palliative Care Schedule, at an average of $83 per patient.
- In 2024–25, pain relief prescriptions accounted for 86% ($34.5 million) of the expenditure on palliative care-related medications, followed by prescriptions for gastrointestinal symptoms and neurological symptoms (8.8% and 3.9% respectively).

Trends:

- There was an increase of 16% in the benefits paid for palliative care attendance and case conference services between 2023–24 and 2024–25 (from $5.9 million to $6.8 million), after having declined by an average annual rate of 7.0% in the previous 5 years (from $8.5 million in 2018–19, in real terms).
- Between 2016–17 and 2024–25, expenditure on palliative care-related medications grew by an average annual rate of 11%, driven largely by a sharp 44% increase between 2020–21 and 2021–22 (to $39.3 million, in real terms) following the introduction of new medications. Since then, growth has continued at a slower annual rate of 0.9% to $40.4 million (in real terms) in 2024–25.

Expenditure on admitted patient palliative care

The Independent Health and Aged Care Pricing Authority (IHACPA) holds the National Hospital Cost Data Collection (NHCDC). This collection matches hospital patient-level activity data with the costs incurred by the hospital in administering care for the patient.

In 2023–24, among the 772 public hospitals that reported data to IHACPA, 313 public hospitals (41%) provided admitted patient palliative care data, with a total hospital cost of $666.7 million on admitted palliative care. This represents 16% of all subacute care costs ($4.2 billion) and 1.0% of total cost ($65.5 billion) in these reporting hospitals.

Of the $666.7 million spent on admitted palliative care:

- salaries and wages accounted for 65% of the total costs, with nursing salaries and wages accounting for the largest proportion (32%)
- almost 9 in 10 (89%) were for clinical services
- direct clinical costs (nursing, medical and clinical supplies) accounted for the largest share of total costs (60%), with 32% for nursing, 15% for medical and 13% for clinical supplies
- most of the expenditure was funded through the Health Service Budget, accounting for 79% of the total, followed by private health insurance, which contributed 18%.

Sociodemographic and regional characteristics

In 2023–24 for expenditure on admitted patient palliative care:

- people aged 65 years and over accounted for 76% of expenditure
- people living in the most socioeconomically disadvantaged areas accounted for a higher share of expenditure (26%) compared with people in the least disadvantaged areas (14%)

There were regional variations in expenditure which generally aligned with population distributions across states and territories. *Major cities* accounted for 65% of expenditure compared to just 2.2% in remote and very remote areas.

Note, that regional differences may be influenced by variations in hospital admission policies, practices, and service types.

Trends

Since 2013–14, the total expenditure on admitted patient palliative care has increased at an average annual rate of 4.3% in real terms. After a slight decrease in 2019–20, the total expenditure on admitted patient palliative care increased at an average annual rate of 4.8% (from $525.5 million to $666.7 million, in real terms). The number of reporting hospitals has also increased form 225 in 2019–20 to 313 in 2023–24.

When accounting for the number of reporting hospitals each year, average expenditure per hospital (in real terms) has remained similar between 2019–20 and 2023–24 (between $2.0 million - $2.3 million).

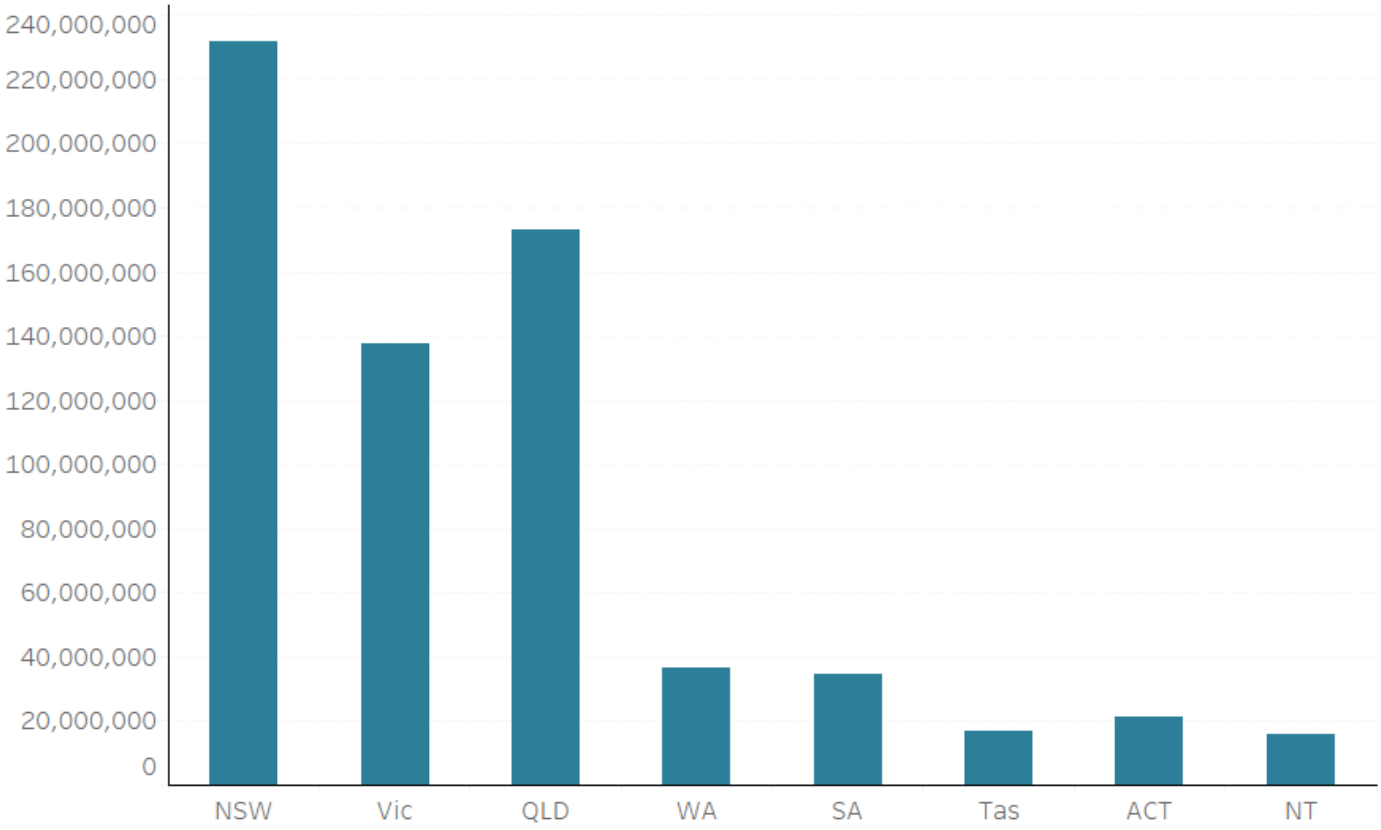
Figure EXP 1: Expenditure on admitted patient palliative care in public hospitals

Expenditure 2023–24 | **Expenditure 2013–14 to 2023–24**

Select measure

- ○ Expenditure per line item in Salaries and wages ($)
- ○ Expenditure per cost centre ($)
- ○ Expenditure per cost bucket ($)
- ● Expenditure by states and territories ($)

Figure EXP 1.1: Expenditure by states and territories ($) on admitted patient palliative care in public hospitals, 2023–24



Source and notes: AIHW. Expenditure on palliative care Table 4 and 5.
https://www.aihw.gov.au/pcsia

Footnotes

Trend interpretation notes

1. The period reviewed in this report includes COVID-19 pandemic years, and interpretation of data in this repot should consider the impacts of this period on the findings present.
2. When considering trends in expenditure, increasing or changing cost profiles may reflect improved cost and/or activity reporting, such as more hospitals, or care type changes for palliative care.

Expenditure on non-admitted patient palliative care

In 2023–24, 229 public hospitals reported non-admitted patient palliative care data to IHACPA, with a hospital expenditure of $218.9 million on non-admitted patient palliative care.

Of the $218.9 million spent on non-admitted patient palliative care:

- salaries and wages accounted for 66% of the total costs, with nursing salaries and wages accounting for the largest proportion (33%)
- 87% was for clinical services, followed by pharmacy and allied health (7.1% and 3.3%, respectively)
- direct clinical costs accounted for the largest share of total expenditure (60%), with 33% for nursing, 14% for medical and 12% for clinical supplies
- the majority of expenditure was funded through the Health Service Budget (91% of total expenditure), followed by the Medicare Benefits Schedule (6.5%).

Sociodemographic and regional characteristics

In 2023–24, for expenditure on non-admitted patient palliative care:

- people aged 65 and over accounted for 69% of expenditure
- people living in the most socioeconomically disadvantaged areas accounted for a higher share of expenditure (24%) compared to people in the least disadvantaged areas (13%)

There were regional variations in expenditure which generally aligned with population distributions across states and territories. M*ajor cities* accounted for 53% of expenditure compared to just 3.3% in remote and very remote areas.

