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Palliative Care Needs Assessment 2025-28

Western Sydney Primary Health Network

Greater Choice for At Home Palliative Care – an Australian Government initiative

December 2025

We acknowledge the First Nations peoples of Australia as the Traditional Custodians of the land on which we work and live. We pay our respect to Elders past, present and future and extend that respect to all Aboriginal and Torres Strait Islander peoples.

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Acronyms

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AWP	Activity Work Plan
CALD	Culturally and Linguistically Diverse
DoHDA	Australian Department of Health, Disability and Ageing
ED	Emergency Departments
GP	General Practitioner
GCfAHPC	Greater Choice for At Home Palliative Care
HSI	Health Systems Improvement
LGA	Local Government Area/s
MBS	Medicare Benefits Schedule
N.D.	No date available for publication
NHMD	National Hospital Morbidity Database (admitted patient palliative care)
NNAP(el)D	National Non-Admitted Patient (episode-level) Database
NSW	New South Wales
PHN	Primary Health Network
PMT	Project Management Team
SEIFA	Socio-Economic Indexes for Areas
WSLHD	Western Sydney Local Health District
WSPHN or 'the region'	Western Sydney Primary Health Network

Executive Summary

The Western Sydney Primary Health Network (WSPHN) 2025-2028 palliative care needs assessment provides a comprehensive evidence-based analysis of the region's geographic and cultural profile, community needs for palliative care, and regional workforce support to improve capacity and capability in delivering palliative care. It aligns with the 2025-29 grant funding guidelines for PHNs under the Greater Choice for At Home Palliative Care (GCfAHPC) program and includes considerations for future planning and commissioning activities within the region to support efficient, equitable and culturally responsive palliative care within the WSPHN region.

Methodology

The palliative care needs assessment utilised a comprehensive quantitative approach to identify and analyse the WSPHN region's palliative care health needs and workforce capacity and capability. Quantitative data was sourced from key national data sets, and directly from community members and health professionals in the region, through two surveys. This data provided insights into population demographics, cultural diversity, chronic disease prevalence, palliative care awareness and utilisation, and workforce challenges and additional support. The results reported in this needs assessment were synthesised to support a robust evidence-based understanding of palliative care within the region.

Key findings

Population and cultural demography

Over one million people reside in the WSPHN region, with a forecasted increase in the population of 16 per cent by 2024. The region is marked by its cultural diversity and high concentrations of parents and home-builders, young workforce and children. However, there is also a growing number of older people in the region experiencing increasing rates of chronic conditions. The population in the region is distributed across the four Local Government Areas (LGAs) of Blacktown, Cumberland, Parramatta and The Hills Shire. The Blacktown LGA is the largest in the region with the highest proportion of First Nations residents. Meanwhile the Cumberland LGA has the largest culturally diverse population with the highest proportion who spoke a language other than English at home and a notable proportion who spoke little to no English. Both the Cumberland and Blacktown LGAs are also marked with the highest levels of socio-economic disadvantage within the WSPHN region.

Palliative care utilisation

Palliative care service usage in the region remained consistently lower than rates in NSW and Australia, over time. However, a deeper analysis of need in the region indicated that palliative care interventions mainly involved allied health or clinical nursing services for non-admitted patients and were delivered alongside cancer treatment for admitted patients. Furthermore, palliative care service needs were disproportionately greater among residents over 74 years of age, and in the most socio-economically disadvantaged areas. These same residents were characterised with higher rates of chronic conditions prevalence, particularly among those deteriorating conditions that were likely to require palliative care (e.g., cancer, lung conditions, kidney disease and heart disease). Furthermore, concerns among socio-economically disadvantaged communities about the cost of palliative care and increasing misconceptions about its purpose, potentially contributed to delays in seeking this care until hospitalisation.

Western Sydney community awareness and need for palliative care

Palliative care usage can be attributed to the level of community awareness and understanding of the type of care involved, and the implementation of active end-of-life planning. Awareness of palliative care was high among the Western Sydney community, with most understanding that it supported people to continue living comfortable lives. While most people in the community also placed a high importance on discussing their end-of-life preferences, only a small proportion engaged in any active end-of-life planning. Common barriers to engaging in planning activities included misconceptions about the purpose, setting and duration period for palliative care delivery. In addition to these barriers, people from socio-economically disadvantaged areas were also concerned about cultural insensitivity among palliative care providers and language and literacy barriers led to further mistrust.

The primary types of palliative care support received by people in the region involved information about the care process, the administration of medication and managing symptoms. However, having adequate access to after-hours care, ensuring the reduction of physical suffering and providing access to home nursing care were highlighted as the greatest areas of need for people receiving palliative care. Additionally, access to grief counselling and 24-hours specialist care were among the highest priority areas of need for carers in the region.

Confidence, barriers and additional support for palliative care workforce

The palliative care workforce in the region comprised highly experienced health professionals including general practitioners, primary care nurses, allied health professionals and community workers. The workforce was highly confident with palliative care related activities such as case conferencing and medication administration. However, they were less confident with supporting the development of Advance Care Plans and the co-ordination of community palliative healthcare. Social and emotional barriers contributing to confidence levels included having to discuss the end-of-life process and transition to palliative care with patients, their families and carers. Meanwhile, other barriers experienced by the palliative care workforce in the region included the lack of sufficient staff to provide high quality palliative care, time pressures on current staff and the lack of available local services.

Further education and learning opportunities were highly supported by the palliative care workforce, particularly if they were delivered online or face-to-face. Best practice in palliative care, allied health support, and the regulatory framework for palliative care delivery were the key topics of interest, aligning with palliative care activities that health professionals in the region were least confident about.

1 Introduction

Under the 2025-2029 Grant Opportunity Guidelines, all Primary Health Networks (PHNs) are required to update their palliative care needs assessment that was conducted as part of the national rollout of the GCfAHPC program in 2021.

This report provides the 2025-28 palliative care needs assessment of the Western Sydney Primary Health Network (WSPHN) region ('the region'). This is the second report submitted to the Department by the WSPHN. It builds on the previous needs assessment report by incorporating new evidence and insights to refine the understanding of regional palliative care health needs and inform future strategic health initiatives.

The Needs Assessment supports PHN decisions about the commissioning of services, delivery of Practice Support and Health Systems Improvement (HSI) activities. It is also used to guide other reporting obligations to the Department such as the Activity Work Plan (AWP), half yearly and annual performance reporting.

1.1 Needs assessment aims, objectives and assessment questions

The purpose of the 2025-28 Palliative Care Needs Assessment is to inform planning and commissioning activities conducted by the WSPHN in palliative care with a view to:

- Improve the efficiency and effectiveness of palliative care services for the population of Western Sydney, particularly those at risk of poor health outcomes, and
- Improve health services coordination, access, and quality support for the Western Sydney population.

The 2025-28 Palliative Care needs assessment was guided by the following questions:

- What is the demographic and cultural profile of the Western Sydney region?
- What are the current rates of palliative care awareness, service utilisation and care needs among the Western Sydney community?
- To what extent is the Western Sydney palliative care workforce able to meet palliative care needs in the community?

1.2 Palliative Care context in Australia and Western Sydney

Palliative Care is person or family-centred care that improves the quality of life of people and their families who are facing problems associated with life-limiting illnesses[1,2]. The care received does not hasten the end-of-life, nor does it prolong life expectancy[3]. Instead, it aims to help people live their life as fully and comfortably as possible by relieving suffering through early identification, assessment and treatment of pain, and supporting other physical, psychosocial and spiritual issues[4].

Palliative care is not age-specific as it is available to children, young people, adults and the elderly. It can be accessed for a few weeks, months or many years. It can be delivered alongside other treatments (e.g., chemotherapy), or after these treatments have ended[5]. End-of-life care is an important component of palliative care and is usually provided to patients with progressive, advanced or incurable conditions or old age during a specific timeframe, usually the last 12 month of life[6].

In Australia, an estimated 50% to 90% of the 160,000 people who die each year would benefit from the palliative care. Furthermore, the increasing prevalence of chronic conditions (e.g., cancer) coupled with the ageing population have contributed to increased demand for palliative care services[7]. This has led to palliative care services being provided in almost all health care settings, including general practice, hospitals, and residential and community aged care[8].

