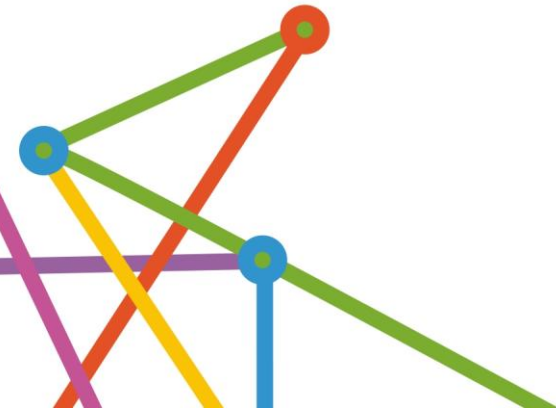


# Palliative Care Needs Assessment

January 2026



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## Abbreviations and acronyms

<b>Abbreviation</b>	<b>Full term</b>
<b>ACCHS</b>	Aboriginal Community Controlled Health Service
<b>ACCO</b>	Aboriginal Community Controlled Organisation
<b>ACHWA</b>	Aboriginal Health Council of Western Australia
<b>ACP</b>	Advance Care Planning
<b>ACCRM</b>	Australian College of Rural and Remote Medicine
<b>After-hours</b>	Timeframes that sit outside of standard business hours
<b>AHD</b>	Advance Health Directive
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>ASR</b>	Age-standardised rate
<b>ED</b>	Emergency department
<b>ERP</b>	Estimated resident population
<b>FTE</b>	Full-time equivalent
<b>GCfAHPC</b>	Greater Choices for At Home Palliative Care program
<b>GP</b>	General Practitioner
<b>PHN</b>	Primary Health Network
<b>MPaCCS</b>	Metropolitan Palliative Care Consultancy Service
<b>PaICATS</b>	Palliative Care After-Hours Telehealth Service
<b>PCOC</b>	Palliative Care Outcomes Collaboration
<b>PCWA</b>	Palliative Care Western Australia
<b>PWG</b>	Project Working Group
<b>CQI</b>	Continuous Quality Improvement
<b>RACH</b>	Residential aged care home
<b>RACGP</b>	Royal Australian College of General Practitioners
<b>SA3</b>	Statistical Area 3
<b>SPICT</b>	Supportive and Palliative Care Indicators Tool
<b>WA</b>	Western Australia
<b>WACHS</b>	Western Australia Country Health Service
<b>WAVED</b>	WA Virtual Emergency Department

# Executive Summary

The Palliative Care Needs Assessment (**Needs Assessment**) responds to the requirements of the Greater Choices for At Home Palliative Care (**GCfAHPC**) and After-Hours Primary Health Care programs, funded by the Australian Government Department of Health Disability and Ageing.

Based on the collection and analysis of quantitative and qualitative data, the Needs Assessment summarises the current strengths, barriers, and service gaps in palliative care across the three Primary Health Networks (**PHNs**) operated by WA Primary Health Alliance (WAPHA) in Western Australia (**WA**), focusing on the after-hours period.

After-hours was a deliberate addition to WAPHA’s update of the Palliative Care Needs Assessment based on themes identified through our work to date in our Greater Choices for at Home Palliative Care program.

These themes include:

1. People living with life-limiting illness and who are likely to die in the next 12 months, commonly experience crisis events that result in potentially preventable hospitalisations.
2. Current eligibility criteria for community specialist palliative care services that offer 24-hour support is limited by prognosis timeline of three months, which disadvantages people living with a life-limiting condition where prognostication is less predictable. Therefore, access to afterhours advice and support is limited.
3. GPs are well positioned to provide a palliative approach to people living with a life-limiting condition but do not routinely screen for unmet palliative care needs and do not have a consistent approach to anticipatory care planning that provides a strategy to access support in the afterhours period.
4. Home Care Package (HCP) providers caring for people living with a life-limiting illness may offer some support in the after-hours period, but their hours of service are commonly limited to business hours.

To support choice to remain at home for as long as possible or to choose to die at home, the needs of people living with a life limiting illness require consideration of access to care beyond the standard operating hours of services outside the hospital setting.

This Needs Assessment provides an evidence base for the planning and commissioning of services and builds on the extensive work already undertaken since the previous Needs Assessment in 2022.

The Needs Assessment identified seven key recommendations (see **Table 1** below), which outline how WAPHA can address gaps in palliative care service provision, strengthen coordination between services, and build consistency and capacity within the current and future service landscape. It is important that WAPHA effectively identifies, understands and prioritises the needs in each PHN to support place-based service design and the commissioning of appropriate and tailored solutions.

**Table 1:** Needs Assessment Recommendations

No.	Recommendation	Justification	Relevant program	Opportunities
1	<b>Improve community literacy of end-of-life care, including advance care planning (ACP)</b>	Communities demonstrate ongoing misconceptions about end-of-life and palliative care, which can limit early uptake and utilisation of ACP	GCfAHPC	1.1 Continue to support local, place-based community awareness activities to increase knowledge and understanding of the importance of ACP and end-of-life care ( <b>all PHNs</b> ). 1.2 Continue to focus on workforce capacity and capability to support access to

				<p>earlier ACP and recognition of unmet palliative care need (<b>all PHNs</b>).</p> <p>1.3 Build workforce capacity relating to the use of evidence based palliative care screening tools that align with the Support at Home program eligibility criteria.</p>
2	<p><b>Provide targeted support to under-served population groups to improve palliative care literacy and equitable access to services</b></p>	<p>Individuals from under-served population groups face unique barriers to accessing palliative care services that are aligned with their choices and preferences</p>	GCfAHPC	<p>2.1 Promote existing resources to support under-served population groups (e.g. people living with dementia) that would benefit from ACP and palliative care awareness (<b>all PHNs</b>).</p> <p>2.2 Where there are gaps in resources, develop and share tailored resources for under-served population groups with partner organisations (<b>all PHNs</b>).</p> <p>2.3 Increase the uptake of interpreter involvement in discussions related to palliative care (<b>Perth North PHN and Perth South PHN</b>).</p> <p>2.4 Co-design and pilot new models of care that enhance referral pathways between adjacent sectors (e.g. homelessness, disability services) and specialist palliative services to increase access to palliative care (<b>Perth North PHN and Perth South PHN</b>).</p>
3	<p><b>Provide tailored support to families, carers, kin and supporters who play a critical role in enabling quality palliative care at home and in the community</b></p>	<p>Families, carers, kin and supporters play a critical role in enabling quality palliative at home and in the community but lack support for their social and emotional wellbeing</p>	GCfAHPC	<p>3.1 Strengthen awareness of palliative care support that can be provided under the Support at Home program, particularly for carers (<b>all PHNs</b>).</p> <p>3.2 Following 3.1, work in collaboration with key stakeholders to develop awareness raising campaigns to increase uptake of existing (or new) support services for carers, including bereavement care (<b>all PHNs</b>).</p>

4	<b>Support the earlier recognition of unmet palliative care needs, including referrals to specialist palliative care services through the promotion of validated assessment tools</b>	Access to palliative care services varies for individuals in both timing and level of care	GCfAHPC	<p>4.1 Continue to build capacity and capability in general practice to embed evidence based palliative screening tools into routine care of people with advanced chronic conditions (<b>all PHNs</b>).</p> <p>4.2 Enhance communication between specialist and generalist palliative care services through advocacy for timely sharing of clinical information and improved use of My Health Record (<b>all PHNs</b>).</p>
5	<b>Build the capacity and capability of current and future generalist palliative care service providers through investment in GP professional development and capability building</b>	The confidence and capability of GPs to deliver generalist palliative care services varies, with contributing factors including access to training, experience, and clarity of roles between GPs and specialist providers	GCfAHPC	<p>5.1 Work in collaboration with RACGP and ACCRM to promote the role of generalist palliative care as an aspect of general practice (<b>all PHNs</b>).</p> <p>5.2 Expand activities that currently focus on the implementation of ACP and palliative care screening tools as part of routine care in general practice (<b>all PHNs</b>).</p> <p>5.3 Co-design a formalised approach to 'shared care' with key partners to manage the needs of people with a complex chronic condition whose life expectancy is 12 months or less (<b>all PHNs</b>).</p>
6	<b>Design and pilot care coordination models to address the holistic needs of patients, families, kin and supporters</b>	The holistic needs of patients and their families, carers, kin and supporters are not effectively met through current care models, resulting in the increased risk of unplanned emergency department ( <b>ED</b> ) presentations and reduced choice to remain at home for end-of-life care	GCfAHPC	<p>6.1 Co-design models of care that can be piloted between generalist and specialist palliative care services to provide holistic, multidisciplinary care and that enables knowledge sharing and increases service capacity (<b>all PHNs</b>).</p> <p>6.2 Increased awareness of existing MBS item numbers that support care coordination (<b>all PHNs</b>).</p>
7	<b>Raise awareness of, and advocate for, models that provide 24/7 palliative care support</b>	There are gaps in after-hours service provision, particularly in Country WA, and for patients who are not already engaged in specialist palliative	GCfAHPC & After-Hours	<p>7.1 Raise awareness about available options for after-hours palliative care support for general practice (<b>all PHNs</b>).</p> <p>7.2 Explore opportunities to build the capacity and capability</p>

		care services	<p>of after-hour services, such as GP locums and Medicare Urgent Care Clinics, to recognise and respond to palliative care needs <b>(all PHNs)</b>.</p> <p>7.3 Enhance current approaches to anticipatory care by working with general practice to implement a consistent approach to after-hours management planning for people with complex chronic conditions whose life expectancy is 12 months or less <b>(all PHNs)</b>.</p> <p>7.4 Explore the current availability of palliative care core medications during the after-hours period and develop opportunities to increase availability within each PHN <b>(all PHNs)</b>.</p> <p>7.5 Support 24/7 models of palliative care, which may involve collaboration between generalist and specialist palliative care providers, to avoid crisis-driven ED presentations <b>(Country WA PHN)</b>.</p> <p>7.6 Partner with key stakeholders to expand the use of telehealth specialist support services, particularly during the after-hours period <b>(all PHNs)</b>.</p>
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These recommendations have been mapped to proposed SMART goals (see Appendix 1).

# Introduction

## 1.1 Context

WA Primary Health Alliance (WAPHA) is the operator of the three Primary Health Networks (**PHNs**) in Western Australia (**WA**): Perth North PHN, Perth South PHN, and Country WA PHN. WA's health system is recognised as the largest single area health system in the world by geographical size, covering over 2.5 million square kilometres. Through its state-wide structure and strong partnerships, WAPHA aims to strengthen, improve and connect the primary care system and our approach is informed by the completion of needs assessments.

In 2025, WAPHA engaged Impact Co. to conduct an updated Palliative Care Needs Assessment (referred to as the **Needs Assessment** hereafter), focusing on supports in the after-hours period and the experience of under-served population groups (e.g. people experiencing homelessness). The purpose of this Needs Assessment is to build stronger evidence base for planning and commissioning services across the three PHNs in WA.

The Needs Assessment has been funded by the Australian Government through two program initiatives – GCfAHPC, and After-Hours Primary Health Care.

The GCfAHPC program aims to increase access to quality palliative care at home and in the community over four years from 2025-26 to 2028-29. The objectives of the GCfAHPC initiative are to:

- Increase awareness (workforce and community) of and access to safe, quality palliative care at home and support end-of-life care systems and services in primary health and community care.
- Enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations.
- Generate and use data to support continuous improvement of services across sectors.
- Use available technologies to support flexible and responsive palliative care at home, including in the after-hours period.

The objectives of GCfAHPC align strongly to those of the After-Hours Primary Health Care program, which aims to improve service availability and integration, including for people approaching the end-of-life, in the after-hours period.

## 1.2 About palliative care

*“Palliative care is person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life. Palliative care helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness.” – Palliative Care Australia, 2024*

The medical management and coordination of care for people living with a life-limiting illness may be undertaken by a wide range of health professionals including GPs, geriatricians, oncologists, paediatricians, other specialists, nurses, allied health professionals and pharmacists.

Palliative care can be categorised as generalist or non-specialist – which is provided by professionals who are not trained in the palliative care specialty, and specialist – which is provided by professionals who have undergone specific training in palliative care or medicine (Iupati et al., 2023). Specialist palliative care settings can include acute hospitals, outpatient clinics, the home and hospices.

Generalist or non-specialist palliative care is provided by primary healthcare professionals - such as

GPs, community nurses and allied health staff, to patients with life-limiting illness and their families. These services provide a palliative approach for people with uncomplicated needs associated with a life-limiting illness and/or end of life care. Generalist providers have a critical role in identifying unmet palliative care need and triggering timely access to specialist palliative care services when necessary.

There are many myths associated with palliative care (such as the belief that palliative care is limited to individuals with a cancer diagnosis), that continue to impact on timely access to appropriate care which commonly results in an absence of end-of-life planning and choice regarding preferred place of care and/or death (Palliative Care Australia, 2018).

### 1.3 Progress from the last Needs Assessment

**Table 2** outlines the five areas of needs identified in the 2022 GCfAHPC Needs Assessment that informed WAPHA’s development of the GCfAHPC program of activities.

