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An Australian Government Initiative

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Palliative care needs assessment 2025-2029

September 2025

Contents

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Executive summary

Primary Health Tasmania's Palliative Care Needs Assessment provides an overview of the current palliative care landscape in Tasmania. It brings together evidence on service activity, demand, workforce capacity and stakeholder perspectives to identify gaps in access and opportunities to improve care. It is designed to directly inform planning for the Greater Choice for At Home Palliative Care (GCfAHPC) program.

Key Findings

- Demand for palliative care in Tasmania is increasing.
- Need and access to palliative care varies across Tasmania, with disadvantaged and rural and regional areas experiencing greater challenges.
- Admitted palliative care in Tasmania is higher than the national average.
- People, families and carers often feel unprepared for end-of-life care with low health and grief literacy contributing to delayed access, anxiety and unsupported bereavement.
- Palliative care workforce capacity, capability and sustainability vary across Tasmania.

Priority Recommendations

Based on our findings, the following high-level priorities have been identified for consideration for 2025-2029.

Effectively addressing these priorities will require a coordinated, statewide approach involving all stakeholders and service providers.

The recommendations prioritise equity, community-based care, enhance capability and improved system integration. They align with the shared goals of the Greater Choice program, which are:

1. Increase awareness and access to quality palliative care at home
    - Strengthen outreach and shared-care arrangements across rural and remote regions, especially in several north-west and regional LGAs with high-admission rate, and low-workforce capacity.
    - Enhance access to community-based and after-hours palliative care, with particular focus on high needs areas where services are limited.
    - Increase visibility and access to respite and bereavement supports for families, carers and primary care providers.
2. Improve coordination across primary care, aged care and specialist services
    - Improve access and equity through statewide coordination, timely identification of need across diagnoses.
3. Build workforce capability and community confidence
    - Provide targeted support for unpaid carers, with particular focus on several regional and rural LGAs with limited paid workforce availability to sustain home-based care and reduce avoidable admissions.
    - Implement targeted, culturally safe education initiatives to improve access for priority populations, including rural and remote communities, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) populations, socioeconomically disadvantaged groups, and older people.
    - Build primary care capacity for a palliative approach, with a focus on after-hours coverage, anticipatory medicines, shared care plans and carer support to support safe home-based care.
4. Use data and technology to support flexible, responsive care
    - Embed telehealth as part of a hybrid palliative health service, complemented by in-person outreach and local support, with targeted investment in digital capability across health providers.
    - Use current available data and strengthen access to additional data, including hospital utilisation, priority populations and access to medications to support care in the community.

1. Snapshot - our findings and priorities

Key findings

Our desktop review of key policy and resource literature outlined the following key determinants of access to quality palliative care.

Determinants of palliative and end of life care access in Tasmania

Tasmania's access profile is shaped by several factors, including an older, widely dispersed population, a mixed public–primary–aged-care delivery system, health infrastructure, and marked geographic variation in service reach.

Geography, rurality and dispersion

A large share of Tasmanians lives outside urban areas, including island communities, which increases travel time and complicates equipment delivery and after-hours response. Tasmania's population is older and more regionally distributed than the national profile, underscoring higher demand and potential barriers for rural residents.[1]

Consistent with international evidence, rural residence is associated with lower use of palliative services, indicating a need for strong outreach and shared-care arrangements across regions.[2] National evidence shows rural and remote residents have poorer access to healthcare and must often travel longer distances or relocate for specialised services, which is directly relevant to Tasmania's regional footprint.[3]

Demography and complexity

Tasmania has one of the oldest median ages in Australia, and Hobart has the oldest of any capital city. This increases demand for coordinated palliative care across diagnoses and raises carer reliance and frailty. This age structure elevates the need for earlier identification and community-based care options statewide.[4] Tasmania also carries a high burden of chronic conditions which intensifies service demand and adds pressure on already limited regional care pathways.[5]

Socioeconomic and household factors

Out-of-pocket costs for travel and parking, non-subsidised medicines or equipment, and lost carer income can deter help-seeking, particularly outside major centres. Higher socioeconomic status is consistently associated with increased utilisation and that poverty constrains use, indicating the importance of reducing financial and logistical burdens on Tasmanian patients and carers.[2, 3]

Service configuration, capacity and integration

Access depends on the distribution and capability of specialist and generalist services, referral clarity, rapid response, anticipatory prescribing, equipment logistics, workforce availability, and reliable after-hours coverage.[6] Tasmania's Palliative and End of Life Care Policy Framework 2022–2027 identifies statewide coordination, timely identification of need across diagnoses, and strengthening home and community-based care as priorities to improve access and equity.[7]

Larger hospital bed capacity is associated with higher acceptance of palliative care in the evidence base, highlighting how local capacity and configuration can influence uptake.[2]

Workforce distribution and capability

Recruitment and retention outside major centres, protected time and support for general practice and residential aged care to deliver a palliative approach, and access to specialist advice are recurring determinants. Tasmania's framework commits investment to strengthen the statewide palliative care system, including community-based care, which is central to equitable access.[7]

System navigation and information sharing

Clear referral triggers, shared care plans and interoperable information flows across hospital, community and aged-care services enable smoother, earlier access and reduces preventable transfers. The Tasmanian framework's emphasis on statewide coordination and consistent pathways aligns with evidence that system-level features shape acceptability and utilisation.[2, 7] National performance measures aligned with the National Palliative Care Strategy stress effective, safe, appropriate, continuous and accessible care; local implementation requires routine monitoring of geographic and population-group variation.[8]

Digital inclusion and telehealth readiness

Telehealth supports symptom review, family meetings and bereavement care, but relies on connectivity, devices and skills. The Tasmanian Government reports an upgraded video-conferencing platform to support virtual care, while sector documents note uneven digital capability across providers.[9] At the same time, Tasmania remains among the most digitally disadvantaged jurisdictions, so hybrid models are required to avoid widening access gaps.[10]

Cultural safety and acceptability

Culturally safe, person-centred practice and supported decision-making are critical for Aboriginal Tasmanians and for people from culturally and linguistically diverse backgrounds. Tasmanian health system plans commit to improving Aboriginal cultural respect in care delivery, and local service models emphasise working in culturally safe ways at end of life.[11]

National Indigenous health guidance likewise highlights principles that improve acceptability and equitable use of palliative care.[12] Evidence syntheses show acceptability is influenced by sociodemographic and service factors, reinforcing the need for tailored communication, family involvement and trusted relationships.[2]

Health literacy, navigation and timing

Timely identification of need across cancer and non-cancer diagnoses, clinician confidence to initiate goals-of-care discussions, and practical navigation support affect whether offers of care are made and accepted early enough to be most effective. The Tasmanian Policy Framework stresses early, coordinated pathways across hospital, primary, community and aged-care settings.[7]

Additionally, our analysis of quantitative and qualitative data shows:

Population need

- Tasmania's need for palliative and end-of-life care is rising as the population ages and multimorbidity becomes more common across cancer and non-cancer conditions, including cardiovascular disease, chronic respiratory illness, dementia, and frailty, among others.
- Access and service use vary substantially by where people live. Workforce and service activity are concentrated near population centres, while several regional local government areas (LGAs) rely more on travelling clinicians and unpaid carers.
- Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities require culturally safe, navigable pathways.
- Digital and socioeconomic disadvantage in parts of Tasmania can limit the benefit of telehealth and add travel or out-of-pocket burdens to families and patients needing palliative care.

Service utilisation and integration

- Tasmania has substantially higher reliance on hospital-based palliative care than nationally, with admitted palliative care hospitalisation rates around 40% higher than the Australian average. This indicates ongoing pressure on community and after-hours capacity and the need to consider sustainable opportunities to shift care closer to home.
- General practice is an important role in palliative care coordination and symptom management, yet community-based activity remains under-measured, and GPs report the need for clearer referral pathways, after-hours support, anticipatory prescribing and rapid access to specialist advice.

- Community and non-admitted palliative care activity is under-measured, despite strong evidence of clinical effort in homes and community settings.