The context for palliative care in the WSPHN mirrors that of the national level. The Western Sydney region comprises the four LGAs of Blacktown, Cumberland, Parramatta and the Hills Shire. Together these LGAs are home to 1.08 million residents, representing 13% of the New South Wales population[9]. While the region has a relatively young age profile, it also has a large and growing older population, with more than 183,062 people aged 60 years and over, including 30,485 aged 80 years and above[10]. Older residents in the region experience significantly higher prevalence of life-limiting chronic conditions such as cancer, than their younger counterparts, placing increasing pressure on palliative care services in the region to meet this demand.

1.3 Methodology

The 2025-28 Palliative Care needs assessment involved a four-phased approach to collect, analyse and synthesise primary and secondary data to provide a comprehensive understanding of palliative care needs in Western Sydney.

- **Phase 1: Project planning and scoping** – Involved defining the parameters for the palliative care needs assessment including the identification of data sources, data collection and analysis methods. An internal project management team (PMT) was established to support the needs assessment.

[1] Source: Australian Institute of Health and Welfare, 2025a
[2] A life-limiting illness is an active, progressive, or advanced disease, that has little or no prospect of cure and that a person is likely to die from at some point in the future (e.g., cancer, motor neurone disease, end-stage kidney disease).
[3] Source: Palliative Care NSW, 2022
[4] Source: Palliative Care Australia, 2025a
[5] Source: Palliative Care Australia, 2025a
[6] Source: World Health Organization, 2025
[7] Australian Institute of Health and Welfare, 2025a
[8] Van Gaans, Erny-Albrecht & Tieman, 2022
[9] ABS (2021a-d). Census of Population and Housing.
[10] ABS (2021e-h). Census of Population and Housing.

- **Phase 2: Community and stakeholder consultation** – Involved the collection and analysis of data from two surveys – a survey of people primarily within the WSPHN region (n=49), and a survey of health professionals (n=82) within the WSPHN region.
- **Phase 3: Secondary data collection and analysis** – Involved the collection and analysis of AIHW data to update metrics from the 2022 Palliative Care needs assessment and introduce new metrics to provide additional insights about palliative care need in Western Sydney.
- **Phase 4: Synthesis and reporting** – Involved combining findings from all data sources to provide a comprehensive assessment of current needs for palliative care.

1.4 Structure of this report

This report is divided into 6 chapters and is structured as follows:

- **Chapter 1: Introduction (this chapter)** presents the palliative care needs assessment aim, objectives and assessment questions, national and regional context of palliative care and methodology.
- **Chapter 2: WSPHN profile** introduces the demographic and cultural characteristics of the WSPHN region, covering geographic boundaries, population size, life expectancy, place of birth and linguistic diversity.
- **Chapter 3: Palliative care patient data** examines palliative care hospitalisations, MBS subsidised palliative care and prescribed medication.
- **Chapter 4: Community awareness, usage and needs for palliative care** examines community understanding and familiarity with palliative care and end-of-life planning, their usage of palliative care support and their perceptions of palliative care needs.
- **Chapter 5: Palliative care workforce capacity and capability** examines health professional confidence in palliative care service delivery, challenges and barriers experienced and how they can be supported to provide or coordinate palliative care services.
- **Chapter 6: Summary of findings and future considerations** provides a synthesis of the data analysis from previous chapters and options to inform WSPHN activity work plans that align with palliative care needs in the region.

2 WSPHN Profile

This chapter explores the geographic, demographic and cultural profile of the region. It is divided into two sections: the first examines the geographic and demographic context, and the second focuses on cultural and linguistic diversity.

Summary of key traits about the region 2021-2024

1. There are over one million people residing in the region with 8.2% growth expected by 2024, particularly in the Parramatta (10.3%) and the Hills Shire (10.4%) LGAs.
2. Seven in ten First Nations people in the region reside in Blacktown LGA (71.1%).
3. Parents and homebuilders (aged 35 to 49 years) are the largest population group in the region, NSW and Australia. However, the proportion of parents and homebuilders is slightly higher in the region (23.0%) than NSW (20.1%) and Australia (20.2%).
4. One in six people in the region is aged 60 years or over (16.9%).
5. Two in three Cumberland LGA residents speak a language other than English at home compared to one in two across the region (65.2% vs 51.5%). Additionally, Cumberland has the highest proportion of residents who speak little to no English (14%) and the lowest rates of Australian and English ancestry (10.6% and 9.2%).
6. Cumberland and Blacktown LGAs (SEIFA – 904 and 987) are more socio-economically disadvantaged than Parramatta and The Hills Shire (SEIFA – 1030 and 1098).
7. Prevalence rates for chronic conditions likely to require palliative care was highest among people aged 75 years and over. For example, 162.0 per 1,000 people aged 75-84 years were affected by heart disease, while the rate was 234.8 per 1,000 people aged 85 years and over.

2.1 Geographic and demographic context

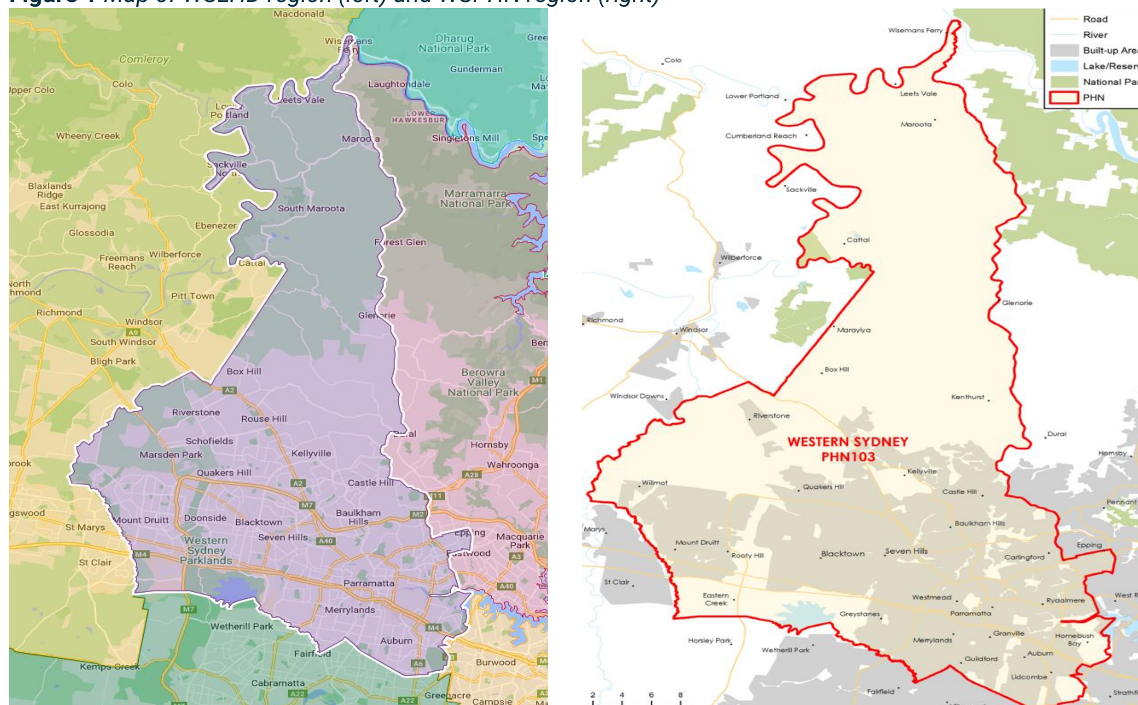
This section examines the geographic boundaries, population characteristics, age distribution, and life expectancy in the region, providing an overview of the demographic factors that shape health needs.

2.1.1 Geographic boundaries

The region covers about **782 square kilometres**, stretching from Wisemans Ferry in the North to Regents Park in the South, and from Epping in the East to Ropes Crossing in the West.[11] It overlaps with the same boundaries as the Western Sydney Local Health District (WSLHD); see Figure 1. The traditional custodians of the region are **the Darug people.**

[11] Informed Decisions, 2023a; Department of Health, Disability and Ageing , n.d.

Figure 1 *Map of WSLHD region (left) and WSPHN region (right)*



Source: NSW Health (2022); Department of Health, Disability and Ageing (2025). Compiled by WSPHN.