**Table 2:** Needs identified in the 2022 GCfAHPC Needs Assessment

No.	Needs
1	To promote a systematic approach, including the use of the “surprise question” ( <i>Would you be surprised if your patient died in the next year?</i> ) to support the recognition of palliative care need in general practice.
2	There is a need to survey generalist palliative care providers to establish their palliative care educational needs and to use this information to deliver a coordinated approach to palliative care training.
3	To develop a continuous quality improvement ( <b>CQI</b> ) activity relating to ACP that supports improved uptake of ACP at routine health assessments for non-Aboriginal and Aboriginal people.
4	To promote culturally appropriate information relating to ACP to Aboriginal people with chronic conditions by developing awareness of ACP and the benefits of palliative care with Aboriginal health workers.
5	There is a need to increase awareness of ACP and the benefits of palliative care within the communities of the Goldfields. There is also a need to support GPs to identify palliative care need within their patient population and develop a plan of care that reflects the generalist palliative care role.

Since the completion of the previous GCfAHPC Needs Assessment in 2022, WAPHA has delivered and/or is currently delivering several activities that align with the GCfAHPC objectives. These include:

- Various initiatives to increase the uptake of advance care planning, including the Palliative Care Champions Pilot and subsequent Palliative Care Champions projects.
- Addressing the ACP and palliative care information needs of people living with sensory loss.
- Improving community awareness and understanding about ACP and palliative care services, including with various priority populations.
- Establishing streamlined referral pathways through Clinician Assist to support place-based service finding.
- Assessment of ACP and palliative care understanding and capability in Aboriginal Community Controlled Health Services (**ACCHSs**) in WA.

# Methodology

## 2.1 Methodology summary

This Needs Assessment used a staged, sprint-based approach overseen by a project working group with Impact Co. and WAPHA.

The project combined quantitative data analysis, literature and policy review, and service mapping to assess the need, demand, supply and gaps in palliative care across the three PHN catchments in WA. In-depth consultation was conducted with service providers, system stakeholders and community representatives to further understand the barriers, enablers and opportunities for improvement. The data collected was then synthesised into a set of recommendations, which were refined through a validation workshop.

**Appendix 2** provides a more detailed description of the methodology.

## 2.2 Summary of inputs

In total, Impact Co. facilitated 34 hours of consultations with 51 participants (**Table 3** outlines represented organisations).

This included:

- **25 in-depth interviews with 35 participants**
- **Three community focus groups with nine participants**
- **Three GP focus groups with seven GPs**

**Table 3:** Organisations represented in consultations

Organisation type	Name of organisation
Specialist palliative care	<ul style="list-style-type: none"><li>• Palliative Care Outcomes Collaboration (<b>PCOC</b>)</li><li>• Silverchain</li><li>• Western Australia Country Health Service (<b>WACHS</b>)</li><li>• Metropolitan Palliative Care Consultancy Service (<b>MPaCCS</b>)</li><li>• WA Palliative Medicine Specialist Group (<b>WAPMSG</b>)</li></ul>
Peak body or government	<ul style="list-style-type: none"><li>• Palliative Care WA</li><li>• Palliative Care Team at WA Health</li><li>• Carers WA</li><li>• Pharmacy Guild of Australia</li></ul>
Primary health care provider	<ul style="list-style-type: none"><li>• GP Collaborative, Albany</li><li>• Community pharmacist</li><li>• Arche Health</li></ul>
Consumer services	<ul style="list-style-type: none"><li>• Linkwest</li></ul>
Homelessness	<ul style="list-style-type: none"><li>• St Barts</li><li>• Homeless Health Care</li></ul>
Emergency services	<ul style="list-style-type: none"><li>• St Johns WA</li><li>• WA Virtual Emergency Department</li></ul>
Aged care	<ul style="list-style-type: none"><li>• Ageing Australia</li><li>• Residential Aged Care Line</li></ul>

Community-based support	<ul style="list-style-type: none"> <li>Compassionate Communities Australia</li> </ul>
Aboriginal-led organisations	<ul style="list-style-type: none"> <li>Aboriginal Health Council of Western Australia (<b>AHCWA</b>)</li> <li>Elder Care Support Program as part of AHCWA</li> </ul>
Dementia	<ul style="list-style-type: none"> <li>Dementia Australia</li> </ul>

## 2.3 Composite Index Approach

A composite index was developed to identify priority locations with the greatest need for palliative care, emulating the Australian Institute of Health and Welfare's (**AIHW**) mortality condition-specific approach.

The composite index considers population estimates for those in need of palliative care, based on health conditions most associated with predictable deaths, alongside population ageing and measures of socioeconomic disadvantage. Normalised indicator scores were summed to produce a Palliative Care Need Score for each SA3.

**Appendix 2** provides a full list of the data indicators that informed the composite index calculation.

## 2.4 Limitations

Two key limitations during the development of this Needs Assessment were identified. These, along with the respective mitigation strategies, are outlined below.

- **Limited representation from individuals with a lived or living experience.** Due to the sensitivities related to the service area, there is a lack of representation from people living with a life limiting illness and/or their family/ carers.

*How this was mitigated:* To obtain the consumer or lived experience perspective, engagement occurred with stakeholders who are well placed to provide insights into the needs of people living with a life limiting illness, namely Community Resource Centres located in regional and remote parts of the Country WA PHN and their peak body Linkwest as well as Carers WA. Engagement included representatives from 6 Community Resource Centres and two-Family Centres, facilitated by Linkwest. WAPHA has developed an initiative to build community capacity and capability relating to end-of-life planning by partnering with Linkwest and Palliative Care WA. This initiative is in its second year and will result in 46 out of 150 Community & Neighbourhood Centres having expanded their scope to include promoting awareness and coordinating access to ACP resources and support. Some of the Centres who engaged in our interviews are/have been through the Greater Choices program. These centres are engaged with community members to promote ACP and understand the role of palliative care in supporting people with a life limiting illness and how to signpost local access to palliative care services.

- **Availability of service supply data.** There is currently no available dataset that quantifies the level of support provided by generalist palliative care services providers across WA or Australia. There are also no Medicare Benefit Schedule items or proxies that are suitable to estimate the number of GPs who provide palliative care supports to their patients. Additionally, there were data suppressions relating to palliative care medical practitioner workforce data.

*How this was mitigated:* The rate of full-time equivalent (**FTE**) GPs per 100,000 estimated resident population (**ERP**) was adopted as a proxy to estimate the number of generalist palliative care service providers. However, there is significant variation in the level of generalist palliative care delivered by each GP and the degree to which other health

disciplines are involved in delivering generalist care. As a result, service supply was not included in the composite index but informed by stakeholder consultation instead. Consultation was sought through a variety of approaches including seven focus groups with primary health providers, a GP panel, and interviews with SPC service providers, peak bodies and community service providers.

## The current service landscape

This section provides an overview of the current palliative care service landscape in WA, considering both generalist and specialist palliative care.

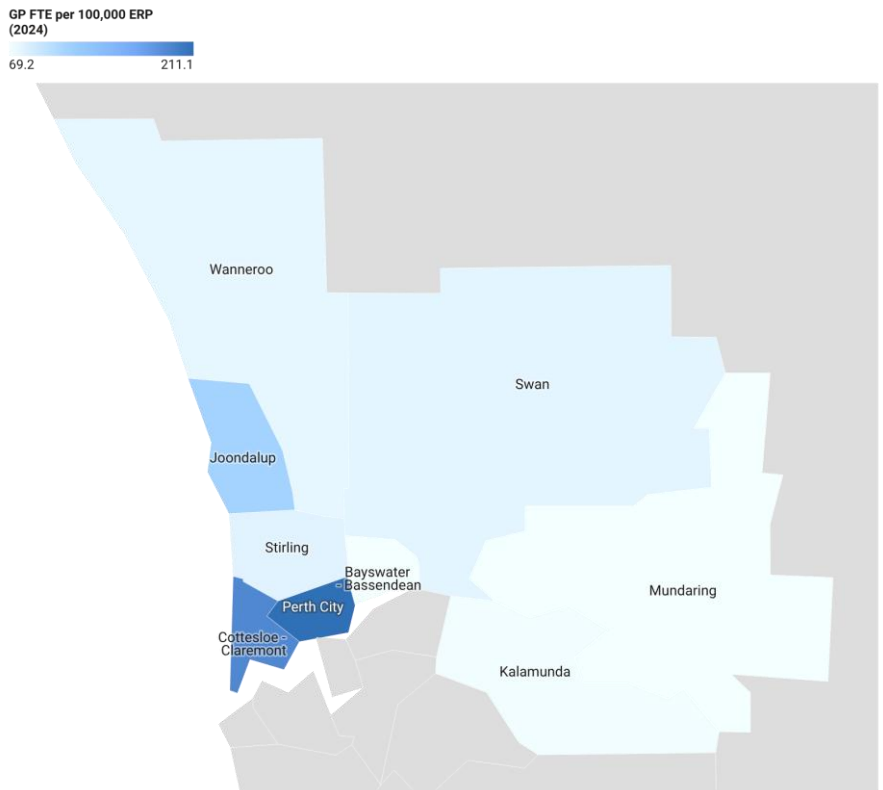
Please note:  
FTE is insufficient by itself to infer access to palliative care. People who live in the same location(s) where palliative care workers are based do not necessarily have greater access to care. Conversely, whilst we recognise that palliative care workforce provides services beyond the physical locations of where they are based, the reality remains that patients who must travel longer distances to those services face additional challenges in accessing the care they need. This is especially relevant for under-served populations or patients who are very unwell, as these challenges may act as a barrier preventing or delaying access to the care they need

### 3.1 Generalist palliative care in WA

Due to data limitations, this analysis could not directly estimate generalist palliative care service provision in WA. Instead, the analysis used FTE GPs per 100,000 population as a proxy measure for the basis of comparison across PHN regions. These figures represent workforce distribution rather than actual availability of GP services or access to care. In metropolitan areas, higher GP FTE rates generally reflect greater workforce concentration, whereas outer-metropolitan and regional areas tend to have lower GP supply. In some remote regions, GP FTE may appear high on a per-capita basis due to small population denominators and co-located service models, however this does not necessarily indicate greater service depth or accessibility. As such, GP FTE figures should be interpreted as an indicator of potential capacity for GP-led generalist palliative care service provision, rather than a direct measure of availability. It should also be noted that access to care is impacted by several factors including the immense geographical spread in each PHN, and that the provision of generalist palliative care support by GPs is variable.

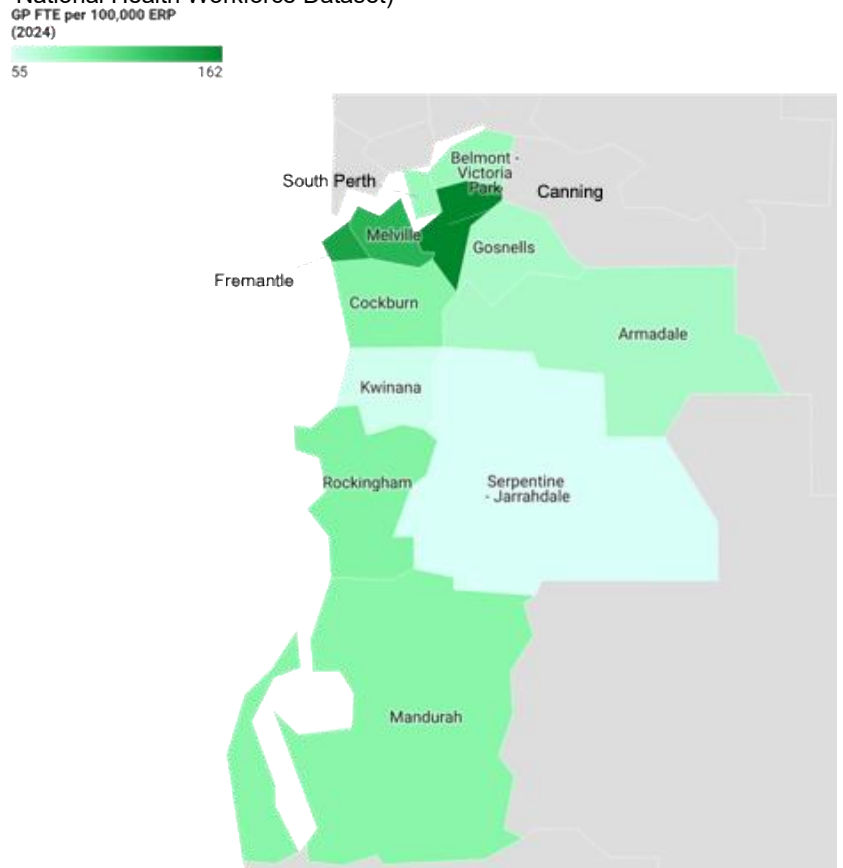
- Perth North PHN** – The number of GPs varied considerably across the Perth North PHN region. The Perth City SA3 had the highest rate with 211.1 GP FTE per 100,000 population, followed by Cottesloe – Claremont (191.8). In comparison, Bayswater – Bassendean had the lowest rate with 69.2.