Stakeholder experience

- Stakeholders across general practice, community providers, and specialist services consistently described practical requirements for success, including:
  - clear referral and escalation pathways
  - rapid advice and after-hours coverage
  - protected time for care coordination
  - reliable anticipatory prescribing and equipment logistics
  - shared tools for care planning and information exchange

Together these results suggest both a need to rebalance care toward the home - where it is safe and preferred - and an opportunity to improve measurement of care outside hospital, so planning and decisions reflect the work already occurring in the community.

Identified priorities

Based on our findings, the following priorities have been identified for consideration for 2025-2029. These priorities are aligned to the Greater Choice for At Home Palliative Care (GCfAHPC) program objectives. Specific details on potential actions are provided in the Priorities section.

Primary Health Tasmania will use these findings to shape flexible, evidence-based models and to support statewide partners with practical tools, clinical education, strengthened HealthPathways and improved information sharing so Tasmanians can receive coordinated, dignified palliative care.

- **Increase awareness and access to quality palliative care at home**
  - Improving access to care for priority groups
  - Improve access to after-hours palliative care
- **Improve coordination across primary care, aged care and specialist services**
  - Improve statewide coordination of care
- **Build workforce capability and community confidence**
  - Strengthen support for unpaid carers
  - Strengthen person centred palliative care
  - Strengthen primary care capacity in palliative care
- **Use data and technology to support flexible, responsive care**
  - Improve access to care through digital solutions
  - Use and improve access to data to monitor priorities and improvement

2. Background

Palliative care is a person-centred approach that aims to improve the quality of life of people living with a life-limiting illness and their families.[13] It involves the prevention and relief of suffering through early identification, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.[13] It is not limited to end-of-life care but may be provided alongside curative or disease-modifying treatment from the time of diagnosis, and across all settings including hospitals, general practice, residential aged care, community services, and at home.[14, 15]

Tasmania faces a rising demand for palliative care driven by population ageing, increasing prevalence of chronic and complex conditions, and community expectations for care that is holistic and closer to home. [6] Over the next decade, more Tasmanians will require support for conditions such as cancer, cardiovascular disease, chronic respiratory illness, dementia, and multimorbidity.[6]

Purpose of this document

The purpose of this needs assessment is to:

- provide an overview of key palliative care standards and Tasmania's palliative care landscape
- build a shared evidence base about palliative care activity and demand in Tasmania
- identify service and workforce gaps that limit equitable access to care
- provide an assessment of Tasmania's palliative care system and opportunities for improvement
- capture the perspectives of stakeholders most affected by palliative care challenges
- recommend opportunities to strengthen service integration, workforce capacity, and culturally safe, person-centred care.

The findings will inform Primary Health Tasmania's planning decisions and align with national and local palliative care strategies, ensuring that investment is targeted to areas of greatest need and impact.

Why is this needs assessment important?

The assessment provides a structured analysis of population health needs, service capacity and stakeholder perspectives, along with priority actions to guide planning and system improvements.

Together, these findings provide guidance on potential system improvement and partnership activity that makes it easier for Tasmanians to receive safe, coordinated palliative care in the community when this is preferred and appropriate.[6]

The findings will inform the development of targeted, evidence-based practical actions that Primary Health Tasmania can take within scope of the Greater Choice for At Home Palliative Care Program (GCfAHPC)[16], that responds to Tasmania's regional context and community access needs for palliative care at home.

This needs assessment complements Palliative Care Tasmania's *'State of Palliative Care'* report by clarifying demand patterns, access and integration issues.

Scope of this needs assessment

The focus is on community and primary care-based palliative services, recognising their central role in enabling people to receive care in their preferred setting.

This assessment uses public sources, including Australian Institute of Health and Welfare (AIHW) palliative care services data, Medicare Benefits Schedule statistics, and published literature and policy documents. These sources provide a foundation but capture only selected aspects of activity.

Primary Health Tasmania also undertook internal analyses using confidential datasets, including hospital and emergency department activity, general practice data and insights from consultations with clinicians, aged care providers, carers and community stakeholders. These datasets cannot be shared due to data governance, confidentiality obligations and data sharing agreements. (Please refer to the note on data governance and interpretation at the beginning of the document).

Brief overview of leading practices in palliative care

The leading practices in palliative care drawn upon as part of the needs assessment include global, national, and Tasmanian policy frameworks that define expectations for high-quality care.[17, 18]

International guidance	The World Health Organisation considers palliative care as an ethical responsibility of health systems and emphasises integration across all levels of care, supported by an appropriately skilled workforce and access to essential medicines.
National guidance	In Australia, the National Palliative Care Strategy 2018 and National Palliative Care Standards outline principles for person-centred, coordinated, and evidence-based care.
Tasmanian guidance	Locally, the Tasmanian Palliative and End of Life Care Policy Framework 2022–27 aligns with these principles and addresses local system challenges.[19]

Together, these frameworks provide a benchmark against which gaps and improvement opportunities in Tasmania's palliative care system can be identified.[7]

Further details are included in Appendix A.

Standards consistently emphasise early identification, anticipatory care, multidisciplinary teamwork, shared care planning, carer support, cultural safety, and measurement of outcomes. These define the normative benchmark used to interpret local data and system performance.

3. Population health needs

This section provides a snapshot of demographics, and the health profile of Tasmania, to quantify the demand for palliative care.

These insights directly inform the service needs and system analysis that follow, highlighting how population characteristics drive uneven access and the necessity for targeted interventions.

Key findings

Tasmania's key population statistics

Growing ageing population

Median age projected to increase from 41.9 years (2023) to 48.8 years by 2053.

Higher palliative care need

Tasmania has a higher underlying need for palliative care due to an older population, high multimorbidity, and a higher burden of disease.

Uneven regional ageing

Population ageing will vary across Tasmania, with George Town ageing most rapidly and Flinders projected to be the oldest LGA by 2053, while Glamorgan–Spring Bay ages least and Brighton remains the youngest.

Rising palliative care demand

These trends indicate increasing demand for palliative care, both at end of life and earlier in long-term illness.

Implications for palliative care in Tasmania

Together, these factors point to:

a growing and increasingly complex need for palliative care across the state

the need for targeted planning to ensure all Tasmanians can access appropriate and culturally safe palliative care services

Evidence

- **Our population is ageing** - Tasmania has one of the oldest populations in Australia, with the proportion of residents aged 65 years and over projected to increase further over the next decade.[20] This demographic shift, combined with high rates of chronic disease, cancer, dementia, and multimorbidity, is expected to drive significant growth in the demand for palliative care.[21]
- **Tasmania's high chronic conditions burden means multiple health conditions require palliative care** - The need for palliative care extends across multiple conditions.[22] While cancer remains a significant contributor to death and a major driver of palliative care demand, non-malignant conditions such as chronic obstructive pulmonary disease, congestive heart failure, renal disease, neurodegenerative disorders, and frailty also contribute substantially.[23] See Table 1 for Tasmania's leading causes of death.
- **Health needs are increasing in complexity** - Increasingly, palliative care must support patients with complex multimorbidity and longer illness trajectories.
- **Tasmania has higher demand for palliative care than elsewhere in Australia[6]** - Tasmania has a disproportionately high demand for palliative care compared to other Australian jurisdictions. This elevated need is strongly linked to Tasmania's higher burden of disease, reflecting both premature mortality and years lived with disability.[6] The burden of disease, measured by the combined impact of Years of Life Lost and Years Lived with Disability, indicates a significant requirement for both end-of-life and earlier-stage palliative care services, independent of the state's older age profile.
- **Palliative care need is not evenly distributed across the state** - Local Government Areas such as West Coast, George Town, and Break O'Day exhibit more than twice the likely demand for palliative care compared to Hobart, Launceston, and other jurisdictions.[6] These geographic disparities underscore the importance of tailoring service planning and outreach to local population health profiles, ensuring equitable access to care across Tasmania. These disparities justify LGA-targeted outreach clinics and travel-aware rostering.

