WQPHN

Palliative Care

Health Needs Assessment

January 2026

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WESTERN QUEENSLAND

An Australian Government Initiative

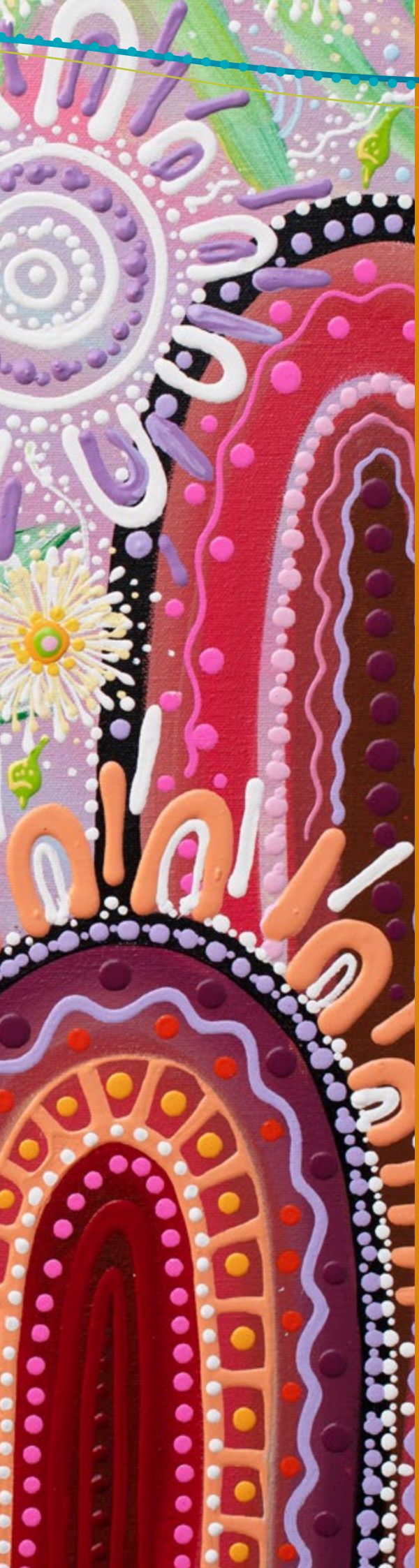
WQPHN gratefully acknowledges the valued input of numerous people, partners and organisations that have contributed insights to inform this Palliative Care Health Needs Assessment.

In particular, WQPHN extends its heartfelt gratitude to the following stakeholders:

- The North West Hospital and Health Service, the Central West Hospital and Health Service and the South West Hospital and Health Service
- Members of the Nukal Murra Alliance
- Members of the WQPHN Care Governance Committee
- Members of the WQPHN Community Advisory Committee
- Members of the WQPHN Service Provider Network, and
- WQPHN staff.

Each of these stakeholders has provided invaluable input that has shaped and enriched this Palliative Care Health Needs Assessment. Through these contributions, WQPHN has gained a deeper understanding of the strengths, needs and challenges impacting our various communities, and commits to using these insights to inform our future palliative care work.

Australian Government Disclaimer



Acknowledgement of Country

Western Queensland Primary Health Network (WQPHN) acknowledges the Aboriginal and Torres Strait Islander traditional custodians on whose land we walk, work and live across Western Queensland. We acknowledge the stories, traditions and living culture and their continuing connection to the land and waters of our catchment. We pay respect to Elders past and present and commit to building respectful and inclusive partnerships with Aboriginal and Torres Strait Islander peoples to improve health outcomes in our region.

Figure 1
Healing Country - Yapatjarra Muu (Kalkadoon Artist: Brooke Sutton) Commissioned for WQPHN Reconciliation Action Plan 2020

Executive Summary

The 2025 Palliative Care Health Needs Assessment is mandated by the Commonwealth Government Department of Health, Disability and Ageing for all Primary Health Networks (PHNs) in Australia. Its purpose is to evaluate the palliative care needs of local communities and guide service planning and resource allocation under the Greater Choices for At Home Palliative Care Program. This assessment serves as an update to the inaugural 2023 report and will inform WQPHN's commissioning of palliative care services from July 2026 onward.

Approach

This section outlines the foundation for the 2025 Palliative Care Health Needs Assessment, emphasizing a commitment to building on previous analyses, community input, and the work of earlier assessments. It highlights the relationship between the broader Western Queensland Joint Regional Health Needs Assessment – which informs all health service planning – and the more focused approach of this palliative care assessment. Additionally, it notes the transition from the primarily qualitative approach of the 2023 assessment to the current, more comprehensive methodology that integrates both qualitative and quantitative data to better address the region's palliative care needs.

Quantitative Data Reviewed

This assessment takes a comprehensive approach to understanding palliative care needs in Western Queensland by drawing on a broad range of quantitative datasets from national and local sources. The analysis covers key metrics such as in-patient and community-based service utilisation, expenditure, prescribing patterns, outcomes, workforce capacity, hospitalisations, and mortality trends. In addition to external datasets from the Australian Institute of Health and Welfare, extensive internal data collections have been reviewed to provide a robust evidence base.

Qualitative Reports Reviewed

A comprehensive review was conducted of key local, state, and national reports, frameworks, strategies, and plans relevant to palliative care. These documents offer crucial insights into the contextual factors, emerging trends, system-level priorities, and policy directions that shape palliative care services. Notable sources include the National Palliative Care Strategy (2018), its Implementation Plan, Queensland-specific strategies and priority reports, frameworks addressing Aboriginal and paediatric palliative care, as well as recent market research with palliative care health practitioners. A high-level summary of the pertinent findings from these resources is provided in the WQPHN Palliative Care Health Needs Assessment – Insights Summary.

Stakeholder Consultation

Stakeholder engagement for the Palliative Care Health Needs Assessment has added critical value beyond traditional data analysis by incorporating local perspectives and expert insights, thereby strengthening trust and collective ownership. In alignment with the GCfAHPC Program – which aims to raise awareness of local palliative care options and improve coordination of home-based services – the PHN implemented a targeted Palliative Care Survey focused on identifying practical barriers, enablers, and potential solutions to accessing existing palliative care in the region. This deliberate approach ensured that insights were relevant and actionable, enabling resources to be directed towards the most meaningful improvements in service coordination and community support.

Identified Needs

The assessment identified 19 needs for the region. These needs were priority rated according to strength of supporting evidence and opportunity for GCfAHPC program influence.

Next Steps

The next steps for the PHN will focus on using the insights and prioritised needs identified in this updated Palliative Care Health Needs Assessment (HNA) to engage with local communities. Through genuine consultation, the PHN will gather community perspectives to help guide the planning and commissioning of services under the GCfAHPC Program, beginning in July 2026.

Tier 1a – High Need & high to medium potential for GCfAHPC program contribution	
5	Aboriginal and Torres Strait Islander people face additional cultural, geographic and systemic barriers to accessing appropriate palliative care
7	There is low awareness and health literacy about palliative care service options in the community.
10	Insufficient support for family caregivers – both before and after a person's death.
13	The low confidence and knowledge of some health care providers delay conversations about palliative care and reduces early engagement.
17	Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life.

Tier 1b – High Need & low to nil potential for GCfAHPC program contribution with advocacy potential	
1	People in the WQPHN region experience a disproportionately high burden of disease and mortality, increasing the need for palliative care.
2	The WQPHN region has a severe shortage of specialist palliative care workforce.
3	Extremely low hospitalisation rates for palliative care place unsustainable pressure on community-based services and generalist clinicians.
8	Fragmented care coordination and unclear service pathways.
9	Inadequate support for home-based palliative care – including equipment, personal care services and after-hours care.
14	Clinicians in Western Queensland experience greater challenges accessing specialist support, clinical resources and complex care pathways compared to their urban counterparts.
15	Clinicians providing palliative care experience emotional fatigue due to the challenging nature of the work.
18	Some populations within the WQPHN region experience compounding barriers which increases the complexity and difficulty in delivering palliative care interventions.
19	General practitioners in the WQPHN region require greater support as they carry substantial responsibility for delivering palliative care in the context of limited access to specialist resources.

Tier 2 – High Need, outside of GCfAHPC program remit	
4	There is a lack of in-patient palliative care facilities available within the region.
6	Geographic isolation and vast distances hinder access to palliative care.
11	Telehealth infrastructure in rural and remote areas is inadequate, restricting timely and effective access to palliative care services and specialist support.
12	Current investment in palliative care services is inadequate to meet the needs of the community.
16	Interventions in the final 12 months of life are not serving to improve quality of life for patients, family and carers.

Potential Opportunities and Partial Solutions

Community consultation identified both aligned and emerging opportunities beyond the current GCfAHPC program scope, highlighting areas where broader advocacy and crosssystem collaboration may be needed. While not designed to solve deeper systemic challenges, presents opportunity to ease local pressures by strengthening coordination, workforce capability, and earlier engagement with palliative care.

Contents

Glossary

General practitioner	A medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community. A GP is a medical practitioner who is vocationally registered under Section 3F of the Health Insurance Act 1973 (Cwlth), and/or a Fellow of the Royal Australian College of General Practitioners, or a general practice registrar.
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.
Palliative care case conference	A meeting held between the palliative care patient (if able to attend), their family and their legal substitute decision-maker, and members of the care team including the doctor to assess care plans and clinical care needs.
Palliative care nurse	The classification of nurses in Australia varies with the type of training they have undertaken. Nurse practitioners, registered nurses and enrolled nurses need to complete a variety of short or more comprehensive courses (including 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.
Palliative care related hospitalisation	Defined as episodes of admitted patient care where palliative care was a component of the care provided during all or part of the episode. These hospitalisations can be divided into two 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.
Palliative care-related prescriptions	Unless otherwise specified, palliative care-related prescriptions are defined as medications listed in the Pharmaceutical Benefits Scheme (PBS) Palliative Care Schedule. The information on prescription medicines has been sourced from the processing of the PBS/Repatriation Schedule of Pharmaceutical Benefits (RPBS) and refers to medications prescribed by approved prescribers and subsequently dispensed by approved suppliers (community pharmacies or eligible hospital pharmacies). Consequently, it is a count of medications dispensed rather than a count of prescriptions written by clinicians.
Palliative medicine	Palliative medicine is defined as the specialist care of people with terminal illnesses and chronic health conditions in community, hospital and hospice settings. Palliative medicine physicians work collaboratively with a multidisciplinary team of health professionals to provide end-of-life care, provide relief from pain and symptoms of illness, and optimise the quality of life for a patient. Palliative medicine treats the physical aspects of illness, but also integrates psychological and spiritual facets of patient care (RACP 2020).

Palliative medicine attendances	Specialised medical services provided by palliative medicine specialists or consultant physicians to manage symptoms and improve the quality of life for individuals with serious illnesses, often in collaboration with a multidisciplinary team.
Palliative medicine physician / specialist	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.
Primary Palliative care service event	Defined, for the purposes of Palliative care service in Australia, Non-admitted patient palliative care, it refers to non-admitted patient care service event 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. It must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.
Specialist palliative care	Specialist palliative care is care delivered by palliative medicine physicians / specialists in various settings (in-patient and out-patient hospital services, and community-based services).

1. Introduction

1.1. About Us

Western Queensland Primary Health Network (WQPHN) is an independent not for profit organisation funded by the Australian Government to improve primary healthcare service delivery to the people of Western Queensland. We are one of seven PHNs across Queensland and one of 31 across Australia. **Our vision is to achieve Healthier Western Queensland communities.**

Our mission is to pave our way towards improved health outcomes for all Western Queenslanders through a comprehensive, integrated primary health care system in collaboration with our stakeholders, partners and communities.

Since 2015, WQPHN has been responding to changing community needs through consistent performance in the commissioning of services. Stretching across almost one million square kilometres of Queensland, our diverse region is like no other. It is home to some of the most remote, isolated communities in Australia, each with their own health and wellbeing needs, risks and challenges.

We work closely with health service providers and key stakeholders across Western Queensland to assess the healthcare needs of rural and remote communities and deliver a range of primary health care services that meet the identified needs and close service gaps for people living in the region.

Our aims are consistent with the aims of all PHNs across Australia:

- **To increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and**
- **To improve coordination of care to ensure patients receive the right care in the right place at the right time.**

We have identified six key guiding actions as our values.