**Figure 1:** GP FTE per 100,000 population across Perth North PHN (2024, National Health Workforce Dataset)



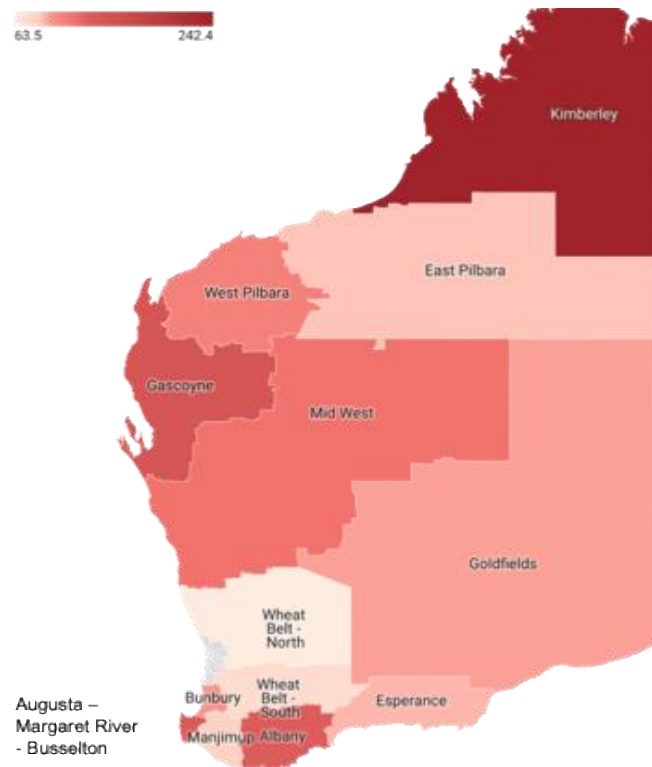
- Perth South PHN** – The highest rate of GPs was in Canning (162.2), which was three times higher than the lowest rate in Serpentine – Jarrahdale at 55.1. Fremantle and Melville also have high rates of GPs.

**Figure 2:** GP FTE per 100,000 population across Perth South (2024, National Health Workforce Dataset)



- Country WA** – The Kimberley recorded the highest rate of GPs at 242.4, which was 70 per cent higher than the second highest rate in Gascoyne (142.5). The lowest rates were found in Wheatbelt – North (63.5) and Wheatbelt – South (75.2).

**Figure 3:** GP FTE per 100,000 population across Country WA (2024, National Health Workforce Dataset)



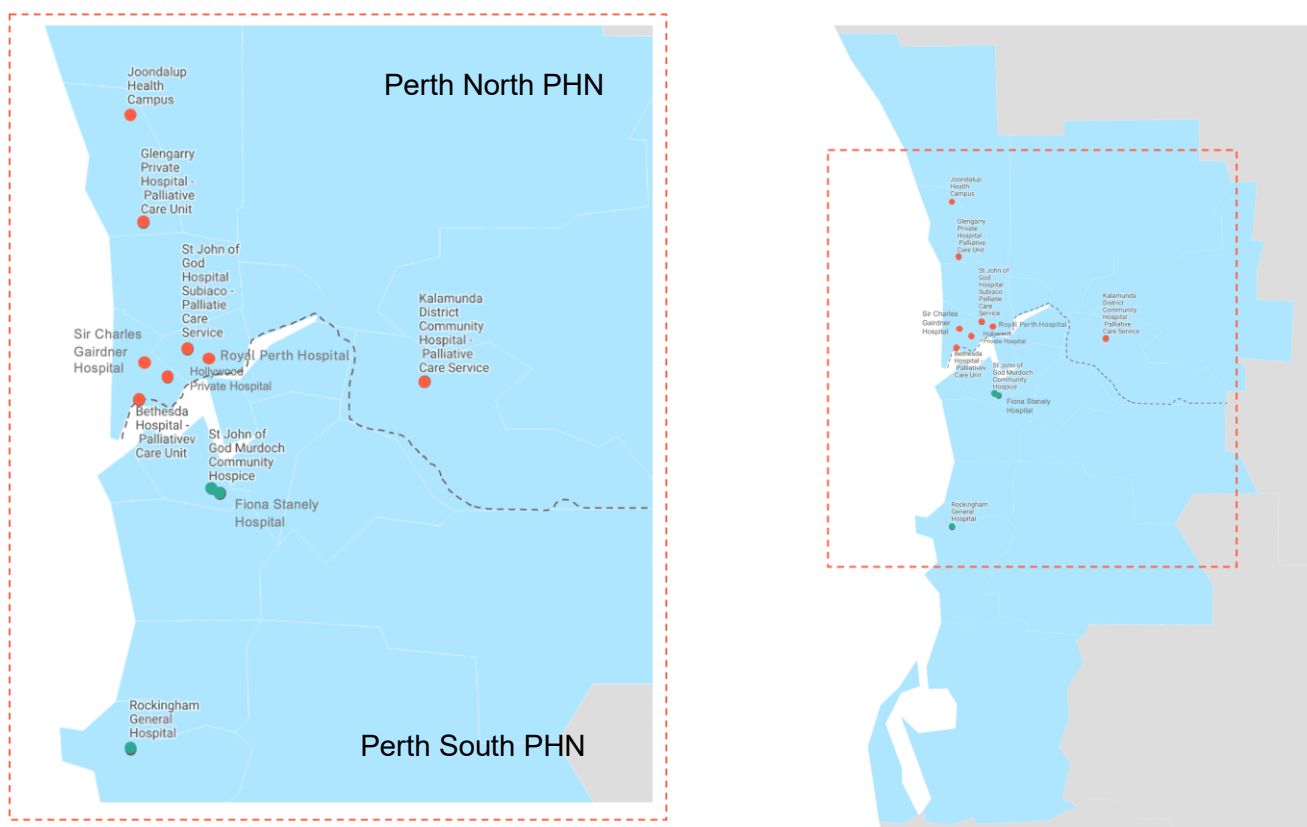
### 3.2 Specialist palliative care in Perth North and Perth South PHNs

The following specialist palliative care services provide care in the Perth North PHN and Perth South PHN catchments:

- eight hospitals/acute settings, including four private hospitals and four public hospitals.
- five hospices/palliative care units (all of which are associated/co-located with hospitals)
- two services that provide support in community and home settings, including MPaCCS, who provide consultancy support in residential aged care homes (RACHs) and other settings, and Silverchain who support people at home.

While residents across both PHNs can access these services, there are limited services physically located in Perth South PHN, as depicted in **Figure 4**. Within the Perth South PHN catchment, Serpentine – Jarrahdale SA3 has no hospitals or hospices, as well as the lowest rate of GPs (refer to **Figure 2**). Collectively, this indicates a lack of available palliative care services, as well as a geographical barrier to accessing services on physical sites (e.g. hospices and outpatient clinics) for residents in the outskirts of the Perth South PHN catchment.

**Figure 4:** Service mapping of specialist palliative care services in Perth North PHN and Perth South PHN



### 3.3 Specialist palliative care in Country WA PHN

WACHS delivers seven specialist palliative care services in the Country WA PHN catchment, as well as 15 district health campuses that act as hubs for sub-regional health district services (outlined in **Table 4**; WACHS, 2025).

Access to in-patient palliative care services exists in four of the seven sub-regions. These services vary in terms of capacity and capability ranging from single rooms dedicated to the care of people requiring palliative care in the Pilbara to a purpose-built 8-bed hospice in Albany. **Table 4** provides a comprehensive view of palliative care services for each region.

**Table 4:** Specialist Palliative Care Services delivered by WACHS in Country WA<sup>1,2</sup>

Specialist palliative care service	Service features
Great Southern Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service – community, regional hospitals, nursing points, RACH</li> <li>• Outpatient clinic</li> <li>• Albany Hospice (Specialist Palliative Care)</li> <li>• Phone/videoconference available</li> </ul>
South-West Regional Palliative Care	<ul style="list-style-type: none"> <li>• Consultancy service – community</li> <li>• Outpatient clinic including telehealth</li> <li>• Access to inpatient care – Busselton Hospice Unit (generalist palliative care) and St John of God Hospital Palliative Care Unit Bunbury (Specialist Palliative Care)</li> </ul>
Goldfields Regional Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service – Kalgoorlie, Esperance, Leonora and Laverton Hospitals, community including RACH</li> <li>• Community – Kalgoorlie, Coolgardie, Kambalda, Esperance</li> <li>• Outpatient services via Kalgoorlie Health Campus</li> </ul>
Kimberley Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service including via telehealth</li> </ul>
Midwest Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service – community, residential care facilities and regional hospitals, nursing posts and Aboriginal Medical Services</li> <li>• Outpatient clinic – Geraldton, Carnarvon and telehealth</li> <li>• St John of God (Geraldton) Hospice (Specialist Palliative Care)</li> </ul>
Pilbara Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service – community, Aboriginal Medical Services and nursing posts</li> <li>• Outpatient clinic – Port Hedland and Karratha</li> <li>• Access to inpatient – Hedland Health Campus, Karratha Health Campus, Roebourne Hospital</li> </ul> <p>**NB The Pilbara Palliative Care service is delivered through a partnership arrangement between WACHS Palliative Care Service and Bethesda Health Care (based in Perth metropolitan area).</p>
Wheatbelt Palliative Care Service	<ul style="list-style-type: none"> <li>• Consultancy service – community, RACH and regional hospitals</li> <li>• Outpatient Clinic</li> <li>• Generalist community nurse</li> </ul>

*Dependency on primary health infrastructure*

In regions where there is limited presence/capacity of primary health services (e.g. Wheatbelt North and Wheatbelt South as depicted in **Figure 3**), the quality of palliative care services, who rely on primary health support (particularly in remote areas), is impacted.

<sup>1</sup> All information sourced from Department of Health WA Service Summary sheets. Not all specified service locations were available or could be identified.

<sup>2</sup> There are a number of small local hospitals across Country WA PHN that may provide care for people approaching end of life. This care is commonly managed by the local GP who has access to advice from WACHS Specialist Palliative Care Team.

### Referrals into WACHS specialist palliative care

WACHS specialist palliative services accept referrals from all healthcare professionals, not just GPs. Additionally, stakeholders highlighted that WACHS specialist palliative services also accept self-referrals from patients and/or their family/carers; however, this represents a small percentage of their total referrals.

### After-hours support

Of WACHS seven specialist services, only the Midwest Palliative Care Service advertises as providing services during the after-hours period, including telephone or telehealth advice to the Midwest area after-hours. As well as telephone/telehealth support, this service offers in-home visits to patients located in the town of Geraldton. However, stakeholder consultations indicated that all WACHS specialist services have access to other after-hours advice or guidance phone lines when a regional palliative care specialist team is not available (see **Table 5** for details).

## 3.4 After-hours palliative care advice and support

**Table 5** summarises the after-hours phone services providing palliative care advice and support to practitioners in WA, as well as their key characteristics.

There are more after-hours palliative care options in the Perth North PHN and Perth South PHN catchments compared to Country WA PHN. However, current services are mainly directed at health practitioners rather than patients or their families. Where patient or carers can access clinical advice and support, this is only available to patients already known to the service.

Stakeholder engagement highlighted three points for consideration:

1. Healthcare awareness of these after-hours services could be strengthened.
2. 000 is frequently the only option for people approaching end of life who are not known to a palliative care service.
3. For patients not known to palliative care services, some are engaging with private after-hours telehealth GP services. The palliative care capacity and capability of these services is unknown.

**Table 5:** Current after-hours phone services and their key characteristics

Services	Hours	Available to practitioners	Available to patients and families	Relevant PHN
MPaCCS	Monday to Friday 4.00pm – 7.30pm	X		Perth North PHN, Perth South PHN
WA Palliative Care Outreach Service (aka 1300 OUTREACH)	24/7	X		Statewide
Silverchain	24/7 on-call service for existing patients	X	X	Perth North PHN, Perth South PHN
Residential Care Line	Monday to Sunday 8.00am – 6.00pm	X		Perth North PHN, Perth South PHN
WACHS Palliative Care Service	Monday to Sunday 8.30am – 4.30pm For existing patients	X	X	Country WA PHN – Great Southern only

Great Southern				
WACHS Palliative Care Midwest	Phone or telehealth support to with in-home visits provided to Geraldton catchment area for existing patients	X	X	Country WA PHN - Midwest only
WA Virtual Emergency Department (WAVED)	Monday to Sunday 8.00am – 8.00pm	X	X	Perth North PHN, Perth South PHN and Greater Bunbury area in the Southwest region of Country WA PHN
Palliative Care After-Hours Telehealth Services (PaLCATS)	Monday to Sunday until midnight for existing patients	X	X	Country WA PHN
WA Paediatric Palliative Care Service	After-hours support is available to existing patients	X	X	Statewide

### 3.5 Summary of key findings

<p><b>Perth North PHN:</b> There is a limited GP workforce in the outskirts of the catchment. Most of the specialist palliative care services in metropolitan Perth are based in this catchment.</p> <p><b>Perth South PHN:</b> All three specialist services in this catchment are centrally located, posing geographic barriers for SA3s in the outskirts. GP rates are also low in these areas (e.g. Serpentine – Jarrahdale) compared to the rest of the catchment.</p> <p><b>Country WA PHN:</b> There are limited after-hours services physically located in the catchment. After-hours telehealth options are available; however, they are focused on existing palliative care patients and are not accessible to the public. WACHS accept referrals from health professionals, patients, and/or their family/carers, unlike other Specialist Palliative Care providers that require a medical referral. This approach supports increased accessibility and timeliness of care.</p>
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## Key priority locations for palliative care in WA

Quantitative data was analysed to inform a targeted approach to palliative care investment based on measured need and equity and will provide WA Primary Health Alliance with guidance on decisions regarding where activities should be commissioned.