2.1.2 Population characteristics

Data from the Australian Bureau of Statistics (ABS) 2021[12] highlights the following insights about the population of the region (see Table 1 and Figure 2):

- **The population has crossed 1 million and continues to grow rapidly:** the total population of the region stood at 1,080,828 residents and was forecasted to increase by 16.1% by 2028. The Hills Shire and Parramatta LGAs were expected to experience the largest increases (21.8% and 16.6%). Overall, the region accounted 13.4% of the NSW population (8,072,161) and 4.3% of the Australian population (25,422,789).
- **Approximately four in ten residents lived in Blacktown LGA:** the population of Blacktown LGA was 396,781, representing 36.7% of all residents in the region. This was followed by Parramatta (256,729; 23.8%), Cumberland (235,440; 21.8%) and the Hills Shire (191,878; 17.8%) LGAs.
- **A large proportion of First Nations residents lived in Blacktown LGA:** of the 16,614 First Nations people in the region, 71.1% (11,812) lived in Blacktown LGA. This was followed by Parramatta (2,079; 12.5%), Cumberland (1,516; 9.1%) and the Hills Shire (1,207; 7.3%).
- **First Nations residents made up six per cent of the First Nations population in NSW and two per cent nationally:** there were 16,614 First Nations residents in the region, representing six per cent of the total First Nations population in NSW (278,043) and only two per cent of the national First Nations population (812,728).

[12] Australian Bureau of Statistics, 2021a-d

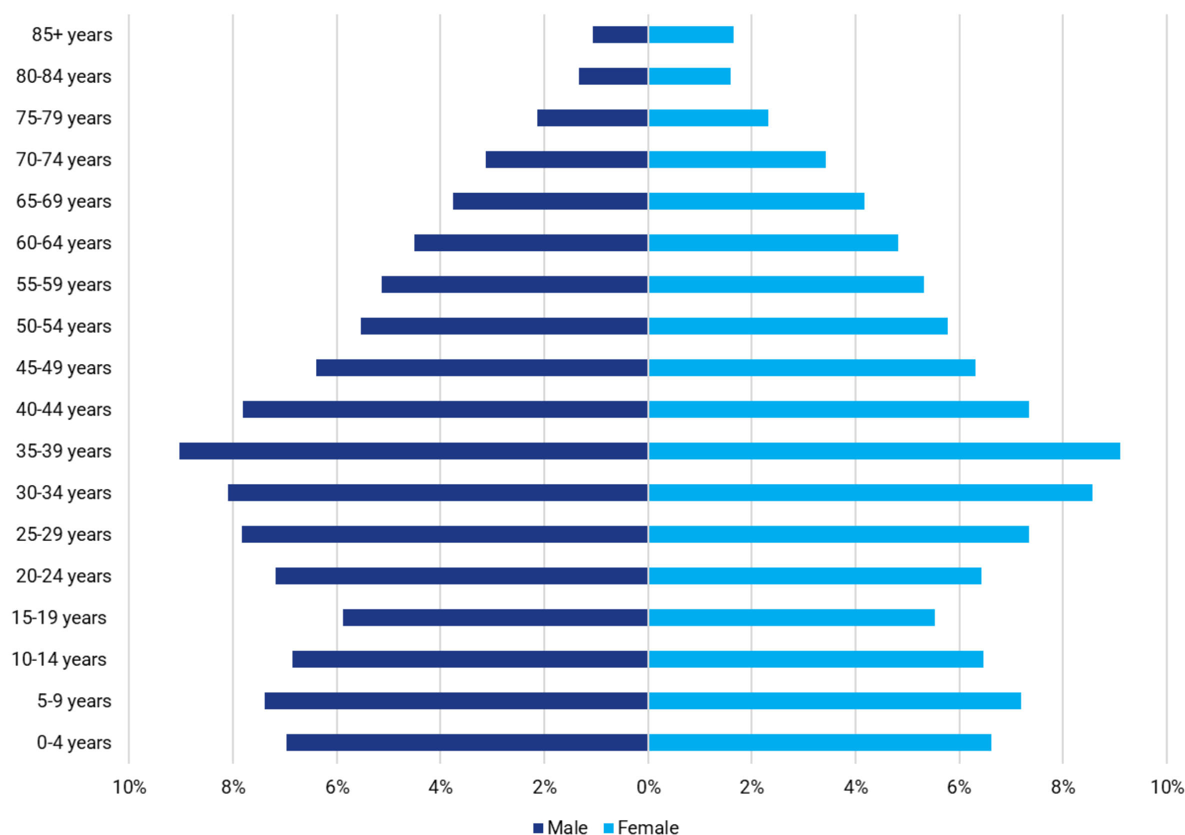
- **Socioeconomic disadvantage varied across LGAs:** Cumberland and Blacktown LGAs had SEIFA scores of 904 and 987 in 2021, indicating greater disadvantage in these LGAs than in NSW (SEIFA Index - 1,001) and Australia (SEIFA Index - 1,000). However, SEIFA scores in the Parramatta and Hills Shire LGAs were 1030 and 1098[13], indicating less disadvantage.

Table 1 *Resident population across the WSPHN region, NSW and Australia, 2021*

	WSPHN region	Blacktown LGA	Cumberland LGA	Parramatta LGA	The Hills Shire LGA	NSW	Australia
Total	1,080,828	396,781	235,440	256,729	191,878	8,072,161	25,422,789
Male	542,769	197,876	121,502	128,734	94,657	3,984,166	12,545,154
Female	538,059	198,905	113,938	127,995	97,221	4,087,995	12,877,635
First Nations	16,614	11,812	1,516	2,079	1,207	278,043	812,728
2028 total forecast	1,254,939	451,981	269,957	299,253	233,748	-	-

Source: Australian Bureau of Statistics (2021a-d). Compiled by WSPHN.

Figure 2 *Age-Sex pyramid of age distribution in Western Sydney PHN in 2021*



Source: Australian Bureau of Statistics (2021e-h). Compiled by WSPHN.

[13] Source: Australian Bureau of Statistics, 2023

2.1.3 Life expectancy

Data from HealthStats NSW 2020[14] revealed the following insights about life expectancy[15] in the region (see Table 2):

- **Residents lived an average of 85.2 years:** average life expectancy in the region was 85.2 years in 2020, which is consistent with the NSW average of 84.5 years.
- **Life expectancy varied by up to five years across LGAs, Parramatta LGA has the highest and Blacktown LGA has the lowest:** average life expectancy in Parramatta LGA was 88.2 years; 85.5 years for males and 90.3 years for females. In contrast, average life expectancy in Blacktown LGA was 83.4 years; 82.1 years for males and 84.9 years for females.
- **Females lived an average of 3.8 years longer than males:** average life expectancy among females across the region was 87.1 years compared to 83.3 years among males. This gender difference is consistent across all LGAs.

Table 2 *Life expectancy at birth in years across the WSPHN region and NSW, 2020*[16]

	WSPHN region	Blacktown LGA	Cumberland LGA	Parramatta LGA	The Hills Shire LGA	NSW
Male	83.3	82.1	82.8	85.5	85.0	82.4
Female	87.1	84.9	88.4	90.3	87.2	86.6
Total persons	85.2	83.4	85.5	88.2	86.4	84.5

Source: HealthStats NSW (2021). Compiled by WSPHN.

2.1.4 Age distribution

Data from the Informed Decisions 2021[17] highlighted the following insights about age groups living in the region (see Figure 3 and Table 3):

- **Slightly higher concentration of parents and homebuilders (35 to 49 years), children (11 years and younger),[18] and young workforce (25 to 34 years) compared to the state:** parents and homebuilders accounted for 23.0% of the population, compared to 20.1% in NSW and 20.2% across Australia. Babies, pre-schoolers, and primary schoolers aged 11 years or younger represented 16.9% of the population, compared to 14.5% in both NSW and Australia. Additionally, 15.9% of people in the region were in the young workforce, slightly higher than NSW (14.1%) and Australia (14.3%).
- **One in six residents were aged 60 years or over:** 16.9% of residents in the region were aged 60 years or over in 2021, slightly lower than in NSW (23.5%) and Australia (23.0%).
- **Cumberland LGA had a slightly higher share of 18 to 24 years adults across the region:** 10.1% of Cumberland LGA residents were among the tertiary education and independence (18-24 years) service age group compared to 9.0% in the region.