Purposeful	We act and engage with a clear intent of what we want to achieve and how this supports our strategic goals.
Authentic	We build open, genuine relationships by working with our stakeholders and colleagues in an honest and trustworthy way.
Impactful	We work and engage with impact, working together towards our shared vision of better health.
Responsive	We communicate regularly with our stakeholders and colleagues. We are responsive to their needs and acknowledge their participation and contributions.
Respectful	We treat everyone with respect, acknowledging their expertise, unique experience and perspective, time and needs.
Transparent	We build trust by openly sharing information, consulting with stakeholders and colleagues clearly and explaining the decisions we make.

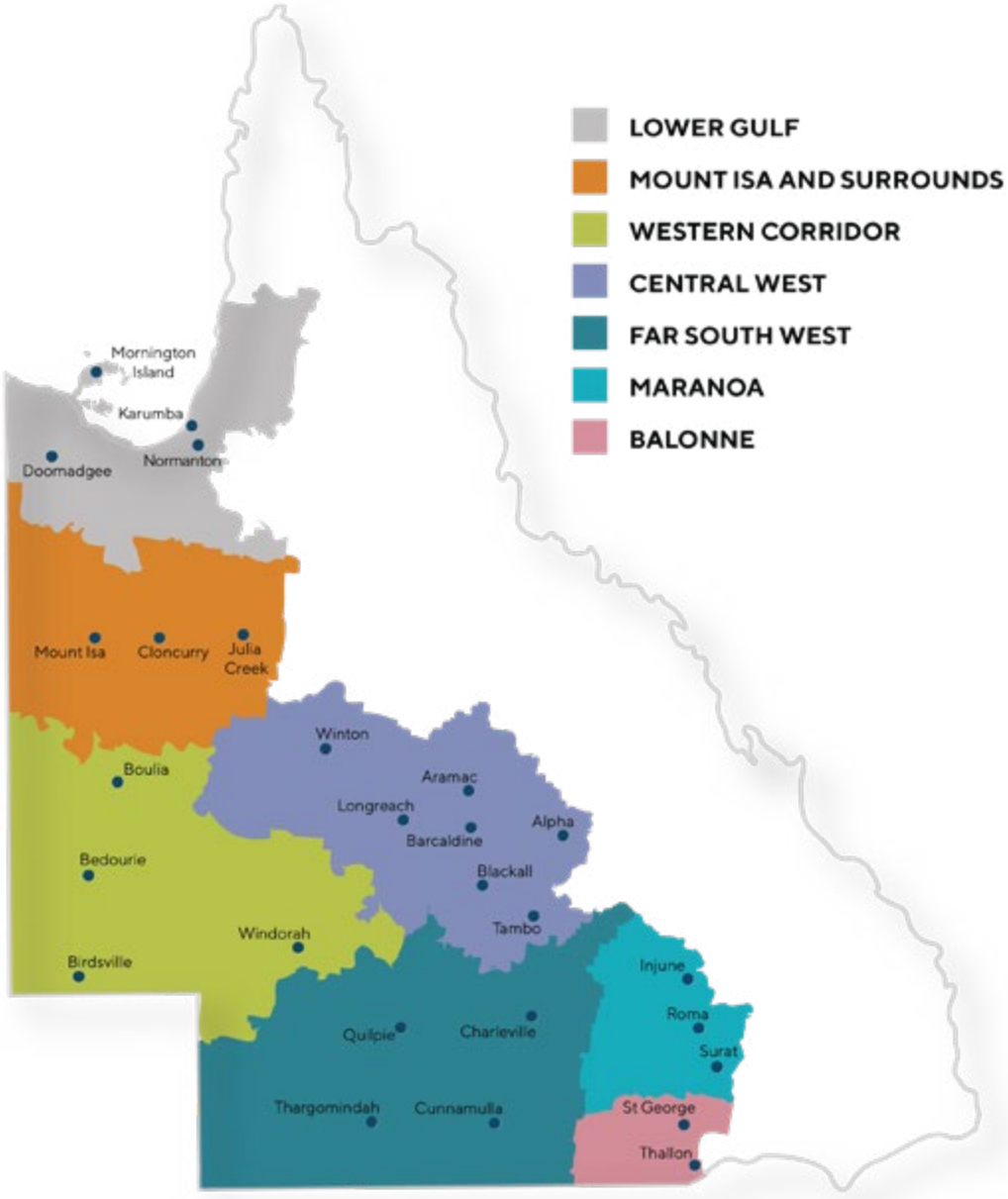
1.2. Our Uniquely Beautiful Region

Covering more than half of Queensland, and bordering the Northern Territory, South Australia and New South Wales, WQPHN is one of the most unique PHNs in Australia. Our patch spans nearly one million square kilometres – more than half of Queensland – and is home to some of the most remote and isolated communities in Australia.

From the wide, river-cut lowlands of the Lower Gulf region through to the vast Mitchell grass plains and the sweeping red-sand deserts of the far west, Western Queensland is a place of dramatic contrasts — endless skies, shifting seasons, and a quiet, rugged beauty unlike anywhere else

The region has a total of 63,678 residents – the smallest of any PHN Australia-wide, and we are the most sparsely populated – with only one person per 13 square kilometres.

Approximately 20% of our residents identify as Aboriginal and Torres Strait Islander – in comparison to the National average of 3.2%. There are 20 Local Government Areas (LGAs), three Hospital and Health Services (HHSs) and we split our region into seven Commissioning Localities.



1.3. About This Document

This Palliative Care Health Needs Assessment is a contractual requirement of the Commonwealth Government Department of Health, Disability and Ageing. All PHNs across Australia are required to undertake an assessment of the palliative health care needs of their respective communities – to guide the planning and resource allocation under the Greater Choices for At Home Palliative Care (GCfAHPC) Program[1]. This 2025 Palliative Care Health Needs Assessment in an update to the inaugural Palliative Care Health Needs Assessment conducted in 2023.

WQPHN will use the insights and prioritised needs identified as part of this 2025 Palliative Care Health Needs Assessment to inform the planning and commissioning of services under the Greater Choices for At Home Palliative Care Program from July 2026 onwards.

1 *https://www.health.gov.au/our-work/greater-choice-for-at-home-palliative-care-program?language=en*

2. The Palliative Care HNA Process

2.1. Our Approach

2.1.1. Building on what we already know

In preparing this assessment, we are committed to building on the substantial groundwork already established through prior analyses and consultations. By leveraging existing knowledge, community feedback, and the lessons learned from previous assessments, we ensure our approach is both informed and responsive to the evolving needs of Western Queensland. In doing so, we are also respectful of the dedicated efforts and insights that have shaped this journey thus far, recognising the value of what has come before as we move forward.

2.1.1.1. The Joint Regional Health Needs Assessment

In November 2024, WQPHN published the Western Queensland Joint Regional Health Needs Assessment 2025-2028[2]. This triennial Health Needs Assessment has broad coverage – beyond just the palliative care focus of this Health Needs Assessment – and therefore involves a broader and more comprehensive process, as it serves as the foundational tool for guiding all health service planning and delivery across the Western Queensland region.

While this Palliative Care Health Needs Assessment will leverage the insights and evidence provided by the broader Joint Regional Health Needs Assessment, it is essential to undertake a more targeted and in-depth analysis of the palliative care needs within the region. Given the fulsome demographic and contextual analysis already undertaken in the Joint Regional Health Needs Assessment, this document does not replicate that content but instead focuses on the unique considerations and service requirements for palliative care.

2.1.1.2. The 2023 Palliative Care Health Needs Assessment

In November 2023, WQPHN published its inaugural Western Queensland Palliative Care Health Needs Assessment, providing an important foundation for understanding palliative care priorities across Western Queensland. While that Assessment was focused on palliative care, its approach was primarily qualitative in nature and did not incorporate extensive quantitative data analysis. This 2025 Palliative Care Health Needs Assessment builds on that earlier work by introducing a more robust, data-driven methodology, combining qualitative insights with comprehensive quantitative analysis to provide a clearer picture of palliative care needs across the Western Queensland region.

2.2. Quantitative Data Review And Analysis

To ensure a comprehensive understanding of palliative care needs, this assessment draws on a wide range of quantitative information sources relevant to palliative care, including numerous reports and datasets from the Australian Institute of Health and Welfare and pertinent local data collections.

Table 1 details the qualitative datasets that have been sourced, reviewed and analysed as part of this Palliative Care Health Needs Assessment.

2 *https://cdn.prod.website-files.com/6498e7a6f8c93e238042358e/68abdb11cc071081e468ea55_WQPHN_WQJRHNA_Report_Approved161224-compressed.pdf*

Table 1: Quantitative Datasets included in Palliative Care HNA

Dataset	Data Period	Source
Palliative Care Services in Australia (PCSiA) 2025 – Expenditure on palliative care	2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/expenditure-on-palliative-care
PCSiA (2025) – Medicare-subsidised palliative medicine attendance and case conference services	2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/medicare-palliative-medicine-and-case-conferences
PCSiA (2025) – Palliative care related medications	2024-2025 2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/palliative-care-related-medications
PCSiA (2025) – Palliative care outcomes	2022-2023 2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/palliative-care-outcomes
PCSiA (2025) – Admitted patient palliative care	2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/admitted-patient-palliative-care
PCSiA (2025) – Non-admitted patient palliative care	2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/non-admitted-patient-palliative-care
PCSiA (2025) – Palliative care workforce	2023-2024	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/palliative-care-workforce
PCSiA (2023) – Palliative care for people living in residential aged care	2021-2022	https://www.aihw.gov.au/reports/palliative-care/palliative-care-services-in-australia/contents/palliative-care-in-residential-aged-care
Specialist paediatric palliative care delivered to children who died in 2021	2021	https://www.aihw.gov.au/reports/palliative-care-services/paediatric-palliative-care-for-children-who-died/summary
Palliative care and health service use for people with life limiting conditions (2024)	2019-2020	https://www.aihw.gov.au/reports/palliative-care-services/health-service-use-people-life-limiting-conditions/contents/about
Mortality Over Regions and Time (MORT) data	2019-2023	https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/contents/mort-books

AIHW Palliative Care Measures data tables	2022	https://www.aihw.gov.au/reports/palliative-care-services/national-palliative-care-measures/contents/measures/all-measures
PCSiA (2025) - Palliative care hospitalisations, MBS and PBS, National Hospital Morbidity Database (NHMD)	2022-2023	https://www.aihw.gov.au/reports-data/health-welfare-services/palliative-care-services/data
Australian Burden of disease study: Impact and causes of illness and death in Australia	2024	https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-and-death-in-aus/data
WQPHN General Practice Primary Health Dataset	2024-2025	Internal data source
JRNA Queensland Health data pack	Mixed	Internal data source
Data Literacy Index	2025	Internal data source
2025 – 2028 WQPHN Joint Regional Health Needs Assessment	2024	https://cdn.prod.website-files.com/6498e7a6f8c93e238042358e/68abdb11cc071081e468ea55_WQPHN_WQJRHNA_Report_Approved161224-compressed.pdf

Regrettably, certain quantitative data could not be incorporated into this assessment. This was primarily due to substantial data suppression, which rendered the information unsuitable for analysis. Such suppression commonly occurs to protect individual privacy, comply with confidentiality requirements, or address concerns regarding small sample sizes that may compromise data integrity. Data from the palliative care services provided by the Royal Flying Doctors Service (RFDS) and the Specialist Palliative Rural Telehealth service (SPaRTa) were both included in this category.

2.3. Qualitative Data Review and Analysis

In addition to quantitative data, a number of local, State and National Reports, Frameworks, Strategies and Plans relevant to palliative care have also been reviewed. These documents provide valuable insights into contextual factors, emerging trends, system-level priorities, and the broader policy direction shaping palliative care services.

- National Palliative Care Strategy (2018)[3]
- Implementation Plan for the National Palliative Care Strategy (2018)[4]
- Queensland Palliative and End-of-Life Care Strategy (Oct 2022)[5]
- Palliative Care Queensland Priorities report (2025)[6]
- Palliative Care Queensland Pre-Budget Submission (2025-2026)[7]
- The Paediatric Palliative Care National Action Plan (Jul 2023)[8]

3 https://www.health.gov.au/sites/default/files/the-national-palliative-care-strategy-2018.pdf
4 https://www.health.gov.au/sites/default/files/documents/2020/10/implementation-plan-for-the-national-palliative-care-strategy-2018_2.pdf
5 https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1183544/palliative-care-strategy-queensland-health.pdf
6 https://palliativecareqld.org.au/wp-content/uploads/2024/11/2025-Priorities-Report-.pdf
7 https://palliativecareqld.org.au/wp-content/uploads/2025/03/2025-26-PCQ-Pre-Budget-Submission-PDF.pdf
8 https://www.health.gov.au/sites/default/files/2023-07/the-paediatric-palliative-care-national-action-plan_0.pdf

- Aboriginal End-of-Life and Palliative Care Framework[9]
- Exploratory Analysis of Barriers to Palliative Care (2020) [10]
- Understanding Palliative Care and the Health Workforce – Market Research the Insights Report (Jun 2023)[11]
- Talking about what matters to you in relation to ageing, end-of-life care and dying (2019)[12]
- Evaluation of the GCfAHPC Program – Midpoint Report (Jun 2025)[13]
- Evaluation of the GCfAHPC Program – Baseline Report (Mar 2025)[14]
- Palliative Care Community Consultation Report – Roma, Charleville, Cloncurry & Mt Isa (Jun 2025)

A high-level summary of the relevant insights from these Reports, Frameworks, Strategies and Plans is included in the WQPHN Palliative Care HNA – Insights Summary.