Note, that regional differences may be influenced by variations in hospital admission policies, practices, and service types.

Trends

Since 2013–14:

- Expenditure on non-admitted patient palliative care has increased substantially at an average annual rate of 16%, in real terms.
- The number of non-admitted patient palliative care reporting hospitals more than doubled (from 113 in 2013–14 to 229 in 2023–24).
- When accounting for the number of non-admitted patient palliative care reporting hospitals each year, expenditure per reporting hospital (in real terms) has also more than doubled, from $448,000 in 2013–14 to $960,000 in 2023–24.

Total expenditure almost doubled between 2019–20 and 2023–24 (from $118.9 million to $218.9 million, in real terms). This growth largely driven by a steep increase between 2020–21 and 2022–23 (32% average annual increase).

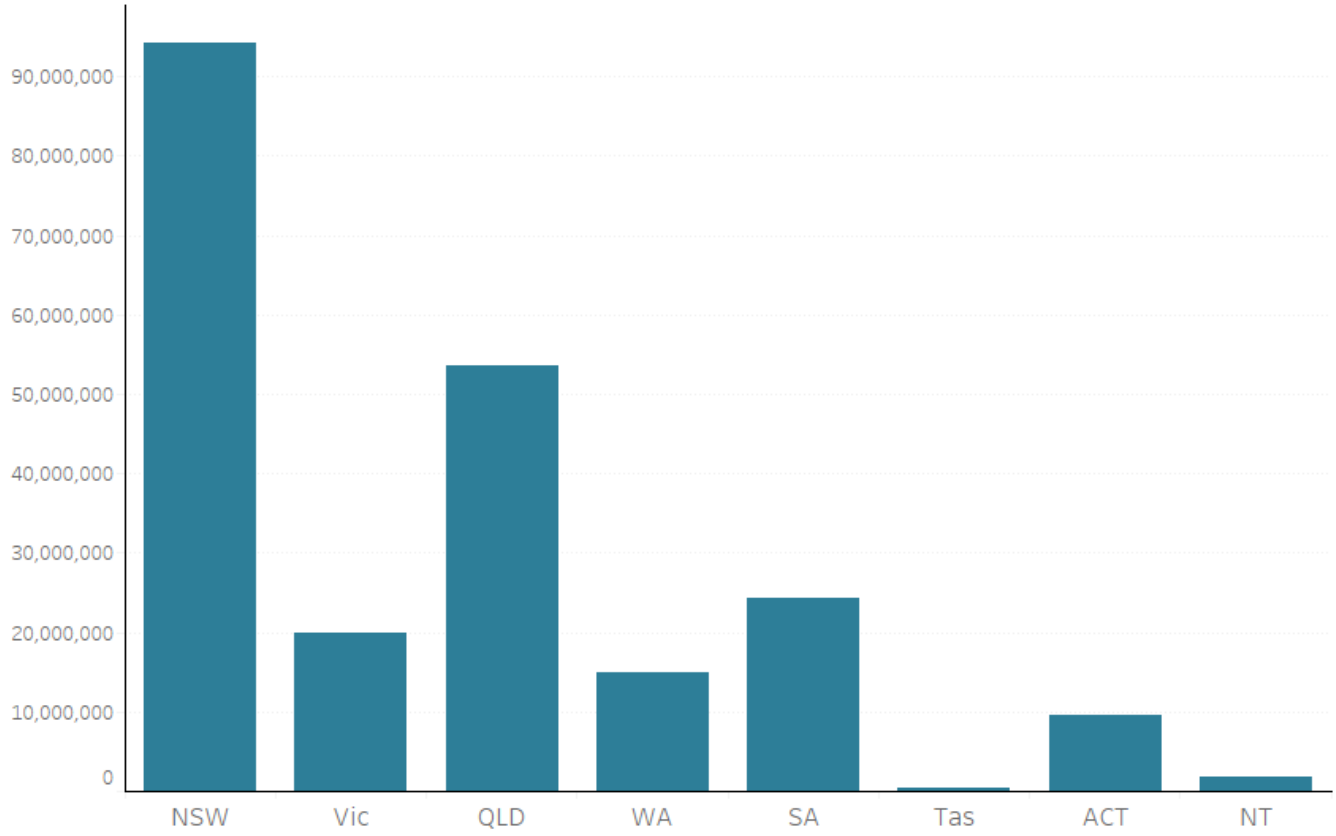
Figure EXP 2: Expenditure on non-admitted patient palliative care in public hospitals

Expenditure 2023–24 | **Expenditure 2013–14 to 2023–24**

Select measure

- ○ Expenditure per line item in Salaries and wages ($)
- ○ Expenditure per cost centre ($)
- ○ Expenditure per cost bucket ($)
- ● Expenditure by states and territories ($)

Figure EXP 2.1: Expenditure by states and territories ($) on non-admitted patient palliative care in public hospitals, 2023–24



Source and notes: AIHW. Expenditure on palliative care Table 1 and 4.
https://www.aihw.gov.au/pcsia

Footnotes

Trend interpretation notes

1. The period reviewed in this report includes COVID-19 pandemic years, and interpretation of data in this repot should consider the impacts of this period on the findings present.
2. When considering trends in expenditure, increasing or changing cost profiles may reflect improved cost and/or activity reporting, such as more hospitals, or care type changes for palliative care.

Expenditure on palliative medicine attendance and case conference services

The Australian Government subsidises palliative care through the MBS for palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists.

In 2024–25:

- $6.8 million was paid for Medicare-subsidised palliative medicine case attendance and case conference services, equivalent to an average of $430 per patient.
- Palliative medicine attendances accounted for 82% ($5.6 million) of Medicare-subsidised palliative medicine case attendance and case conference services, while case conferences made up the remaining 18% ($1.2 million).
- Benefits paid for Medicare-subsidised palliative medicine attendance and case conference services accounted for 0.2% of the total benefits paid for all Medicare-subsidised specialist attendances ($3.3 billion).

Figure EXP 3 also highlights variations across the states and territories in benefits paid and benefits per patient for these services.

Trends

Between 2023–24 and 2024–25, there was an increase of 13% in the benefits paid for palliative care attendance and case conference services (from $6.1 million to $6.8 million), after a previous 5 year decline by an average annual rate of 7.1% (from $8.7 million in 2018–19, in real terms).

Benefits paid per patient for these services followed a similar pattern, increasing by 3.1% in the last year (from $417 to $430 per patient, in real terms), after declining at an average annual rate of 4.7% over the previous 5 years (in real terms).

In contrast, total benefits paid and benefits per patient (in real terms) for all specialist attendances (including palliative medicine physicians/specialists) fluctuated over this period with no clear trend.

For further details on these MBS-subsidised services and people receiving them, see Medicare-subsidised palliative medicine attendance and case conference services chapter.

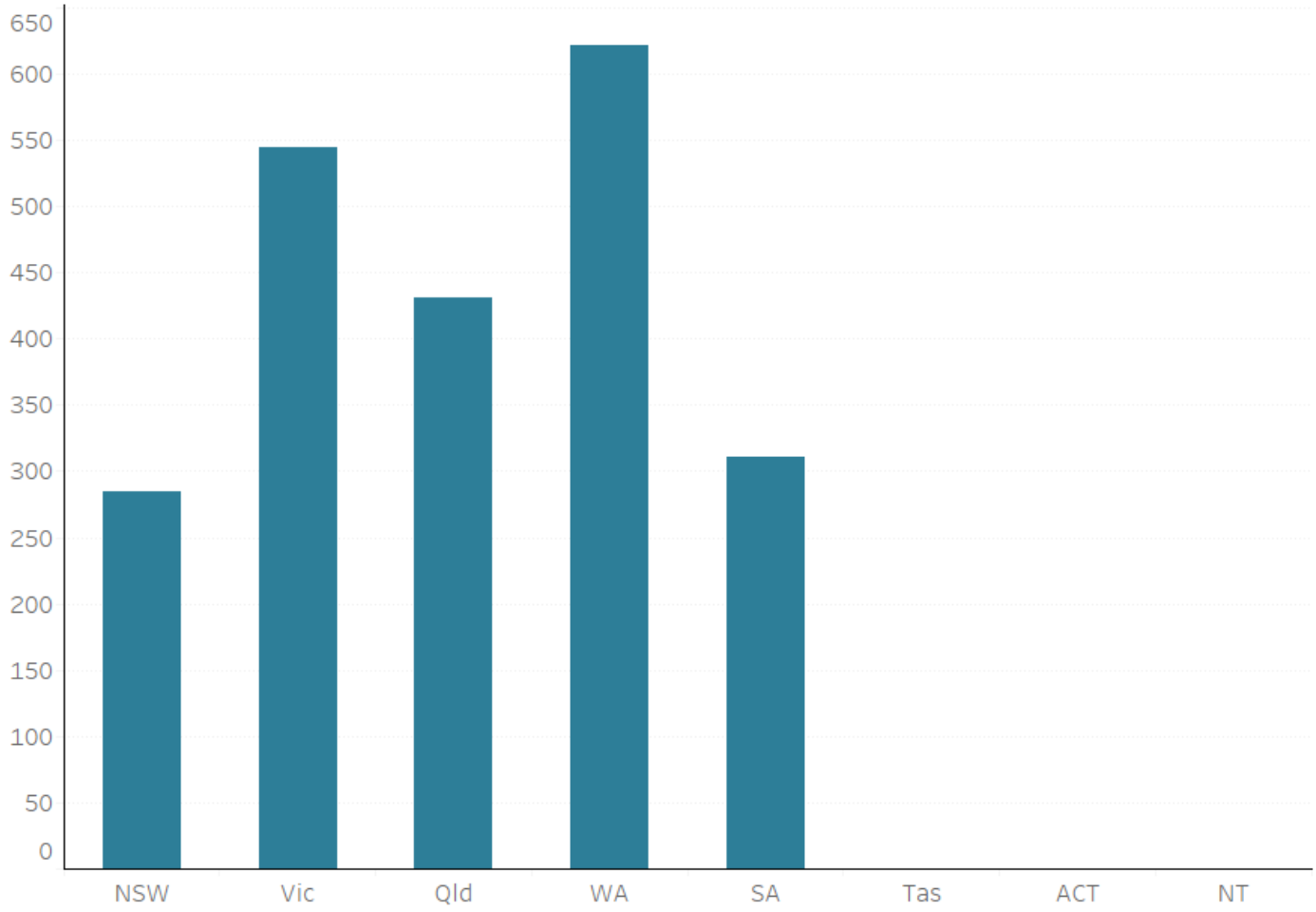
Figure EXP 3: Benefits for palliative medicine attendance and case conference services provided by palliative medicine physicians or specialists