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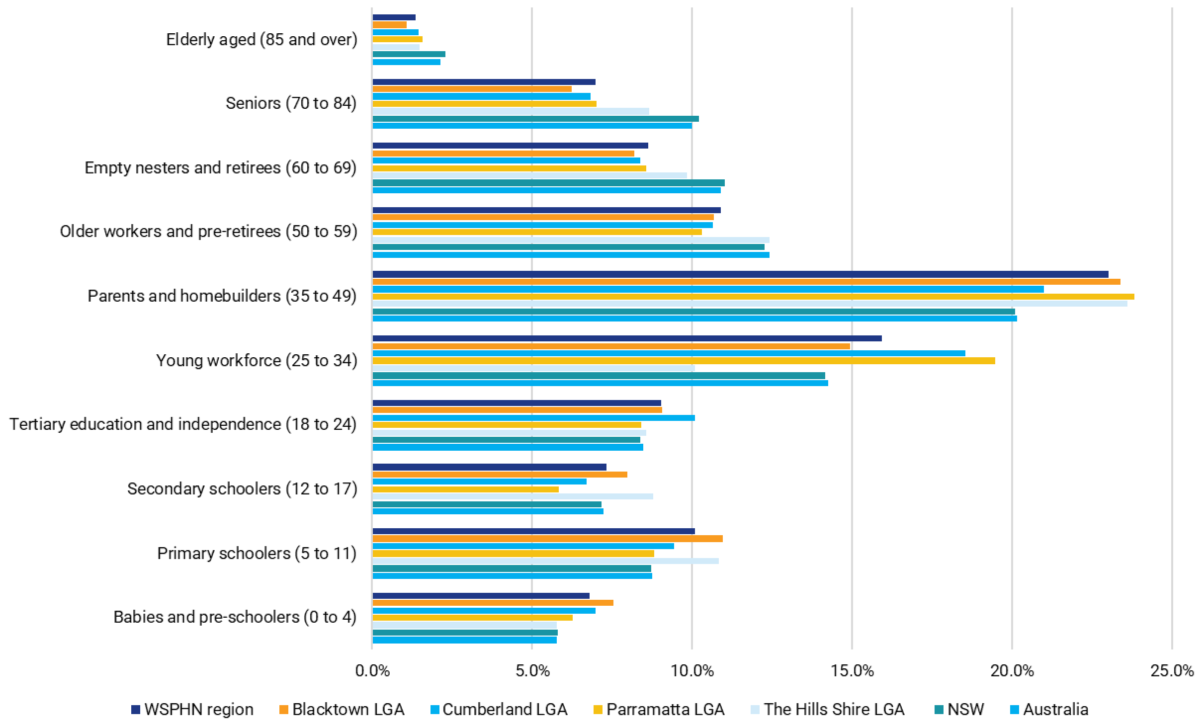
[14] HealthStats NSW, 2021a
[15] Life expectancy is defined as "an estimate of the average length of time (in years) that a person can expect to live, assuming that the current rates of death for each age group will remain the same for the lifespan of that person." Source: HealthStats NSW, 2021a
[16] HealthStats reports that potential drops in life expectancy from 2020 were largely due to the impacts of COVID-19.
[17] Informed Decisions, 2021a-f
[18] The ABS defines a child as a person under 15 years old who is usually resident in a household and forms a parent-child relationship with another member of the household

- **The Hills Shire LGA had a larger population of older workers and pre-retirees (50 to 59 years) across the region:** the proportion of older workers and pre-retirees in the region is 10.9%, slightly lower than the Hills Shire LGA at 12.4%.
- **Older people had the highest prevalence rates of chronic conditions likely to require palliative care:** The prevalence rates of cancer, heart disease, kidney disease, lung conditions[19] and stroke[20] was highest among people aged 75 years and over than any other aged group in the region. For example, heart disease affected 162.0 per 1,000 people aged 75-84 years, and 234.8 per 1,000 people aged 85 years and over. Comparison rates for people aged 25-34 years was 2.7 per 1,000 people in the region.

Figure 3 *Service Age groups across the WSPHN region, NSW and Australia, 2021*



Source: Informed Decisions (2021a-f). Compiled by WSPHN.

Table 3 *Prevalence of chronic conditions most likely to require palliative care per 1,000 people across the WSPHN region by age group, 2021*[21]

Chronic condition	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	≥ 85 years
Cancer (including remission)	1.6	2.9	7.3	18.3	37.9	69.2	86.5	96.2
Heart disease (including heart attack or angina)	2.0	2.7	7.0	20.8	55.2	116.7	162.0	234.8
Kidney disease	1.2	2.0	3.9	6.4	11.8	22.1	35.8	61.1
Lung condition (including COPD or emphysema)	0.8	1.0	2.3	7.4	19.1	38.7	56.8	76.5
Stroke	0.3	0.7	1.9	5.2	12.0	24.7	46.3	64.0

[19] Source: Mounsey, Ferres and Eastman, 2018
[20] Source: Australian Institute of Health and Welfare, 2025b
[21] Note: Two sources were used to determine the top five chronic conditions that are associated with palliative care treatment. Sources: Mounsey, Ferres and Eastman, 2018; Australian Institute of Health and Welfare, 2025b

Source: Australian Bureau of Statistics (2021i). Compiled by WSPHN.

2.2 Cultural and linguistic diversity

This section explores the cultural and linguistic diversity within the region, focusing on indicators such as place of birth, ancestry, language proficiency, and religion. These factors play a critical role in shaping healthcare access and utilisation, highlighting the need for culturally and linguistically appropriate health services.

2.2.1 Place of Birth and Ancestry

Data from the ABS 2021[22] highlighted the following trends in place of birth and ancestry of residents in the region:

- **Australia remains the most common country of birth across all LGAs, with India and China among the top five countries of birth for residents born overseas:** India was among the top five countries of birth across LGAs in the region, with representation ranging between 6.6% of residents in the Hills Shire LGA and 11.9% of residents in Blacktown LGA. Meanwhile, China was among the top five countries of birth in the Cumberland (6.6%), Parramatta (11.3%) and Hills Shire (6.4%) LGAs (see Table 4).
- **The region shows greater ancestral diversity, with lower proportions of Australian and English ancestry:** only 16.5% of residents report Australian ancestry and 15.6% report English ancestry in the region, compared to state and national averages of almost 30%. Chinese (12.3%) and Indian (11.1%) ancestries are more prevalent in the region (see Table 5).
- **Cumberland LGA has the lowest proportion of Australian and English ancestry:** in Cumberland LGA, only 10.6% of residents identify with Australian ancestry and 9.2% with English ancestry, the lowest across the region. This contrasts with the Hills Shire LGA, where Australian and English ancestries are more common, at 22.0% and 22.6% respectively (see Table 6).

Table 4 *Top five countries of birth across the WSPHN region, 2021*

	Blacktown LGA		Cumberland LGA		Parramatta LGA		The Hills Shire LGA	
	Country	Pop. %	Country	Pop. %	Country	Pop. %	Country	Pop. %
First	Australia	50.4	Australia	39.7	Australia	42.4	Australia	57.5
Second	India	11.9	India	8.5	India	11.3	India	6.6
Third	Philippines	6.4	China[a]	6.6	China[a]	11.3	China[a]	6.4
Fourth	New Zealand	2.1	Lebanon	4.8	South Korea	4.3	England	2.7
Fifth	Fiji	1.9	Nepal	4.3	Hong Kong[b]	2.3	Philippines	1.8

Source: Australian Bureau of Statistics (2021a-d). Compiled by WSPHN.
[a]China excludes Special Administrative Regions (SARs) and Taiwan.
[b]Hong Kong as SAR of China.

[22] Australian Bureau of Statistics, 2021a-d

Table 5 *Top five ancestries in the WSPHN region, NSW and Australia, 2021*

	WSPHN region		NSW		Australia	
	Ancestry	Pop. %	Ancestry	Pop. %	Ancestry	Pop. %
First	Australian	16.5	English	29.8	English	33.0
Second	English	15.6	Australian	28.6	Australian	29.9
Third	Chinese	12.3	Irish	9.1	Irish	9.5
Fourth	Indian	11.1	Scottish	7.7	Scottish	8.6
Fifth	Irish	3.8	Chinese	7.2	Chinese	5.5

Source: Informed Decisions (2021e-h, j-k). Compiled by WSPHN.