Table 1: Top 10 leading causes of death 2023, Tasmania and Australia

Cause of death	Number of deaths	State leading cause ranking	Australia leading cause ranking
Ischaemic heart disease (ICD-10 codes I20-I25)	536	1	1
Dementia, including Alzheimer's disease (ICD-10 codes F01, F03, G30)	492	2	2
Chronic lower respiratory disease (ICD-10 codes J40-J47)	298	3	5
Cerebrovascular disease (ICD-10 codes I60-I69)	260	4	3
Malignant neoplasm of trachea, bronchus and lung (ICD-10 codes C33, C34)	239	5	4
Diabetes (ICD-10 codes E10-E14)	167	6	6
Malignant neoplasm of colon, sigmoid, rectum and anus (ICD-10 codes C18-C21, C26.0)	149	7	7
Accidental falls (ICD-10 codes W00-W19)	144	8	11
COVID-19 (ICD-10 codes U07.1-U07.2, U10.9)	131	9	9
Malignant neoplasm of lymphoid, haematopoietic and related tissue (ICD-10 codes C81-C96)	128	10	8

Source: ABS, Causes of Death, Australia, 2023

Abbreviations: ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision.

Additional needs are reflected in Tasmanian population trends:

- Rising life expectancy and an ageing population.[4]
- High prevalence of chronic conditions such as cancer, heart failure, COPD, and dementia.[5]
- Access to palliative care is not evenly distributed.[24, 25]

- Evidence nationally and locally shows that:
  - people in rural and remote areas often experience later referrals and more limited-service availability[24, 25]
  - Aboriginal and Torres Strait Islander communities face barriers related to cultural safety, trust, and service design[24, 25]
  - people from culturally and linguistically diverse backgrounds may encounter language and cultural barriers[26]
  - socioeconomic disadvantage can limit access to timely care and adequate carer support.[26]

4. Service utilisation and integration

Key findings

Current services in Tasmania include specialist palliative care teams, hospital-based palliative units, community-based programs, general practices, and aged care providers.

Analysis shows:

- access remains uneven, particularly in rural and remote areas
- hospital utilisation is higher than the national average
- hospital-based palliative care use increases as socioeconomic status decreases
- 1 in four palliative care residents living in residential aged care homes have at least 1 hospital visit
- general practices (primary care) are not only caring for a growing number of patients with palliative care needs but are also managing an increasing service workload
- higher PBS expenditure.

Implications for palliative care in Tasmania

The above factors point to a need for:

- **Improved collaboration and integration between general practice, specialist palliative care, and aged care**
- **Strengthening after-hours support**

- **Strengthening data collection systems to collect information on type of support provided by the workforce**
- **Supporting consistent coding and data collection to track activity and outcomes.**

- **Building capacity of the primary care workforce to manage end-of-life care**
- **Addressing equity of access for Aboriginal and Torres Strait Islander, rural, and culturally diverse populations**

Evidence

Hospital utilisation

A note on definitions

Admitted patients: people who have been formally admitted to a hospital to receive care and/or treatment.

Non-admitted patient events: refer to care, treatment, or consultation provided in the public hospital system without hospitalisation.

Palliative care related hospitalisations: For the purposes of this report, palliative care-related hospitalisations are defined as episodes of admitted patient care (or hospitalisation) where palliative care was a component of the care provided during all or part of the episode. These hospitalisations can be divided into 2 groups depending on how they are identified in the hospital data as ‘primary palliative hospitalisations’ and other ‘palliative care hospitalisations.’

Primary palliative care hospitalisations: hospitalisations with a recorded care type of palliative care.

Other palliative care hospitalisations: hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

(Definitions - *Based on terminology and classification used in the AIHW palliative care services glossary)*

According to the AIHW, between 2022-2023, there was a total of 3,088 admitted patient palliative care hospitalisations and 9 non-admitted patient palliative care hospitalisations.

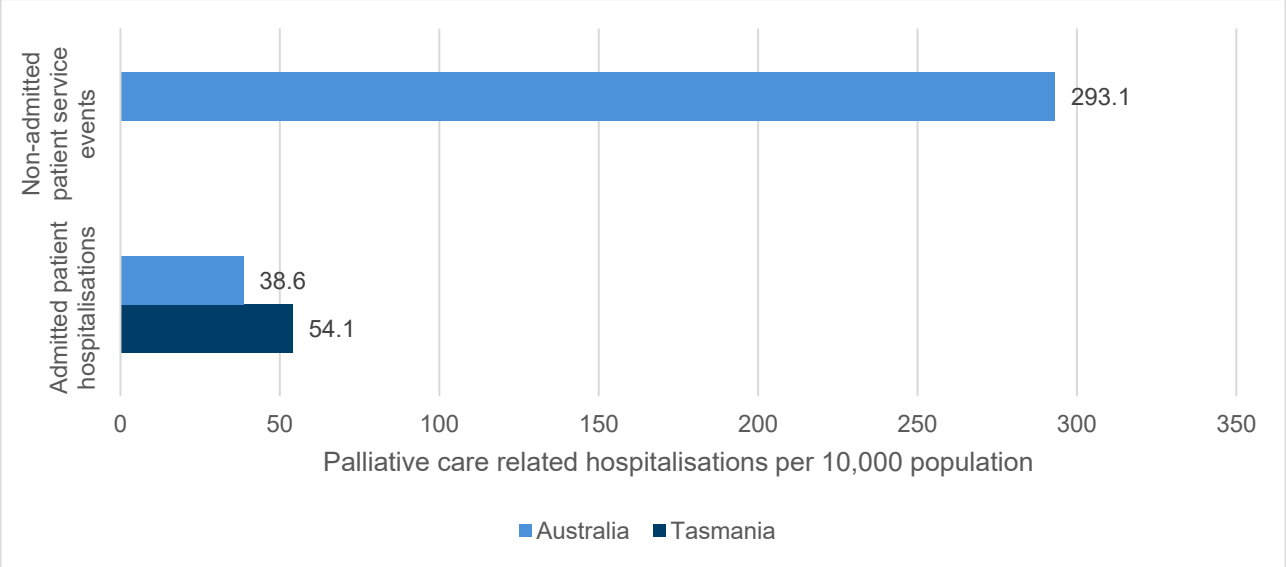
Tasmania has a higher rate of admitted palliative hospitalisations than Australia overall in 2022–23. Tasmania recorded 54.1 admitted palliative care hospitalisations per 10,000 population compared with 38.6 nationally. This is about 40 percent higher than the national rate.

The largest volume of measured palliative activity nationally occurs in non-admitted hospital settings.

Nationally, non-admitted palliative care service events were 293.1 per 10,000 (Figure 1).[27] Tasmanian-level data is not available.