To assess the relative demand in each SA3 across the three PHN catchments, a composite index was created to identify priority locations with the greatest need for palliative care by assessing the relative need in each SA3 relative to each other. Referred to as a Palliative Care Need Score, this composite index was calculated to synthesise quantitative data reflecting the following drivers for palliative care service need:

- ageing population
- death rates and their underlying causes
- variation across population groups (e.g. socioeconomic status).

Further detail on the key drivers of palliative care service need, including for each PHN catchment, can be found in **Appendix 3**.

Based on the results of the Palliative Care Need Score, the priority locations for palliative care in each PHN are:

Priority locations (SA3)			
	Perth North PHN	Perth South PHN	Country WA PHN
1	Stirling	Mandurah	Kimberley
2	Wanneroo	Rockingham	Goldfields
3	Joondalup	Gosnells	East Pilbara

Further detail on the results for each PHN is provided below.

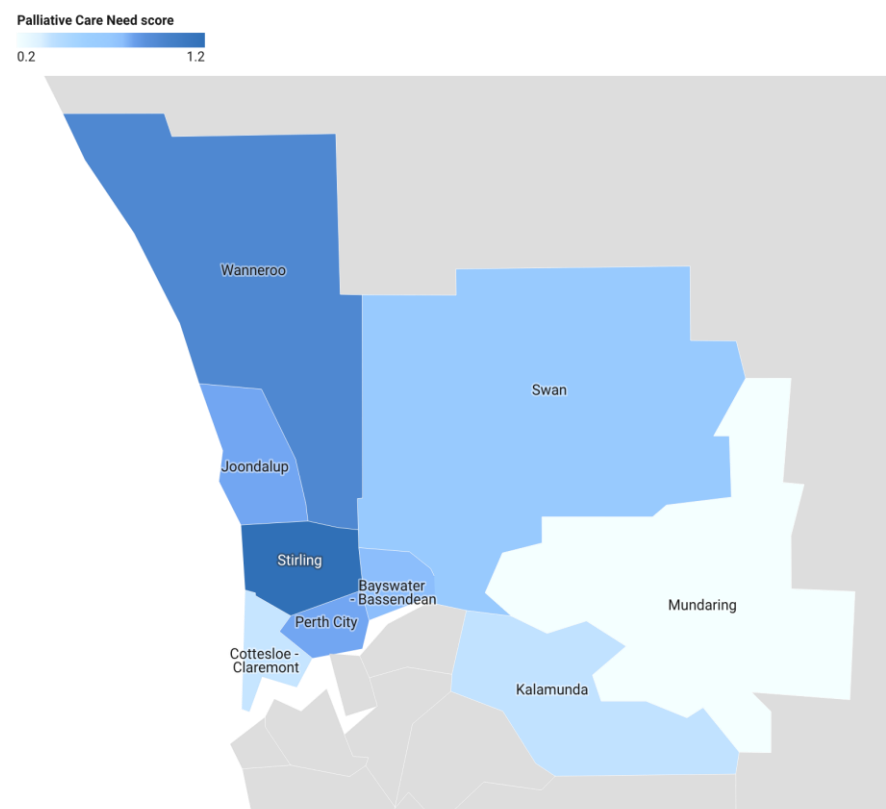
## 4.1 Perth North PHN:

The top three SA3s with the highest Palliative Care Need Score, as per **Figure 5**, in Perth North PHN are:

1. **Stirling** – has the largest population aged 65 years and over. It also has the third lowest rate of FTE palliative care nurses in the catchment.
2. **Wanneroo** – one of the SA3 areas further away from Perth City where specialist palliative care service is located, it has the second highest level of socioeconomic disadvantage in the catchment and third largest population aged 65 years and over. It also has the third highest ASR of deaths in need of palliative care per 100,000 population (based on 41.2 per cent of all deaths), and the lowest rate of FTE palliative care nurses in the catchment.
3. **Joondalup** – has the second largest population aged 65 years and over but the third highest rate of FTE GPs. It also has the third highest rate of FTE palliative care nurses in the catchment; however, this may be skewed by the location of in-patient services located within this area.

**Table 6:** Palliative Care Need Score across Perth North PHN ranked according to SA3 with the highest score of need

Rank	SA3	Palliative Care Need Score
1	Stirling	1.16
2	Wanneroo	0.93
3	Joondalup	0.79
4	Perth City	0.79
5	Bayswater - Bassendean	0.76
6	Swan	0.68
7	Kalamunda	0.39
8	Cottesloe - Claremont	0.38
9	Mundaring	0.23



**Figure 5:** Palliative Care Need Score across Perth North PHN

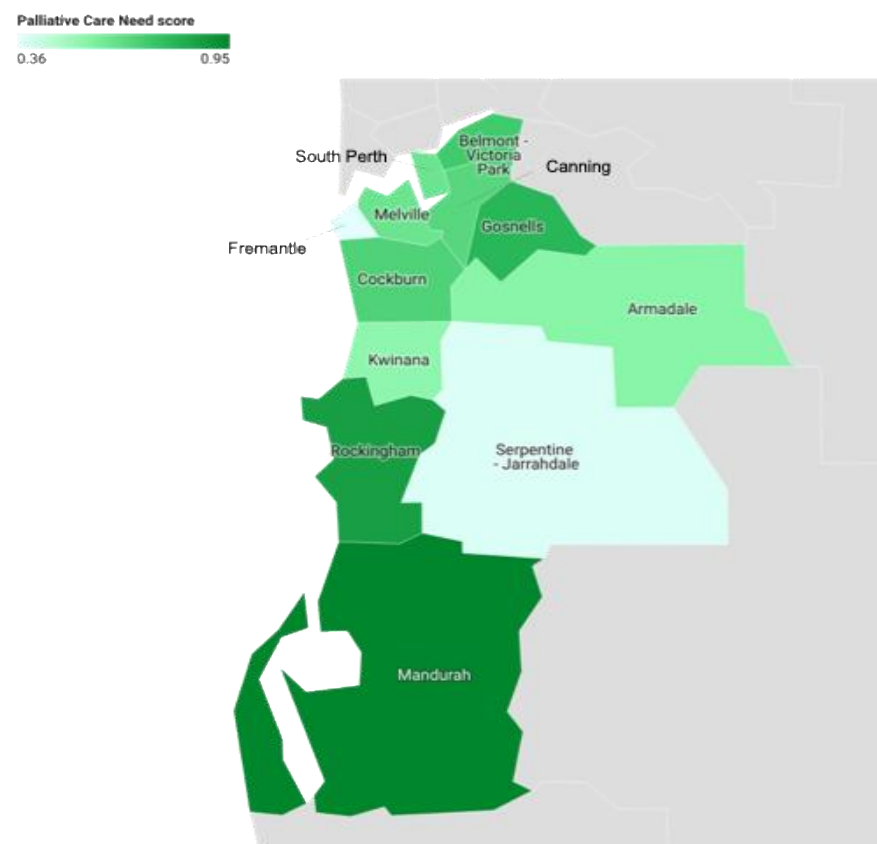
## 4.2 Perth South PHN:

The top three SA3s with the highest Palliative Care Need Score, as per **Figure 6**, in Perth South PHN were:

1. **Mandurah** – has the largest population aged 65 years and over and has the highest level of socioeconomic disadvantage in the catchment. Mandurah is the SA3 further away from Perth City in the catchment, meaning it is furthest away from the physical locations of specialist palliative care services.
2. **Rockingham** – has the third largest population aged 65 years and over and experiences relatively higher levels of socioeconomic disadvantage compared to the rest of the catchment. Rockingham also has the second lowest rate of FTE palliative care nurses.
3. **Gosnells** – experiences relatively higher levels of socioeconomic disadvantage compared to the rest of the catchment and has the fourth largest population aged 65 years and over.

**Table 7:** Palliative Care Need score across Perth South PHN ranked according to SA3 with the highest score of need

Rank	SA3	Palliative Care Need Score
1	Mandurah	0.95
2	Rockingham	0.87
3	Gosnells	0.79
4	Belmont - Victoria Park	0.72
5	Cockburn	0.69
6	Canning	0.67
7	South Perth	0.62
8	Melville	0.62
9	Armadale	0.55
10	Kwinana	0.54
11	Serpentine - Jarrahdale	0.38
12	Fremantle	0.36



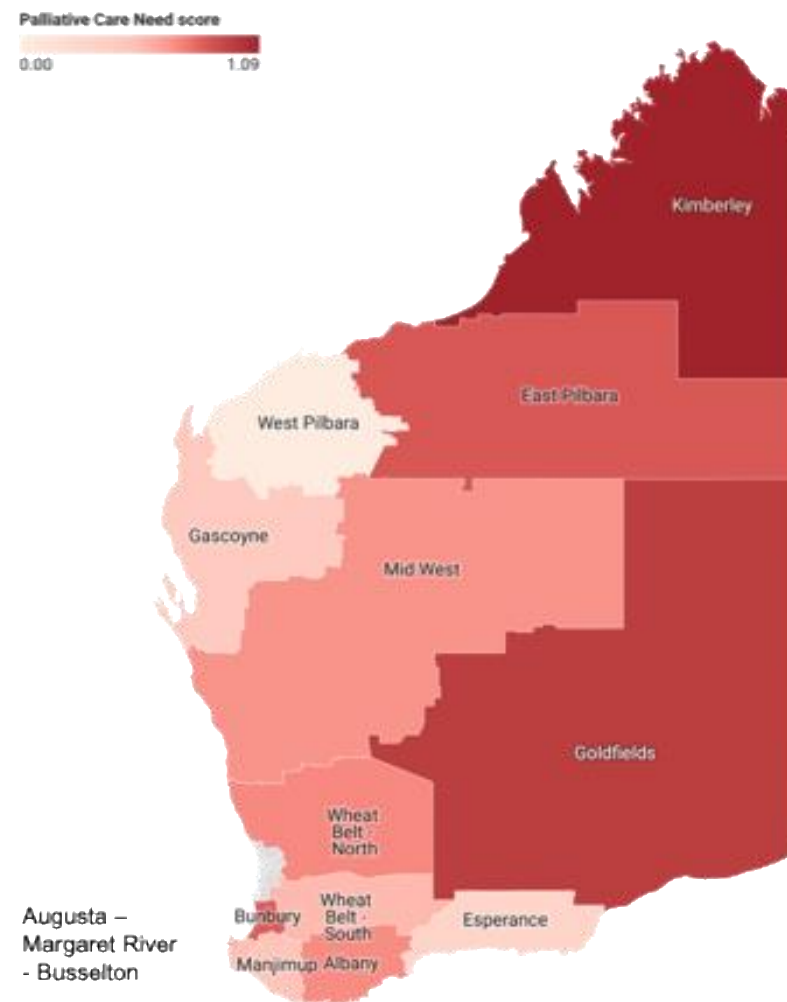
**Figure 6:** Palliative Care Need score across Perth South PHN

### 4.3 Country WA PHN:

The top three SA3s with the highest Palliative Care Need Score, as per **Figure 7**, in Country WA PHN were:

1. **Kimberley** – has the highest ASR of deaths in need of palliative care per 100,000 population (based on 41.2 per cent of all deaths). The area also has the highest level of socioeconomic disadvantage in the catchment. It has the highest rate GP FTE relative to the overall Country WA PHN.
2. **Goldfields** – has the second highest ASR of deaths in need of palliative care per 100,000 population. This area also has the third highest level of socioeconomic disadvantage in the catchment. It has a low rate of GP FTE relative to the Country WA PHN.
3. **East Pilbara** – has the third highest ASR of deaths in need of palliative care per 100,000 population. It has the lowest rate of GP FTE in the catchment and across WA.

Each region in Country WA is supported by WACHS Palliative Care services, but service models vary.



**Table 8:** Palliative Care Need score across Country WA PHN ranked according to SA3 with the highest score of

Rank	SA3	Palliative Care Need Score
1	Kimberley	1.09
2	Goldfields	0.97
3	East Pilbara	0.85
4	Bunbury	0.83
5	Wheat Belt - North	0.72
6	Albany	0.71
7	Mid West	0.69
8	Wheat Belt - South	0.56
9	Augusta - Margaret River - Busselton	0.53
10	Manjimup	0.51
11	Gascoyne	0.43
12	Esperance	0.30
13	West Pilbara	0.00

**Figure 7:** Palliative Care Need score across Country WA PHN

# Key Recommendations

## 5.1 Recommendations overview

This section outlines seven key recommendations (see **Table 9** below) for WAPHA to consider in addressing palliative care support needs across WA.