Table 6 *Top five ancestries across the WSPHN region, 2021*

	Blacktown LGA		Cumberland LGA		Parramatta LGA		The Hills Shire LGA	
	Ancestry	Pop. %	Ancestry	Pop. %	Ancestry	Pop. %	Ancestry	Pop. %
First	Australia	19.1	Chinese	12.6	Chinese	22.3	English	22.6
Second	English	16.8	Lebanese	11.9	English	14.4	Australia	22.0
Third	Indian	13.5	Australia	10.6	Australia	13.9	Chinese	14.7
Fourth	Filipino	9.0	English	9.2	Indian	11.2	Indian	9.1
Fifth	Chinese	4.5	Indian	8.7	Korean	5.90	Irish	6.9

Source: Informed Decisions (2021e-h, j-k). Compiled by WSPHN.

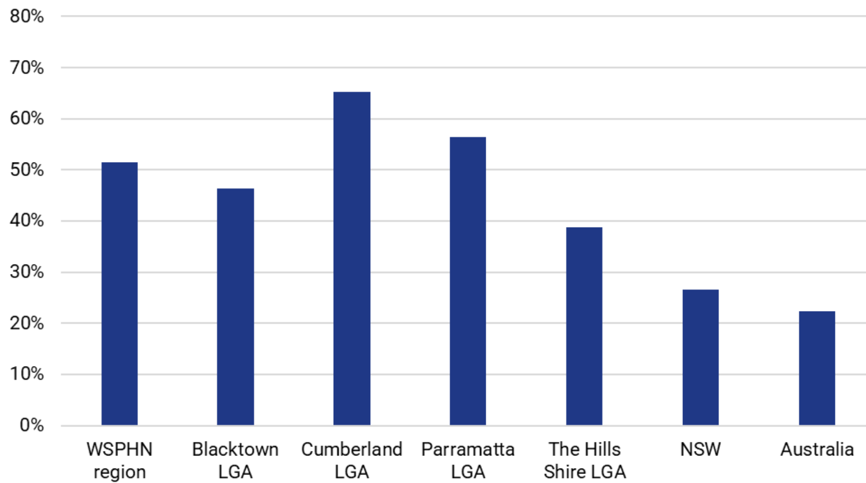
2.2.2 Proficiency in English and language used at home

People with limited or no English proficiency are impacted in their ability to engage in daily life, employment and navigation of the healthcare system. Data from ABS 2021[23] trends in English proficiency and language used in the region:

- **Just over 1 in 2 residents spoke a language other than English at home:** 51.5% of residents spoke a language other than English at home, compared to 26.6% in NSW and 22.3% in Australia. The proportion was significantly high in the Cumberland LGA, where 65.2% of residents spoke a language other than English at home. The rate in other LGAs was 56.4% in Parramatta LGA, 46.3% in Blacktown LGA and 38.8% in the Hills Shire[24] (see Figure 4).
- **Older residents who spoke a language other than English at home was double the rate of NSW:** 45.5% of residents aged 65 years and over in the region spoke a language other than English at home compared to 20.7% in NSW (see Figure 5).
- **About 1 in 7 people living in the Cumberland LGA had limited English proficiency, exceeding other areas and the state and national averages:** 14% of Cumberland LGA population had limited English proficiency, compared to nine per cent in Parramatta LGA, and about five per cent in both the Blacktown and Hills Shire LGAs. Furthermore, the rate in Cumberland LGA is over four times the Australian average (three per cent) and more than three times the NSW average (four per cent)[25]; see Figure 6.

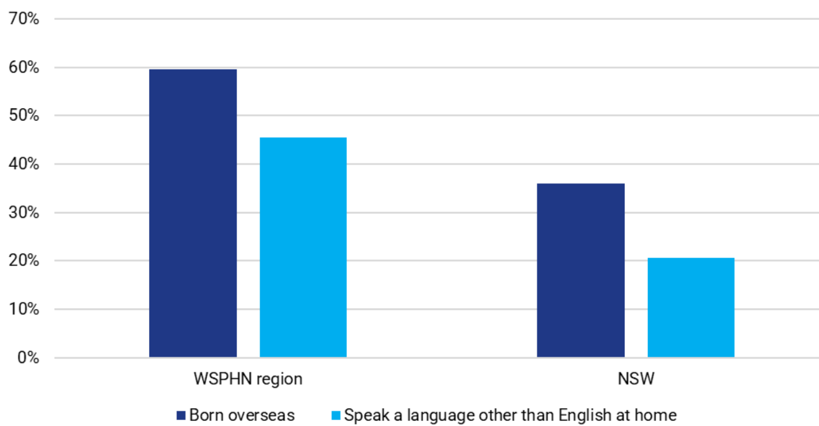
[23] Australian Bureau of Statistics, 2021a-d
[24] Australian Bureau of Statistics, 2021a-d
[25] Informed Decisions, 2021m-r

Figure 4 *Proportion of residents who spoke a language other than English at home across the WSPHN region, NSW and Australia by LGAs, 2021*



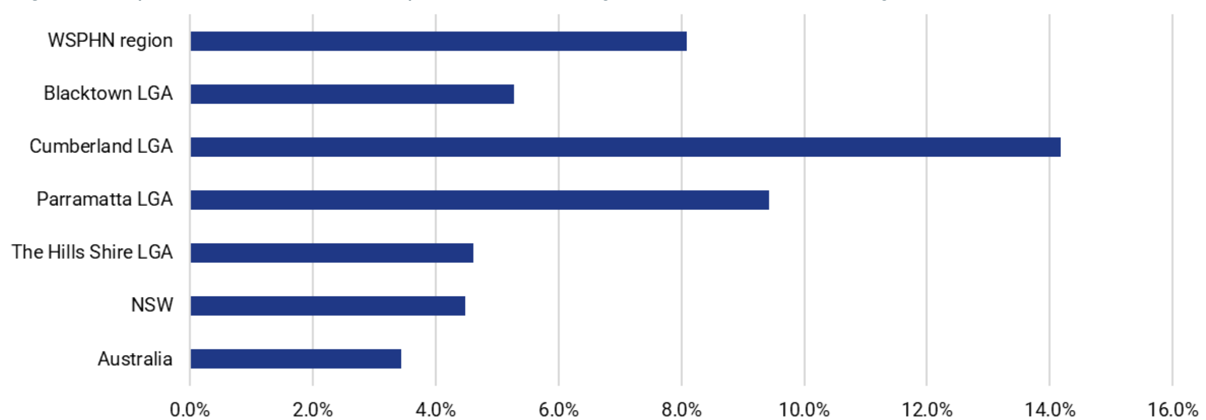
Source: Australian Bureau of Statistics (2021e-h, j-k). Compiled by WSPHN.

Figure 5 *Cultural diversity among residents aged 65 years and over in the WSPHN region and NSW, 2021*



Source: Australian Institute of Health and Welfare (2024a). Compiled by WSPHN.

Figure 6 *Proportion of residents who spoke little to no English across the WSPHN region, NSW and Australia, 2021*



Source: Australian Bureau of Statistics (2021a-d). Compiled by WSPHN.

3 Persons receiving palliative care

This chapter provides an overview of palliative care patient data from AIHW including service events for non-admitted persons, palliative care hospitalisations, MBS subsidised service usage, costs and prescribed medication.