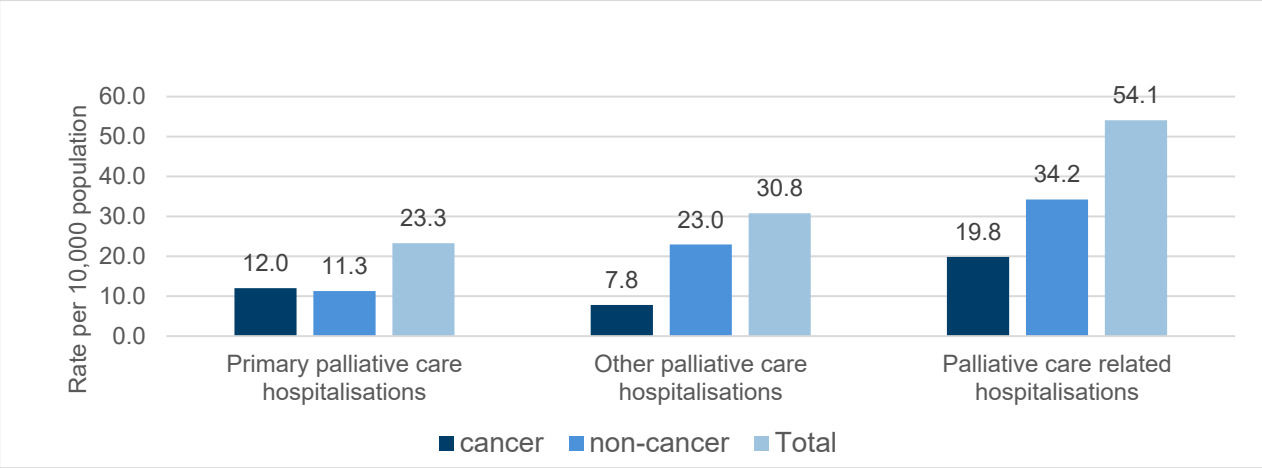
- Total palliative-care-related hospitalisations were 54.1 per 10,000 population (Figure 1).[27, 28] Of these, 19.8 were for cancer and 34.2 for non-cancer conditions.
- For primary palliative care hospitalisations, rates were similar for cancer and non-cancer (12.0 and 11.3 per 10,000; total 23.3) (Figure 2).
- For other palliative care hospitalisations, non-cancer dominated (23.0 vs 7.8 per 10,000; total 30.8).[27, 28]
- Non-cancer conditions account for about two-thirds of all palliative-care-related hospitalisations (34.2 of 54.1; 63%).
- In the “other palliative care” category, non-cancer makes up three-quarters (23.0 of 30.8; 75%). Primary palliative care hospitalisations are near parity between cancer and non-cancer.
- This means most hospitalisations in the broader palliative-care categories are for non-cancer conditions, while the “primary” category is roughly even between cancer and non-cancer (Figure 2).
- Overall hospital use for palliative care rose each year. Most of the growth came from the “other palliative care” category, not from “primary palliative care”. Primary palliative care stayed relatively steady and barely changed in the last year.
- This pattern fits an ageing, multi-morbid population where non-cancer trajectories need support across settings. The figure reflects admitted episodes only. Community and non-admitted activity is not shown.[27, 28]

Figure 1. Rate of palliative care related hospitalisations per 10,000 population, Australia and Tasmania, 2022-23



Source: Adapted from PHN palliative care services information dashboard, AIHW, 2022-23

Figure 2. Rate of palliative care hospitalisations by principal diagnosis, 2022-23

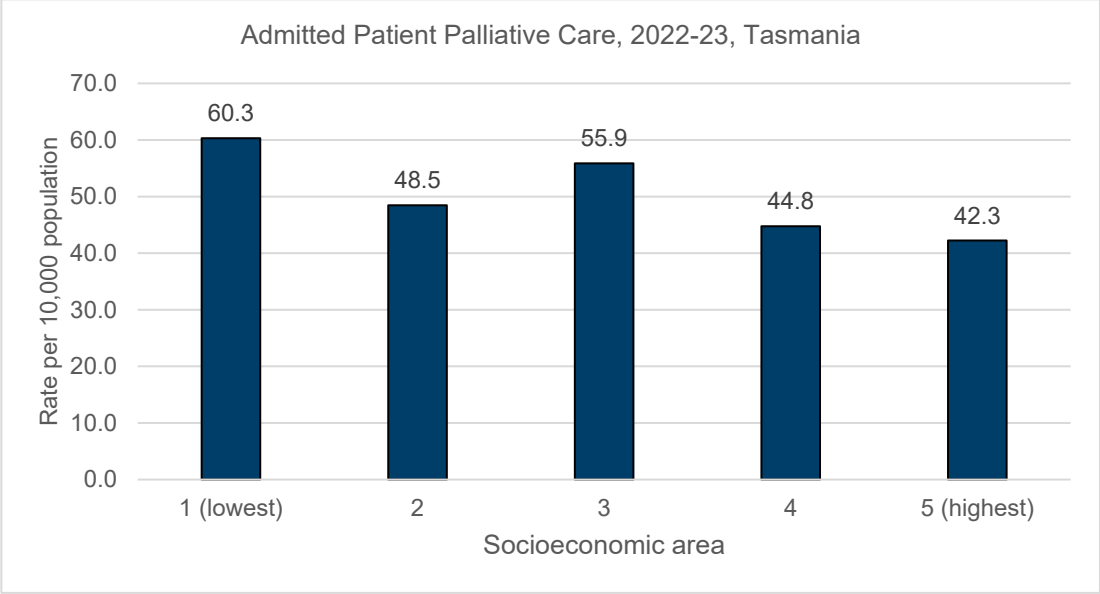


Source: Data from Table 3, Palliative Care Services in Australia (PCSiA) 2025 PHN palliative care services data tables, AIHW. Accessed September 10, 2025.

The influence of socio-economic status on hospital utilisation

- Hospital-based palliative care use increases as socioeconomic status decreases.[27] People in the most disadvantaged areas show the highest rate of hospital admissions for palliative care, while those in the most advantaged areas show the lowest rate. The lower sixty percent of the population has higher use of admitted hospital care than the upper forty percent, with the strongest concentration in the most disadvantaged twenty per cent.
- Admitted palliative care utilisation is higher in more disadvantaged communities (Figure 3). The rate for those in the lowest 20% socioeconomic status is 60.3 per 10,000 population compared with 42.3 in the highest 20%. This is consistent with local variation in case-mix, service configuration, access to community supports, transport, housing stability, and carer availability.
- These data reflect hospital-based episodes only. Community and non-admitted palliative care activity is not captured in this figure and may be under-reported.

Figure 3. Rate of admitted patient palliative care hospitalisations by socioeconomic area (quintiles), Tasmania



Source: Data from Table 2, Palliative Care Services in Australia (PCSiA) 2025 PHN palliative care services data tables, AIHW. Accessed September 10, 2025.

Permanent residential aged care palliative care residents with hospital leave, Tasmania, 2021-22

In 2021–22, about 25 percent of permanent residential aged care residents, classified as Aged Care Funding Instrument (ACFI) palliative care, had at least one hospital-leave episode.[27]

Public hospital expenditure on palliative care in Tasmania

Between 2022-2023 Tasmania accounted for $16,078,005 in admitted patient palliative care costs, 2.7% of the national total for hospitals that reported costing data. For non-admitted palliative care, Tasmania accounted for $640,437, 0.3% of the national total.[29]

This profile indicates that measured public palliative care activity in Tasmania is concentrated in the inpatient setting, while very little outpatient palliative care expenditure is recorded within hospital clinics. However, the small number of hospitals reporting non-admitted palliative care (2 of 24 Tasmanian hospitals that reported data to the Independent Health and Aged Care Pricing Authority), and the low per-hospital amounts suggest differences in service configuration and coding or incomplete costing coverage, rather than low community need.[29]

Medicare benefits for palliative medicine specialists in Tasmania

- AIHW data indicates a total of 78 Tasmanians accessed 189 MBS palliative care-medicine attendances, averaging to 2.4 MBS palliative care-medicine attendances per person.[28]
- Medicare benefits paid for palliative medicine specialist items in Tasmania were very small in 2023–24, totalling $22,852.[29]
- Almost all benefits related to attendances ($22,603), mainly in consulting rooms or hospital ($22,326), with a negligible amount for other settings ($278). Only $249 was claimed for case conference items across the year.[29] Tasmania's share of the national total for these specialist items was about 0.39 percent, and benefits per patient are not published because of small numbers.
- These figures reflect only MBS Group A24 specialist billing. They do not include palliative care provided by general practitioners or services funded directly by public hospitals. The low Medicare totals therefore likely reflect Tasmania's service and funding configuration, rather than low clinical activity, and should not be used as a proxy for overall specialist palliative care provision.