Expenditure 2024–25 | Expenditure 2015–16 to 2024–25

Select measure

- ○ Benefits ($)
- ● Benefits per patient ($)

Figure EXP 3.1: Benefits per patient ($) for palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists, by states and territories, 2024–25



Source and notes: AIHW. Expenditure on palliative care Table 7.
https://www.aihw.gov.au/pcsia

Expenditure on palliative care-related medications

The Australian Government subsidises the cost of pharmaceutical products listed in the PBS Palliative Care Schedule to improve access to essential and affordable medications for people with life-limiting conditions. This specialised schedule complements the General PBS and RBPS Schedules by offering medications tailored to the unique needs of palliative care patients.

In 2024–25:

- the Australian Government spent $40.4 million on palliative care-related prescriptions from PBS Palliative Care Schedule, equivalent to an average of $83 per patient
- pain relief prescriptions made up 86% ($34.5 million) of total expenditure on palliative care-related prescriptions, followed by prescriptions for gastrointestinal symptoms (8.8%, $3.6 million) and prescriptions for neurological symptoms (3.9%, $1.6 million).

Figure EXP 4 also highlights variations across the states and territories in expenditure and expenditure per patient for palliative care-related prescriptions.

Trends

Between 2016–17 and 2024–25, expenditure on palliative care-related prescriptions has increased overall at an average annual rate of 11%. Since 2019–20 expenditure has increased by an average annual rate of 9.4% (from $25.7 million to $40.4 million, in real terms). This is largely driven by a steep increase of 44% between 2020–21 and 2021–22 (from $27.4 million to $39.3 million, in real terms).

Consistent with these patterns, expenditure per patient (in real terms) increased by an average annual rate of 12% (from $47 to $83 per patient, in real terms) since 2019–20. This was again driven largely by a steep increase of 63% between 2020–21 and 2021–22 (from $53 to $87 per patient, in real terms).

For further details on palliative care-related medications from PBS Palliative Care Schedule and people receiving them, see Palliative care-related medications chapter.

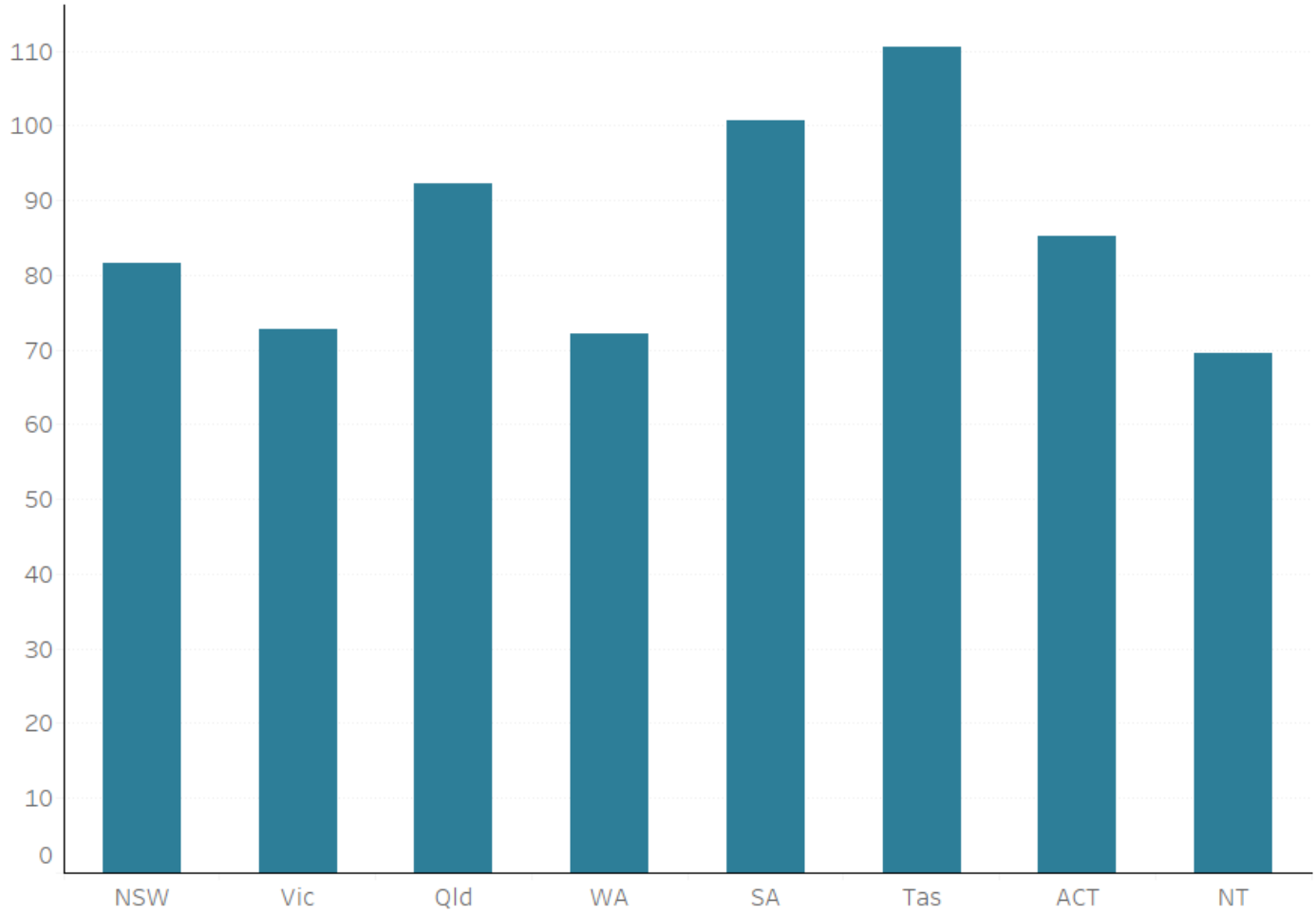
Figure EXP 4: Expenditure on palliative care-related medications from PBS Palliative Care Schedule

Expenditure 2024–25 | **Expenditure 2016–17 to 2024–25**

Select measure

○ Expenditure ($)
◉ Expenditure per patient ($)

Figure EXP 4.1: Australian Government expenditure on palliative care-related medications from PBS Palliative Care Schedule, by states and territories, 2024–25



Source and notes: AIHW. Expenditure on palliative care Table 9.
https://www.aihw.gov.au/pcsia

Data sources

Medicare Benefits Schedule data

The Medicare Benefits Schedule (MBS) is part of Australia's public health insurance scheme. Through the MBS the Australian Government subsidises the costs of a broad range of health services. The MBS subsidies pay all or part of the costs of these services, dependent on factors such as patient eligibility, the type of service and choices by health practitioners regarding the fees they charge for their services. MBS benefits are claimable only for services rendered by an appropriate health practitioner and which are listed on the MBS.