Summary of key needs for palliative care patients

1. The rate of palliative care-related service events in the region was lower in the region (201.6 per 10,000 people) than in NSW (297.5 per 10,000 people) and Australia (356.5 per 10,000 people). Palliative care hospitalisations were also lower in the region (30.5 per 10,000 people) compared to NSW (42.3 per 10,000 people) and Australia (39.8 per 10,000 people).
2. People aged over 74 years in the region had the highest rates of palliative care service event rates (2,106.7 per 10,000 people) and hospitalisations (322.6 per 10,000 people). While palliative care service event rates in the region were lower than in NSW and Australia, the hospitalisation rates was higher (NSW - 307.6 per 10,000 people; Australia - 305.2 per 10,000 people).
3. People from the most socio-economically disadvantaged areas in the region had higher rates of palliative care service events (308.0 per 10,000 people) and hospitalisations (37.9 per 10,000 people) than people in the least disadvantaged areas (113.9 service events; 21.2 hospitalisations per 10,000 people). Furthermore, the rates of palliative care hospitalisations decreased with a reduction in disadvantage.
4. Palliative care hospitalisations in the region were more likely to be provided alongside cancer treatment (6.8 per 10,000 people) than non-cancer treatment (4.7 per 10,000 people).
5. Around 60% of palliative care expenditure in the region was on care provided in a hospital setting. This was lower in comparison to NSW (66.2%) and Australia (74.4%).
6. Only 9.8 per 100,000 people received an MBS-subsidised palliative medicine attendance and case conferencing in the region, compared to 58.1 and 133.6 per 100,000 people in NSW and Australia. The rate of palliative care prescriptions was also lower in the region at 1,395.5 per 100,000 people than in NSW (1,718 per 100,000 people) and Australia (1,779.3 per 100,00 people).

3.1 Service Demand and Utilisation

This section outlines palliative care related service events for non-admitted patients, hospitalisations and expenditure on palliative care for admitted and non-admitted patients.

3.1.1 Non-admitted patient palliative care-related service events (episode-level)

Data from AIHW 2023-24[26,27] on palliative care-related service events for non-admitted patients in the region showed the following:

- **Lower overall rates of palliative care-related service events than in NSW and Australia, and the second lowest among all NSW PHNs:** The rate of palliative care-related service events in the region was 201.6 per 10,000 people, compared to 297.5 and 356.5 per 10,000 people in NSW and Australia**.** This was the second lowest rate among the 10 NSW PHNs, with the Nepean Blue Mountains PHN having the lowest at 82.8 per 10,000 people. Meanwhile, the highest rate was in the South Eastern NSW PHN at 520.3 per 10,000 people (see Table 7 and Figure 7).
- **Palliative care-related service events primarily involved allied health and/or clinical nursing services:** The rate of palliative care-related service events involving allied health or clinical nursing services in the region was 176.7 per 10,000 people, compared to those involving medical consultations at 24.7 per 10,000 people. These rates were lower than in NSW at 201.1 and 91.0 per 10,000 people and Australia at 279.9 and 60.0 per 10,000 people (see Table 7).
- **Highest rates of palliative care-related service events among people aged 75 years and over:** The rate of palliative care-related service events for non-admitted patients aged 75 years and over in the region was 2,106.7 per 10,000 people compared to 2361.1 and 2451.1 per 10,000 people in NSW and Australia. These rates were four times greater than the 55-74 years age group which had the second highest rate of service events in the region (444.4 per 10,000 people), NSW (668.6 per 10,000 people) and Australia (688.6 per 10,000 people); see Table 8.
- **Highest rates of palliative care-related service events among the most socio-economically disadvantaged:** The rate of palliative care-related service events for non-admitted patients from the most socio-economically disadvantaged areas in the region was 308.0 per 10,000 people, compared to 113.9 per 10,000 people from the least disadvantaged areas. Service events in NSW and Australia were also highest among the most socio-economically disadvantaged (377.7 and 414.6 per 10,000) compared to the least disadvantaged (229.0 and 285.6 per 10,000); see Table 9.

[26] Source: Australian Institute of Health and Welfare, 2025c
[27] Source: Australian Institute of Health and Welfare, 2025d

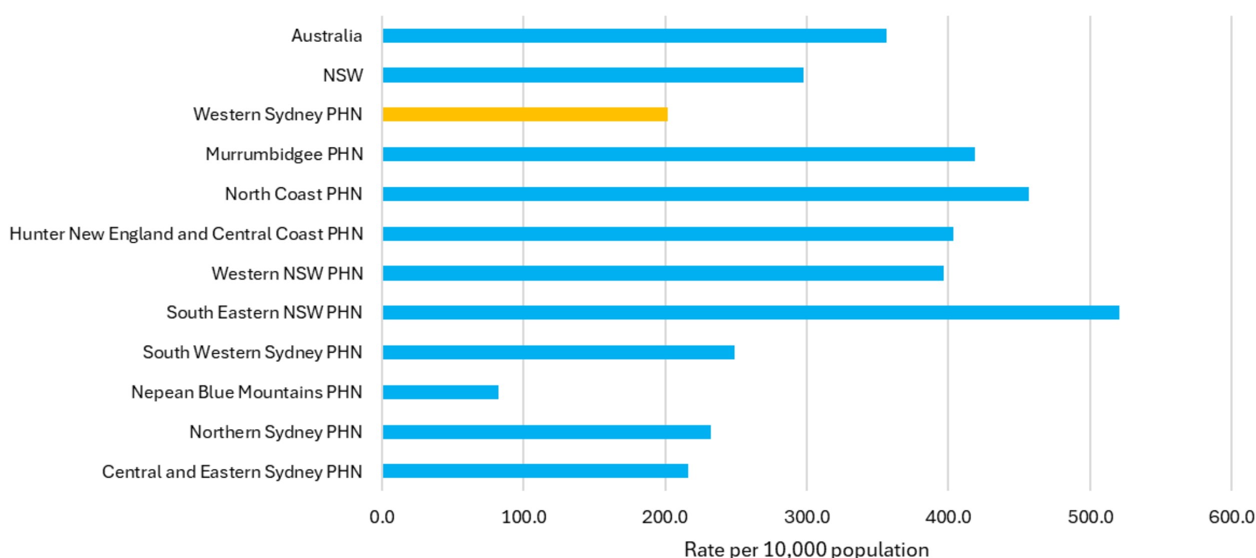
Table 7 *Palliative care-related service events (episode-level) for non-admitted patients[28] per 10,000 people across the WSPHN region, NSW and Australia, 2023–24*

	WSPHN region		NSW*		Australia	
	Number	Per 10,000 people	Number	Per 10,000 people	Number	Per 10,000 people
Medical consultations for palliative care[29]	2,791	24.7	75,414	91.0	159,831	60.0
Allied health and/or clinical nurse specialist interventions for palliative care[30]	19,953	176.7	166,652	201.1	745,803	279.9
Palliative care-related service events (Total)[31]	22,764	201.6	246,508	297.5	949,970	356.5

Source: Australian Institute of Health and Welfare (2025c). Compiled by WSPHN.

**Note:* NSW totals were manually calculated from provided data and excludes Murray PHN as an overlapping region with Victoria.

Figure 7 *Palliative care-related service events (episode-level) for non-admitted patients per 10,000 people, by NSW PHNs, NSW and Australia, 2023-24*



Source: Australian Institute of Health and Welfare (2025c). Compiled by WSPHN.

[28] A non-admitted patient service event is defined as an interaction between one or more health-care provider with a non-admitted patient in an outpatient clinic or other setting, which includes therapeutic and/or clinical content and results in a dated entry in the patient's medical record.
[29] Clinics where medical consultations are typically provided by a medical practitioner, nurse practitioner or midwife practitioner
[30] Clinics where the allied health personnel and/or clinical nurse specialists provide the majority of services.
[31] Note: 20 non-admitted patients had a diagnostic or procedural palliative care-related service event.

Table 8 *Palliative care-related service events (episode level) for non-admitted patient by age groups per 10,000 people, across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region		NSW		Australia	
	Number	Per 10,000 people	Number	Per 10,000 people	Number	Per 10,000 people
0-14 years	324	14.2	2,521	16.8	7,873	16.5
15-34 years	421	12.8	4,787	21.1	13,530	18.6
35-54 years	1,672	52.0	26,033	119.5	86,688	123.5
55-74 years	8,148	444.4	116,415	668.6	380,744	688.6
75 years +	12,186	2,106.7	155,928	2,316.1	508,388	2,451.1
Total	22,764	203.4*	305,776	365.9	997,473	374.1

Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

**Note*: The results in this table are based on data that was updated by AIHW to include PHN related information for people that was missing from previous publications. As such, calculated rates may differ with other tables.