Primary care in palliative care

- Analysis of general practice data indicates that both the average number of unique patients and the average number of visits for palliative care per general practice have increased steadily between 2019 and 2025.[30]
- In 2019, practices recorded around 1 to 1.5 palliative care patients per month and approximately 2 to 3 visits. By 2024, this had risen to 2.5 to 3.5 patients and 4 to 5 visits per month on average, with peaks above these levels in some periods.[30]
- These trends suggest that general practices are not only caring for a growing number of patients with palliative care needs but are also managing an increasing service workload.
- However, these indicators should be interpreted with caution. The analysis is limited to practices participating in Primary Sense and relies on consistent coding of palliative care as a visit reason.
- Patients receiving palliative care in hospitals, residential aged care, community palliative care services, or in general practices not participating in Primary Sense are not captured. As such, these measures do not provide a complete picture of palliative care demand in Tasmania but do offer useful insight into patterns of activity within general practice.
- When considered alongside other evidence sources, the findings highlight the increasing role of general practice in supporting patients with palliative care needs and reinforce the importance of system-wide planning to build primary care capacity.

Palliative care medicines in Tasmania

- AIHW data indicates 12,656 Tasmanians accessed 43,309 PBS palliative care-related medications, averaging to 3.4 prescriptions per person.[27, 28]
- In 2023-24 Australian Government expenditure for PBS Palliative Care Schedule medicines in Tasmania totalled $1,401,263, about 3.7 percent of the national total.

- Expenditure per patient in Tasmania was $108.9, higher than the national figure of $79.9 and the highest among jurisdictions shown. This indicates higher average PBS palliative medicines spend per patient in Tasmania in 2023–24.[29]
- A breakdown of spending by medication type indicates highest need for pain relief.

Table 2. Medication use by type and cost

Medication type	PBS Expense	% Tasmanian palliative PBS expense
Pain relief	$1,240,241	88.5 %
Gastrointestinal symptoms	$87,954	6.3 %
Neurological symptoms	$37,610	2.7 %
Respiratory symptoms	$18,711	1.3 %
Psychological symptoms	$16,747	1.2 %

Geographic analysis of service locations

A high level regional mapping of key palliative care service providers across Tasmania was conducted for this Needs Assessment. Mapping included specialist services, volunteer organisations, other providers within the wider network of hospitals, residential aged care, home support, respite, hospice, community health centres, ambulance and transport, pharmacies, general practices, religious organisations and funeral homes. See Appendix B for service list.

Key findings indicate:

- Government specialist services commonly operate as multidisciplinary teams with physicians, specialist nurses, a social worker and a pharmacist
- Further work is required to describe how providers interact, the type of care delivered, and workforce size and mix across sites. However, current arrangements suggest siloed operations that complicate navigation when needs change.
- Greater integration and collaboration with general practice would improve continuity where referral from GPs is a gateway to specialist care.

Initial work has also occurred to understand the alignment of service demand with service availability. The maps below present crude rates of people needing hospitalisations (public hospitals only) by local government area (LGA) for January 2019 to December 2024.[31] Note: these maps reflect admitted coded activity in public hospitals only. Community, general practice, private hospitals, and residential aged care homes (RACH) palliative care are under-measured at present.

- Figure 4 – shows total palliative care–related admissions per 1,000 population
- Figure 5 – shows residents with at least one palliative care related hospital admission per 1,000 population

Together they provide a spatial view of hospital-reported demand alongside the service footprint outlined above.

Figure 4: Geographic representation of public hospital palliative care admissions, Tasmania

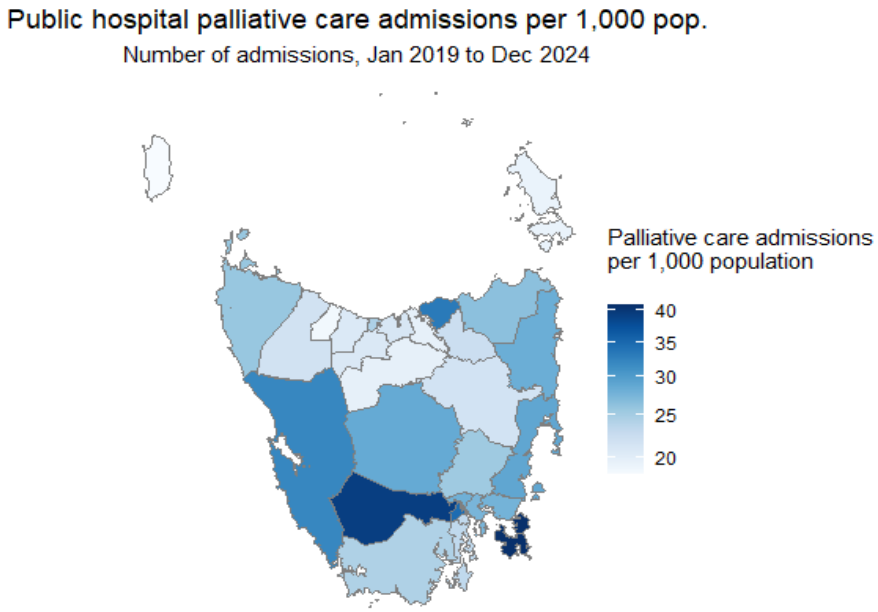
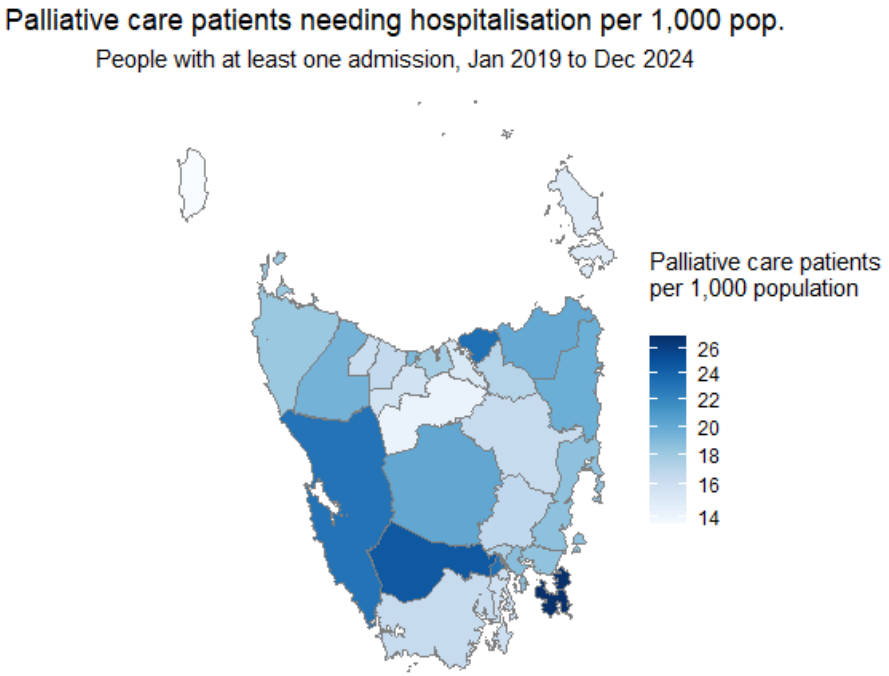


Figure 5: Geographic representation of palliative care patients needing hospitalisation, Tasmania



Analysis indicates:

- areas in the north-west and parts of the south record higher rates of residents with at least one admission.
- admission rates display even more pronounced hotspots in these regions, indicating more frequent hospital encounters per person in the same LGAs.
- several LGAs in the north-east and parts of the south-east show comparatively lower resident and admission rates.

Differences likely reflect a mix of population age structure and morbidity, distance to hospitals, local service configuration, availability of community supports, transport and carer capacity, and coding practices.

Linking these patterns with the service footprint suggests that:

- some high-rate LGAs have fewer local services per older resident, longer travel times to the nearest provider, and limited after-hours options
- differences in age structure, multimorbidity, socioeconomic status, residential aged-care bed density and proximity to hospitals also contribute
- geographic variation indicates uneven reliance on hospital care

Prioritisation should focus on stronger integration between local providers and general practice in high-rate LGAs, with after-hours support, transport and equipment logistics, and clearer shared-care pathways to reduce avoidable transfers. Monitoring will use the datasets currently available to the health system (hospital and, where feasible, general practice data).