Services Australia collects administrative data in processing claims for benefits under the MBS and provides this information to the Australian Government Department of Health, Disability and Ageing. The item numbers and benefits paid by Services Australia are determined based on the MBS, as listed in MBS Online.

The data presented in this report relate to services provided on a 'fee-for-service' basis for which MBS benefits were paid, and only for palliative medicine attendances and case conferencing services that are both provided by palliative medicine physicians or specialists, and are claimed under specialist palliative care MBS item numbers.

Patients who are referred to specialists or physicians in palliative medicine usually have:

- intermediate and fluctuating needs that might result in unplanned use of hospital and other services, and/or
- complex and persistent needs (physical, social, emotional, or spiritual) that are not effectively managed through established protocols (PCA 2018).

Information is also provided on the settings where the attendances were provided – in hospital or consulting room, or in other settings, such as attendance at a person's place of residence, including home, residential aged care or institution (see Table EXP 1). For case conferencing, it refers to community case conference and discharge case conference (see Table EXP 2).

Table EXP 1: MBS items for palliative medicine attendances provided by palliative medicine physicians or specialists in this report

MBS item	MBS group and subgroup	MBS item number
Attendance in a consulting room or hospital, initial brief video conference	Group A24	3003*
Attendance in a consulting room or hospital, initial visit	Group A24	3005
Attendance in a consulting room or hospital, subsequent visit, minor, after initial attendance	Group A24	3014
Attendance in a consulting room or hospital, subsequent visit, other than a minor attendance	Group A24	3010
Attendance in a consulting room or hospital, video conference	Group A24	3015*
Attendance in a place other than consulting rooms or hospital, initial visit	Group A24	3018
Attendance in a place other than consulting rooms or hospital, subsequent visit	Group A24	3023
Attendance in a place other than consulting rooms or hospital, subsequent visit, minor, after initial attendance	Group A24	3028

* Items 3003 and 3015 ceased on 31 December 2021, with telehealth services now claimed against relevant item numbers in Group A40.

Note: Refer to the Medicare Benefits Schedule Book July 2024 edition for full item descriptions (pages 308–309) and further information relating to the MBS items for palliative care (pages 118–119).

Table EXP 2: **MBS items for palliative medicine case conferences provided by palliative medicine physicians or specialists in this report**

MBS item	MBS group and subgroup	MBS item number
Organise and coordinate a community case conference 15–<30 minutes	Group A24	3032
Organise and coordinate a community case conference 30–<45 minutes	Group A24	3040
Organise and coordinate a community case conference >=45 minutes	Group A24	3044
Participate in a community case conference 15–<30 minutes	Group A24	3051
Participate in a community case conference 30–<45 minutes	Group A24	3055
Participate in a community case conference >=45 minutes	Group A24	3062
Organise and coordinate a discharge case conference 15–<30 minutes	Group A24	3069
Organise and coordinate a discharge case conference 30–<45 minutes	Group A24	3074
Organise and coordinate a discharge case conference >=45 minutes	Group A24	3078
Participate in a discharge case conference 15–<30 minutes	Group A24	3083

Participate in a discharge case conference 30–<45 minutes	Group A24	3088
Participate in a discharge case conference >=45 minutes	Group A24	3093

Note: Refer to the Medicare Benefits Schedule Book July 2024 edition for full item descriptions (pages 309–311) and further information relating to the MBS items for palliative care (pages 118–119).

Palliative care physicians and specialists may at times use other MBS item numbers when attending to palliative care patients. These items are not included in the data in this report, as they are not claimed specifically as a palliative care-related service under the MBS. Further, other medical practitioners (general practitioners and medical specialists) and health professionals also attend to terminally ill patients and provide palliative care, without the service being eligible to be claimed specifically as a palliative care-related service under the MBS. In other words, the reported number of patients who receive a palliative care-related service under the MBS is a known underestimate of total palliative care activity. Further, the data does not include referred attendances by palliative medicine physicians or specialists to public in-patients or public outpatients of hospitals and services funded from the Department of Veterans' Affairs National Treatment Account.

It should be noted that a patient may access more than one type of these specific MBS items provided by palliative medicine physicians or specialists during the reporting period and that each service is counted separately in this report.

The MBS data presented in this report (2024–25 and trend data) are based on the date the service was provided rather than the date of service processing, as this more accurately reflects the date a service occurred. This only includes services that were processed on or before 30 Nov 2025. Note that in reports released prior to 2022, the data was based on the date the service was processed by Services Australia and as a result, the data presented since 2022 releases are not comparable with previous releases.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

Services Australia collects administrative data while processing prescriptions dispensed under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data and provides these data to the Australian Government Department of Health, Disability and Ageing.

Through the PBS and RPBS data, the Australian Government subsidises the cost of pharmaceutical products listed on the Schedule of Pharmaceutical Benefits. In 2004, the Australian Government introduced Pharmaceutical Benefits for Palliative Care, referred to as the PBS Palliative Care Schedule. The PBS Palliative Care Schedule, which lists medication items available for palliative care, was established as a separate schedule, complementing the General Schedule to improve access to essential and affordable medications for patients receiving palliative care.

Only the medications listed on the PBS Palliative Care Schedule (referred to as palliative care-related prescriptions) and the medications prescribed by palliative medicine specialists are included in this report.

Palliative care patients who access medications listed on the PBS Palliative Care Schedule can also access medications listed on the General Schedule, for example morphine. The same medications may be listed on the PBS Palliative Care Schedule and the General Schedule, however, medications on the PBS Palliative Care Schedule may be listed with larger quantities and/or more script repeats, making them more suitable for use in palliative care (Department of Health, Disability and Ageing 2016a). This may reduce patient co-payment costs and decrease the frequency of doctor consultations for ongoing symptom management.

Given the overlap in medication items listed on the different schedules, and because the PBS Palliative Care Schedule is intended to complement the General Schedule, it is likely that some medicines prescribed for palliative care are prescribed from the General Schedule. These prescriptions are not included in the count of palliative care-related prescriptions in this report. In addition, medications prescribed for palliative care purposes in some other instances are not included in this report as well, since PBS and RPBS data do not capture over the counter medicines, medicines supplied to public hospital inpatients, and private prescriptions. For example, if a medicine is not listed under the PBS Schedule for a specific indication, but it has market authorisation by the Therapeutic Goods Administration for sale, it would not be included.

Palliative care prescriptions can also be identified through the prescriber. Palliative medicine specialists may prescribe medicines for a range of reasons, some of which may be for palliative care, and may prescribe from different schedules. This report includes information on medications prescribed by palliative medicine specialists from all schedules (Table 8 in Data tables: PCSiA 2025 Palliative care-related medications) and are therefore likely to include prescriptions prescribed for both palliative care and non-palliative care reasons.

The PBS and RPBS data presented in this report (2024–25 and trend data) are based on the date of supply, which is when the prescription was dispensed to the patient. The report includes all prescriptions supplied during 2024-25 financial year that were processed on or before 30 November 2025.

Types of palliative care-related prescriptions

Previously, this report has defined types of palliative care-related medicines by categories based on the Anatomical Therapeutic Chemical (ATC) classification system (WHO 2022). Since 2022, this report has used an updated method to report types of palliative care-related prescriptions, with the categories based on the Palliative Care publication of the Australian Therapeutic Guidelines (Therapeutic Guidelines Limited 2021). Therefore, the medication types (at the ATC level 2) in editions before 2022 are not directly comparable with the 'medication group' in this report.

Table EXP 3 lists the medication items from the PBS Palliative Care Schedule with their corresponding medication groups and ATC codes at levels 2, 3 and 5. Note that most of these medicines are listed in multiple areas in PBS and RPBS, and are not specific to the Palliative Care Schedule. In this report, data extracted using ATC codes for medication groups was filtered by program type (Palliative Care Schedule) to report on all palliative care-related prescriptions.