Table 9 *Palliative care-related service events (episode level) for non-admitted patients by socioeconomic areas (SEIFA quintiles)[32] per 10,000 people, across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region		NSW		Australia	
	Number	Per 10,000 people	Number	Per 10,000 people	Number	Per 10,000 people
1 (lowest)	7,337	308.0	23,818	377.7	207,981	414.6
2	5,485	294.9	23,325	384.0	218,687	430.3
3	5,235	236.1	22,507	294.2	198,946	351.1
4	731	59.1	18,235	210.7	145,836	260.9
5 (highest)	3,976	113.9	18,105	229.0	151,056	285.6
Total	22,764	201.6	107,542	365.9	997,473	374.1

Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

3.1.2 Palliative care-related hospitalisations

Data from AIHW 2023-24[33,34] on palliative care related hospitalisations in the region provided the following insights:

- **Lower rate of total palliative care-related hospitalisations compared to NSW and Australia:** The palliative care-related hospitalisation rate in the region was 30.5 per 10,000 people, compared to 42.3 and 39.8 per 10,000 people in NSW and Australia (see Table 10).
- **Rates of primary palliative care hospitalisations have generally decreased and remained consistently lower than NSW and Australia over time:** The primary palliative care-related hospitalisation rate in the region fell from 13.8 per 10,000 in 2020-21 to 10.0 in 2022-23. This was followed by a slight increase in 2023-24 (11.5 per 10,000 people). In comparison, the rates in NSW have remained static over time from 22.3 per 10,000 people in 2020-21 to 22.4 in 2022-23 and then to 22.9 by 2023-24. Meanwhile, the rates in Australia gradually increased from 19.5 per 10,000 people in 2020-21 to 20.6 in 2022-23 and then to 21.7 by 2023-24 (see Figure 8).

[32] Socioeconomic areas are categorised by the ABS using the Index of Relative Socio-Economic Disadvantage (IRSD), which is based on the usual area of residence of a person. The level socio-economic disadvantage is grouped into five quintiles, where quintile 1 represents the 20% most disadvantaged areas ad quintile 5 represents the least disadvantaged areas.

[33] Source: Australian Institute of Health and Welfare, 2025e

[34] Source: Australian Institute of Health and Welfare, 2025d

- **Higher rates of palliative care-related hospitalisations among people aged 75 years and over compared to NSW and Australia:** The palliative care-related hospitalisation rate among patients aged 75 years and over in the region was 322.6 per 10,000 people compared to 307.6 and 305.2 per 10,000 people in NSW and Australia (see Table 11).
- **Palliative care-related hospitalisation rates decrease with a reduction in socio-economic disadvantage:** The highest rates of palliative care-related hospitalisations in the region were in SEIFA quintiles 1 (37.9 per 10,000 people) and 2 (38.2 per 10,000 people). The rate gradually drops between quintiles 3 (35.1 per 10,000 people) and 5 (21.2 per 10,000 people). Similarly, in NSW, hospitalisations reduce from a high of 51.6 per 10,000 people (quintile 2) to a low of 34.9 per 10,000 people (quintile 5). Furthermore, in Australia, palliative care-related hospitalisations fell from 45.9 per 10,000 (quintile 2) to 34.2 per 10,000 (quintile 5) (see Table 12).
- **Higher rates of primary palliative care hospitalisations with a principal diagnosis of cancer than a non-cancer diagnosis:** 6.8 per 10,000 people in the region with a primary palliative care hospitalisation had a principal diagnosis of cancer, compared to 4.7 per 10,000 people with a non-cancer diagnosis. (see Table 13).

Table 10 *Palliative care-related hospitalisations[35] per 10,000 people across the WSPHN region, NSW and Australia, 2023–24*

	WSPHN region		NSW*[36]		Australia	
	Number	Per 10,000 people	Number	Per 10,000 people	Number	Per 10,000 people
Primary palliative care hospitalisations[37]	1,282	11.5	18,447	22.3	57,009	21.4
Other palliative care hospitalisations[38]	2,136	19.1	16,569	20.0	49,009	18.4
Total palliative care-related hospitalisations	3,418	30.5	35,016	42.3	106,018	39.8

Source: Australian Institute of Health and Welfare (2025e). Compiled by WSPHN.

**Note: NSW totals were manually calculated from provided data and excludes Murray PHN as an overlapping region with Victoria.*

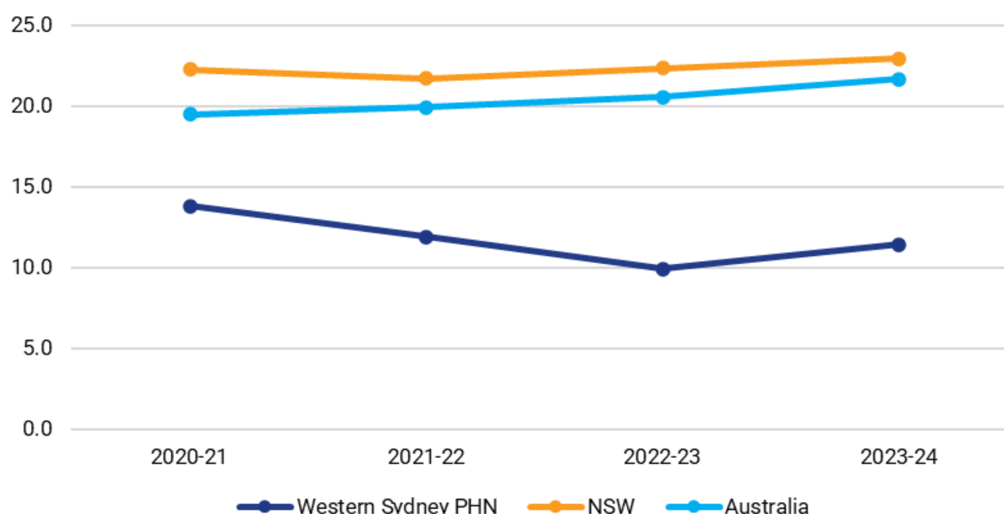
[35] Palliative care-related hospitalisations refer to those episodes of admitted patient care where palliative care was a component of the care provided during all or part of the episode. This measure can be broken down into two groups; 'primary palliative care hospitalisations' and 'other palliative care hospitalisations'.

[36] The NSW total was not provided in publicly available data from AIHW and had to be manually calculated. The Murray PHN region crosses the NSW and Victoria state borders. As such it has been excluded from the manual count.

[37] Primary palliative care hospitalisations refer to hospitalisations where the primary purpose was to provide palliative care, as opposed to a diagnosis of palliative care or other condition.

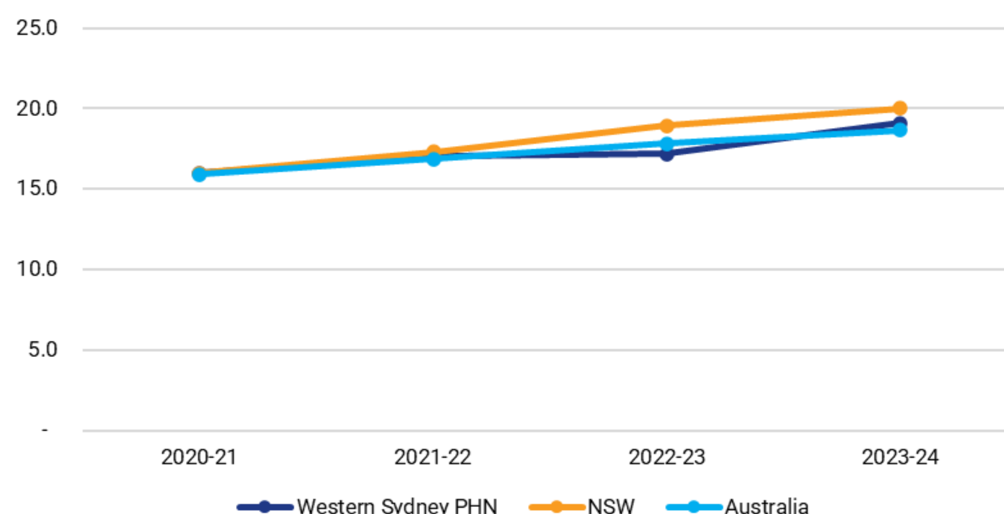
[38] Other palliative care-related hospitalisations refer to hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