Tasmania's specialist palliative care workforce and distribution

Based on the latest National Health Workforce Data Set, Tasmania reported:

- 9 employed palliative medicine physicians in 2022
- Hours worked equated to 10.0 FTE (total) including 6.8 FTE (clinical)[32]
- This corresponds to 1.8 FTE per 100,000 population (total) and 1.2 per 100,000 (clinical), higher than the Australian averages of 1.2 and 0.9 respectively and the highest per-capita physician FTE among states reported
- 101 employed palliative care nurses
- Average hours worked equated to 88.3 FTE (total) including 83.6 FTE (clinical)
- This corresponds to 15.5 FTE per 100,000 population (total) and 14.6 per 100,000 (clinical), higher than the Australian averages of 12.5 and 11.5 and among the highest across jurisdictions[32]

The results indicate that, on a per-capita basis, Tasmania has comparatively strong specialist medical and nursing palliative care capacity; however, the dataset does not show within-state distribution, so local availability (e.g. rural and remote areas) is not assessed.

Using 2021 Census data, Palliative Care Tasmania showed that:

- the paid palliative care workforce is concentrated in the larger LGAs, with the largest FTE in Launceston and Hobart, and substantial capacity in Clarence, Glenorchy and Devonport
- several regional and remote LGAs have very small paid workforces (for example, Central Highlands, West Coast, King Island, Flinders and Southern Midlands), indicating limited local cover outside the main centres[33]

Note: the Census-based total across LGAs (2,504 FTE) is slightly higher than the state analysis because of different methodology. The value here is the geographic pattern rather than a direct comparison of totals.

General practitioner workforce

Primary Health Tasmania's internal data as of September 2025 has recorded that Tasmania has:

- 134 general practices across the state with 71 (53%) located in the south, 36 (27%) located in the north, and 27 (20%) located in the north-west.
- a total GP workforce of 655.5 FTE (501.9 FTE general practitioners, 30.4 FTE general practitioner locums, and 123.2 FTE general practitioner registrars).
- This equates to 117.6 FTE per 100,000 population (total) with 90.0 FTE GPs per 100,000 population, 5.5 FTE GP locums per 100,000 population, 22.1 FTE GP registrars per 100,000 population.[34]

Unpaid palliative care workforce

A significant proportion of palliative care across Tasmania is provided by unpaid carers: with an estimated 3,577 unpaid carers (0.63% of the population).[33] most often this comes from intimate and personal carers, from family and friendship groups, and volunteers. While it is difficult to accurately measure the size and composition of the palliative care workforce in Tasmania, evidence suggests that family caregivers provide 75-90% of care for people with palliative care needs. Additionally, the unpaid palliative care workforce makes up

for some of the disparities present with the spread of paid palliative care workforce. Higher proportions are in several regional LGAs, including Tasman, Break O'Day, West Coast, Glamorgan–Spring Bay, Waratah/Wynyard, George Town, Latrobe, Devonport and Central Coast. These areas rely more on unpaid care due to limited access to traditional palliative care services and would benefit from stronger support for carers and targeted outreach from specialist and primary care service.

5. Stakeholder perspectives

Key findings

Stakeholder input ensures this Needs Assessment reflects real-world experiences and unmet needs. It supports the identification of consultation opportunities where related or existing areas of work (e.g. palliative care and aged care) can be aligned to strengthen work across portfolios.

General practitioners

Primary Health Tasmania conducted a survey of general practitioners between 6 February 2023 and 27 February 2023. Thirty-four GPs responded, with 44% from southern Tasmania, 41% from northern Tasmania, and 15% from north-west Tasmania.

Most respondents reported:

- they understand their role in palliative care
- a need for better access to advance care planning resources and support to strengthen legislative awareness relevant to palliative and end-of life-care.
- barriers including inadequate remuneration, the clinical complexity of providing palliative care, and logistical challenges
- additional system constraints including limited after-hours support, poor coordination across services, and rural resources.

Respondents expressed the need for:

- clear referral and escalation pathways
- rapid clinical advice and after-hours coverage
- protected time for care coordination
- reliable anticipatory prescribing with timely equipment provision
- shared tools for care planning and information exchange.

Implications for palliative care in Tasmania

These issues and needs are consistent with the higher reliance on admitted care, the under-measurement of community work, and should guide local quality improvement and capability building opportunities.

Given the GPs' increasing coordination and symptom management for people needing palliative care, these findings point to practical areas for improvement in Tasmanian general practice, particularly outside standard hours and in rural settings, and could inform local quality improvement and capability building activity.

6. Summary analysis of Tasmania's palliative care system

Following the identification of health and service needs, the prioritisation of needs in a systematic manner must be carried out. However, while this Needs Assessment leverages multiple public data sources to synthesise evidence, the data limitations must be noted.

To analyse need, a societal view on the definition of need was used.[35] This Needs Assessment uses:

- **Comparative need** – to describe the unmet health and service needs within Tasmania by comparison against nation-wide data or similar local populations where data permits.
- **Normative needs** – are then defined against best practices and standards in the palliative care context.,
- **Felt and expressed needs** – are identified through the views of people accessing palliative care services in Tasmania.

Key findings

Comparative need

- Need and access vary by place and circumstance.
- Admitted palliative care is 54.1 per 10,000 in Tasmania versus 38.6 nationally.
- Use is higher in more disadvantaged areas.
- Several regional LGAs have thin or no paid local workforce and rely more on travelling clinicians and unpaid carers.
- Rurality adds travel time and complicates after-hours response.

Normative need

While future service design in Tasmania must strive to satisfy all the determinants of palliative care access, there are several standards that, within the scope of GCfAHPC, can be targeted:

- Palliative care services should aim to provide multidisciplinary care close to or at the patient's home.
- Service provision should be collaborative and integrated alongside defined referral processes to increase accessibility of referrals to palliative care and for smooth transition of palliative care patients with changing needs.

Felt and expressed need

Communities, families, and carers often feel unprepared for end-of-life decision-making, with low health and grief literacy contributing to anxiety, delayed access to care, and unsupported bereavement[36].

People with life-limiting illness, particularly in rural and remote areas, experience barriers to timely and culturally safe palliative care, while carers report feeling isolated when managing complex needs at home.

The workforce also describes low confidence in symptom management and end-of-life conversations.

These challenges are reflected in the need for:

- **clearer information**
- **streamlined referral pathways**
- **improved availability and coordination of palliative services, especially home-based care.**

General practitioners, service providers and communities consistently call for:

- **increased education and training across primary and aged care**
- **more stable resource investment to strengthen workforce capacity, expand access in underserved areas, and ensure holistic, person-centred, and carer-inclusive palliative care.**

The importance of education and awareness for communities and carers:

- **Supports the significant amount of palliative care provided by carers and community**
- **Increases the settings available for the community to receive quality palliative care**
- **Highlights the importance of social and emotional wellbeing of carers involved in palliative care**

The key gaps observed in implementation of best practice and the Tasmanian Palliative and End of Life Care policy framework are summarised in Table 3. Practical opportunities for improvement were also included, noting these extend beyond the scope of the GCfAHPC program.

This should be read alongside the preceding evidence on admitted care reliance, non-admitted under-measurement, and patterns in general practice activity.