2.4. Stakeholder Engagement

Engaging stakeholders in health needs assessments brings vital value beyond the analysis of quantitative and qualitative data alone. While data can illuminate patterns and trends, stakeholder involvement ensures that local perspectives, lived experiences, and expert insights are woven into the understanding of community health needs. This participatory approach not only highlights gaps and priorities that other data may overlook, but also strengthens trust, transparency, and collective ownership of the insights generated.

2.4.1. Our considered approach

To ensure this Palliative Care Health Needs Assessment aligns with the GCfAHPC Program, the stakeholder engagement approach was deliberately tailored to reflect the Program's aims and limitations.

The primary objectives of the GCfAHPC Program are to increase awareness of local palliative care options and to coordinate and facilitate access to home-based palliative care services.

However, the Program does not provide resources for directly commissioning or delivering these services. With this in mind, WQPHN designed a brief Palliative Care Survey and purposefully directed the lines of enquiry toward uncovering the real-world barriers and enablers that influence access to existing palliative care services. This targeted approach ensured that the insights gathered were both relevant and actionable, allowing WQPHN to focus its resources where they can make the most meaningful difference in meeting community needs and enhancing service coordination.

The survey enquired about:

- Barriers that hinder access to existing palliative care services
- Enablers that facilitate access to existing palliative care services, and
- Solutions that may improve access to palliative care services in the region.

Stakeholder engagement in the Palliative Care Health Needs Assessment has added critical value beyond traditional data analysis by incorporating local perspectives and expert insights, thereby strengthening trust and collective ownership. In alignment with the GCfAHPC Program—which aims to raise awareness of local palliative care options and improve coordination of home-based services—WQPHN implemented a targeted Palliative Care Survey focused on identifying practical barriers, enablers, and potential solutions to accessing existing palliative care in the region. This deliberate approach ensured that insights were relevant and actionable, enabling resources to be directed towards the most meaningful improvements in service coordination and community support.

9 *https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/End-of-Life/Aboriginal-EoLPC-Framework.pdf*
10 *https://www.health.gov.au/sites/default/files/documents/2020/02/exploratory-analysis-of-barriers-to-palliative-care-literature-review.pdf*
11 *https://www.health.gov.au/sites/default/files/2023-06/palliative-care-market-research-insights-report.pdf*
12 *https://documents.parliament.qld.gov.au/com/HCDSDFVPC-48D8/RN333456PI-4F5A/tp-13Sept2019-Fox02.pdf*
13 *https://www.health.gov.au/sites/default/files/2025-09/evaluation-of-the-greater-choice-for-at-home-palliative-care-program-midpoint-report-june-2025.pdf*
14 *https://www.health.gov.au/sites/default/files/2025-09/evaluation-of-the-greater-choice-for-at-home-palliative-care-program-baseline-report-march-2025.pdf*

2.5. Bringing It All Together

By integrating findings from quantitative data, existing qualitative reports and strategies, and direct stakeholder feedback, we have developed a comprehensive understanding of the palliative care landscape in the region. This multifaceted approach enables us to triangulate insights, not only revealing overarching patterns and nuanced needs that may otherwise remain hidden but also helping us to identify the areas where needs are most pronounced and require focused attention. The synthesis of these diverse sources of information sets a strong foundation for recognising both emerging and stronger needs in palliative care, which are outlined in the following section.

3. Identified Palliative Care Needs

This section presents 19 palliative care needs that have been identified following review and analysis of the range of data discussed above. Each need is presented alongside the evidence that supports or substantiates the need, as well as the relevant data source. The needs are not presented in any particular order.

1. People in the WQPHN region experience a disproportionately high burden of disease and mortality, increasing the need for palliative care.
2. The WQPHN region has a severe shortage of specialist palliative care workforce.
3. Extremely low hospitalisation rates for palliative care place unsustainable pressure on community-based services and generalist clinicians.
4. There is a lack of in-patient palliative care facilities available within the region.
5. Aboriginal and Torres Strait Islander people face additional cultural, geographic and systemic barriers to accessing appropriate palliative care.
6. Geographic isolation and vast distances hinder access to palliative care.
7. There is low awareness and health literacy about palliative care service options in the community.
8. Fragmented care coordination and unclear service pathways.
9. Inadequate support for home-based palliative care – including equipment, personal care services and after-hours care.
10. Insufficient support for family caregivers – both before and after a person's death.
11. Telehealth infrastructure in rural and remote areas is inadequate, restricting timely and effective access to palliative care services and specialist support.
12. Current investment in palliative care services is inadequate to meet the needs of the community.
13. The low confidence and knowledge of some health care providers delays conversations about palliative care and reduces early engagement.
14. Clinicians in Western Queensland experience greater challenges accessing specialist support, clinical resources and complex care pathways compared to their urban counterparts.
15. Clinicians providing palliative care experience emotional fatigue due to the challenging nature of the work.
16. Interventions in the final 12 months of life are not serving to improve quality of life for patients, family and carers.
17. Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life.
18. Some populations within the WQPHN region experience compounding barriers which increases the complexity and difficulty in delivering palliative care interventions.
19. General practitioners in the WQPHN region require greater support as they carry substantial responsibility for delivering palliative care in the context of limited access to specialist resources.

It is important to recognise that these identified needs are deeply interconnected and often overlap, with each influencing and amplifying the others to a greater or lesser extent. While we have presented evidence for each need individually, this approach does not suggest that they are mutually exclusive. On the contrary, we want to highlight the complex and multifaceted nature of palliative care in the WQPHN region means that improvements or challenges in one area can have significant ripple effects across others. Acknowledging these interdependencies is essential for understanding the broader context and for developing effective, coordinated strategies to address the region's palliative care needs.

Identified need 1	Evidence substantiating the need	Data source
People in the WQPHN region experience a disproportionately high burden of disease and mortality, increasing the need for palliative care. **Need Category:** • **Health**	Communities in Western Queensland PHN experience significant challenges relating to chronic health conditions and their related comorbidities. Older Indigenous and non-Indigenous people across Western Queensland have some high rates of comorbidity (defined as with 2 or more conditions such as cancer, cardiovascular disease, chronic kidney disease, diabetes, musculoskeletal issues and respiratory conditions). Some LGAs are as high as 65.6% for Indigenous people in Winton LGA and 46.2% for non-Indigenous people in Quilpie LGA. These high levels of comorbidity predispose Western Queensland older residents for premature mortality, with the high likelihood of requiring end of life care and support.	WQPHN General Practice Primary Health Dataset
	Mortality data for WQPHN highlights several indicators of premature death, higher rates of death, lower median age at death and higher rates of death from chronic disease, all pointing to an increased need for palliative care for patients in the regions. • WQPHN has a significantly higher age standardised death rate (684.1 per 100,000 population) than the national rate (512.7 per 100,000), second only to NT PHN compared to all other PHNs across the country. This rate has increased for WQPHN in the period 2019-2023, despite decreasing over this time nationally. The rate is significantly higher for males than females in WQPHN. • WQPHN has a significantly higher rate of premature death compared to the national rate, again ranking second to NTPHN compared to all other PHNs nationally. • The median age at death in WQPHN (74.7) is significantly lower than the national median age (84.6). The age is significantly lower for males than females and substantially lower than the median age for Australia. • People in WQPHN are dying from diabetes at a rate 2.26 times that of the national rate. This is the second highest rate of all PHNs in the country for deaths caused by diabetes.	Mortality Over Regions and Time (MORT) data
	The total burden of disease rates rise with increasing remoteness, with the total burden rate in remote and very remote parts of Australia 1.4 times higher than major cities. This supports the disproportionately high burden of disease and mortality in the Western Queensland region. In remote and very remote areas, there are noticeably higher burden rates for kidney and urinary diseases, injuries, infectious diseases, endocrine disorders and cardiovascular diseases. The total burden of disease would be 4.4% lower if all areas had the same rates as major cities.	Australian Burden of disease study: Impact and causes of illness and death in Australia

Identified need 2	Evidence substantiating the need	Data source
The WQPHN region has a severe shortage of specialist palliative care workforce. **Need Category:** • **Workforce**	The WQPHN region has the lowest rate of services provided by a specialist palliative care physician in Queensland, with just 16.4 per 100,000 population, compared with the Queensland average of 63.3 per 100,000 population. The total number of MBS specialist services provided was similarly constrained at 167.9 per 100,000, compared to the Queensland average of 313.9 per 100,000 population.	PCSiA (2025) – Medicare-subsidised palliative medicine attendance and case conference services
	This extreme shortage of specialist palliative care physician involvement means that palliative care in Western Queensland is delivered predominantly by generalist health professionals – general practitioners, rural generalist physicians, registered nurses, and allied health providers—rather than specialist palliative care teams. Only 10 people in the entire region received specialist palliative medicine services in 2022-2023.	PCSiA (2025) – Medicare-subsidised palliative medicine attendance and case conference services
	While PHN-level prescriber breakdowns continue to be unavailable, Queensland state-level data for 2024/25 shows GPs prescribed 89.8% of PBS palliative care medicines, with 1.4% prescribed by palliative medicine specialists and 8.8% by other clinicians (including nurse practitioners and non-palliative specialists). Western Queensland PHN maintains a very low rate of people accessing MBS specialist palliative medicine services, with updated estimates still under 20 per 100,000—well below the Queensland average of approximately 60 per 100,000. This, combined with persistent workforce constraints, means Western Queensland likely continues to have a higher proportion of GP-prescribed palliative care medications than Queensland overall—likely approaching or exceeding 92% GP-prescribing in the region for PBS items, with minimal specialist involvement.	PCSiA (2025) – Palliative care related medications
	In 2022, Queensland had 59.1 FTE health practitioners employed in the specialist palliative care workforce at a rate of 1.1 per 100,000 (range for states 0.8-1.8).	AIHW Palliative Care Measures data tables
	National data on palliative care workforce distribution and workplace settings show the lack of palliative care specialist services in WQPHN. • The highest rates of palliative medicine physicians are in major cities compared to other remote areas, with rates decreasing as remoteness increases. The highest rates of palliative care nurses are in inner regional areas, followed by major cities, then outer regional and the lowest rates in remote and very remote.	PCSiA (2025) – Palliative care workforce

	• Most of the palliative medicine physician workforce work in a hospital setting (70.1%). 11.4% work in other community health care services, 7.5% work in outpatient services and 5.4% work in private practice. • For palliative care nurses, 50.9% work in hospitals, 25.5% work in community health care services 14.4% work in hospices a, 2.1% work in residential aged care facilities and 2.0% work in outpatient services. • At a state level, Queensland has around the state average FTE per 100,000 population for both palliative medicine physicians and palliative care nurses compared to other states.	
	Patients in WQPHN experience delays in receiving palliative care services with increasing waiting times. • 79% of patients received an appointment within the recommended waiting times, with the average waiting time being 39 days in 2023/2024. • Average waiting times for palliative care services have steadily increased from 2019/2020 to 2023/2024 from 19 days to 39 days with a spike in 2021/2022 likely due to the impacts of COVID-19. • Average waiting times are lowest in Central West HHS at 12 days and significantly higher in South West (48 days) and North West (50 days).	JRNA Queensland Health data pack
	Stakeholders highlighted that there are few palliative care health providers across the region: • "[We] had 3 amazing palliative care nurses... now there's only 1 and she's limited to Longreach" • "Not enough qualified or available staff especially for new people requiring palliative care" • "Lack of community nurses across all communities in our region"	2025 WQPHN Palliative Care Survey
	The Queensland Palliative and End-of-Life Care Strategy consultation themes call for 'growth, training and support for a multidisciplinary workforce' and explicitly 'increasing specialist palliative care workforce' to support generalists and deliver high-quality care.	Queensland Palliative and End-of-Life Care Strategy