The recommendations have been informed by the quantitative data analysis as well as the engagement with key stakeholders undertaken by Impact Co.

The recommendations focus on service design and commissioning, capacity building, partnerships and communication and cover both metropolitan-based PHNs (Perth North and Perth South) and the Country WA PHN. All activities described in the recommendations fall under the scope of GCfAHPC and/or the After-Hours program.

Measurements and targets are provided as a guidance regarding measuring impact, noting quantitative baseline data is limited/not available. These recommendations will be prioritised as part of the current GCfAHPC program funding which is scheduled to end in June 2029.

**Table 9:** Key Recommendations, measures and targets

No.	Recommendation	Relevant Program	Measures and Targets
1	Improve community literacy of end-of-life care, including advance care planning	GCfAHPC	Measure: No. of attendees at community literacy activities.
2	Provide targeted support to under-served population groups to improve palliative care literacy and equitable access to services for these groups	GCfAHPC	Measure: number of participants at targeted activities across Greater Choices initiatives.
3	Provide and raise awareness of tailored support to families, kin and supporters who play a critical role in enabling quality palliative care at home and in the community	GCfAHPC	Measure: Carer involvement at awareness events.
4	Support earlier recognition of unmet palliative care needs, including referrals to specialist palliative care services through the promotion of validated assessment tools	GCfAHPC	Measure: Number of referrals to specialist palliative care services from general practices participating in Palliative Care Champions activities.
5	Build the capacity and capability of generalist palliative care service providers through investment in GP professional development and capability building	GCfAHPC	Target: 10% of general practices in WA have completed a Palliative Care Champions project.

6	Design and pilot care coordination models to address the holistic needs of patients, their families, carers, kin and supporters	GCfAHPC	<p>Target 1: Adoption of national palliative care resources for carers by key stakeholders such as Carers WA.</p> <p>Target 2: Increase awareness of existing MBS item number options that support care coordination by general practice.</p> <p>Target 3: Promote opportunities to enhance utilisation of case conferencing in general practice.</p>
7	Raise awareness of and advocate for models that provide 24/7 palliative care support	After-Hours	<p>Target 1: Ensure that all Clinician Assist pathways relating to palliative care provides current information regarding access to specialist palliative care advice and referral guidance.</p> <p>Target 2: Develop a shared care model of palliative care for each WA PHN that includes after-hours support.</p> <p>Target 3: Develop a service map for each WA PHN that identifies community pharmacies that hold stock of the four, core palliative care medicines.</p>

## 5.2 Recommendations in detail

### RECOMMENDATION 1: Improve community literacy of end-of-life care, including advance care planning

There is limited community awareness and understanding of palliative care and ACP, which impacts equity and access, particularly within under-served communities. There is a need to increase awareness and improve equity through community awareness raising initiatives, workforce capability building, and improved early access and uptake of ACP.

#### EVIDENCE OF NEED

##### Limited awareness and understanding of palliative care

Stakeholders reported low awareness and limited understanding of palliative care. This was primarily attributed to:

- Misconceptions about palliative care, including the beliefs that palliative care is only for older people, people who are dying, and/or can only be provided by a specialist physician.
- Hesitance to initiate conversations about palliative care and end of life planning due to stigma, taboo and discomfort with conversations related to ageing, dying and death.

Limited opportunities for conversations about palliative care and end-of-life planning leave people and families unprepared and increase crisis-driven responses at the end of life. All service providers engaged in the consultation highlighted the need for greater preparedness, with one GP stating that they would *“like to see everyone have an advanced health directive, even before they require palliative services.”*

Palliative care literacy tends to be low amongst under-served populations, and accessible and inclusive information is often not available, which contributes to misconceptions and limited conversations about palliative care and end-of-life. Where information specific to under-served populations is available, community members can still have limited awareness of this information or how to access it. As highlighted by service providers working in cohort-specific organisations, sensitivity and nuance is critical when discussing palliative care and end-of-life with the cohorts they work with. Correspondingly, stakeholders consistently emphasised the need to build capability and capacity within the mainstream workforce, including the development of appropriate resources, to better support conversations about palliative care and ACP with under-served communities. This is explored further in **Recommendation 2**.

Community understanding about palliative care and ACP in remote and very remote communities is also low. Primary health providers working in Country WA PHN noted the need for more targeted efforts to raise awareness about what palliative care is, eligibility, access and palliative care options for residents living in Country WA.

This highlights the need to develop place-based initiatives that focus on community capacity building activities such as those developed by WAPHA and delivered in partnership with peak bodies such as PCWA and Linkwest. Stakeholder engagement has highlighted the need to continue and expand this approach.

Stakeholders highly regarded the Compassionate Communities model in de-stigmatising end-of life and activating community networks and resources. In turn, communities that have greater end-of-life, death and grief literacy are more equipped to implement a Compassionate Communities model.

## Early access and uptake of advanced care planning

ACP was highlighted by all stakeholders as critical to facilitating patient choice and there was consensus that ACP needs to be integrated into routine care across healthcare settings.

Stakeholders identified opportunities to support GPs to build capability in relation to the following aspects of ACP:

- initiating trauma-informed conversations about ACP with patients and their family/carers
- effective documentation during the ACP process
- introducing ACP conversations earlier, at/closer to the time of diagnosis (e.g. dementia diagnosis).

Stakeholders emphasised the importance of promoting equitable access to, and completion of, earlier ACP in the community. Examples include:

- **Further embed ACP in disease-specific care pathways and primary care for older adults.** While ACP is referenced in Clinician Assist WA pathways for palliative care, there is an opportunity to review other clinical guidelines relating to all life-limiting conditions and to add ACP information. This will help to promote early discussion and planning for end-of-life.
- **Build clinician capability and confidence.** Invest in training and education for clinicians across specialties, particularly GPs, to support ACP. For example, provide decision-making frameworks and practice opportunities so that clinicians feel confident in initiating and navigating values-based discussions about end-of-life care.
- **Partner beyond the health system.** Explore ways to strengthen the use of WA Health documentation for ACP processes beyond clinical settings (e.g., financial and/or legal planning).
- **Integrate ACP into transition planning** as a person moves from their home into a residential aged care home (RACH). Stakeholders emphasised ACP documents are often not completed when people enter RACHs, highlighting the need to raise awareness about the importance of starting ACP conversations with individuals and their families/carers during this critical period. This may include supporting general practice to increase their capacity, home care package services and RACHs to strengthen combined approaches that support end-of-life decision making and ACP.

*“If someone received a dementia diagnosis, there should immediately be a process for discussing ACPs. A lot of healthcare is in siloes, and they are not thinking about the palliative care journey until it’s too late.”*

**Stakeholder**

## OPPORTUNITIES

This recommendation presents the following key opportunities for WAPHA:

- 1.1** Continue to support community awareness activities to increase knowledge and understanding about the importance of ACP and end-of-life care, in particular for under-served communities (**all PHNs**).
- 1.2** Continue to focus on workforce capacity and capability to support access to earlier ACP and recognition of unmet palliative care need (**all PHNs**).

**RECOMMENDATION 2: Provide culturally responsive and targeted support to under-served communities to improve palliative care literacy and equitable access to services for these groups**

Individuals from under-served communities have unique needs in relation to accessing palliative care services. There are opportunities to increase palliative care literacy and equitable access to services for these groups by promoting or developing tailored resources and co-designing or piloting new models of care that enhance referral pathways across typically siloed sectors.

**EVIDENCE OF NEED**

Stakeholders identified specific barriers faced by the following under-served communities:

*People with disabilities*

Discussing palliative care and end-of-life with a person with disability requires additional expertise to ensure that the process is inclusive of family/carers, but that decision-making is determined by the choices made by the individual. Accessibility to ACP for people living with a disability is likely to be impacted by limited understanding of ACP within the workforce who support them. Stakeholder engagement also highlighted the need to build capacity in the disability sector relating to screening for unmet palliative care need and to build stronger pathways between the disability sector and specialist palliative care services. Additionally, stakeholder engagement highlighted a gap in current community specialist palliative care services for people living in Specialist Disability Accommodation.

There is also an opportunity to explore the development of new models of specialist palliative care service provision to meet the needs of people living with disability through consultation and co-design with the disability sector.

*Aboriginal people*

Given the higher burden of chronic disease for Aboriginal people, there is a need to increase awareness of ACP and palliative care supports and care through early screening for their unmet palliative care needs.

In relation to care provision, stakeholders consistently reinforced the importance for Aboriginal people to remain on Country during the end-of-life period, which can be incompatible with available service models, particularly in regional, remote and very remote areas. Individuals are often hesitant to travel to seek additional clinical support if it means leaving Country and their support network. Additionally, previous negative experiences with health services, including not having cultural needs listened to, also leads to reduced engagement with palliative care services.

*“I’m dealing with a lot of people who are about to die – the best thing to do is be surrounded by their family. As long as they have some family around...they can pass on peacefully”*

**Stakeholder**

Stakeholders highlighted that like other under-served communities, conversations about palliative and end-of-life care could be started earlier with Aboriginal people. These conversations need to be culturally responsive (with in-language options) and should incorporate cultural and spiritual elements of care alongside clinical needs. Stakeholders emphasised that palliative care conversations should be led by staff from Aboriginal medical services. However, stakeholders highlighted that there is an opportunity to strengthen the capacity and capability of this workforce through appropriate training, skills development, and resources to feel confident to initiate and manage palliative care needs in their communities.

A systemic review of Indigenous peoples’ wishes for palliative care across Australia, New Zealand, Canada and the United States found the following common preferences: dying close to or at home;

having the involvement of family/kin; and the integration of cultural practices (Shahid, et al, 2018). The review found that adequately addressing these preferences resulted in improved quality of care in terms of access to services, client satisfaction, symptom management, and reduced ED and hospital admissions.

Evidently, there is an opportunity to improve the responsiveness of palliative care supports for Aboriginal communities in WA, including the preference for supports to be provided on Country. Additionally, there is an opportunity to further collaborate with health care providers, particularly Aboriginal Community Controlled Health Services (ACCHSs) and their peak body (AHCWA), to review current models of palliative care against peer-reviewed models and continue to build on current palliative care activities in this space.

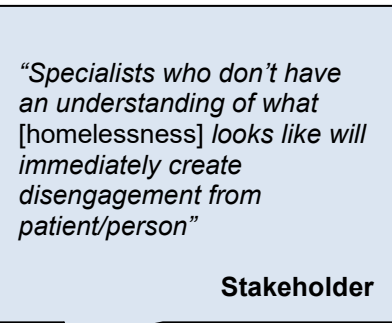
### *Multicultural communities*

Conversations about palliative care and end-of-life care are often informed by culture, religion and faith. Stakeholders consistently highlighted the need for greater cultural awareness amongst specialist and non-specialist palliative care service providers to ensure palliative care conversations and care provision are responsive to the needs of multicultural and multifaith communities. Culturally responsive care depends on access to interpreters and in-language resources, as well as on health professionals who have the skills and confidence to meaningfully integrate cultural needs with clinical care. Furthermore, providers need to actively develop, tailor and test strategies to effectively and meaningfully engage with culturally and linguistically diverse communities, as providing resources alone is unlikely to be sufficient.

### *People experiencing homelessness*

While population health data relating to the incidence or prevalence of homelessness for each PHN in WA is unavailable, research indicates the average age of death for people who have experienced homelessness is around three decades earlier than the general population (Tuson, et al. 2024).

Stakeholders reported that people with current or previous homelessness experience a range of barriers to accessing palliative care support. This includes previous negative experiences with services, which can impact on help-seeking behaviour and perceptions of safety and access. A history of alcohol or drug use or behavioural issues can further exclude people from receiving services.



*“Specialists who don’t have an understanding of what [homelessness] looks like will immediately create disengagement from patient/person”*

**Stakeholder**

Evidently, current models of specialist palliative care are not amenable to the potential additional care requirements of people experiencing homelessness. There is an opportunity to coordinate consultation between the homelessness sector and specialist palliative care services to develop specific pathways or co-design a model that enhances access to specialist palliative care for individuals experiencing homelessness.

### *People living with dementia*

Data indicates that the incidence of dementia is increasing (AIHW, 2025b). Stakeholders consistently emphasised the need for bespoke and updated information and resources relating to palliative care and dementia. There is a need to implement a consistent approach to facilitating ACP whilst decision-making capacity is intact for people living with dementia.

WAPHA currently funds a small project with PCWA, which explores the impact of an ACP service offered as part of a memory clinic. Although the outcomes of this project are yet to be determined, there was strong support amongst stakeholders for this initiative to be expanded and continued.