Table 3. Identified implementation gaps in the Tasmanian palliative care landscape in comparison with best practices and Tasmanian palliative care policy framework

Priority area (Tasmanian Palliative and End of Life Care Policy Framework)	Current outlook	Potential opportunities for development

Community awareness and understanding (Priority 2)	• In 2024, Palliative Care Tasmania and the Death Literacy Institute found that[36]:
	  • Only 20% of Tasmanians knew how to navigate the healthcare system for someone dying or needing age care
	  • 33% felt confident navigating the funeral industry
	  • Half of Tasmanians do not know where to find information on palliative care, and even fewer (22%) knew how to access local information
		• Health promotion and community awareness resources on difficult topics such as grief, normalisation of death, and encouragement to talk about advance care planning
		• Promotion of a central help service and after-hours services to support the community in navigating grief, find resources. Ideally, there should be 24-hour phone support
		• Develop standard resources to support families and carers including culturally safe, multicultural support

Building capacity and capability of the workforce to provide equitable access (Priority 4)	• Access to palliative care services (especially specialist palliative care) is particularly problematic for patients in rural and remote areas requiring palliative care[37] • Demand for non-oncology palliative care services is significant. Non-cancer conditions accounted for about two-thirds of all palliative-care-related hospitalisations during 2022-23. • There is a high reliance on unpaid carers for home-based care • Majority of Tasmanian palliative care hospitalisations are admitted. Compared to national levels, rates of non-admitted palliative care in Tasmania are much lower (almost none). • Barriers for care providers around time constraints, renumeration, and lack of professional collaboration limited home-visit services provided by rural care providers[38]	• Advocate for the Inclusion of palliative care as a specific component of MBS urgent after-hours care items • Deliver culturally safe ongoing training and support (including peer support, mentoring and emotional) to palliative care providers • Scholarships and incentives can be offered to support specialists in palliative care • Carry out workforce planning and modelling of the palliative care workforce. Potentially, planning should involve creative and innovative staffing models (e.g. a nurse practitioner feasibility study can be conducted for new palliative care service models)[39] • Improve access of palliative care services for all age-groups (not only focusing on people aged 65+) and support for individuals with diagnoses other than cancer (such as neurodegenerative disease)
Coordinated and integrated palliative care services (Priority 5)	• Despite ongoing process and being a priority area in the Tasmanian palliative and end of life care framework, palliative care services are described as fragmented, with inconsistent coordination between specialist, primary, and aged care centres. • This is because palliative care delivery is likely to involve different tiers of government, a range of infrastructural arrangements, and involvement from both specialists and unpaid carers (such as friends and family).	• Establish local interdisciplinary teams and defined referral pathways involving GPs, primary care providers, palliative care specialists, allied health professionals, support services, social workers, and Aboriginal Health workers • Practice shared case management across palliative care services to facilitate high quality care • Consistency in information and data collection and clinical documentation is ideal to support flexibility and standardisation
Conduct ongoing review and evaluation of the framework (Priority 6)	• The Department of Health, Disability, and Ageing (DHDA) Tasmania is leading the implementation of the Tasmanian Palliative and End of Life Care policy framework in collaboration with 'Partners in Palliative Care' Reference group[18]. • DDHA Tasmania is developing a monitoring and evaluation strategy as well.	• Ensure visibility of monitoring and evaluation framework to service providers and commissioners • Complete evaluation of the Tasmanian Comprehensive Palliative Care in Aged Care (CPCiAC) project • Ensure sufficient data collection systems are in place and data required for rigorous monitoring and evaluation is available

The priority areas in Table 3 align with the evidence and stakeholder feedback: community awareness needs, uneven workforce capacity, significant non-cancer demand, heavy reliance on unpaid carers, low measured non-admitted activity, rural access constraints, and coordination gaps.

Implications for primary care in Tasmania

- This needs assessment provides an insight into the unique health and service needs of the Tasmanian population and highlights the growing need for improvement in the palliative care sector.
- By aligning future initiatives with key national and local policies, designing of services following best practices, and enhancing data collection for monitoring and evaluation purposes to inform service improvement, a strong starting point to improve palliative care service delivery can be established.
- Together, these findings indicate a need to rebalance care toward homes that are safe and preferred, while improving measurement outside hospital so investment reflects the work already occurring in the community.

The following sections translate these needs into actionable priorities through stakeholder perspectives and the priority actions and future directions.

7. Priority recommendations

Synthesising the health needs, service mapping, system analysis, and stakeholder perspectives, this section outlines current efforts and future directions to address identified gaps, ensuring a cohesive path toward improved palliative care in Tasmania.

The following recommendations are informed by evidence from hospital, primary care, workforce, and expenditure data. This evidence indicates that the system heavily relies on admitted care, where community-based activities are under-measured and unevenly accessible. The recommendations prioritise equity, community-based care, enhance capability and improved system integration.

It is important to note that effectively addressing these priorities will require a coordinated, statewide approach involving all stakeholders and service providers; however, these opportunities reflect what can be prioritised within the scope of the GCfAHPC program.

Increase awareness and access to quality palliative care at home

Improving access to care for priority groups

- Strengthen outreach and shared-care arrangements across rural and remote regions, especially in several north-west and regional LGAs with high-admission rate, and low-workforce capacity.

  Opportunity:

  - Strengthen coordination and service linkage to build local system capability
  - Improve continuity of care and service availability using innovative solutions
  - Support rural and remote services through better integration and education opportunities.

Improve access to afterhours palliative care

- Enhance access to community-based and after-hours palliative care, with particular focus on high needs areas where services are limited

  Opportunity:

  - Promote after-hours advice lines and community resources
  - Co-develop protocols and escalation pathways for after-hours support with local and remote services.

Improve awareness of and access to respite and bereavement supports

- Increase visibility and access to respite and bereavement supports for families, carers and primary care providers

  Opportunity:

  - Promote referral pathways and service directories.
  - Improved coordination and identification of needs between palliative care, carer support, and community services.

Improve coordination across primary care, aged care and specialist services

Improve statewide coordination of care

- Improve access and equity through statewide coordination, timely identification of need across diagnoses

  Opportunity:

- Develop standardised assessment tools to identify palliative care needs and facilitate early across diagnoses
- Create statewide referral and pathway guides to improve service navigation.
- Investigate options for collaboration with existing services providers to expanded home- and community-based palliative care

Build workforce capability and community confidence

Strengthen support for unpaid carers

- Provide targeted support for unpaid carers, with particular focus on several regional and rural LGAs with limited paid workforce availability to sustain home-based care and reduce avoidable admissions

Opportunity:

- Embed carer support awareness into care planning,
- Develop carer information packages and digital resources for accessing supports.
- Improve access to education including grief literacy for carers.

Strengthen person centred palliative care

- Implement targeted, culturally safe education initiatives to improve access for priority populations, including rural and remote communities, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) populations, socioeconomically disadvantaged groups, and older people.

Opportunity:

- Co-design service pathways with Aboriginal and Torres Strait Islander communities, Multicultural populations, and other priority groups
- Create culturally tailored awareness materials to improve access to services.

Strengthen primary care capacity in palliative care

- Build primary care capacity for a palliative approach, with a focus on after-hours coverage, anticipatory medicines, shared care plans and carer support to support safe home-based care

Opportunity:

- Support general practices and community providers to adopt a consistent palliative approach through targeted education, local clinical pathways and practical tools (e.g. shared care plan templates, anticipatory prescribing guidance).
- Strengthen links with after-hours services and community pharmacies.
- Develop locally agreed referral and escalation pathways between general practice, community palliative care and specialist services,
- Identify opportunities to increase provider access to specialist phone or telehealth advice.
- Support general practice to identify protected time for care coordination.
- Develop and support the use of shared tools for care planning.

Use data and technology to support flexible, responsive care

Improve access to care through digital solutions

- Embed telehealth as part of a hybrid palliative health service, complemented by in-person outreach and local support, with targeted investment in digital capability across health providers

Opportunity:

- ➢ Promote telehealth awareness among providers and patients.
- ➢ Work with primary care and specialist services to support and encourage hybrid consultations to improve service reach, particularly in priority rural and remote locations.

Use and improve access to data to monitor priorities and improvement

Use current data and strengthen access to additional data, with particular focus on the following:

- **Hospital utilisation** - monitor non-admitted activity to understand how investment shifts palliative care from hospital to community.

  Opportunity:

  - ➢ Establish a locally led monitoring process using existing community palliative care and primary care data (e.g. service contacts, home visits, telehealth, after-hours calls) to regularly review trends in non-admitted activity.

- **Priority populations** - Improve data collection to track community activity and equity across rural, Aboriginal and Torres Strait Islander, and CALD populations

  Opportunity:

  - ➢ Enhance routine data collection by consistently capturing demographic and location information across community and primary care services.