Identified need 3	Evidence substantiating the need	Data source
Extremely low hospitalisation rates for palliative care place unsustainable pressure on community-based services and generalist clinicians. **Need Category:** • **Services** • **Workforce**	The WQPHN region has the lowest rate of hospital-based palliative care services in Queensland, with just 29.1 hospitalisations per 10,000 population – significantly below the state average of 38.1 per 10,000. In contrast, the region has one of the highest rates of non-admitted palliative care service events, which includes outpatient, community and in-home visits, at 330.3 per 10,000 population, compared to the Queensland average of 228.9.	PCSiA (2025) – Admitted patient palliative care PCSiA (2025) – non-admitted patient palliative care
	Western Queensland PHN has the lowest rate of Queensland PHNs for palliative care related hospitalisations (29.1 per 10,000) despite having the highest rate for hospitalisations for all reasons 6,103.8 per 10,000). Although palliative care is not one of the leading services related groups (SRGs) for episodes in hospitals in WQPHN, the top SRGs are diseases and conditions which are typically associated with palliative care at the latter stages of the disease. For example, renal dialysis is the leading number of episodes of care in hospitals in WQPHN. Renal dialysis is the only treatment at end-stage renal disease prior to renal failure which commonly leads to palliative care. Furthermore, Cardiology and Respiratory conditions which are typically life-limiting illnesses often require palliative care to manage symptoms and improve quality of life. These are the 2nd and 3rd leading SRGs of episodes in WQPHN, respectively.	PCSiA (2025) – Admitted patient palliative care JRNA Queensland Health data pack
	While PHN-level prescriber breakdowns continue to be unavailable, Queensland state-level data for 2024/25 shows GPs prescribed 89.8% of PBS palliative care medicines, with 1.4% prescribed by palliative medicine specialists and 8.8% by other clinicians (including nurse practitioners and non-palliative specialists). Western Queensland PHN maintains a very low rate of people accessing MBS specialist palliative medicine services, with updated estimates still under 20 per 100,000 well below the Queensland average of approximately 60 per 100,000. This, combined with persistent workforce constraints, means Western Queensland likely continues to have a higher proportion of GP-prescribed palliative care medications than Queensland overall, approaching or exceeding 92% GP prescribing in the region for PBS items, with minimal specialist involvement. This ongoing pattern underscores the critical role of general practitioners in palliative medication management in remote areas. The PBS Palliative Care	PCSiA (2025) – Palliative care related medications

	Schedule remains essential, specifically enabling GPs to prescribe these medicines without requiring specialist agent referral or approval—ensuring continuity of care and access where specialists are unavailable.	
	In 2022-2023 there were 124,252 palliative care service events delivered in Queensland at a rate of 230.7 per 10,000 population. This was below the average of all states (330.8, per 10,000), with only Tasmania having a lower rate of service events. Queensland had similarly low rates compared to other states for all service types including specialist palliative care service events, medical consultations for palliative care and allied health and/or clinical nurse specialist interventions for palliative care. Western Queensland PHN had the second highest rate of palliative care service events (336.4 per 10,000) of all Queensland PHNs, second to Central Queensland, Wide Bay, Sunshine Coast PHN. Western Queensland PHN was also ranked second to Central Queensland, Wide Bay, Sunshine Coast PHN in rate of palliative care service events for each of the three palliative care service types.	PCSiA (2025) – non-admitted patient palliative care
	Stakeholders noted that the extremely limited access to in-patient palliative care had shifted the burden onto community-based and generalist services, highlighting the pressure on community-based palliative care: • "Very hard to provide a good home service with limited health people in the community" • "Local hospitals have limited palliative capacity and medicines" • "Nursing home patients being cared for by GP/ nursing home staff"	2025 WQPHN Palliative Care Survey

Identified need 4	Evidence substantiating the need	Data source
There is a lack of in-patient palliative care facilities available within the region. **Need Category:** • **Infrastructure, facilities & equipment** • **Services**	Hospitalisation and service data points to the lack of specialised in-patient services in WQPHN, with many communities without a palliative care unit, hospice or dedicated beds available locally. Western Queensland PHN has the lowest rate of Queensland PHNs for palliative care related hospitalisations (29.1 per 10,000) despite having the highest rate for hospitalisations for all reasons 6,103.8 per 10,000). Palliative care related hospitalisations are lowest in remote and very remote areas 34.5 per 10,000) despite these areas having the highest rates of hospitalisations for all reasons (6640.7 per 10,000). The highest rates of palliative care hospitalisations occur in inner regional (45.7 per 10,000) and outer regional (43.2 per 10,000).	PCSiA (2025) – Admitted patient palliative care
	The WQPHN JRNA highlights the lack of in-patient specialist palliative care facilities available across the region. During the 2023-2024 financial year, approximately 45 people accessed South West HHS palliative care services, with 10% of patients managed via St George and the remainder between Roma and Charleville. Informed by consumer and broader partner co-design South West HHS has set a clear direction towards transitioning an existing palliative care service model that is largely supporting 'crisis' care when end of life is imminent, to facilitating early engagement in the consumer's journey to provide support which best optimizes their quality of life and aligns their care goals for their palliative and end of life journey. In Central West HHS, palliative care services are supported by a Palliative Care Coordinator in the Primary Health Care team and through the Specialist Palliative Care Rural Telehealth (SPaRTa) program. In the North West HHS, the need for palliative care has grown significantly across the region. The average length of stay is 8.7 days with a relative utilisation of adult palliative services at 225%. This demonstrates the need for additional palliative care services.	WQPHN Joint Regional Health Needs Assessment November 2024 - 2028

Identified need 5	Evidence substantiating the need	Data source
Aboriginal and Torres Strait Islander people face additional cultural, geographic and systemic barriers to accessing appropriate palliative care. **Need Category:** • **Aboriginal and Torres Strait Islander peoples**	Aboriginal and Torres Strait Islander patients are underrepresented in the use of palliative care services that report to the national palliative care outcomes collaboration (PCOC), making up 1.9% of patients compared to 3.2% of the overall population. Patients who use these services are predominantly English speaking as their main language (89.4%). This is substantially higher than the national rate for people speaking English as their main language, (72%) which potentially highlights a barrier to non-English speaking patients accessing these services.	PCSiA (2023) – Palliative care outcomes
	Palliative care hospitalisations for Aboriginal and Torres Strait Islander patients in 2022-23 were 31.6 per 10,000 which is lower than the national rate of 39.1 per 10,000. Aboriginal and Torres Strait Islander patients had slightly lower rates of palliative care services in public hospitals (30.0 per 10,000) than the national rate (33.2 per 10,000) and significantly lower rates in private hospitals (1.6 per 10,000 compared to 5.7 per 10,000).	PCSiA (2025) – Admitted patient palliative care
	Communities in Western Queensland PHN experience significant challenges relating to chronic health conditions and their related comorbidities. older Aboriginal and Torres Strait Islander people and non-Indigenous people across Western Queensland have high rates of comorbidity defined as with two or more conditions such as cancer, cardiovascular disease, chronic kidney disease, diabetes, musculoskeletal issues and respiratory conditions. Some LGAs are as high as 65.6% for Indigenous people in Winton LGA and 46.2% for non-Indigenous people in Quilpie LGA. These high levels of comorbidity predispose Western Queensland older residents for premature mortality, with the high likelihood of requiring end of life care and support.	WQPHN General Practice Primary Health Dataset
	Indigenous cultural needs were highlighted by a number of stakeholders, expressing the strong wish Aboriginal people have to return to country for the final stages of life. If palliative services are not available on country (locally), the only option might be a distant hospital, which is deeply unsatisfactory culturally. Stakeholders noted the cultural misalignment that sometimes occurs between clinical preferences, resources and services and the preferences of Aboriginal and Torres Strait Islander people. Additionally, the importance of spiritual care and large family presence was mentioned, with stakeholders noting the lack of culturally appropriate care providers	2025 WQPHN Palliative Care Survey

and that even where hospitals have a palliative room, it may not accommodate big family gatherings or feel culturally welcoming. If care models don't align with community values – or if people fear losing autonomy or dignity (e.g. a common fear noted was "dying in hospital and away from community") – they might avoid engaging with palliative services altogether, or delay until a crisis.

- "As a mostly Indigenous community, people would like to come back to country for the final stages of life."
- "Lack of spiritual[ly] and culturally appropriate care providers."
- "Palliative care rooms in Mount Isa hospital not culturally appropriate, e.g. access to large family groups, access to fresh air, outside, plants, nature, gathering space, child-friendly facilities."

Aboriginal Australians face significantly greater health challenges and earlier mortality than non-Aboriginal peers. Life expectancy is lower, and chronic diseases occur up to 20 years earlier. These disparities make culturally appropriate palliative care even more critical. However, historical experiences and systemic factors (including past mistreatment and ongoing inequities) contribute to mistrust of healthcare services among some Aboriginal people. Mainstream end-of-life care models, dominated by Western biomedical paradigms, may not meet Aboriginal needs unless they integrate Aboriginal perspectives, rituals and 'ways of working'.

Aboriginal End-of-Life and Palliative Care Framework

- "Throughout all communication and care activities, cultural safety is paramount. This means the health system and staff adapt to the needs of Aboriginal people, rather than expecting the patient to adapt to the system. Showing cultural respect – i.e. recognition and protection of Aboriginal traditions and continued advancement of their rights – creates a safe environment where patients and families feel their differences are understood and valued. By following the above strategies – asking, listening, showing respect, and involving community – health professionals can greatly improve engagement and partnership with Aboriginal people at end of life."

"Cultural needs may outweigh medical needs." Always consider that an Aboriginal person's cultural obligations and spiritual wishes at end of life might take precedence over clinical priorities, and plan care accordingly.

The Queensland Palliative and End-of-Life Care Strategy emphasises collaboration with Aboriginal and Torres Strait Islander organisations to ensure culturally safe pathways and support for 'return to Country. This is evident in goal three of seven which elevates"

Queensland Palliative and End-of-Life Care Strategy

	the individual needs and preferences of people be respected: 'People with a life-limiting illness receive compassionate and high-quality care that is aligned to their preferences and is respectful of their culture, age, identity, emotional, and spiritual needs.' • "There needs to be staff who have connections with our mob while in hospital, so we need to make sure that Aboriginal and Torres Strait Islander Liaison Officers are present. Need adequate staff numbers.	

Identified need 6	Evidence substantiating the need	Data source
Geographic isolation and vast distances hinder access to palliative care. **Need Category:** • **Remoteness**	Western Queensland PHN serves approximately 63,700 people across nearly one million square kilometres—making it the smallest population and most sparsely populated PHN in Australia with only one person per 13 square kilometres. This extreme remoteness fundamentally shapes service delivery practices.	PCSiA (2025) - Palliative care hospitalisations, MBS and PBS, National Hospital Morbidity Database (NHMD)
	Remote and very remote patients with life limiting illness had a higher proportion of potentially preventable hospitalisations in the last 3 months of life suggesting poor management of their life limiting illness in the community. Patients in remote and very remote areas had the lowest proportions of specialist care services in the last 12 months of life that began more than 3 months before death suggesting these patients are not receiving palliative care services earlier in their disease progression in their final year of life.	AIHW Palliative Care Measures data tables
	Nationally, palliative care related hospitalisations are lowest in remote and very remote areas 34.5 per 10,000) despite these areas having the highest rates of hospitalisations for all reasons (6640.7 per 10,000). The highest rates of palliative care hospitalisations occur in inner regional (45.7 per 10,000) and outer regional (43.2 per 10,000).	PCSiA (2025) – Admitted patient palliative care
	Western Queensland PHN has the lowest rates of palliative medicine specialist attendance in Queensland, with just 86 services provided in 2023/2024, at a rate of 135 per 100,000 of the population. Comparing specialist palliative care attendances and case conferences by remoteness area, the rate drops drastically in remote and very remote regions, such as Western Queensland PHN.	PCSiA (2025) – Medicare-subsidised palliative medicine attendance and case conference services