## OPPORTUNITIES

This recommendation presents the following key opportunities for WAPHA:

- 2.1 Promote existing resources to support under-served population groups (e.g. people living with a disability) who would benefit from ACP and palliative care awareness (**all PHNs**).
- 2.2 Where there are gaps in resources, develop and share tailored resources for under-served population groups with partner organisations (**all PHNs**).
- 2.3 Increase the uptake of interpreter involvement in discussions related to palliative care (**Perth North PHN and Perth South PHN**).
- 2.4 Co-design and pilot new models of care that enhance referral pathways between adjacent sectors (e.g. homelessness, disability services, ACCHSs) and specialist palliative services to increase access to palliative care (**Perth North PHN and Perth South PHN**).

**RECOMMENDATION 3: Raise awareness and advocate for tailored support to families, kin and supporters who play a critical role in enabling quality palliative care at home and in the community**

Families, carers, kin and supporters play a critical role in enabling quality palliative care at home and in the community, however they often don't feel confident, prepared or supported throughout the palliative care journey. There is an opportunity for WAPHA to seek clarity on the carer support that will be provided under the Support at Home program, as well as develop awareness campaigns to improve access to existing (or new) support services for carers.

## EVIDENCE OF NEED

Family members, carers, kin and broader social support networks (hereafter families/carers) play critical and influential roles in supporting a patient through palliative and end-of-life care. This can include emotional support, transportation, accompaniment to appointments, financial assistance, coordinating supports and, in some instances, the delivery of medication under the guidance and directive of practitioners. When a patient dies, it has a huge impact on their loved ones, and whether there has been a positive or negative death experience in palliative care can have ongoing implications for families/carers.

Carer Gateway, facilitated by Carers WA, is the primary carer support service available in WA. Carer Gateway provides free services such as peer support groups, counselling, self-guided coaching, online skill courses and access to emergency respite to carers nationwide. The Australian Government's Support at Home program will also provide carer support, however the parameters of this support are currently not clear.

*"Carers need a break or [they] are going to break".*

**Stakeholder**

Despite the availability of the Carer Gateway (and the future availability of Support at Home), stakeholders reported that additional targeted approaches are needed to increase the confidence, preparedness and support for families/carers throughout the palliative care journey. This includes earlier involvement and preparation of families/carers, which can reduce after-hours ambulance callouts. Additionally, family/carers require both psychological and practical support (e.g. transport assistance) to effectively support loved ones. Finally, appropriate and accessible respite and bereavement support are critical for family/carers during this time. Stakeholders reported that limited availability of publicly funded respite contributes to carer burnout, which in the long-term leads to greater demand for RACHs and hospital beds in palliative care units.

Stakeholders shared that when families/carers are included in conversations and are provided with adequate support and resources, the outcomes for the person they are caring for improve. When families/carers understand and feel empowered to support their loved one, they can continue to deliver care in a way that is sustainable. In turn, this can lead to shorter hospital stays, reduced clinical interventions and increased likelihood for the patient to remain comfortably at home.

## OPPORTUNITIES

This recommendation presents the following key opportunities for WAPHA:

- 3.1 Increase awareness of palliative care support that will be provided under the Support at Home program, particularly for families/carers (**all PHNs**).
- 3.2 Following 3.1, develop awareness campaigns to improve access to existing (or new) support services for carers (**all PHNs**).

**RECOMMENDATION 4: Support the earlier recognition of unmet palliative care needs including referrals to specialist palliative care services through the promotion of validated assessment tools**

Access to palliative care services across WA varies for individuals in both timing and level of care. There is an opportunity to support more timely, consistent, and equitable access to services by standardising referral pathways, eligibility criteria, and screening tools, as well as enhancing communication and information-sharing between specialist and generalist palliative care services.

## EVIDENCE OF NEED

Referral pathways and eligibility criteria for palliative care services vary significantly across WA, creating a fragmented system where access differs depending on geography and clinician. For example, despite GPs being the primary point of contact for patients during early disease stages, less than 16 per cent of specialist palliative care referrals originate from general practice, compared to 63 per cent from hospitals (WA Palliative Care Outcomes Report, 2025). Fragmentation creates confusion for referrers, inequitable access for patients, and inefficiencies because of duplicative assessments and multiple referral attempts.

Several systemic issues underpin these challenges:

- **Opportunities exist to further support the routine use of screening tools in general practice:** General practice does not routinely use screening tools to identify unmet palliative care needs and/or trigger referral to specialist palliative care services. There is an opportunity to strengthen capability within general practice to embed evidence-based tools into routine care of people with advanced chronic conditions who are likely to die in the next 12 months.
- **There are opportunities to strengthen GP confidence and awareness:** This includes symptom control, medication prescribing, and ACP. Additionally, GPs may not be aware of existing resources such as Clinician Assist WA, a clinical support tool which provides locally accepted guidance for assessing and managing patients in Western Australia, including for the management of symptoms related to end-of-life care, and referral to specialist palliative care services.
- **There are inconsistent referral pathways and eligibility criteria:** Referral processes vary widely across metropolitan hospitals, outpatient clinics, and regional services. Eligibility

*“People refer [to palliative care services] too late, which reinforces the message that palliative care is only for people close to death. But this message is reinforced because referrals are rejected when people aren’t sick enough.”*

**Stakeholder**

criteria differ between providers, creating duplication, confusion, and inequitable access. Patients often experience gaps when transitioning between services or geographic areas.

- **Restrictive eligibility criteria can lead to late referrals:** Referral criteria in community services, like Silverchain, often require that patients have high levels of symptoms or are nearing the end-of-life (in Perth North and Perth South PHN). This means that while evidence supports earlier referral to specialist palliative care services, current service provision is often limited to people approaching the last three months of life.
- **Information sharing and care coordination is fragmented:** Challenges related to discharge communication, siloed clinical information systems, and limited shared decision-making pathways can hinder continuity of care. GPs are not routinely included in hospital care planning, and emergency services may have limited access to patient goals and care plans. As such, there is an opportunity for WAPHA to advocate for timely sharing of clinical information between acute services and general practice, which could involve improved utilisation of My Health Record.

*“The evidence says early referral is important, but there isn’t capacity in the services themselves to keep people on the books.”*

**Stakeholder**

The nature of these challenges varies across the PHNs. **Perth North PHN** and **Perth South PHN** have greater referral complexity due to multiple hospital-based models and outpatient clinics with differing processes. On the other hand, **Country WA PHN** experiences challenges due to workforce shortages, with limited GP access exacerbating referral timelines, particularly in the after-hours period.

To address these challenges, stakeholders supported a more standardised approach to referrals and eligibility criteria, as well as greater promotion of existing tools, with flexibility in how the tools are applied given to patients with diverse presentations of palliative need.

Standardising referral pathways and eligibility criteria, as well as promoting the use of existing evidence-based screening tools can:

- enable earlier identification of palliative care needs
- improve clarity among referrers
- improve equity and consistency in access across WA
- support proactive care planning and reduce crisis-driven hospitalisations.

## OPPORTUNITIES

This recommendation presents the following key opportunities for WAPHA:

- 4.1** Continue capacity and capability building for general practice to embed evidence based palliative screening tools into routine care of people with advanced chronic conditions through the Palliative Care Champions project. **(all PHNs).**
- 4.2** Enhance communication between specialist and generalist palliative care services through advocacy for timely sharing of clinical information and improved use of My Health Record **(all PHNs).**

## RECOMMENDATION 5: Build the capacity and capability of current and future generalist palliative care service providers through investment in GP professional development and capability building

Inconsistent access to training, varying levels of experience and engagement, and the absence of formal shared-care arrangements with specialists contribute to variation in GPs' confidence and capability to deliver generalist palliative care. Furthermore, stakeholders noted that the impending retirement of many GPs with generalist palliative care expertise could further decrease palliative care capability.

There is an opportunity to strengthen the capability and capacity of GPs and community health professionals to deliver high-quality generalist palliative care, enabling earlier identification, proactive management, and effective collaboration with specialist services.

### EVIDENCE OF NEED

A sustainable palliative care system requires a strong specialist workforce for complex cases and a capable generalist workforce to manage most palliative care needs in primary and community settings, particularly in response to addressing the needs described in **Recommendation 1**.

The capability and confidence of generalist palliative care providers currently vary, depending on geography, local relationships, and access to specialist support. These factors are explored further below.

- **Variability in palliative care focus and experience:** Available evidence indicates palliative care may not be a primary clinical focus for all GPs, that the number of patients requiring palliative care is perceived to be low in some practices, and that competing clinical priorities can limit participation in palliative care education and training (Department of Health, 2017).
- **Geographical differences:** Regional GPs often demonstrate higher confidence due to a broader scope of practice and limited specialist access, with support often only accessible via telehealth consultations. In contrast, metropolitan GPs, with easier access to specialist services, tend to refer rather than manage palliative care themselves, limiting opportunities for skill development.
- **Palliative care training and education is not mandated:** Only a small proportion of medical and nursing schools in Australia mandate palliative care training (Monzón et al., 2025). Stakeholders reinforced the need to embed palliative care education into GP training and ongoing professional development.
- **No formalised approach to shared care:** As there is no formalised approach to shared care, GPs often lack clarity on when and how to refer to specialists, as well as what their role is post-referral. This creates uncertainty and can reduce confidence among GPs.

*“Australia has a well-developed palliative care system when we think of palliative care though, we are thinking about specialist palliative care. We are undeveloped in generalist palliative care – only just starting within mainstream community and disability services to do this.”*

**Stakeholder**

Supporting GPs to increase confidence and enhance their awareness and skills can:

- support earlier identification of palliative needs and initiation of ACP
- reduce unnecessary hospitalisations and ED presentations
- improve patient and family experience through proactive, community-based care.

## OPPORTUNITIES

This recommendation presents the following key opportunities for WAPHA:

- 5.1** Partner with the RACGP WA to promote the role of generalist palliative care as an aspect of general practice (**all PHNs**).
- 5.2** Expand activities that currently focus on the implementation of ACP and palliative care screening tools as part of routine care in general practice (**all PHNs**).
- 5.3** Co-design a formalised approach to 'shared care' with key partners to manage the needs of people with a complex chronic condition whose life expectancy is 12 months or less (**all PHNs**).

### RECOMMENDATION 6: Design and pilot care coordination models to address the holistic needs of patients, families, kin and supporters

Addressing the holistic needs of patients and their families/carers requires strong care coordination models focused on knowledge sharing, pathways for integrated care and mutual capacity building, particularly between generalist and specialist service providers. There is an opportunity to design and pilot care coordination models to better address the holistic needs of patients and their families/carers.

## EVIDENCE OF NEED

While palliative care has traditionally focused on symptom management and clinical interventions, supporting patients' and family/carers' social, emotional and spiritual wellbeing is also critical. The holistic needs of patients and their families/carers are not effectively met through current care models, leading to greater care coordination requirements across service providers.

While these areas may not all fall under the remit of the GCfAHPC program, stakeholders identified the following forms of holistic care as being important in palliative care:

- **Comprehensive psychological support** throughout the palliative care journey (e.g. access to psychologists and social workers who can support the emotional and psychological needs of patients and families/carers).
- **Coordinated, team-based care** that is supported by an appropriate funding model and enabled by the effective communication (e.g. case conferencing) between a person's care team (including GPs, specialists, family members and the patient).
- **Practical support for daily living** such as cleaning, laundry, and cooking supports.
- **Informal community support** including social prescribing and/or the Compassionate Communities model which mobilises local networks, groups, and services to offer support to individuals in their community.

Care coordination models that focus on shared care and collaboration can better meet patient and family/carers' holistic needs throughout the palliative care journey. However, there are challenges to delivering coordinated care, including:

- Fragmented information-sharing across care settings, particularly at points of transition.
- Limited shared decision-making pathways between care teams.
- Lack of awareness about centralised palliative care service information e.g. available services, eligibility and referral criteria, and relevant contact details
- Decreasing opportunities for GP care coordination/continuity as a patient moves between

care settings, especially from in-home to acute care settings.

- Different funding sources across services (e.g. State or Commonwealth Government funded), which may contribute to fragmentation.

A strong example of shared and coordinated care is the WACHS model in Country WA PHN. This model involves a program of palliative care consultants visiting remote and very remote towns supported by teams of GPs with specialist interest, social workers, and specialist nurses. The team serves a large regional area using a consultancy model to support primary care with advice and practical support. Other regional centres contract local private GPs to participate in palliative care teams, but the model is not uniformly implemented across all regional areas.

*“Palliative care is shared care.”*

**Stakeholder**

These examples present an opportunity to learn from and leverage similar approaches. Building strong shared and coordinated models of care requires sustained investment in relationship-building, structured role integration, and formalised opportunities for mutual capacity-building and knowledge sharing across specialist and non-specialist palliative care services. Moreover, shared models of care should be co-designed with service providers and community to ensure that care coordination is place-based, and responds to local needs, priorities and service contexts.

## OPPORTUNITIES

- 6.1** Co-designed models of care that can be piloted between generalist and specialist palliative care services to provide holistic, multidisciplinary care and that enable knowledge sharing and capacity building (**all PHNs**).
- 6.2** Increased awareness of existing MBS item number options that support care coordination (**all PHNs**).
- 6.3** Explore opportunities to enhance utilisation of case conferencing in general practice (**all PHNs**).