- **Access to medications to support care in the community** - improve monitoring system that track access and equity in medicines alongside non-admitted and community activity to understand whether clinical need is being met outside admitted care

  Opportunity:

  - ➢ Introduce local reporting that links community activity data with high-level medicines access indicators (e.g. anticipatory prescribing, after-hours supply arrangements).
  - ➢ Use this information to identify barriers to timely access in rural and priority populations and inform targeted local improvements in prescribing pathways.

Collaboration is critical

The focus of GCfAHPC is on system improvement and is therefore highly reliant on others delivering improvements.

Therefore, to refine and deliver these actions, it will be essential that Primary Health Tasmania will continue structured consultations and active collaboration with abroad range of stakeholders and service providers to deliver on these priorities.

These include, but are not limited to our work with:

- General practitioners and primary care providers
- Palliative care specialists and statewide and national palliative care initiatives
- Peak bodies
- Aged care providers
- Carers and families
- Local community groups and priority populations
- Other Primary Health Networks

Appendices

Appendix A. Brief of leading practices in palliative care, including global, national, and local standards

Global standards in palliative care

Broad guidelines developed by international organisations to promote equity, accessibility, and person-centred care globally.

Global health organisations such as WHO have released statements on practice and ethics of palliative care. Following the 67th world health assembly, the World Health Assembly Resolution 67.19 - Strengthening of palliative care as a component of comprehensive care throughout the life course was released[17]. This resolution recognised the importance of palliative care, when indicated, in improving the quality of life, well-being, comfort and human dignity of individuals and stated that palliative care is an ethical responsibility of health systems and that all health professionals have an ethical duty to alleviate pain and suffering, irrespective of whether the disease of condition can be cured.[17]

In summary, WHO urged member states to integrate palliative care into all levels of the health system, to ensure access to essential medicines in palliative care (such as opioids for pain management through balanced regulation), to ensure provision of development and training for the palliative care workforce depending on their level of interaction with clients, to strengthen policies and financing by inclusion of palliative care in national health strategies and budgets, and to foster partnerships between relevant stakeholders to support the provision of services for patients requiring palliative care

National standards in palliative care

Policies and frameworks that translate international principles into actionable priorities tailored to the Australian context.

Australia sets clear expectations for palliative care through the National Palliative Care Strategy 2018 and Palliative Care Australia's National Palliative Care Standards. In this needs assessment they serve as the reference point for what good care looks like and how services should be organised.

National palliative care strategy 2018

The National Palliative Care Strategy's vision is that people with life-limiting illness receive the care they need to live well.[18] It treats palliative care as person-centred and holistic, recognises death as part of life, and places carers within scope. Care should be accessible, shared across the system, and based on evidence.

To make this practical, the Strategy directs attention to seven system goals: help people understand and find palliative care, build capability across settings, match care to needs and preferences, coordinate across services, invest in a skilled workforce and fit-for-purpose systems, improve data and research, and keep governance visible so action follows.[18]

Local standards in palliative care

Regional strategies and initiatives that address the unique challenges of Tasmania's palliative care landscape, such as rurality, geographic isolation and socio-economic disparities.

Tasmanian palliative and end of life care policy framework 2022-27

There are strong overlap and alignment between the Tasmanian principles for palliative care and the principles outlined in the national strategy. Locally, the TPE framework builds on the national palliative care strategy principles and offers a pathway for improving palliative and end of life care in Tasmania.[9]

The Tasmanian policy framework outlines six priority areas to guide palliative care services[9]:

1. Enhance holistic person-centred and family inclusive palliative and end of life care
2. Increase community awareness and understanding of palliative and end of life care
3. Enhance psychosocial support and bereavement care for patients, families, and caregivers
4. Build capacity and capability of the workforce to provide equitable access to quality palliative and end of life care
5. Build and deliver coordinated and integrated palliative care services to contemporary standards
6. Conduct ongoing review and evaluation of the delivery and outcomes from the implementation of this framework

Therefore, palliative care services in Tasmania must be aligned with priority areas outlined in national and local policy frameworks while striving to achieve the standards set within best practices. All relevant stakeholders must be aware of the 'gap' that exists between best practices and the current Tasmanian palliative care landscape which will be expanded upon in later sections. This will also inform which improvement opportunities can be identified.

Appendix B. Palliative care services across Tasmania

Services	Location		Additional information
Specialist palliative care services			
Specialist Palliative Care service- Community Palliative Care	Activities Centre, Repatriation Centre, 90 Davey St Hobart, TAS 7000	Southern Tasmania	
J.W. Whittle Palliative Care Unit	Lower Ground Floor, Peacock Building Repatriation Centre, Hampden Road 88 Davey St Hobart, TAS 7000	Southern Tasmania	10 single rooms
Gibson Unit palliative care	30 Cascade Road, South Hobart TAS 7004	Southern Tasmania	21 bed oncology and palliative care unit
Specialist Palliative Care Service - Community Palliative Care	Allambi Building 33-39 Howick Street Launceston, TAS 7250	Northern Tasmania	12 bed facility
Melwood Palliative Care Unit	24 Lyttleton Street Launceston, TAS 7250	Northern Tasmania	15 bed facility
Mersey Community Hospital Palliative Care Inpatient Service (PCIS)	Torquay Road, Latrobe TAS 7307	Northwest Tasmania	
Specialist Palliative Care Service - Community Palliative Care	Level 3, Parkside, 1 Strahan Street, Burnie, TAS 7320	Northwest Tasmania	
Volunteer services			
Hospice Volunteers South Tas Inc.	Tel: 0362319249	Phone & Outreach service, Southern Tasmania	In home palliative care volunteer support
The Volunteer Support Service - Palliative Care Service	Tel: 0367774544	Northern Tasmania	
Hospice Care Association of Northwest Tasmanian Inc.	Tel: 0364777747	Phone & walk-in, Northwest Tasmania	
Other Palliative care organisations			

One Care community home care services	Phone, walk-in & Outreach service, statewide	OneCare Home Care helps clients remain healthy and independent in your own home.
Just Better care	Phone, walk-in & outreach service, Southern Tasmania	Provides in-home support, and social and community support
Palliative care Tasmania	Phone & online services (outreach services for some training programs such as 'Learning through loss'	Provides non-clinical services. Palliative Care Tasmania is Tasmania's peak body for palliative care.
Palhelp	Phone & outreach services, Southern Tasmania	Palhelp programs include assistance with Advance Care Planning, social support and My Life Story, biography writing service. Not available for people with dementia or some Alzheimer's patients.
Homely retreats	Phone & outreach services	Homely Retreats is NGO dedicated to providing personalised support and respite experiences for Tasmanian families affected by cancer.

***Note**: this list intends to provide an overview of services available and is not meant to be comprehensive. While the sources used to structure this table makes every effort to keep information up to date, there is a possibility of changes. Calling a service provider is recommended to obtain latest information*

Appendix C. Limitations of palliative care data sources in Tasmania

Limitations	Description
Limited datasets sources	Reporting is constrained by available datasets. Data suppression protects confidentiality and may prevent fine-grained reporting.
General practice and primary care data	General practice data reflect only participating practices and depend on consistent coding of palliative activity. Other primary care datasets also depend on accurate coding and do not capture all providers.
Hospital data	Hospital datasets emphasise admitted care and may underreport palliative care activity where coding is incomplete. Public hospital data dominates reporting, resulting in under-measurement of community-based care.
Community and non-admitted care	Community, private hospital and residential aged care palliative activity is not captured comprehensively, so the true volume of non-admitted work is likely higher than reported.
Geographic data	Geographic comparisons should be interpreted with caution, as maps data rely largely on public hospital activity and are influenced by age structure, morbidity and proximity to hospital services' collections.
Missing data	Palliative care data do not consistently capture key information, including the distribution of paid and unpaid carers, or identification of priority populations such as Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities at the local level.

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