The highest rates of palliative medicine physicians are in major cities compared to other remoteness areas, with rates decreasing remoteness increases. The highest rates of palliative care nurses are in inner regional areas, followed by major cities, then outer regional and the lowest rates in remote and very remote.	PCSiA (2025) – Palliative care workforce
In WQPHN, nearly two thirds of all outpatient services are delivered remotely via phone (44%) or telehealth (20%) with 35% being delivered in person. While this is supportive of patients in remote areas to limit travel to and from consultations, this may present access barriers to some communities where internet and phone services are poor. Of the 3 HHS in the PHN, South West had the highest rate of in person services (41%), followed by Central West (34%) and North West had the lowest (30%). Aboriginal and Torres Strait Islander patients had higher rates of in person services at 40%.	JRNA Queensland Health data pack
Survey respondents repeatedly cited long travel distances as ongoing barriers to care: • "The distances in the Central West region are a barrier. We have an amazing palliative care team, but they are based two hours away in Longreach. How do we support those in palliative care when help isn't available?" • "Specialist palliative care services are often too far away. Travel distance, lack of transport, and limited visiting health professionals make it difficult...to get regular support."	2025 WQPHN Palliative Care Survey
Survey respondents noted issues with transport costs: • "The cost, the distance of travel." (referring to barriers to access) • "...resource and financial constraints." (referring to barriers to access)	2025 WQPHN Palliative Care Survey
Health providers noted the challenges of service provision in the rural regions given the vast distance. Without accessible transport in these remote areas, patients must rely on family or pay high costs to reach distant hospitals/hospices. Often this means people delay assessment and care or have to relocate away from home (to a larger town) to receive end-of-life support.	2025 WQPHN Palliative Care Survey
The Queensland Palliative and End-of-Life Care Strategy calls for service models using telehealth, outreach and culturally safe local options for rural and remote communities, to address the tyranny of distance.	Queensland Palliative and End-of-Life Care Strategy

Identified need 7	Evidence substantiating the need	Data source
There is low awareness and health literacy about palliative care service options in the community. **Need Category:** • **Health literacy**	Stakeholders highlighted the widespread lack of understanding of what palliative care entails and what support is available, leading to delays in people seeking care.: • "I actually don't know what is available in my area. How do I tell people what's out there when I don't even know?" • "Lack of information about what it's all about." • "Google search takes you mostly to the hospital or 'My Community Directory' – which then takes you to the hospital. Where is the information on at-home care?" • "Confusion around the service and what palliative care means. It seems difficult to make the initial connection."	2025 WQPHN Palliative Care Survey
	Stakeholders shared the sentiment that sometimes, people don't know what they don't know: • "I think some of the barriers are that people do not have the health literacy to understand what palliative care is let alone when they should seek out a service and clinicians with all good intentions, think they can do it all and do not seek specialist advice early or offer palliative care services to patients. This means sometimes that patients do not seek palliative care services until the final weeks of their lives and they live prior to that with pain that they should not have to endure because their clinician does not want to ask for assistance with alternate solutions in particular, to pain or complex care. There needs to be ongoing information and support for both clinicians, community members and patients, so there are many with enough information to support people in their palliative care journey."	2025 WQPHN Palliative Care Survey
	Many participants expressed a lack of awareness of how to access palliative care information and services. They often don't know what palliative care options exist, or how to get them. For example, one person wondered aloud, "Once I access palliative care, do you get choices?" – reflecting uncertainty about whether entering palliative care means losing autonomy. People want reassurance that they will still have choices and control even in end-of-life care. They also want better information that palliative care can sometimes be given at home or in local care facilities, not only in hospitals – many were not aware of community-based palliative resources until too late.	Talking about what matters to you in relation to ageing, end-of-life care and dying

Stakeholders noted that information doesn't always reach people: • "I have heard members of the public say I didn't know it was available when activities have been advertised as posters in stores, library and newsletters on the radio etc. I feel the only way is large street banners or word of mouth."	2025 WQPHN Palliative Care Survey
Stakeholders acknowledged the reluctance to talk about palliation until it becomes unavoidable: • "Something we don't think much about until there is a need." • "There have been efforts to increase community awareness, however generally people don't want to know about palliative care until they need to access it. Trying to change this perspective is a slow and difficult journey, but positive steps are being made." • "Getting the word out and educating the community on their options and what is available to them, is unfortunately a big battle in every sector."	2025 WQPHN Palliative Care Survey
Results of the Death Literacy Index indicate the majority of respondents reported low levels of factual knowledge about palliative care, such as navigating the health system to support a dying person, navigating funeral services and options, and documents needing completion in planning for death.	Death Literacy Index
Many community members struggle to find plain-language explanations about crucial topics like how home-care packages work, what palliative care services are available, how to do advance care planning, or even how to get help when something goes wrong. Misinformation or conflicting advice from different sources is a common problem, leaving people unsure whom to trust.	Talking about what matters to you in relation to ageing, end-of-life care and dying
The Queensland Palliative and End-of-Life Care Strategy cements the value of developing and disseminating 'Information about Palliative Care' to community members, with its commitment to Goal 2: • Information about care – people with a life-limiting illness, their families and carers receive information that enables and supports them to make informed choices about palliative and end-of-life care.	Queensland Palliative and End-of-Life Care Strategy

Identified need 8	Evidence substantiating the need	Data source
Fragmented care coordination and unclear service pathways **Need Category:** • **Services** • **Health literacy**	Despite the widespread workforce shortages, the palliative care service landscape in Western Queensland is fragmented with multiple providers (e.g., hospital and health services, primary care, aged care providers, and NGOs including Blue Care, Selectability, etc.) causing confusion about roles and referral processes. Stakeholders shared frustration navigating the system and the resulting lack of clarity: • "Fragmented services" (referring to barriers). • "Confusion around the service". • "There are mixed messages coming through about who to go to and how etc (other than HHS)." • "Where does the GCfAHPC align and how?" • "Awareness – what is available in the community and who delivers support and services. Who knew RFDS had a palliative care team!" • "[We need] greater awareness and connection across services... A one stop shop that connects people to pall[iative] care... [people] don't know where to go."	2025 WQPHN Palliative Care Survey
	The lack of clarity regarding palliative care services and pathways leads to people missing out on care. Stakeholders, including health professionals, found the system non-intuitive, with uncertainty over whether the hospital, a community nursing service, or another agency is responsible for various aspects of care. • "Knowing who to go to at the time of need for palliative care and support for loved ones" • "Lack of referrals to palliative care" (referring to barriers to access)	2025 WQPHN Palliative Care Survey
	Poor coordination leads to some patients being missed or referred too late, with the result being that patients who would benefit are not being introduced to palliative care early enough. Stakeholders also noted that many palliative interventions are initiated "too late" in the illness. This results in patients suffering unmanaged symptoms that could have been addressed with timely referral.	Understanding Palliative Care and the Health Workforce – Market Research Insights Report
	Participants often feel confused and overwhelmed by the aged care, palliative care, and end-of-life systems. They strongly desire clear, accessible information and guidance so they can understand their options and plan ahead. "Give me the knowledge to make informed decisions," was a sentiment widely shared.	Talking about what matters to you in relation to ageing, end-of-life care and dying

The National Palliative Care Strategy calls for agreed care pathways and collaboration tools to improve transitions – ensuring that everyone works together to create a consistent experience of palliative care across care settings. The specific strategies it identifies include: • Collaboration tools (such as technology and agreed care pathways) are used to monitor and improve the coordination of palliative care and transitions between care settings • Communication between and across national, state/territory, and local palliative care networks improves the consistency of care across jurisdictions • People affected by life-limiting illnesses are included in the development, implementation and evaluation of palliative care services • Funding mechanisms, including existing Medicare Benefit Schedule item numbers, facilitate advance care planning and care coordination across all settings • Collaboration with Aboriginal and Torres Strait Islander people and organisations, guided by the Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health	National Palliative Care Strategy
The Implementation Plan for the National Palliative Care Strategy asserts the value of improved coordination and interoperability across providers by highlighting three key activities within Action Area 2 which aim to achieve improved collaboration and coordination of palliative care: • Identifying and implementing service models that improve collaboration and coordination of care • Improving the sharing of patient data in and across care settings • Addressing interface issues, including funding barriers that inhibit cross-sectoral collaboration.	Implementation Plan for the National Palliative Care Strategy

Identified need 9	Evidence substantiating the need	Data source
Inadequate support for home-based palliative care – including equipment, personal care services and after-hours care **Need Category:** • **Services**	Timely commencement of palliative care – where care commences within two days of the patient being ready, is 97.1% for inpatient palliative care, and 87.3% for community-based palliative care. A similar trend is noted for the responsiveness in managing patients with urgent needs – where patients are unstable for three days or less. This is 90.7% for inpatient palliative care, and 79.9 for community-based palliative care.	PCSiA (2025) – Palliative care outcomes
	With ongoing workforce limitations, there simply aren't enough skilled people on the group to provide home-based palliative care across Western Queensland – including healthcare professionals (nurses, doctors and allied health) and formalised support workers (personal and home care workers and respite carers). • "There is a lack of community nurses across all communities in our region." • "It's very hard to provide a good home service with limited health people in the community." • "[There are] limited options for staying at home to receive palliative care." • "Lack of resources for pall[iative] beds in the home, someone to come shower or sponge the pal[iative] patient." • "Need more on the ground nursing staff to assist with EOL [end-of-life] care and better access to at home services for smaller towns."	2025 WQPHN Palliative Care Survey
	In addition to the above need, the Western Queensland region has limited round-the-clock palliative care service for patients at home. Families and community clinicians highlighted that if a patient at home has a crisis in the evening or on a weekend, there is no palliative-specific on-call team to assist. • "People being accessible afterhours to offer services to patients at home." • "24 hr service allowing people to stay at home with support."	2025 WQPHN Palliative Care Survey
	Stakeholders reported challenges in accessing equipment to support palliative care, such as access to syringe drivers or Niki pumps, the medication and the expertise to set it up – all of which are harder to arrange in remote areas. • "Access to palliative care equipment at home." (referring to barriers to access) • "Less red tape around using palliative care equipment. QH regulation says any request for equipment or supplies needs to be signed by a 'Palliative care specialist' which is unnecessary bureaucracy when most the care is being provided by rural generalists."	2025 WQPHN Palliative Care Survey

Identified need 10	Evidence substantiating the need	Data source
Insufficient support for family caregivers – both before and after a person's death **Need Category:** • **Services**	The Queensland Palliative and End-of-Life Care Strategy highlights the importance and value of carers in the provision of palliative care and elevates support for families and carers as one of their seven goals "Support for families and carers – families and carers receive timely and compassionate support while caring for people with a life-limiting illness and during bereavement." • "It is important to recognise that bereavement support is a fundamental part of end-of-life care and supporting families and carers following the passing of a loved one." • "Support for carers is also very high on the list, as in my experience, the carers' needs are two-fold, during the end-of-life process, then the bereavement stage after. There are still fairly significant gaps for this support, especially for those who don't even know where to start looking. And the information isn't readily available."	Queensland Palliative and End-of-Life Care Strategy
	Stakeholders noted the burden and stress experienced by family carers, highlighting the importance of respite support to avoid overwhelm. They also noted that once someone becomes a carer, they often end up shouldering more responsibility: • "Once you are a carer, you become the 'go-to' carer for others." • "Mental health support for carers at home." • "Offer hands on basic carers training or first aid, this would make the person who may become the carer more confident so that they have the know they have the ability to care alongside palliative care support." • "End of life care is hard work and often partners also elderly or even children who can also be older do not have the capacity, physical strength, knowledge or the required empathy to care for someone at end of life."	Talking about what matters to you in relation to ageing, end-of-life care and dying and 2025 WQPHN Palliative Care Survey
	Stakeholders highlighted the critical role that family caregivers play in advocating and supporting their loved ones: • "It feels that for people to die at home out here - they need a good, dedicated team of carers and determination - not expecting a high level of community support from a nursing agency to help." • "People who don't have a "carer" and/or who don't have accommodation and/or don't receive timely access to home support services do not have choices about EOL care and are more likely to choose VAD or being inappropriately accommodated on a general ward that is not conducive to EOL care."	2025 WQPHN Palliative Care Survey

	Stakeholders noted that it "takes a village" to age and die well highlighting the vital role of family and community support alongside formal care. Many rely on spouses, children, friends, and neighbours to help them manage at home. These informal carers are essential for keeping elders safe, comfortable, and socially connected. However, participants acknowledge the heavy burden this places on caregivers, and they stress that carers need more help too.	Talking about what matters to you in relation to ageing, end-of-life care and dying
	The Queensland Palliative and End-of-Life Care Strategy consultation themes highlight the importance of compassionate carer support: • "It is important to recognise that bereavement support is a fundamental part of end-of-life care and supporting families and carers following the passing of a loved one." Support for families and carers features as goal four of seven: • Families and carers receive timely and compassionate support while caring for people with a life-limiting illness and during bereavement.	Queensland Palliative and End-of-Life Care Strategy