Table EXP 3: PBS Palliative Care Schedule medicines according to medication group

Medication group	ATC level 2	ATC level 3	ATC level 5	Medication name/s

Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AB01	Indomethacin
Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AE01	Ibuprofen
Pain relief	Anti-inflammatory and antirheumatic products	Anti-inflammatory and antirheumatic products, non-steroids	M01AE02	Naproxen
Pain relief	Analgesics	Opioids	N02AA01	Morphine (excluding PBS items 11760Y and 11761B)
Pain relief	Analgesics	Opioids	N02AA03	Hydromorphone
Pain relief	Analgesics	Opioids	N02AA05	Oxycodone
Pain relief	Analgesics	Opioids	N02AA55	Oxycodone + Naloxone
Pain relief	Analgesics	Opioids	N02AB03	Fentanyl
Pain relief	Analgesics	Opioids	N02AE01	Buprenorphine
Pain relief	Analgesics	Opioids	N02AC	Methadone
Pain relief	Analgesics	Other analgesics and antipyretics	N02BE01	Paracetamol
Gastrointestinal symptoms	Stomatological preparations	Stomatological preparations	A01AD02	Benzydamine
Gastrointestinal symptoms	Drugs for functional gastrointestinal disorders	Propulsives	A03FA01	Metoclopramide
Gastrointestinal symptoms	Drugs for functional gastrointestinal disorders	Belladonna and derivatives, plain	A03BB01	Hyoscine butylbromide (aka butylscopolamine)*
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AD15	Macrogol – 3350
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AD15	Macrogol – 3350 + Sodium Chloride + Bicarbonate + Potassium Chloride
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AG20	Citric Acid + Lauryl Sulfoacetate Sodium + Sorbitol
Gastrointestinal symptoms	Drugs for constipation	Drugs for constipation	A06AH01	Methylnaltrexone
Neurological symptoms	Antiepileptics	Antiepileptics	N03AE01	Clonazepam
Respiratory symptoms (Chronic breathlessness)	Analgesics	Opioids	N02AA01	Morphine (PBS items 11760Y and 11761B only)**
Psychological symptoms	Psycholeptics	Antipsychotics	N05AD01	Haloperidol
Psychological symptoms	Psycholeptics	Hypnotics and Sedatives	N05CD07	Temazepam
Psychological symptoms	Psycholeptics	Hypnotics and Sedatives	N05CD02	Nitrazepam
Psychological symptoms	Psycholeptics	Anxiolytics	N05BA01	Diazepam
Psychological symptoms	Psycholeptics	Anxiolytics	N05BA04	Oxazepam

*Hyoscine Butylbromide can also be used to manage respiratory secretions.

**These PBS items are listed on the PBS as Restricted Benefit which can only be prescribed for specific therapeutic uses.

Relevant changes to the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme over time

Reporting of 'subsidised' and 'under co-payment' prescription data

The maximum co-payment a patient pays depends on their level of entitlement, which is determined by the patient's concessional status and whether they have qualified for the PBS safety net. Current and historical co-payments can be found on the PBS website.

Since 2022, this report combines under co-payment and subsidised data in most tables. An additional table by patient beneficiaries shows the palliative care data by co-payment type in a single table for 2024–25 (Table 4 in Data tables for Palliative care-related medications), rather than including this split in every table.

Changes to restriction levels on the Palliative Care Schedule

On 1 June 2016, as part of the Post-market Review of Authority Required PBS Listings, changes were made to items listed on the Palliative Care Schedule. The restrictions for a number of Palliative Care Schedule items were changed and some medications were added or deleted. The restriction level of certain Palliative Care Schedule items, specifically those in the 'pain relief' and 'gastrointestinal symptoms' categories, were changed, in many cases from 'Authority Required (STREAMLINED)' to 'Restricted Benefit', reducing the level of restriction. Certain versions of medications were delisted due to initial and continuing treatment restrictions being simplified and merged under a single item code.

It should also be noted that data from 2016–17 onwards are not comparable with previous years, given the above-mentioned changes to the PBS restriction level from June 2016 and new listings of medications in the PBS Palliative Care Schedule (Department of Health, Disability and Ageing 2016b).

National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHCDC) is an annual collection of public hospital cost data in Australia, managed by the Independent Health and Aged Care Pricing Authority (IHACPA), and is the primary data collection used to develop the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the funding of public hospitals services.

IHACPA uses classifications to categorise, cost and price hospital activity. Hospital activity relates to the management of (diagnostics and interventional) and the resources used by the patient in relation to their treatment. Classification systems are used to describe activity related to the following types of patient care: admitted acute care, subacute and non-acute care, non-admitted care, emergency care and mental health care. Palliative care belongs to subacute care, a specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. Note that not all hospitals submitting data to IHACPA report subacute data (including palliative care). The data presented in this report are related to records and costs that are linked and in scope for NHCDC reporting only, unless otherwise stated.

In this report:

- admitted patient palliative care includes either palliative care episodes or palliative care phases, which are identified by using the 'Care type' as 'Palliative care'
- non-admitted patient palliative care refers to palliative care service events, which are identified by using either 'Care type' as 'Palliative care', or 'Tier 2 Non-Admitted Services classification' as 'Palliative care' in Medical Consultation Classes or in Allied Health and/or Clinical Nurse Specialist Interventions Classes.

Note that expenditure for non-admitted patient palliative care, defined by 'Tier 2 Clinic Codes', does not specifically capture non-specialist care that falls outside these codes.

Also note, the expenditure data on admitted and non-admitted patient palliative care in this report may not match jurisdiction reported palliative care costs in other reports, as the definitions for palliative care between the AIHW and Budget Estimates differ.

The health departments of Australia's states and territories submit their cost data to IHACPA. Taken together, the collection represents the primary source of information about the cost of treating patients in Australian hospitals. To support consistency in the costing process, IHACPA works with stakeholders to develop and implement national costing standards. The Standards prescribes the set of line items and cost centres used for mapping hospital costs. IHACPA then creates cost buckets as cost pools within the hospital, by combining line items and cost centres, which are made up of:

- Line items: these represent types of costs (for example, salaries and wages or goods and services) incurred by hospitals which are reported on in the general ledgers of hospitals.
- Cost centres: these represent departmental cost, objects within a hospital that relate to a particular function of the hospital – for example, the hospital operating room (IHACPA 2023).

The current version of the standards is the Australian Hospital Patient Costing Standards Version 4.1. For more information about data specifications, see IHACPA's Data collection page.

References

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Department of Health, Disability and Ageing (2011) *Pharmaceutical Benefits Scheme Collection of Under Co-payment Data*, Department of Health, Disability and Ageing, Australian Government, accessed 10 February 2025.

IHACPA (Independent Health and Aged Care Pricing Authority) (2023) *National Hospital Cost Data Collection (NHCDC) Public Sector Report 2020–21*, IHACPA, Australian Government, accessed 19 February 2025.

PCA (Palliative Care Australia) (2018) *Palliative Care Service Development Guidelines*, PCA website, accessed 20 January 2025.

Therapeutic Guidelines Limited (2021) *Therapeutic Guidelines: Palliative Care*, Therapeutic Guidelines Limited website, accessed 28 February 2025.

WHO (World Health Organization) (2022) *ATC Structure and principles*, WHO website, accessed 28 February 2025.

Palliative care in general practice

General practitioners (GPs) play an important role in palliative care as well as the health-care system more broadly. However, there is no nationally consistent, routinely collected primary healthcare data collection that enables reporting on the provision of palliative care by GPs.

Furthermore, while the Medicare Benefits Schedule (MBS) includes specific items for palliative medicine specialist services (delivered by palliative medicine specialists) for which it will reimburse a proportion of the MBS fee (see Services provided by palliative medicine specialists section) there are no palliative care-specific items that can be used by GPs or other medical specialists who may be providing palliative care (such as oncologists). It is therefore likely that GPs use other MBS items, for example, those for chronic disease management and home visit items, when providing patients with palliative care. Consequently, the extent of palliative care-related services delivered by GPs cannot be established from existing Medicare data.

This section presents information on palliative care-related encounters provided by GPs using data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity. The BEACH survey was run for the last time in 2015–16.

Downloads

The information in this section was last updated in October 2017.

Key points

- In 2015–16, about 1 in 1,000 GP encounters reported for the BEACH collection was palliative care-related.
- About 9 in 10 palliative care encounters were with people aged 65 and over, and 4.8% were with those aged under 55.
- Females accounted for a greater proportion of GP palliative care-related encounters (53.0%) than males (47.0%), but there was no difference between the sexes in palliative care encounter rates (about 1 per 1,000 of GP encounters for both males and females).
- In 2015–16, 1.3% of palliative care-related encounters were recorded as being with Indigenous Australians.

Box 1: Bettering the Evaluation and Care of Health survey

The Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity was undertaken annually by the Family Medicine Research Centre at the University of Sydney between 1998 and 2016. For each year's data collection, a random sample of about 1,000 General Practitioners (GPs) each reported details of 100 consecutive GP encounters of all types on structured encounter forms. Each form collected information about the consultations (for example, date and type of consultation), the patient (for example, date of birth, sex, and reasons for encounter), the problems managed and the management of each problem (for example, treatment provided, prescriptions and referrals). Data on patient risk factors, health status and GP characteristics were also collected.

Additional information on the 2015–16 BEACH survey can be obtained from General practice activity in Australia 2015–16 (Britt et al. 2016). The BEACH survey was run for the last time in 2015–16.

The BEACH survey is a paper-based survey of a sample of GPs and their encounters with patients. The BEACH survey provides information on the reasons patients visited the GP, the problems managed and the types of management provided for each problem.

The 2015–16 BEACH data presented in this section relate to 96,500 GP encounters from a sample of 965 GPs over the period from April 2015 to March 2016, inclusive. After weighting (to ensure that national general practitioner age, sex and activity patterns are reflected) the data include 97,398 (weighted) encounters (Britt et al. 2016). For further information about the 2015–16 BEACH survey methodology see the Family Medicine Research Centre General practice activity in Australia 2015–16 report.