### RECOMMENDATION 7: Raise awareness of, and advocate for, models that provide 24/7 palliative care support

There are gaps in after-hours service provision, particularly in Country WA PHN and for patients who are not already engaged in specialist palliative care services. There are also low levels of awareness of current after-hours service options. Opportunities exist to raise awareness about current after-hours services, develop and advocate for additional 24/7 supports, and expand the use of telehealth services during the after-hours period.

## EVIDENCE OF NEED

Access to after-hours service provision is a significant barrier in WA. This entails both limited services that provide direct support during the after-hours period (i.e. not just phone advice), as well as limited awareness of these services amongst the community (i.e. when/how to use them).

Individuals in Country WA PHN in particular, especially patients not engaged in specialist palliative care services, have limited access to after-hours support. As outlined in **Section 3**, while multiple phone services provide after-hours support, they are predominantly directed towards health practitioners, rather than patients and family members.

When symptoms escalate or crises occur in the after-hours period, families/carers often need to choose between waiting until the morning or Monday (if it is the weekend), calling an ambulance, or managing without professional support. All three scenarios typically cause anxiety and distress for

the patient and their families/carers and can undermine confidence. Stakeholders highlighted that these scenarios often result in ED presentations and that a common reason for ambulance callouts during the after-hours period was due to limited understanding of alternative services and options for support. Correspondingly, sudden changes in condition may mean that an individual becomes eligible for community-based specialist palliative care support but still needs to wait to be referred by a doctor or nurse practitioner working in specialist palliative care. As such, there is an opportunity to explore options for Home Care Package providers and paramedics to be able to refer to community-based specialist palliative care services. There is also an opportunity to enhance current approaches to anticipatory care for people with complex chronic conditions who may be in their last 12 months of life by ensuring there is an after-hours management plan created.

*"It is very challenging to try and find out what is in the best interest for the patient. The limitation [when we respond to an emergency call] is so big, we don't know the prognosis, the primary diagnosis, and a patient's end goal. If the family and/or the patient are terrified, we just go to the hospital."*

**Stakeholder**

In line with feedback from stakeholders, research emphasises the importance of 24/7 models. Providing after-hours support in palliative care models is an important factor that has been identified across several systematic reviews (Firth et al., 2023). For example, in their systematic review of specialist palliative care models, Bainbridge, Seow and Sussman (2016), identified that access to 24/7 specialist palliative care was a component in 50 per cent of specialist palliative care programs considered efficacious and which resulted in a significant reduction in healthcare costs. The same review identified that services which provide 24/7 specialist palliative care as well as both hands-on clinical care alongside advisory care, had the greatest evidence of effectiveness.

Together, these findings demonstrate the need for enhanced support in the after-hours period and highlight the recurring theme that access to support from specialist palliative care services in the after-hours period is determined by being a registered patient with the specialist palliative care service provider. For patients who have palliative needs, but who do not meet the eligibility criteria for these services, there is a gap in access to palliative care advice or opportunities for referral to and assessment by specialist palliative care services. Opportunities to address this need include increasing the awareness and understanding of existing supports, as well as developing new after-hours supports targeted at patients who are not currently engaged in specialist palliative care services.

## **OPPORTUNITIES**

- 7.1** Raise awareness about available options for after-hours palliative care support within general practice and the community **(all PHNs)**.
- 7.2** Explore ways to build capacity and capability of after-hour services, such as GP locums and Medicare Urgent Care Clinics, to recognise and respond to palliative care needs **(all PHNs)**.
- 7.3** Enhance current approaches to anticipatory care by increasing uptake of after-hours management plans for people with complex chronic conditions whose life expectancy is 12 months or less **(all PHNs)**.
- 7.4** Explore the current availability of palliative care core medications during the after-hours period and develop opportunities to build capacity within each PHN **(all PHNs)**.
- 7.5** Support 24/7 models of palliative care, which may involve collaboration between generalist and specialist palliative care providers, to avoid crisis-driven ED presentations **(Country WA PHN)**.
- 7.6** Partner with key stakeholders to expand the use of telehealth specialist support services, particularly during the after-hours period **(all PHNs)**.

# Appendices

## Appendix 1: Detailed Methodology

Table 10: Detailed Methodology

<b>Sprint 1: Kick-off</b>
<p>Project working group (PWG) formed with WAPHA key personnel to meet fortnightly throughout the project and oversee project progress.</p> <p>Kick-off meeting held to confirm project objectives, scope and deliverables, key project risks, governance structure and reporting cadence, communication protocols and a discussion about what success looks like for the final Needs Assessment.</p>
<b>Sprint 2: Stocktake and planning</b>
<p>This sprint involved:</p> <ul style="list-style-type: none"><li>• Rapid review of key documentation including updated quantitative data provided by WAPHA.</li><li>• Identification of stakeholders to be involved in qualitative engagements.</li><li>• The development and confirmation of a set of key lines of enquiry for the Needs Assessment and a Stakeholder Engagement Plan.</li></ul>
<b>Sprint 3: Literature and policy review</b>
<p>Literacy and policy review to identify historical and current policy drivers, enablers and systemic constraints affecting palliative care, including:</p> <ul style="list-style-type: none"><li>• Review of national frameworks (e.g.: Palliative Care Service Development Framework 2018).</li><li>• Desktop review of peer-reviewed and grey literature on:<ul style="list-style-type: none"><li>○ use of telehealth for people approaching the end-of-life</li><li>○ integration models between primary care and specialist palliative care</li><li>○ palliative care models aimed at reducing unnecessary presentations to emergency department</li><li>○ innovative workforce approaches (e.g. nurse-led models).</li></ul></li></ul>
<b>Sprint 4: Service mapping</b>
<p>Examination of population demographics, causes of death and service demand for palliative care across the three WA PHNs. Composite indices were used to identify:</p> <ul style="list-style-type: none"><li>• areas with high need but low service availability</li><li>• areas with high rates of avoidable emergency departments (ED) presentations</li><li>• workforce distribution.</li></ul> <p>Development of service maps that document and categorise palliative care services including:</p> <ul style="list-style-type: none"><li>• specialist palliative care</li><li>• primary care providers</li><li>• community supports</li><li>• telehealth and online services</li><li>• ambulance services.</li></ul>

<p>Service characteristics captured included hours of operation, referral criteria and pathways, acceptance processes, workforce availability, service capacity and waiting times, and coverage areas (i.e., postcode), where available.</p>
<p><b>Sprint 5: Engagement – service providers and other key stakeholders</b></p>
<p>Consultations with a range of service providers and other key stakeholders to validate key insights and trends identified in previous sprints and to develop a deeper understanding of the experiences of stakeholders including key barriers/challenges and enablers and opportunities to improve palliative care services. Key stakeholders were identified in collaboration with WAPHA and consultation was undertaken as either a 1:1 interview or a focus group with stakeholders. The themes that were explored included:</p> <ul style="list-style-type: none"> <li>• barriers to accessing palliative care including referral pathways</li> <li>• service fragmentation</li> <li>• system interoperability</li> <li>• equity gaps</li> <li>• workforce challenges</li> <li>• role of primary health in palliative care</li> <li>• potential solutions for the future.</li> </ul>
<p><b>Sprint 6: Engagement – lived experience and community</b></p>
<p>While Impact Co. initially intended to undertake targeted facilitation with people with lived and living experience of accessing palliative care or supporting someone who has accessed palliative care, the PWG collaboratively decided on an alternative approach. This involved engagement with community stakeholders including from Community Resource Centres and other stakeholders who work in the community.</p>
<p><b>Sprint 7: Synthesis and draft</b></p>
<p>Synthesis of insights gathered from <i>Sprints 2 to 6</i> into a draft Needs Assessment Report. This report presented insights based on the integration of the quantitative, qualitative and literature findings. A preliminary set of recommendations was also presented in the Report to be validated by WAPHA in <i>Sprint 8</i>.</p>
<p><b>Sprint 8: Validation and co-design</b></p>
<p>Validation of the draft Needs Assessment by WAPHA and design of solutions with internal stakeholders. A validation workshop was facilitated with the PWG and other key PHN personnel with the purpose of testing the key findings and recommendations (including prioritisation) and discussing feasible service responses and models. A draft program logic and suggested evaluation methodology was presented and validated.</p>
<p><b>Sprint 9: Finalise</b></p>
<p>Incorporation of feedback from <i>Sprint 8</i> into the Needs Assessment Report and refinement of the recommendations into clear prioritised and actionable strategies. The final Needs Assessment was presented back to WA Primary Health Alliance.</p>
<p><b>Sprint 10: Knowledge transfer</b></p>
<p>Knowledge transfer and implementation planning via two implementation support meetings (at three and nine months post-project completion).</p>

## Appendix 2: List of quantitative data indicators

The table below outlines the quantitative data indicators that were used to inform this Needs Assessment, including those that were used to calculate the Palliative Care Need Score.

**Table 11:** Quantitative data indicators

Data Indicator	Data current to	Source	Informed Palliative Care Need Score calculation?
Population projections	2025	Public Health Information Development Unit (PHIDU)	
Population projections (aged 65 years and above)	2025	PHIDU	
Population projections (2030)	2025	PHIDU	
Non-Aboriginal population aged 65 years and above	2021	Australian Bureau of Statistics (ABS)	Yes
Aboriginal population aged 50 years and above	2021	ABS	Yes
IRSD (Index of Relative Socioeconomic Disadvantage)	2021	ABS	Yes
Total deaths ASR per 100,000	2019 -2023	AIHW – Mortality Over Regions and Time Books	
General practitioner FTE	FY 2024-2025	Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP)	
Avoidable mortality from selected causes (0 – 74 years) ASR per 100,000 (2017-2021) <ul style="list-style-type: none"> <li>• cerebrovascular diseases</li> <li>• chronic obstructive pulmonary disease (COPD)</li> <li>• circulatory system</li> <li>• diabetes</li> <li>• ischaemic heart disease</li> <li>• respiratory disease</li> <li>• cancer</li> </ul>	2024	PHIDU	Yes
Nurses with a job area in palliative care FTE	2024	National Health Workforce Dataset	

## Appendix 3: The drivers of need for palliative care

The increasing demand for palliative care is largely driven by a growing and ageing population, as well as the increasing prevalence of chronic illnesses (Palliative Care Australia, 2024).

To assess the relative demand in each SA3 relative to each other across each of the three PHN catchments, data was extracted according to the following drivers for palliative care service need:

- death rates and their underlying causes
- ageing population
- variation across population groups (e.g. socioeconomic status).

A detailed overview of the above drivers for palliative care service need is outlined below:

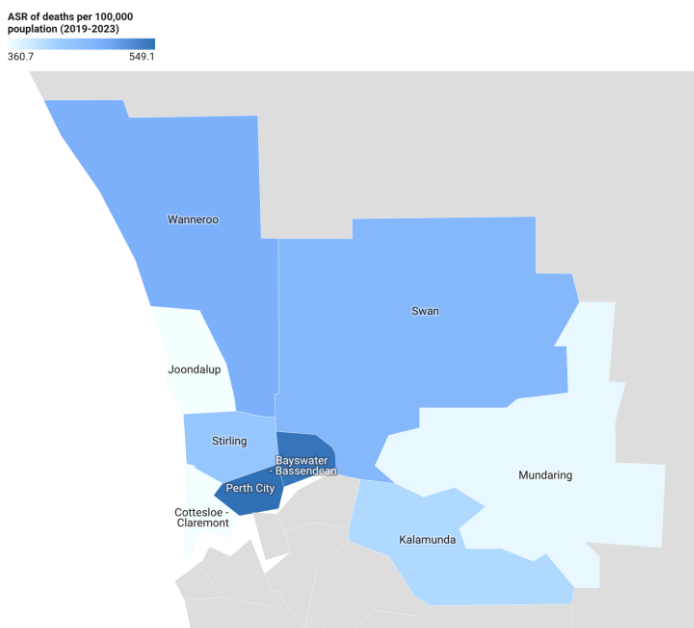
### 1. THE RATE OF DEATHS AND THEIR UNDERLYING CAUSE

- In 2024, there were 187,268 registered deaths in Australia, with 84 per cent registered for people aged 65 years and above (ABS, 2025a).
- In WA, there were 17,969 registered deaths, which equated to 9.6 per cent of the national total.
- In 2023, the underlying leading cause of death for individuals in WA aged 44 years and below, were external causes, while the leading cause of death for those aged over 45 years were chronic-related illnesses.
- For those aged 75 years and over, dementia (including Alzheimer’s disease) was also one of the top two causes of death.
- For those aged 65 to 74 years, lung cancer was the leading cause of death.

#### Perth North PHN:

- The overall death rate was highest in Perth City, Baywater – Bassendean, Wanneroo and Swan (see **Figure 8**).
- There were consistently high rates for avoidable mortality for selected causes (0 to 74 years) in Bayswater – Bassendean, Swan, Mundaring and Wanneroo.