Identified need 11	Evidence substantiating the need	Data source
Telehealth infrastructure in rural and remote areas is inadequate, restricting timely and effective access to palliative care services and specialist support **Need Category:** • **Infrastructure, facilities & equipment** • **Remoteness**	In WQPHN, nearly two thirds of all outpatient services are delivered remotely via phone (44%) or telehealth (20%) with 35% being delivered in person. While this is supportive of patients in remote areas to limit travel to and from consultations, this may present access barriers to some communities where internet and phone services are poor. Of the 3 HHS in the PHN, South West had the highest rate of in person services (41%), followed by Central West (34%) and North West had the lowest (30%). Aboriginal and Torres Strait Islander patients had higher rates of in person services at 40%.	JRNA Queensland Health data pack
	The National Palliative Care Strategy asserts an increasing role for technology in supporting those affected by life-limiting illnesses to access a range of services, including through remote consultations or through the use of tools in the home to support independence. Addressing telehealth infrastructure is necessary to achieve this. The National Strategy also stresses the need to address structural barriers to improve communication and information sharing across within and across sectors, including technology infrastructure, funding mechanisms and systems such as the My Health Record.	National Palliative Care Strategy
	The Queensland Palliative and End-of-Life Care Strategy calls for service models that are working well, such as Specialist Palliative Rural Telehealth Service (SPaRTa), PallConsult and PalAssist, to be expanded. This was supported by numerous local stakeholders who noted the extreme value of these telehealth services to support local Western Queensland residents to receive quality care. • "I feel we have an excellent palliative care service with high quality multi-disciplinary care. This includes: ◊ SPARTA telehealth palliative care ◊ PallConsult palliative care advice services ◊ Excellent palliative care nurses through CWHHS. ◊ Committed general practitioners who are able to do home visits as well as provide inpatient and nursing home palliative care services. ◊ Access to pharmacological therapies through local pharmacies."	Queensland Palliative and End-of-Life Care Strategy and 2025 WQPHN Palliative Care Survey

Telehealth service utilisation for GP services across the WQPHN region is significantly lower than the National rates.

NWHHS

- 7.3% of GP services in the North West region were telehealth and phone consultations, much lower than the National and PHN proportions of 18.8% and 13.0% respectively. Telehealth services are more commonly used in Mount Isa (10.3%) and are much less frequently used in Carpentaria (6.9%) or Mornington (2.0%).
- Telehealth usage in the North West region is steadily increasing but is still significantly below the National level. In 2022-23, telehealth services in the region accounted for 7.3% total GP services, up from 3.0% in 2019-20 and 6.8% in 2020-21 (National level was 18.8% in 2022-23).
- Telehealth services are less utilised in very remote areas like Mornington Island (2.0% in 2022-23), Carpentaria (6.9% in 2022-23), Cloncurry (1.1% in 2021-22), which put pressures on traditional face to face GP services in these areas.

CWHHS

- Usage of telehealth services dropped from 16.0% in 2020-21 to 10.9% in 2022-23, below the National and PHN usage. The proportion of telehealth usage significantly decreased in Blackall-Tambo, from the peak at 25.9% in 2020-21 to only 6.3% in 2022-23.

SWHHS

- Telehealth services increased from 13.7% in 2020-21 to 16.2% in 2022-23, still below the National rate but surpassed the PHN. The proportion of telehealth usage increase in all areas, for instance, Balonne from 10.6% (2020-21) to 15.4% (2022-23), Murweh from 15.7% (2020-21) to 21.3% (2022-23).
- There is an increasing uptake of telehealth services in the South West region is still much below the National level. In 2022-23, telehealth services in the region account for 16.2% total GP services, up from 6.9% in 2019-20 (National level at 18.8% in 2022-23).
- Telehealth services are less popular in very remote areas like Paroo (12.1% in 2022-23), Balonne (15.4% in 2022-23). However, in more developed areas like Maranoa, only 15.7% of GP services are done via phone or video, raising concerns about digital health literacy as well as the availability of the services in the region.

WQPHN Joint Regional Health Needs Assessment

November 2024 - 2028

Internet access is a critical part of telehealth and remote health service delivery infrastructure. The WQPHN has significant proportions of the population without access to the internet, presenting a significant barrier to delivering palliative care services via telehealth.

The proportion of private dwellings without access to the internet is considerably higher in the Western Queensland region (22.9%), compared with the National (14.1%) and State (13.6%). The only LGA in the entire WQPHN region to have lower than national or state levels is Diamantina at just below 10%.

The rates are significantly higher in the North West region, with 47.5% of dwellings in Mornington, 41.8% in Burke and 37.7% in Doomadgee not having access to the internet. This is up to 3.5 times higher than the State rate.

In the Central West region, the proportion is very high, with 32.7% of dwellings in Barcoo and 29.6% of dwellings in Boulia without access to the internet.

The rates are significantly higher in the South West region, with 35.2% of dwellings in Paroo not having access to the internet, more than 2.5 times the State rate.

Identified need 12	Evidence substantiating the need	Data source
Current investment in palliative care services is inadequate to meet the needs of the community **Need category:** • **Funding**	WQPHN region has the lowest expenditure on admitted and non-admitted patient palliative care of all Queensland PHNs, with just 2.71% ($5,139,901) of total spend in Queensland. This is in comparison to Central Queensland, Wide Bay, Sunshine Coast PHN expenditure of $41,431,059 (21.86%) and $41,108,393 (21.69%) expenditure in Northern Queensland. Interestingly, Western Queensland PHN proportional expenditure on non-admitted palliative care services is the highest of all Queensland PHNs, at 32.66% of their total spend, this supports other evidence which shows a greater reliance on community-based palliative care models in the region. Nationally, expenditure on palliative care services is increasing, however expenditure on non-admitted palliative care services has increased at a considerably higher rate. Expenditure on admitted patient palliative care has increased from $336,838,582 in 2013/2014 to $594,526,776 in 2022/2023 – an increase of 76.50%. Expenditure on non-admitted patient palliative care has increased from $38,843,791 in 2013/2014 to $204,112,178 in 2022/2023 – an increase of 425.47%.	Palliative Care Services in Australia (PCSiA) 2025 – Expenditure on palliative care
	95.5% of the non-admitted patient palliative care service events in WQPHN were funded through health service budget funding meaning these services are not funded through Medicare benefits or patient contributions.	PCSiA (2025) – non-admitted patient palliative care
	Both the Palliative Care Queensland Priorities for 2025, and the Pre-Budget Submission 2025-2026 emphasise boosting funding for community services due to reliance on home/community models and insufficient 24/7 support.	PCQ Priorities and PCQ Pre-Budget Submission

Identified need 13	Evidence substantiating the need	Data source
The low confidence and knowledge of some healthcare providers delays conversations about palliative care and reduces early engagement **Need category:** • **Services** • **Health**	Health care professionals expressed a high willingness to provide palliative care, however: • Two thirds reported low or average confidence in their knowledge of legal rights and responsibilities • Half reported low or average confidence coordinating community-based palliative care • Just under half reported low or average confidence of prescribing related needs • Just under half reported low or average confidence in preparing advance care plans. • One third reported low or average confidence identifying who could benefit from palliative care. • One third reported low or average confidence in their knowledge of best practice care One third reported low or average confidence on advice for family on disease treatment transition.	Understanding Palliative Care and the Health Workforce – Market Research and Insights Report
	Confidence and experience were highlighted as important in supporting early conversations about palliative care, with 88% of health care professionals comfortable providing palliative care, but only 77% willing to have conversations about palliative care: • "We often get palliative care involved too late, with poorly managed symptoms that we could have avoided with early palliative care discussions." • "Good palliative care is early, if you've got someone with a life limiting illness, as soon as they develop any sort of symptoms that would interfere with the quality of life, is when it should be discussed. " • "People can't process it at the last minute, last week I was getting treatment and this week I'm dying. That's a western culture; it's a missed opportunity not to talk about it openly and what it could look like for you." • "As a community we are not good at talking about death and dying." • "[We need more] open conversations."	Understanding Palliative Care and the Health Workforce – Market Research and Insights Report and 2025 WQPHN Palliative Care Survey
	Stakeholders – health care providers and community members alike, reported value in the Last Aid training: • "I found the Last Aid course to be very beneficial - even as someone not currently in need of palliative care for myself or a loved one - I found it hugely beneficial in starting the conversation of "what needs to be sorted out in advance" - regardless of whether it is a palliative care situation or sudden death. I think this course is an excellent tool for community members as well as health workers to sit through. And to be honest, I would probably do it	2025 WQPHN Palliative Care Survey

	again if it came back to the area - as I learnt a lot during the last one but didn't put it into practice and I feel like I need to do it again to take action!!"	
	Stakeholders spoke strongly about the need for more training for health workers and community members alike: • "More... training and education for local staff." • "Upskilling medical and nursing teams in each place about pall[iative] care - who to call for help, who to refer to, where to find this information. Constant education for community and health staff." • "[We need] coordination, training and resources to build skilled staff and great awareness." • "[We need] increased specialised palliative care training for nurses and IHW [Indigenous Health Workers]." • "[We need] better training for VAD [Voluntary Assisted Dying] – the more doctors and nurses who train and can support patients, the better!"	2025 WQPHN Palliative Care Survey
	The top five information needs identified as most useful to assist in providing palliative care to patients, based on a survey with 605 health care professionals are: • Myth-busting – debunking misconceptions around palliative care (60%) • Conversation coaching – improving and easing difficult conversations (60%) • Information on allied health support – increase awareness of resources across the ecosystem (52%) • Best practice on palliative care treatments – increased understanding on what care to provide (47%) • Understanding the regulatory and legal framework (44%)	Understanding Palliative Care and the Health Workforce – Market Research and Insights Report

Identified need 14	Evidence substantiating the need	Data source
Clinicians in the WQPHN experience greater challenges accessing specialist support, clinical resources and complex care pathways compared to their urban counterparts **Need category:** • **Workforce** • **Remoteness**	Compared to metropolitan health care professionals, regional, rural and remote health care professionals find palliative care more challenging, but conversely more rewarding. They are less likely to agree they know how and where to access appropriate information and resources to support palliative patients.	Understanding Palliative Care and the Health Workforce – Market Research the Insights Report
	Regional, rural and remote health care professionals face additional barriers compared to metropolitan counterparts in delivering palliative care. The most commonly reported challenge of metropolitan health care professionals was managing the difference in family and patient opinions about care (28% of respondents). Other challenges were noted, but they were generally only reported by approximately 10% of respondents. Conversely, the most commonly reported challenges of regional, rural and remote health care professionals are more aligned with care provision and accessing necessary resources to support care provision: • After-hours contact with patients or staff at care facilities (39%) • Availability of local services (24%) • Availability of respite services (20%) • Difficulty accessing specialty advice (19%) • Coordinating patient care teams (18%)	Understanding Palliative Care and the Health Workforce – Market Research the Insights Report
	A number of health practitioners raised the challenges in accessing Voluntary Assisted Dying (VAD) for their patients. Whilst VAD became legal in Queensland in early 2023, National legislation forbids discussing VAD over the phone or internet – inadvertently impacting rural patients disproportionately. Stakeholders suggested making VAD more accessible in rural areas by changing rules to allow telehealth assessments and reducing the training burden on doctors, which currently is a lengthy online course. They also urged advocacy to change federal law that currently forbids discussing VAD over the phone or internet. For these health professionals, the importance of VAD highlights their view that palliative care and assisted dying form a continuum of end-of-life options, and that rural patients should have equal access to all available choices.	2025 WQPHN Palliative Care Survey

Identified need 15	Evidence substantiating the need	Data source
Clinicians providing palliative care experience emotional fatigue due to the challenging nature of the work **Need category:** • **Workforce**	National data on palliative care workforce distribution and workplace settings show the lack of palliative care specialist services in WQPHN. The highest rates of palliative medicine physicians are in major cities compared to other remote areas, with rates decreasing as remoteness increases. The highest rates of palliative care nurses are in inner regional areas, followed by major cities, then outer regional and the lowest rates in remote and very remote. Most of the palliative medicine physician workforce work in a hospital setting (70.1%). 11.4% work in other community health care services, 7.5% work in outpatient services and 5.4% work in private practice. For palliative care nurses, 50.9% work in hospitals, 25.5% work in community health care services 14.4% work in hospices a, 2.1% work in residential aged care facilities and 2.0% work in outpatient services. At a state level, Queensland has around the state average FTE per 100,000 population for both palliative medicine physicians and palliative care nurses compared to other states. These workforce shortages place additional pressure on the current workforce and are likely to leave less time for clinicians to focus on self-care and reflective practice to manage the additional emotional challenges of palliative care work. The distribution of the workforce in WQPHN may also contribute to a lack of support for clinicians. Most specialist palliative care services in WQPHN are delivered in non-hospital settings where clinicians are more likely to be dispersed geographically and centralised support services, which are more likely to be present in hospitals, would not be available or easy to access.	PCSiA (2025) – Palliative care workforce
	More than half (60%) of all health care professionals delivering palliative care services assert that providing quality palliative care is challenging, with less experienced health care professionals asserting this considerably more strongly (closer to 90%). A prominent theme when discussing challenges was families' emotional stress: • "The biggest challenge is family distress. More so than patients. Through our training we're taught about supportive listening, but nothing targeted towards palliative care."	Understanding Palliative Care and the Health Workforce – Market Research the Insights Report

- "Dealing with families because the patient is accepting what is happening, but the families have not and do not want their loved one to pass away and families can get angry and abusive and refuse your services as don't think that palliative care is required"
- "Dealing with the families if they're upset, then it makes me upset, I don't like seeing people upset and it's controlling the emotions is the hardest part."
- "Dealing with the families, no one is on the same page and trying to get consensus moving forward. Sometimes I feel myself my emotions get in the way, and I get upset about it. Accessing resources might be challenging also".