Palliative care-related encounters in this section have been identified using the 4 ICPC-2 PLUS palliative care-related codes that were recorded against three discrete BEACH survey data elements (Reason for encounter, Problem/Diagnosis and Referral).

More information about this survey and the data is in the Technical notes section.

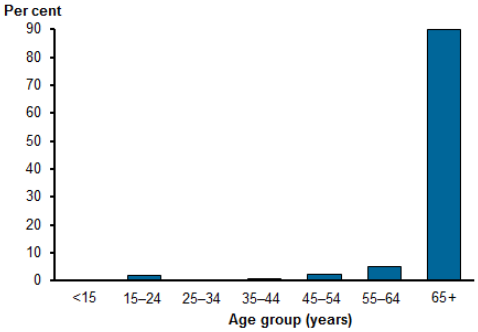
Palliative care-related encounters

According to BEACH, about 1 in 1,000 GP encounters in 2015–16 were palliative care-related. This corresponds to approximately 6 encounters per 1,000 population in 2015–16. It should be noted that palliative care-related GP encounters are difficult to define as palliative care is not a medical diagnosis in its own right; rather, it is a process related to a stage in managing an illness. As such, GPs may record the problems they manage as part of the palliative care process (for example, lung cancer) – not the palliative care process itself. In cases where the patient's health is gradually deteriorating and there is no specific problem being dealt with, palliative care may be recorded as the problem managed. As such, the number of encounters reported as palliative care is likely to be an underestimate of the actual number of palliative care-related encounters by GPs.

Patient demographics

In 2015–16, about 9 in 10 palliative care GP encounters were with people aged 65 and over, and 4.8% with those aged under 55 (Figure GP.1). Females accounted for a greater proportion of GP palliative care-related encounters (53.0%) than males (47.0%), but there was no difference between the sexes in palliative care encounter rates (about 1 per 1,000 of encounters with both males and females). In 2015–16, 1.3% of palliative care-related encounters were recorded as being with Indigenous Australians, less than half the proportion of the general population which is Indigenous.

Figure GP.1: Palliative care-related GP encounters by age group, 2015–16



Source data: Family Medicine Research Centre (University of Sydney) 2017 analysis of BEACH Survey 2015–16

Source: Palliative care in general practice tables 2015-16.

General practice palliative care-related attitudes and awareness

A study commissioned by the Australian Government Department of Health researching the awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice estimated that palliative care consultations account for about 1 in every 100 GP consultations (1%) (Department of Health 2017). The differences in the results between this survey and the BEACH survey are likely to be due to different methodologies including aspects such as the composition of the populations of GPs who responded to each survey and how a palliative care encounter or consultation was defined.

Other findings from this survey were that GPs' understanding of what constitutes palliative care and end of life care varies widely and that differing palliative care settings have very different requirements in terms of best practice. The report on the survey also provided a range of recommendations including better defining the role of GPs in palliative care, promoting a better understanding of the clinical triggers for commencing palliative care, the development of local directories to enable GPs to access palliative care resources and better communication and integration with other parts of the health system including encouraging referrals to specialist palliative care teams or GP experts (Department of Health and Aged Care).

The discontinuation of the BEACH survey (which ran from 1998 to 2016) presents a challenge for future reporting on the pivotal role that general practitioners have in delivering high quality palliative care. AIHW is currently working with stakeholders to establish a consistent data collection on palliative care activity in general practice, to better inform the community and enable decision-makers at all levels to monitor GPs' provision of high quality palliative care to Australians that meets their needs.

References

Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L et al. 2016. General practice activity in Australia 2015–16. General practice series no. 40. Sydney: Sydney University Press.

Department of Health and Aged Care 2017. Final report: research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice. Canberra: Department of Health and Aged Care.

Technical notes

Technical notes chapter contains information on data presentation calculation methodologies, codes and classifications used in compiling the data for *Palliative care services in Australia.* It includes:

- Statistical notes
- Classifications
- Disease-related information

Statistical notes

Crude rates

A crude rate provides information on the number of events (for example, palliative care-related hospitalisations) relative to the population 'at risk' (for example, the entire population) in a specified period. No age adjustments are made when calculating such a rate and crude rates are used throughout this publication. Note that owing to the differences in approaches used to calculate population rates for different analyses, the rates shown throughout this report for Australia (sometimes labelled as the 'Total') may differ slightly from one analysis to another.

Population rates

The majority of the population rates in this publication are crude rates, which are calculated using the ABS estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2022–23 financial year data were calculated using ERP at 31 December 2022, while rates for 2022 calendar year data were calculated using ERP at 30 June 2022), unless otherwise specified due to data availability.

The population data were sourced from the ABS and the most up to date estimates available at the time of analysis were used. To derive estimates of the resident population, the ABS uses the 5-yearly Census of Population and Housing data as follows:

- all respondents to the Census are coded in relation to their state or territory, statistical local area and postcode of usual residence; overseas visitors are excluded,
- an adjustment is made for persons missed in the Census (approximately 2%),
- Australians temporarily overseas on Census night are added to the usual residence Census count.

The resulting numbers provide an estimate of the resident population in the Census year. In the following years, the Census numbers are adjusted by taking into account indicators of population change, such as births, deaths and net migration. More information on the process used to derive population estimates is available from the Population page in ABS website.

Age-specific rates

Age-specific rates provide information on the incidence of a particular event in a specified age group relative to the total number of people 'at risk' of that event in the same age group. It is calculated by dividing the number of events occurring in each specified age group by the corresponding population in the same group, and then multiplying the result by a constant (for example, 10,000) to derive the rate.

Age-standardised rates

Age-standardised rates are rates that adjust the crude rate to eliminate the effect of differences in population age structures when comparing crude rates for different periods of time, different geographic areas and/or different population sub-groups (for example, between one year and the next and/or states and territories, Indigenous and non-Indigenous populations).

Direct standardisation was used in this report. To calculate age-standardised rates, age-specific rates were multiplied against a standard population. Directly age-standardised rates were adjusted using the current Australian standard population (that is, the non-recast Australian estimated resident population (ERP) as at 30 June 2001).

Average annual rates of change

Average annual rates of change or growth rates have been calculated as geometric rates:

Average rate of change=$((P_n/P_o)^{(1/n\ -1)})$ x 100.

In this formula: 'Pn' is the value in the later time period, 'Po' is the value in the earlier time period and 'n' is the number of years between the two time periods.

Descriptive analyses

Information presented in *Palliative care services in Australia* is based on descriptive statistics. When examining results, it should be considered that patterns of relationship between variables may be influenced by known and unknown confounding factors. Furthermore, relationships between variables do not necessarily reflect underlying causal links.

Patient day statistics

Patient day statistics can be used to provide information on hospital activity that, unlike hospitalisation statistics, accounts for differences in length of stay. As the National Hospital Morbidity Database (NHMD) contains records for patients ceasing hospitalisation during a specific reporting period (such as 1 July 2021 to 30 June 2022), this means that all patients who ceased hospitalisation during the reporting period are included, regardless of whether or not they were admitted during that period. Thus, not all patient days reported will have occurred during the reporting period. However, it is expected that, in general, patient days for patients who ceased hospitalisation in 2021–22, but who were admitted before 1 July 2021, will be generally counterbalanced by the patient days for patients still in hospital after 30 June 2022 who will cease hospitalisation in future reporting periods.

Classifications

Indigenous status

Australia's Aboriginal and Torres Strait Islander people hold a unique place in the country's society and culture. Accurate, consistent statistics are essential to understanding their wellbeing and developing policies that promote positive social and economic outcomes. Information about Aboriginal and Torres Strait Islander people is collected through self-identification questions, using the ABS Standard Indigenous Question (SIQ), which is widely used by government agencies and organisations (ABS 2014).

The statistical variable "Indigenous status" is recognised as one of the core indicators for measuring cultural and linguistic diversity, endorsed by the Ministerial Council of Immigration and Multicultural Affairs and supported by the Council of Australian Governments. All jurisdictions are required to use the standard ABS Indigenous question in key data collections, as outlined in the National Indigenous Reform Agreement (ABS 2014).

Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin (AIHW 2024). The Indigenous status variable in this report is based on the ABS standard and is used to classify individuals' Indigenous status. It has a hierarchical structure with four detailed categories grouped into two broad categories: Indigenous Australians (Aboriginal, Torres Strait Islander, or both) and Non-Indigenous Australians. Additionally, there is a supplementary category for responses that are 'Not stated/inadequately described,' which is primarily used when data cannot be clearly mapped or when a response is unclear or unavailable (AIHW 2024). For more detailed guidance, refer to the Indigenous status page in ABS website.