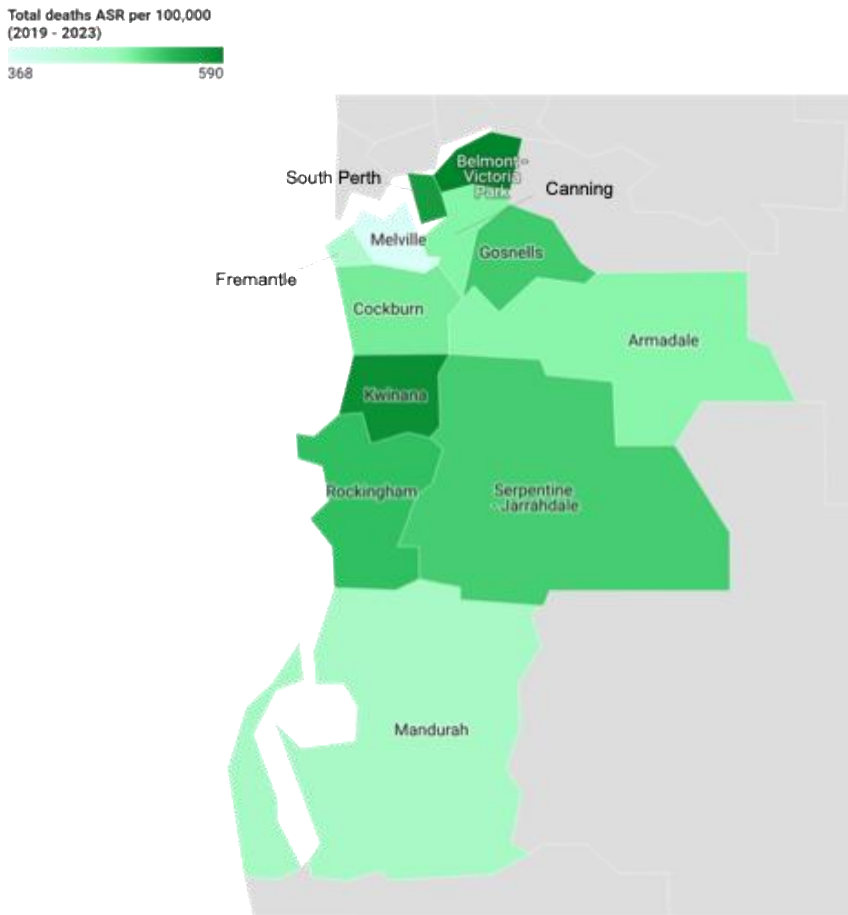
**Figure 8:** ASR of deaths per 100,000 population in Perth North PHN (2019 – 2023, AIHW)



## Perth South PHN

- The overall death rate was highest in Belmont – Victoria Park, Kwinana, Rockingham, Gosnells and Serpentine – Jarrahdale (see **Figure 9**).
- There were consistently high rates for avoidable mortality for selected causes (0 to 74 years) in Kwinana, Belmont – Victoria Park, Rockingham, Gosnells and Mandurah.

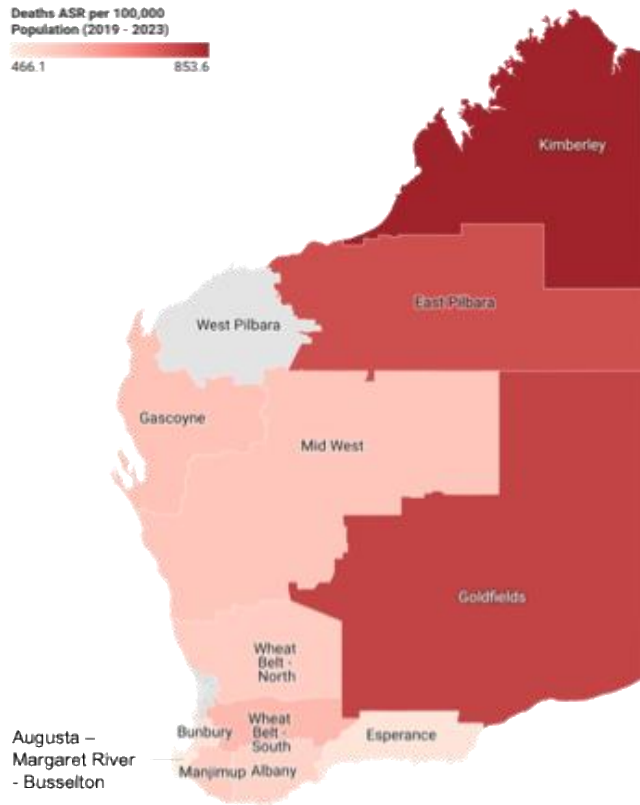
**Figure 9:** ASR of deaths per 100,000 population in Perth South PHN (2019 – 2023, AIHW)



## Country WA PHN

- The overall death rate was highest in Kimberley, Goldfields and East Pilbara (see **Figure 10**)
- There were also consistently high rates for avoidable mortality for selected causes (0 to 74 years) in Kimberley, Goldfields and East Pilbara.

**Figure 10:** ASR of deaths per 100,000 population in Country WA PHN (2019 – 2023, AIHW)



## 2. THE AGEING POPULATION

While palliative care may be required at any age, the need for palliative care increases in the ageing population (AIHW, 2025c). As such, the need or demand for palliative care services will increase as the ageing population increases.

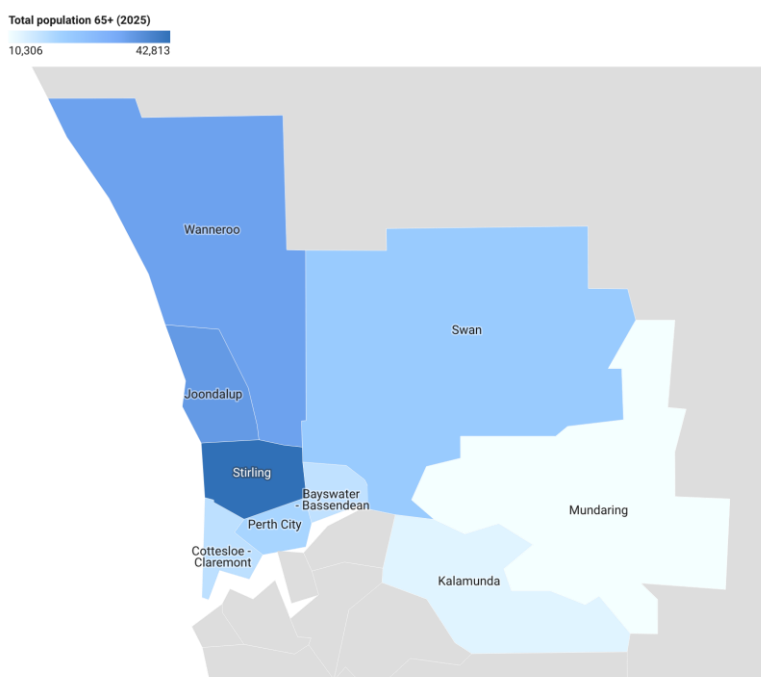
From 2023 to 2024, the number of registered deaths in Australia increased by 2.3 per cent (or 4,137 - ABS, 2025). Correspondingly, the percentage of registered deaths for people aged 65 years and over in Australia in 2025 had grown by three per cent from the preceding 10 years.

In WA, people aged 65 years and over comprised 20 of the total population in 2025, although this varied within each PHN catchment (ABS, 2025b).

### Perth North PHN

- Approximately 210,000 residents (17 per cent) living in this catchment are aged 65 years and above.
- The highest number of residents aged 65 years and over were found in Stirling, Joondalup and Wanneroo.
- By 2030, the older population growth is expected to be highest in Wanneroo, Swan and Perth City and Mundaring – with an expected growth of more than 20 per cent.

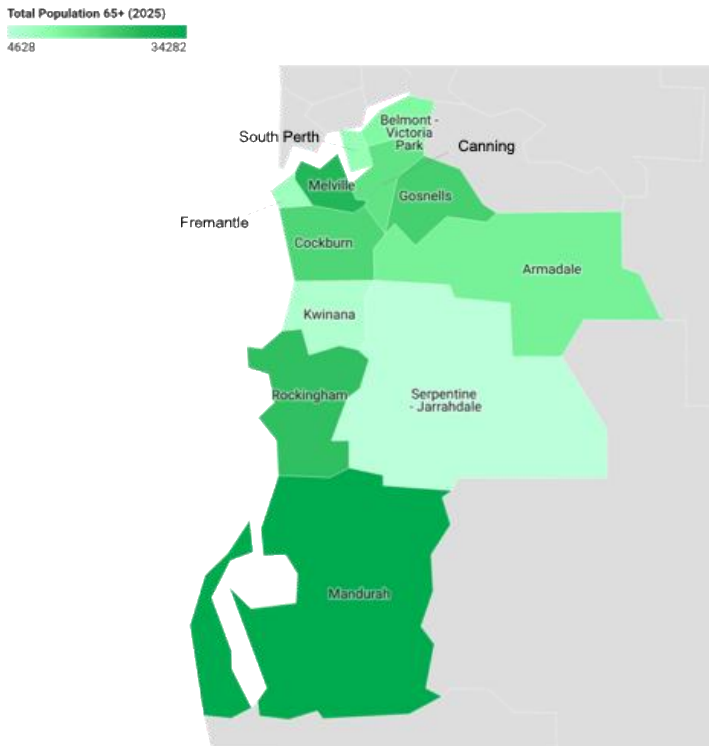
**Figure 11:** Population aged 65+ in Perth North PHN (2025, PHIDU)



## Perth South PHN

- Approximately 203,000 residents (18 per cent) living in this catchment are aged 65 years and above.
- The highest number of residents aged 65 years and over were found in Mandurah, Melville and Rockingham.
- By 2030, the older population growth is expected to be highest in Serpentine – Jarrahdale, Kwinana, Rockingham and Cockburn – with an expected growth of more than 30 per cent.

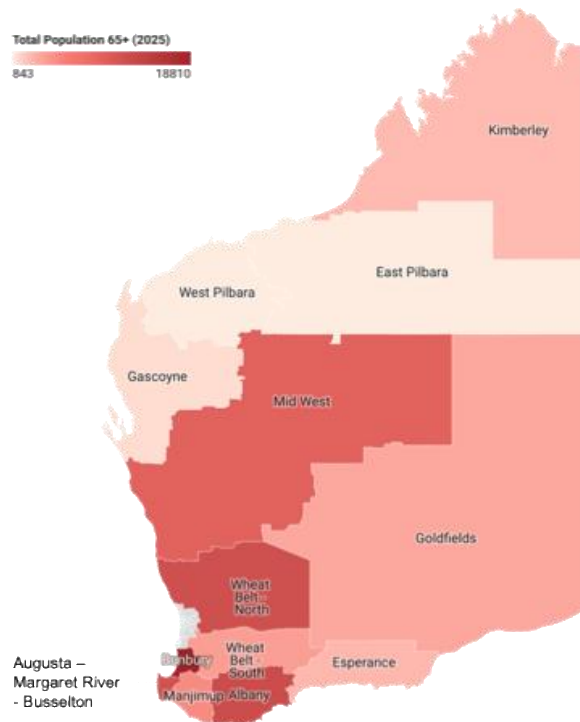
**Figure 12:** Population aged 65+ in Perth South PHN (2025, PHIDU)



## Country WA PHN

- Approximately 87,000 residents (15 per cent) living in this catchment are aged 65 years and above.
- The highest number of residents aged 65 years and over were found in Bunbury, Albany and Wheat Belt – North.
- By 2030, all SA3s in Country WA will experience a decrease in their older population, with the greatest change expected in Gascoyne, East Pilbara, Albany and the Mid West.

**Figure 13:** Population aged 65+ in Country WA PHN (2025, PHIDU)



### 3. VARIATIONS ACROSS POPULATION GROUPS

The rates and leading causes of death vary between population groups (AIHW, 2025a). This is attributed to a variety of factors including demographic variables, risk factor prevalence and access to services.

Data from the AIHW *National Mortality Database* covering deaths registered in Australia from 2021 to 2023, highlights three specific demographic factors having a significant impact on rates and leading causes of death (AIHW, 2025a):

- **Remoteness area:** The age-standardised death rate increased with increasing remoteness and was 1.6 times higher in *Very Remote Australia* than in *Major cities* (779 vs 499 deaths per 100,000). Except in *Major cities*, coronary heart disease was the leading cause of death across every other area.
- **Socioeconomic status:** The death rate decreased with higher socioeconomic status, with the crude rate highest for people living in the lowest socioeconomic areas and lowest in the highest socioeconomic areas (849 vs 565 per 100,000 population).
- **Aboriginal people:** The age-standardised death rate for Aboriginal people across five jurisdictions (New South Wales, Queensland, WA, South Australia and Northern Territory) was almost double the rate for all persons in Australia (943.9 vs 512.7 per 100,000 population - AIHW, 2025a). In 2023, there were 5,256 deaths in Australia and 737 deaths in WA registered for persons identifying as Aboriginal. This represented 2.9 per cent of total deaths in Australia and 4.2 per cent of deaths in WA. WA had the second highest proportion of deaths for persons identifying as Aboriginal compared to other states and territories. The Northern Territory had the highest proportion (46 per cent), while Queensland had the third highest proportion (3.4 per cent).

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