The most frequently reported challenges are listed below, along with the percentage of health care professionals who ranked each within their top five most difficult aspects of providing palliative care:

Talking with the patient about the death and dying process (78%)

Preparing your patient for end—of-life care (74%)

Initiating conversations with patients about families about the transition to end-of-life care (72%)

Fulfilling the patient's wishes (63%)

Comforting patients (57%)

The National Palliative Care Strategy has recognised the importance of a skilled and supported workforce and calls for greater investment so that care providers have the support they need to maintain their health and wellbeing.

National Palliative Care Strategy

Identified need 16	Evidence substantiating the need	Data source
Interventions in the final 12 months of life are not serving to improve quality of life for patients, family and carers. **Need category:** • **Health**	Queensland had the highest rate of patients who received potentially non-beneficial treatments at the end of life with 10.3% of patients with life limiting illnesses receiving such treatment (the National average is 8.3%). A potentially non-beneficial treatment refers to a treatment or intervention that is unlikely to prolong life or provide comport at the end of life (including cardiopulmonary resuscitation, intravenous feeding, mechanical ventilation, imaging, initiation of chemotherapy or dialysis within the last 30 days of life, or receipt of chemotherapy in the last 14 days of life). At a national level: • Men (9.6%) had a higher rate than women (6.9%) • The rate was highest in the 15-24 age group (28.1%), followed by the 0-14 age group (25.2%), and • The rate was highest where liver disease (20%) and respiratory disease/HIV (18.3%) were the cause of death.	AIHW Palliative Care Measures data tables
	The percentage of palliative care phases where family or carer problems improved or remained at a low level following an intervention has decreased slightly from 2018 to 2022 from 75.0% to 73.6%. The age groups with the lowest proportion of palliative care phases with improvement was 0-14 (63.2%).	AIHW Palliative Care Measures data tables
	Queensland had the highest rate of patients with life limiting illness who had potentially preventable hospitalisations (PPH) in the final 3 months of life with 13.0% (the National average is 11.9%). At a national level, men (12.5%) had a slightly higher rate than women (11.3%). The rate was highest where respiratory disease/HIV (31.5%) and renal disease (19.2%) were the cause of death.	AIHW Palliative Care Measures data tables
	More prescriptions are written in the last year of life for people who are not receiving specialist palliative care (SPC) than those who are receiving SPC. More patients who were issued prescriptions in their last year of life were not receiving specialist palliative care. The majority of prescriptions were issued by GPs for both SPC and non-SPC patients. Dialysis has the greatest percentage of patient receiving treatment in the last 0-14 before death. Chemotherapy has the lowest percentage of patients receiving an intervention in the last 0-14 and 15-29 days before death and the highest percentage receiving intervention in the last 30-90 days before death. One third of patients received their final pathology intervention in the final 0-14 days before death. One fifth of patients received their final imaging intervention in the final 0-14 days before death.	Palliative care and health service use for people with life limiting conditions (2024)

Identified need 17	Evidence substantiating the need	Data source
Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life. **Need category:** • **Health**	38.4% of people nationally who died with predictable deaths in 2019-2020 received specialist palliative care (SPC) in their last year of life, suggesting a large proportion of people with predictable deaths are missing out on care in their last year of life. The average number of overnight hospital admissions in the last 3 months of life for people receiving SPC was 1.7 compared to 1.4 for those not receiving SPC. This indicates people already receiving SPC are more likely to be hospitalised in the 3 months prior to death.	Palliative care and health service use for people with life limiting conditions (2024)
	Nationally, the majority of patients who receive specialist palliative care in the SPC population* receive care in the final 0-7 days before death. This suggests that patient who have predictable deaths are not receiving palliative care services until the end-of-life stage of their illness. Patients in the SPC population are more likely to receive care for their first SPC service in a hospital inpatient setting 0-14 days before death. One month to 12 months before death, patients are more likely to receive services in outpatient clinics or through Medicare services. This suggests that patients at the end-of-life stage of their illness are more likely to be hospitalised before receiving palliative care services if they have not been engaged in palliative care services in the community and are likely missing out on services that could improve quality of life in their final year. *SPC population is defined as people aged 40 years and over who received services (inpatient care, outpatient clinics, private consultations via MBS items) from palliative care specialists/physicians in the last year of life and died from predictable deaths in 2019-20 (excludes WA and NT, due to data availability).	Palliative care and health service use for people with life limiting conditions (2024)
	More than two-thirds (68.8%) of patient deaths occur in hospital, with 18.4% occurring at home and 11.0% occurring in a residential aged care home.	PCSiA (2025) – Palliative care outcomes

	Stakeholders noted that identification, referral and interventions occurred too late: • "Palliative care interventions and referrals... actioned and resourced too late" • "...generally when people think of palliative care they only think of the last few weeks or days of a person's life when they are totally dependent on caregivers, and most people find this unpleasant and avoid thinking about it. Instead, focus on the fact that palliative care begins when a life-limiting illness is first diagnosed. Focus on what palliative care can do to assist straight after a diagnosis when the person is still relatively healthy and independent." • "This means sometimes that patients do not seek palliative care services until the final weeks of their lives, and they live prior to that with pain that they should not have to endure because their clinician does not want to ask for assistance with alternate solutions in particular, to pain or complex care." • "We often get palliative care involved too late, with poorly managed symptoms that we could have avoided with early palliative care discussions." • "Good palliative care is early, if you've got someone with a life limiting illness, as soon as they develop any sort of symptoms that would interfere with the quality of life, is when it should be discussed. "	2025 WQPHN Palliative Care Survey and Understanding Palliative Care and the Health Workforce – Market Research Insights Report
	The National Palliative Care Strategy asserts early identification and referral: • "Health professionals provide early referrals for palliative care for those affected by life-limiting illness..."	National Palliative Care Strategy

Identified need 18	Evidence substantiating the need	Data source
Some populations within the WQPHN region experience compounding barriers which increase the complexity and difficulty in delivering palliative care interventions. **Need category:** • **Health**	WQPHN has unique geographic and demographic distributions that create greater barriers to some populations accessing palliative care services. Aboriginal and Torres Strait Islander peoples, people living in remote and very remote locations, people with poor or no access to phone and internet services, people with complex chronic conditions and comorbidities are all identified in the data as receiving care at a later stage, receiving higher rates on of non-beneficial care, having poorer outcomes following interventions or have no services available. Aboriginal and Torres Strait Islander patients are underrepresented in the use of palliative care services that report to the national palliative care outcomes collaboration (PCOC), making up 1.9% of patients compared to 3.2% of the overall population. Patients who use these services are predominantly English speaking as their main language (89.4%). This is substantially higher than the national rate for people speaking English as their main language, (72%) which potentially highlights a barrier to non-English speaking patients accessing these services.	PCSiA (2023) – Palliative care outcomes
	Palliative care hospitalisations for Aboriginal and Torres Strait Islander patients in 2022-23 were 31.6 per 10,000 which is lower than the national rate of 39.1 per 10,000. Aboriginal and Torres Strait Islander patients had slightly lower rates of palliative care services in public hospitals (30.0 per 10,000) than the national rate (33.2 per 10,000) and significantly lower rates in private hospitals (1.6 per 10,000 compared to 5.7 per 10,000). Aboriginal and Torres Strait Islander patients had significantly higher rates of hospitalisations in public hospitals for all reasons (6264.9 per 10,000) compared to the national rate (2740.0 per 10,000) and significantly lower rates in private hospitals (1662.8 per 10,000) compared to the national rate (1919.6 per 10,000). Palliative care related hospitalisations are lowest in remote and very remote areas 34.5 per 10,000) despite these areas having the highest rates of hospitalisations for all reasons (6640.7 per 10,000). The highest rates of palliative care hospitalisations occur in inner regional (45.7 per 10,000) and outer regional (43.2 per 10,000).	PCSiA (2025) – Admitted patient palliative care

Western Queensland PHN has the lowest rate of Queensland PHNs for palliative care related hospitalisations (29.1 per 10,000) despite having the highest rate for hospitalisations for all reasons 6,103.8 per 10,000).

Cancer as a principal diagnosis for hospitalisation accounted for 40% of all palliative care related hospitalisations. The next most common principal diagnosis was cerebrovascular disease at 4.5%, highlighting the gap in palliative care services for non-malignant illness. Queensland had the lowest average length of stay for overnight hospitalisations for palliative care related hospitalisations (9.5 per 10,000) and also had one of the lowest average lengths of stay for hospitalisations for all reasons (5.2 per 10,000). These rates highlight the need for in-community services, and support for GP led delivery of palliative care interventions.

Winton, Quilpie, Murweh, Doomadgee and Paroo LGAs appear in the top five LGAs in the region for Cancer, renal failure and two or more comorbidities for both Aboriginal and Torres Strait Islander patients and non-indigenous patients. These Central West and Far South West localities may warrant targeted responses to support the delivery of palliative care services to patients in these regions.

WQPHN General Practice Primary Health Dataset

Communities in Western Queensland PHN experience significant challenges relating to chronic health conditions and their related comorbidities. Older Indigenous and non-Indigenous people across Western Queensland have some high rates of comorbidity defined as with 2 or more conditions such as cancer, cardiovascular disease, chronic kidney disease, diabetes, musculoskeletal issues and respiratory conditions.

Some LGAs are as high as 65.6% for Indigenous people in **Winton LGA** and 46.2% for non-Indigenous people in **Quilpie LGA**. These high levels of comorbidity predispose Western Queensland older residents for premature mortality, with the high likelihood of requiring end of life care and support.

Looking specially at two key conditions which highly relate to palliative care, namely, kidney disease and cancer, there is a significant variation between communities across Western Queensland PHN. Renal impairment (kidney disease), often leading towards renal failure, is significantly prominent in older residents of **Mornington and Doomadgee LGAs.** These LGAs consist largely of remote Indigenous communities which may require additional palliative care services. Communities of **Murweh, Quilpie, Cloncurry and Balonne** have the highest prevalence of Cancer in Western Queensland.

Identified need 19	Evidence substantiating the need	Data source
General practitioners in the WQPHN region require greater support as they carry substantial responsibility for delivering palliative care in the context of limited access to specialist resources. **Need category:** • **Services** • **Workforce**	The delivery of palliative care services and medications in WQPHN relies substantially on general practice due to shortages of palliative care specialists, lack of inpatient services and dispersed population over remote and very remote communities. The Western Queensland PHN region has the lowest hospitalisation rate for palliative care services of all Queensland PHNs, with 29.1 per 10,000 population, compared to an average of 38.1 per 10,000 population across all Queensland PHNs. In comparison, the region has a significantly higher non-admitted service event rate of 330.3 per 10,000 population, compared to the Queensland average of 228.9 per 10,000 population. The combination of below-average hospitalisation rates alongside substantially above-average community service events suggests the region relies on a service model oriented toward community-based and home-based palliative care, rather than hospital-based care. Whilst this may align with consumer-preferences for receiving palliative care and dying at home, it is likely also impacted by the health workforce shortages across the region, and the substantial distances people need to travel for hospital-based services. The region has the lowest rate of services provided by a specialist palliative care physician, with just 16.4 per 100,000 population, compared with the Queensland average of 63.3 per 100,000 population. The total number of MBS specialist services provided was similarly constrained at 167.9 per 100,000, compared to the Queensland average of 313.9 per 100,000 population. This extreme shortage of specialist palliative care physician involvement means that palliative care in Western Queensland is delivered predominantly by generalist health professionals—general practitioners, rural generalist physicians, registered nurses, and allied health providers—rather than specialist palliative care teams. Only 10.4 people in the entire region received specialist palliative medicine services in 2022-2023. In contrast to the stark specialist physician shortage, PBS palliative care medication access in Western Queensland PHN remains relatively comparable to the Queensland average: • People receiving medications: 1,751 per 100,000 vs Queensland average 1,909 per 100,000 (-8.3%)	PCSiA (2025) - Palliative care hospitalisations, MBS and PBS, National Hospital Morbidity Database (NHMD)

- Prescriptions dispensed: 5,019 per 100,000 vs Queensland average 5,713 per 100,000 (-12.1%) and
- Prescriptions per person: 2.87 vs Queensland average 2.97 (-3.4%).