The AIHW recommends 'First Nations' as the preferred term to refer to Aboriginal and Torres Strait Islander people.

Australian Statistical Geographical Standard for Remoteness Areas

The Australian Statistical Geographical Standard for Remoteness Areas (ASGS) was developed by the Australian Bureau of Statistics (ABS) to collect and disseminate geographically classified statistics (ABS 2011; ABS 2016; ABS 2021).

The ASGS's remoteness structure categorises geographical areas in Australia into five remoteness areas:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote.*

The Australian Statistical Geography Standard page in ABS website includes detailed information on ASGS, including the key changes made between each edition.

Data on remoteness of geographical location in the National Hospital Morbidity Database (NHMD) are collected based on patients' usual residential address and in the National Public Hospital Establishments Database (NPHED), this is determined by hospital street address. This release provides hospital data on remoteness using 2022–23 NHMD (ASGS 2021 edition). Further information on the quality of the usual residence of the patient data in the NHMD can be found in National Hospital Morbidity Database (NHMD) Technical appendices/notes 2022–23.

Index of Relative Socio-economic Disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD) is one of four Socio-Economic Indexes for Areas (SEIFA) developed by the ABS (ABS 2018). The IRSD represents the socioeconomic position of Australian communities by measuring aspects of disadvantage, such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. Areas are then ranked according to their level of disadvantage.

When the IRSD is used in this report, people living in the 20% of areas with the greatest overall level of disadvantage are described as living in the 'lowest socioeconomic areas'. The 20% of people at the other end of the scale – those living in areas with the least overall level of disadvantage – are described as living in the 'highest socioeconomic areas'.

It is important to note that the IRSD reflects the overall or average socioeconomic position of the population of an area; it does not show how individuals living in the same area might differ from each other in their socioeconomic position.

Primary Health Network areas

Primary Health Networks (PHNs) are administrative regions established to deliver primary care services and coordinate with local hospitals to enhance the overall efficiency of healthcare delivery (ABS 2022).

PHN can refer to both the organisation that services a defined geographic region, and the geographic region itself. In this report, PHN refers to the geographic region.

Australia has 31 PHN regions which are independent organisations working to streamline health services which closely align with the state and territory local hospital networks (Department of Health and Aged Care 2021). Statistical information in this report is presented using the boundaries of these 31 Primary Health Networks as released by the Department of Health and Aged Care.

Maps of the geographical areas covered by the various Primary Health Networks can be obtained from the Primary Health Networks page in Department of Health and Ageing website.

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 was released in June 2018. Member States will begin reporting health data using ICD-11 in 2022. Read ICD page in WHO website for further information.

ICD-10-AM

Diagnosis, procedure and external cause in hospital data for 2022–23 were reported to the NHMD by all states and territories using the 12th edition of the Australian Modification of ICD-10 (referred to as ICD-10-AM), which was based on ICD-10 (NCCH 2013). ICD-10 was modified for the Australian setting by the National Centre for Classification in Health 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 Table 1 in Technical notes: Disease-related information).

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Disease-related information

Information on the number of hospitalisations due to a particular disease, including cancer and other specific diseases (see below), is based on the principal diagnosis, such that the number of hospitalisations for which a certain disease was coded as the principal diagnosis is counted. The principal diagnosis is 'the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care' (ACCD 2016; AIHW 2022).

Information relating to cancer

The ICD-10-AM diagnosis codes used in the Admitted patient care section to identify patients with cancer mirrors the approach used in AIHW's *Cancer in Australia 2021* (see Appendix D in AIHW 2021). This approach considers that, for some cancer-related hospitalisations, the treatment relating to the patient's cancer (such as chemotherapy or the insertion of a drug delivery device) is recorded as the principal diagnosis, rather than the specific form of cancer the person had, as per ICD-10-AM coding standards (NCCH 2010). Thus, two different criteria are used to identify those hospitalisations with a principal diagnosis of cancer; these are summarised below.

Approach used to identify hospitalisations with a principal diagnosis of cancer

Hospitalisations that met one of the following criteria were considered to have a principal diagnosis of cancer.

- Those with a principal diagnosis code of C00–C96, D45, D46, D47.1 or D47.3–D47.5 from the 'Neoplasms' chapter of ICD-10-AM.

  Note that some ICD-10-AM 'D' codes are included in this list of invasive neoplasms (that is, cancers) since the related diseases – such as polycythaemia vera (D45) – were not considered to be invasive at the time of the publication of ICD-10 (WHO 1992) but were reclassified as invasive with the publication of the ICD classification that dealt specifically with neoplasms (WHO 2000).
- Those with a principal diagnosis from Chapter 21 of ICD-10-AM (that is, ICD-10-AM 'Z' codes) that was directly related to receiving health services or treatment for cancer as follows:
  - Follow-up examination after treatment for malignant neoplasms (Z08)
  - Breast prophylactic surgery for risk-factors related to malignant neoplasms (Z40.00)
  - Ovary prophylactic surgery for risk-factors related to malignant neoplasms (Z40.01)
  - Radiotherapy session (Z51.0)
  - Pharmacotherapy session for neoplasm (Z51.1)
  - Convalescence following radiotherapy (Z54.1)
  - Convalescence following chemotherapy (Z54.2)

Source: AIHW 2021.

Information relating to other specific diseases

Some diagnoses for palliative care patients are shown at a specific disease level. The best way to group ICD-10-AM codes to identify some diseases (such as heart failure, stroke, and chronic obstructive pulmonary disease) is not always straightforward, as different approaches are used in the literature. From 2020, groupings similar to those used in AIHW's reporting on *Deaths in Australia* (AIHW 2024) have been used, with some variations. A full list is shown in Table 1 below.

Table 1: Diagnosis code groups used to identify specific diseases

Diagnosis codes (ICD-10-AM)	Disease description
A00–A09	Intestinal infectious diseases
A15–A19	Tuberculosis
A20, A44, A75–A79, A82–A84, A85.2, A90–A96, A98.0, A98.1, A98.2, A98.8, B50–B57	Vector-borne diseases and rabies
A21–A28	Certain zoonotic bacterial diseases excl. plague
A30–A49 excl. A33–A37, A39, A40–A41, A44	Other bacterial diseases excl. vaccine-preventable diseases, meningitis, septicaemia
A33–A37, A80, B01, B05, B06, B15, B16, B17.0, B18.0, B18.1, B18.9, B19, B26	Vaccine-preventable diseases
A39, G00–G03	Meningitis
A40–A41	Septicaemia
A50–A64	Infections with predominantly sexual mode of transmission
A65–A69	Other spirochaetal diseases
A70–A74	Other diseases caused by chlamydia
A80–A89 excl. A80, A82–A84, A85.2	Viral infections of the central nervous system excl. vaccine-preventable diseases, vector-borne diseases and rabies

A98.3, A98.4, A98.5, A99	Unspecified and selected other viral haemorrhagic fevers
B00–B09 excl. B01, B05, B06	Viral infections with skin and mucous membrane lesions excl. vaccine-preventable diseases
B15–B19 excl. B15, B16, B17.0, B18.0, B18.1, B18.9, B19	Viral hepatitis excl. vaccine-preventable diseases
B20–B24	Human immunodeficiency virus (HIV) disease
B25–B34 excl. B26	Other viral diseases excl. mumps
B35–B49	Mycoses
B50–B64 excl. B50–B57	Protozoal diseases excl. vector-borne diseases
B65–B83	Helminthiases
B85–B89	Pediculosis, acariasis and other infestations
B90–B94	Sequelae of infectious and parasitic diseases
B95–B98	Bacterial, viral and other infectious agents
B99	Other infectious diseases
C00–C14	Malignant neoplasms of lip, oral cavity and pharynx
C15	Oesophageal cancer
C16	Stomach cancer
C17	Malignant neoplasm of small intestine
C18–C20, C26.0	Colorectal cancer
C21	Anal cancer
C22	Liver cancer
C23, C24	Gallbladder cancer
C25	Pancreatic cancer
C26, C39, C76–C80 excl. C26.0	Cancer of unknown or ill-defined primary site
C30, C31, C35–C38	Selected malignant neoplasms of respiratory and intrathoracic organs
C32	Laryngeal cancer
C33, C34	Lung cancer
C40–C41	Malignant neoplasms of bone and articular cartilage
C43	Melanoma of the skin
C44	Other malignant neoplasms of skin
C45–C49	Malignant neoplasms of mesothelial and soft tissue
C50	Breast cancer
C51, C52, C57, C58	Malignant neoplasms of vulva, vagina, other female genital organs, placenta
C53–C55	Uterine cancer
C56	Ovarian cancer
C60, C62, C63	Malignant neoplasms of penis, testis, other male genital organs
C61	Prostate cancer
C64	Kidney cancer
C65, C66, C68	Malignant neoplasms of renal pelvis, bladder, other urinary organs
C67	Bladder cancer
C69, C70, C72	Malignant neoplasms of eye, adnexa, meninges, spinal cord, other parts of the central nervous system
C71	Brain cancer
C73–C75	Malignant neoplasms of thyroid and other endocrine glands

C81–C86, C96	Lymphomas
C88, C90	Malignant immunoproliferative diseases, multiple myeloma and malignant plasma cell neoplasms
C91–C95	Leukaemia
C97	Malignant neoplasms of independent (primary) multiple sites
D00–D48	Benign neoplasms, in situ and uncertain behaviour
D50–D53, E40–E64	Malnutrition and nutritional anaemias
D55–D59	Haemolytic anaemias
D60–D64	Aplastic and other anaemias
D65–D69	Coagulation defects, purpura and other haemorrhagic conditions
D70–D77	Other diseases of blood and blood-forming organs
D80–D89	Certain disorders involving the immune mechanism
E00–E07	Disorders of thyroid gland
E09	Impaired glucose regulation
E10–E14	Diabetes
E15, E16	Other disorders of glucose regulation and pancreatic internal secretion
E20–E35	Disorders of other endocrine glands
E65–E68	Obesity and other hyperalimentation
E70–E89 excl. E86, E87	Selected metabolic disorders excl. dehydration
E86–E87	Disorders of fluid, electrolyte and acid-based balance (dehydration)
F00, F01, F03, G30	Dementia and Alzheimer disease
F04–F09	Organic mental disorders excl. dementia
F10–F19	Mental and behavioural disorders due to psychoactive substance use
F20–F29	Schizophrenia, schizotypal and delusional disorders
F30–F39	Mood (affective) disorders
F40–F48	Neurotic, stress-related and somatoform disorders
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60–F69	Disorders of adult personality and behaviour
F70–F79	Mental retardation
F80–F89	Disorders of psychological development
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder
G04–G09	Inflammatory diseases of the central nervous system excl. meningitis
G10, G11, G13	Huntington disease and hereditary ataxia
G12	Spinal muscular atrophy and related syndromes
G14	Post-polio syndrome
G20	Parkinson disease
G21–G26	Extrapyramidal and movement disorders excl. Parkinson disease
G31–G32	Other degenerative diseases of nervous system excl. Alzheimer disease
G35–G37	Demyelinating diseases of the central nervous system
G40, G41	Epilepsy and status epilepticus
G42–G47	Episodic and paroxysmal disorders excl. epilepsy
G50–G59	Nerve, nerve root and plexus disorders

G60–G64	Polyneuropathies and other disorders of the peripheral nervous system
G70–G73	Diseases of myoneural junction and muscle
G80–G83	Cerebral palsy and other paralytic syndromes
G90–G99	Other disorders of the nervous system
H00–H59	Diseases of the eye and adnexa
H60–H95	Diseases of the ear and mastoid process
I00–I02	Acute rheumatic fever
I05–I09	Chronic rheumatic heart disease
I10–I15	Hypertensive disease
I20–I25	Coronary heart disease
I26–I28	Pulmonary heart disease and diseases of pulmonary circulation
I30–I33, I39–I41, I43–I45, I52	Selected other forms of heart disease
I34–I38	Non-rheumatic valve disorders
I42	Cardiomyopathy
I46	Cardiac arrest
I47–I49	Cardiac arrhythmias
I50–I51	Heart failure and complications and ill-defined heart disease
I60–I69	Cerebrovascular disease
I70	Atherosclerosis
I71	Aortic aneurysm and dissection
I72–I79	Diseases of arteries, arterioles and capillaries excl. atherosclerosis, aortic aneurysm and dissection
I80–I89	Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
I95–I98	Other and unspecified disorders of the circulatory system
J00–J06, J20–J22	Acute respiratory diseases excl. influenza and pneumonia
J09–J18	Influenza and pneumonia
J30–J39	Other diseases of upper respiratory tract
J40–J44	Chronic obstructive pulmonary disease (COPD)
J45–J46	Asthma
J47	Bronchiectasis
J60–J70	Lung diseases due to external agents
J80–J84	Pulmonary oedema and other interstitial pulmonary diseases
J85–J86	Suppurative and necrotic conditions of lower respiratory tract
J90–J94	Other diseases of pleura
J95–J99 excl. J96	Other diseases of the respiratory system
J96	Chronic respiratory failure
K00–K14	Diseases of oral cavity, salivary glands and jaws
K20–K31	Diseases of oesophagus, stomach and duodenum
K35–K46, K56	Appendicitis, hernia and intestinal obstruction
K50–K52	Non-infective enteritis and colitis
K55, K57–K64	Other diseases of intestines excl. paralytic ileus and intestinal obstruction without hernia
K65–K67	Diseases of peritoneum
K70–K76	Liver disease

K80–K87	Disorders of gallbladder, biliary tract and pancreas
K90–K93	Other diseases of the digestive system
L00–L08	Infections of the skin and subcutaneous tissue
L10–L14	Bullous disorders
L20–L30	Dermatitis and eczema
L40–L45	Papulosquamous disorders
L50–L54	Urticaria and erythema
L55–L59	Radiation-related disorders of the skin and subcutaneous tissue
L60–L75	Disorders of skin appendages
L80–L99	Other disorders of the skin and subcutaneous tissue
M00–M99	Diseases of the musculoskeletal system and connective tissue
N00–N08	Glomerular disease
N10–N16	Renal tubulo-interstitial disease
N17–N19	Kidney failure
N20–N23	Urolithiasis
N25–N29	Other kidney or ureter disorders
N30–N39	Other urinary disorders
N40–N51	Diseases of male genital organs
N60–N64	Disorders of breast
N70–N77	Inflammatory diseases of female pelvic organs
N80–N98	Non-inflammatory disorders of female genital tract
N99	Other disorders of genitourinary tract
O00–O99	Pregnancy, childbirth and the puerperium
P00–P96, Q00–Q99	Certain conditions originating in the perinatal period, congenital malformations, deformations and chromosomal abnormalities
R00–R94, R96–R99	Other ill-defined causes
R95	Sudden infant death syndrome (SIDS)
S00–S99	Injuries to specific parts of the body
T00–T98	Injuries to multiple body regions, crushing, asphyxiation, poisoning by drugs, other
V01–V89	Land transport accidents
V90–V94	Water transport accidents
V95–V97	Air and space transport accidents
V98–V99	Other and unspecified transport accidents
W00–W19	Accidental falls
W20–W49 excl. W32–W34	Exposure to inanimate mechanical forces excl. firearms
W32–W34	Non-intentional firearm discharge
W50–W64	Exposure to animate mechanical forces
W65–W74	Accidental drowning and submersion
W75–W84	Accidental threats to breathing
W85–W99	Exposure to electric current, radiation and extreme ambient air temperature and pressure
X00–X09	Exposure to smoke, fire and flames
X10–X19	Contact with heat and hot substances
X20–X29	Contact with venomous animals and plants

X30–X39	Exposure to forces of nature
X40–X49	Accidental poisoning
X50–X57	Overexertion, travel and privation
X58	Exposure to other specified factors
X59	Exposure to unspecified factor
X60–X84	Suicide
X85–Y09	Assault
Y10–Y34	Event of undetermined intent
Y35–Y36	Legal intervention and operations of war
Y40–Y59	Drugs, medicaments and biological substances causing adverse effects in therapeutic use
Y60–Y69	Misadventures to patients during surgical and medical care
Y70–Y82	Medical devices associated with misadventures in diagnostic and therapeutic use
Y83–Y84	Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Y85–Y89	Sequelae of external causes of morbidity and mortality
Y90–Y98	Supplementary factors related to causes of morbidity and mortality classified elsewhere
Z00–Z99	Factors influencing health status and contact with health services

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Notes

Amendments

31 July 2023 – FTE and FTE per 100,000 population for all employed specialist medical practitioners, by states and territories in Table Wk.4 and FTE and FTE per 100,000 population for all employed specialist medical practitioners, by remoteness areas in Table Wk.5 have been updated in Data table: 2020 Palliative care workforce, due to recently identified errors in the reported data.

25 Mar 2022 – The residential aged care section of the Palliative Care Services in Australia web report released in May 2021 has been removed due to a recently identified error in the reported data. The process for identifying residents in the aged care data appraised as requiring palliative care under the Aged Care Funding Instrument (ACFI) is complex with methods evolving over time to improve accuracy in data processing. More detailed information on palliative care for people living in residential aged care will be released in May 2022.

27 Jan 2022 – Subtotals and their associated rates have been updated in Table MBS.5 in the medicare-subsidised palliative medicine services 2019-20 data table.

Data

Data tables: PCSiA 2025 Expenditure on palliative care

Data
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Data tables: PCSiA 2025 Palliative care-related medications

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Data tables: PCSiA 2025 Medicare-subsidised palliative medicine attendance and case conference services

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