Western Queensland ranks third among the seven Queensland PHNs for medication user rates, falling within the middle range rather than being a clear outlier. The prescriptions per person metric (2.87) is very similar to the state average (2.97), suggesting that once people access the PBS palliative care schedule, they receive a similar intensity of medication support as elsewhere in Queensland.

The relatively maintained medication access, despite severe specialist shortages and geographic remoteness, is possibly due to some combination of the following factors:

- GPs are effectively prescribing palliative care medications without requiring specialist involvement
- PBS medication availability through community pharmacies functions reasonably well even in remote areas
- The PBS Palliative Care Schedule specifically enables GPs to prescribe these medications without specialist referral
- Telehealth and remote prescribing may be facilitating access

Western Queensland PHN serves approximately 63,700 people across nearly one million square kilometers making it the smallest population and most sparsely populated PHN in Australia with only one person per 13 square kilometers. This extreme remoteness fundamentally shapes service delivery practices.

General practitioners are the primary care providers for patients and are positioned to provide the support needed for palliative care, particularly prescribing appropriate medications, in the community if well supported and trained.

More prescriptions are written in the last year of life for people who are not receiving SPC than those who are receiving SPC. More patients who were issued prescriptions in their last year of life were not receiving specialist palliative care. The majority of prescriptions were issued by GPs for both SPC and non-SPC patients.

Palliative care and health service use for people with life limiting conditions (2024)

While PHN-level prescriber breakdowns are not available, Queensland state-level data provides important context about who prescribes palliative care medications. GPs prescribe 90.2% of all palliative care-related medications in Queensland, with only 1.7% prescribed by palliative medicine specialists, and 8.1% prescribed by other clinicians.

Given that Western Queensland PHN has only 16.4 people per 100,000 receiving MBS specialist palliative medicine services, compared to the Queensland average of 63.3 per 100,000, together with minimal specialist physician presence in the region, it's likely that Western Queensland has an even higher proportion of GP-prescribed medications than the Queensland average. The region's 90%+ GP prescription rate at the state level likely approaches 95%+ in Western Queensland, with virtually all palliative medications prescribed by general practitioners rather than specialists.

This pattern demonstrates the critical role of GPs in palliative medication management in remote areas. The PBS Palliative Care Schedule specifically enables general practitioners to prescribe these medications without requiring specialist referral or approval, facilitating access in areas where specialists are unavailable.

PCSiA (2023) – Palliative care related medications

4. Prioritised Palliative Care Needs

This section presents a structured framework for prioritising the identified palliative care needs within the WQPHN region. In determining the strength of the need, we have made an assessment as to whether the need was evident in the population health data analysis, the stakeholder consultations, as well as aligned with National and State priorities and/or with findings from other research. Regarding GCfAHPC program influence, we have indicated a high/medium/low rating based on the potential for the GCfAHPC Program to make a meaningful contribution (even if partial), how aligned the identified need is with other WQPHN priorities, and the level of resourcing available to address the need.

A prioritisation outcome has subsequently been determined, based on both of these assessments, ensuring that decision-making is evidence-informed, resource-conscious, and strategically aligned with broader health priorities and program objectives.

Need evidence key	
Evident in population health data analysis	Multiple sources OR strong WQPHN specific data
	One or few sources OR National/State based data
	No data
Evident in stakeholder consultation	Multiple sources OR strong WQPHN specific data
	One or few sources OR National/State based data
	No data
Alignment with National/State priorities and/or other research	Yes
	No

GCfAHPC influence key	
GCfAHPC Program can make a meaningful contribution (even if partial)	High
	Medium
	Low
Alignment with another PHN focus area	High
	Medium
	Low
Resourcing available to address this need	High
	Medium
	Low

Scale Key: High Medium Low

Prioritisation outcome	
Tier 1a	**High need & high to medium potential for GCfAHPC contribution** There is strong evidence substantiating this need, and the GCfAHPC Program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this need as part of their planned future and commissioning processes under the GCfAHPC Program.
Tier 1b	**High Need & low to nil potential for GCfAHPC contribution** There is strong evidence substantiating this need, however the potential for the GCfAHPC Program to make a meaningful contribution (even if partial) is low or nil. There may be opportunities for WQPHN to partially influence this need via partnership, and/or advocacy.
Tier 2	**High need, outside of GCfAHPC remit** There is strong evidence substantiating this need; however, it is unable to be addressed within the remit of the GCfAHPC Program.
Tier 3	**Low to moderate need** There is low to moderate evidence substantiating this need. This may be due to the need being a lower and/or lesser priority, or it may be due to issues with data availability, collection and/or analysis. WQPHN should keep a watching brief on this need, with a view to exploring additional data if appropriate.

The tables below outline the prioritisation outcomes for each identified need, including the supporting evidence and assessment for prioritisation.

4.1. Potential opportunities

A key question within the WQPHN Stakeholder survey asked respondents to offer comment on what they believe may work to address the barriers they saw in their respective communities. Whilst many suggestions are well aligned with the objectives of the GCfAHPC program, consultation has also highlighted additional issues and emerging opportunities that fall outside the program's current scope and funding parameters. Acknowledging these broader concerns is important, as they point to areas where continued advocacy, strategic planning, and cross-system collaboration could be required. Where possible, these potential opportunities will be used to support the next phase of work to inform planning to address the prioritised needs and will be used to inform decisions about resource allocation under the GCfAHPC Program.

4.2. Partial Solutions

While the GCfAHPC program is not intended to resolve the deeper systemic challenges faced by rural and remote communities, it can make a meaningful contribution through strengthened coordination, education, and awareness. By improving linkages between locally available services, supporting workforce capability, and promoting earlier, more informed engagement with palliative care, the program provides practical contributions that ease some of the pressures created by geographical isolation, workforce shortages, and fragmented service pathways.

Identified Need 1	People in the WQPHN region experience a disproportionately high burden of disease and mortality, increasing the need for palliative care			
Need category	**Health**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation			■
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC program influence			■
	Alignment with another PHN focus area		■	
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 2	The WQPHN region has a severe shortage of specialist palliative care workforce			
Need category	**Workforce**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation		■	
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area		■	
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 3	Extremely low hospitalisation rates for palliative care in WQPHN place unsustainable pressure on community-based services and generalist clinicians			
Need category	**Service | Workforce**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation		■	
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area		■	
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 4	There is a lack of in-patient palliative care facilities available within the region			
Need category	**Infrastructure, Facilities and Equipment | Service**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis		■	
	Evident in stakeholder consultation		■	
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area			■
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 2:** There is strong evidence substantiating this need, however it is unable to be addressed within the remit of the GCfAHPC program			

Identified Need 5	Aboriginal and Torres Strait Islander people face additional cultural, geographic and systemic barriers to accessing appropriate palliative care
Need category	**Aboriginal and Torres Strait Islander**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1a:** There is strong evidence substantiating this need, and the GCfAHPC program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this needs as a part of their planned future and commissioning processes under the GCfAHPC program			

Identified Need 6	Geographic isolation and vast distances hinder access to palliative care
Need category	**Remoteness**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 2:** There is strong evidence substantiating this need, however it is unable to be addressed within the remit of the GCfAHPC program			

Identified Need 7	Low awareness and health literacy about palliative care service options in the community
Need category	**Health Literacy**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation	■		
	Alignment with National/State priorities/ research	■		
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)	■		
	Alignment with another PHN focus area	■		
	Resourcing Available to address this need	■		
Prioritisation outcome	**Tier 1a:** There is strong evidence substantiating this need, and the GCfAHPC program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this need as a part of their planned future and commissioning processes under the GCfAHPC program			

Identified Need 8	Fragmented care coordination and unclear service pathways
Need category	**Service**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			■
	Evident in stakeholder consultation		■	
	Alignment with National/State priorities/ research	■		
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area		■	
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 9	Fragmented care coordination and unclear service pathways			
Need category	**Service**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 10	Insufficient support for family caregivers – both before and after a person's death			
Need category	**Service**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1a:** There is strong evidence substantiating this need, and the GCfAHPC program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this need as a part of their planned future and commissioning processes under the GCfAHPC program			

Identified Need 11	Telehealth infrastructure in rural and remote areas is inadequate, restricting timely and effective access to palliative care services and specialist support
Need category	**Infrastructure, Facilities and Equipment | Remoteness**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation	■		
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area		■	
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 2:** There is strong evidence substantiating this need, however it is unable to be addressed within the remit of the GCfAHPC program			

Identified Need 12	Current investment in palliative care services is inadequate to meet the needs of the community
Need category	**Funding**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis	■		
	Evident in stakeholder consultation			■
	Alignment with National/State priorities/ research		■	
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			■
	Alignment with another PHN focus area			■
	Resourcing Available to address this need			■
Prioritisation outcome	**Tier 2:** There is strong evidence substantiating this need, however it is unable to be addressed within the remit of the GCfAHPC program			

Identified Need 13	The low confidence and knowledge of some healthcare providers delays conversations about palliative care and reduces early engagement
Need category	**Service | Health**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1a:** There is strong evidence substantiating this need, and the GCfAHPC program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this need as a part of their planned future and commissioning processes under the GCfAHPC program			

Identified Need 14	Clinicians in Western Queensland experience greater challenges accessing specialist support, clinical resources and complex care pathways compared to their urban counterparts
Need category	**Workforce | Remoteness**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 15	Clinicians providing palliative care experience emotional fatigue due to the challenging nature of the work			
Need category	**Workforce**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 16	Interventions in the final 12 months of life are not serving to improve quality of life for patients, family and carers			
Need category	**Health**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 17	Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life
Need category	**Health**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1a:** There is strong evidence substantiating this need, and the GCfAHPC program can make a meaningful contribution (even if partial). WQPHN should consider actions to address this need as a part of their planned future and commissioning processes under the GCfAHPC program			

Identified Need 18	Some populations within the WQPHN region experience compounding barriers which increases the complexity and difficulty in delivering palliative care interventions
Need category	**Health**

Scale		High	Medium	Low
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

Identified Need 19	General practitioners in the WQPHN region require greater support as they carry substantial responsibility for delivering palliative care in the context of limited access to specialist resources			
Need category	**Workforce**			
Scale		**High**	**Medium**	**Low**
Evidence strength	Evident in population health data analysis			
	Evident in stakeholder consultation			
	Alignment with National/State priorities/ research			
GCfAHPC influence	GCfAHPC Program can make a meaningful contribution (even if partial)			
	Alignment with another PHN focus area			
	Resourcing Available to address this need			
Prioritisation outcome	**Tier 1b:** There is strong evidence substantiating this need, however the potential for the GCfAHPC program to make a meaningful contribution (even if partial) is low or nil. There may be opportunity for WQPHN to partially influence this need via partnership and/or advocacy.			

5. Next Steps

The next steps for the PHN will focus on using the insights and prioritised needs identified in this updated Palliative Care Health Needs Assessment (HNA) to engage with local communities. Through genuine consultation, the PHN will gather community perspectives to help guide the planning and commissioning of services under the GCfAHPC Program, beginning in July 2026. It is essential for the PHN to acknowledge the limitations of the GCfAHPC Program and to manage community expectations respectfully and realistically regarding what can be delivered. By taking this approach, service design and implementation will be both responsive to local needs and priorities, and achievable with available resources, while remaining firmly grounded in authentic community collaboration

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PAVING OUR WAY POW26

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An Australian Government Initiative

Certification Oceania

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Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community. We pay our respect to them and their cultures and to elders past and present.