Figure 8 *Rate of primary palliative care-related hospitalisations per 10,000 people across the WSPHN region, NSW and Australia, 2020-2024*



Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

Figure 9 *Other palliative care-related hospitalisations per 10,000 people across the WSPHN region, NSW and Australia, 2020-2024*



Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

Table 11 *Palliative care-related hospitalisations by age groups per 10,000 people across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region		NSW		Australia	
	Number	**Per 10,000 people**	**Number**	**Per 10,000 people**	**Number**	**Per 10,000 people**
0-14 years	58	2.5	431	2.9	941	2.0
15-34 years	61	1.9	457	2.0	1,124	1.5
35-54 years	275	8.5	2,181	10.0	6,934	9.9
55-74 years	1,159	63.2	11,558	66.4	35,231	63.7
75 years +	1,866	322.6	20,709	307.6	63,300	305.2
Total	3,418	30.5	35,336	42.3	107,542	40.3

Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

Table 12 *Palliative care-related hospitalisations by socioeconomic area (SEIFA quintiles)[39] per 10,000 people across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region		NSW		Australia	
	Number	**Per 10,000 people**	**Number**	**Per 10,000 people**	**Number**	**Per 10,000 people**
1 (lowest)	904	37.9	7,808	45.4	65,013	47.5
2	711	38.2	8,688	51.6	64,684	45.9
3	779	35.1	7,130	43.5	48,259	39.7
4	282	22.8	4,806	35.7	28,333	32.6
5 (highest)	743	21.3	6,812	34.9	44,679	34.2
Total	3,418	30.5	35,336	42.3	305,776	365.9

Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

Table 13 *Palliative care-related hospitalisations by principal diagnosis per 10,000 people across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region		NSW		Australia	
	Number	**Per 10,000 people**	**Number**	**Per 10,000 people**	**Number**	**Per 10,000 people**
Primary palliative care hospitalisations	1,282	11.5	18,635	22.3	57,845	21.7
Cancer	759	6.8	8,610	10.3	27,789	10.4
Non-cancer	523	4.7	10,025	12.0	30,056	11.3
Other palliative care hospitalisations	2,136	19.1	16,701	22.3	49,697	18.6
Cancer	638	5.7	5,089	6.1	14,842	5.6
Non-cancer	1,498	13.4	11,612	13.9	34,855	13.1
Palliative care related hospitalisations	3,418	30.5	49,697	18.6	107,542	40.3
Cancer	1,397	12.5	14,842	5.6	42,631	16.0
Non-cancer	2,021	18.1	34,855	13.1	64,911	24.3

Source: Australian Institute of Health and Welfare (2025d). Compiled by WSPHN.

3.1.3 Expenditure on admitted and non-admitted palliative care attendances

Data from AIHW 2023-24[40] on non-admitted palliative care-related service events showed the following:

- **Slightly lower expenditure on admitted patient palliative care than NSW and Australia, but higher on non-admitted patient care:** 60.4% of expenditure on palliative care in the region was on admitted patients compared to NSW (66.2%) and Australia (74.4%). Meanwhile, 39.6% of expenditure in the region was on non-admitted palliative care compared to 33.8% (NSW) and 25.6% (Australia); see Table 14.

[39] Socioeconomic areas are categorised by the ABS using the Index of Relative Socio-Economic Disadvantage (IRSD), which is based on the usual area of residence of a person. The level socio-economic disadvantage is grouped into five quintiles, where quintile 1 represents the 20% most disadvantaged areas ad quintile 5 represents the least disadvantaged areas.

[40] Source: Australian Institute of Health and Welfare, 2025f

Table 14 *Expenditure on admitted and non-admitted patient palliative care across the WSPHN region, NSW and Australia 2022-23*

	WSPHN region		NSW		Australia	
	Amount ($)	**Per cent (%)**	**Amount ($)**	**Per cent (%)**	**Amount ($)**	**Per cent (%)**
Admitted patient palliative care	16,934,357	60.4	206,775,001	66.2	594,526,776	74.4
Non-admitted patient palliative care	11,085,314	39.6	105,582,888	33.8	204,112,178	25.6
Total palliative care	28,019,670	100.0	312,357,889	100.0	798,638,955	100.0

Source: Australian Institute of Health and Welfare (2025f). Compiled by WSPHN.

3.2 Medicare

This section presents MBS-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists and people receiving them across NSW PHNs, and NSW and Australia as a total.

3.2.1 MBS-subsidised palliative care medicine attendance

Data from AIHW 2023-24[41] on MBS-subsidised palliative medicine attendance and case conferencing services[42] provided by palliative medicine physicians or specialists[43] shows the following insights (see Table 15):

- **Slightly higher rate of services per person than Australia, but slightly lower than NSW:** 109 people in the region received 258 MBS-subsidised palliative medicine attendance and case conferencing services, amounting to 2.4 services per person. This was slightly lower than in NSW (2.8 per person) and slightly higher than in Australia (2.0 per person).
- **Rate of attendance in the region was much lower than NSW and Australia:** 9.8 per 100,000 people in the region received an MBS-subsidised palliative medicine attendance and case conferencing service. Comparative rates in NSW and Australia were 58.1 and 133.6 per 100,00 people.

Table 15 *MBS-subsidised palliative medicine attendance and case conference services provided by palliative medicine physicians/specialists across the WSPHN region, NSW and Australia, 2023–24*

	WSPHN region	NSW*	Australia
Number of people	109	4,816	35,630
Number of services	258	13,453	70,390
Rate of people (per 100,000 population)	9.8	58.1	133.6
Services per person	2.4	2.8	2.0

Source: Australian Institute of Health and Welfare (2025g). Compiled by WSPHN.

**Note: NSW totals were manually calculated from provided data and excludes Murray PHN as an overlapping region with Victoria.*

[41] Source: Australian Institute of Health and Welfare, 2025g

[42] MBS subsidised palliative medicine attendance refers to services provided by palliative medicine physicians or specialists and claims under specialist palliative care MBS item numbers (MBS 3005, 3010, 3014, 3018, 3023, 3028).

[43] Palliative medicine physicians are required to have completed 3 years of full-time equivalent training in either a paediatric or adult setting under the supervision of another palliative medicine physician.

3.3 Prescribed medications in palliative care

This section reports on palliative care medications prescribed under the Pharmaceutical Benefits Scheme (PBS) Palliative Care Schedule.

3.3.1 Prescribed medications in palliative care

Data from AIHW 2023-24[44] on palliative care-related medications distributed under the PBS Palliative Care Schedule provided the following insights:

- **Lower rate of palliative care prescriptions than NSW and Australia:** 1,395.5 per 100,000 people in the region were prescribed palliative care medication, compared to 1,718 and 1,779.3 per 100,000 people in NSW and Australia. However, prescription per person were similar at 3.0 in the region, 3.2 in NSW and 3.1 in Australia (see Table 16).

Table 16 *Palliative care-related prescriptions under the PBS Palliative Care Schedule across the WSPHN region, NSW and Australia, 2023-24*

	WSPHN region	NSW*	Australia
Number of people	15,616	142,364	474,366
Number of prescriptions	46,599	450,416	1,446,933
Rate of people (per 100,000 people)	1,395.5	1,718.3	1,779.3
Prescriptions per person	3.0	3.2	3.1

Source: Australian Institute of Health and Welfare (2025h). Compiled by WSPHN.

[44] Source: Australian Institute of Health and Welfare, 2025h

4 Community awareness and needs for palliative care

This chapter presents findings from a survey of community members both within and outside Western Sydney (n=49). The survey explored participants' awareness and experiences of palliative care, as well as their perceptions of the needs of people receiving palliative care and those who support them.

Summary of community awareness, usage and needs for palliative care in the region

1. Nine in ten respondents had heard of palliative care (89.8%), while eight in ten believed it permitted patients to continue living as comfortably as possible (81.8%).
2. Nine ten respondents reported it was very or extremely important for them to discuss their preferences for end-of-life care (88.6%), and over half were aware of palliative care planning processes such as the NSW Advance Care Directive (52.3%). However, only 30% had implemented any type of palliative care planning.
3. The hospital (22.2%), a family member (16.7%) and print or digital media (13.3%) were the primary sources of information accessed by community members.
4. The main types of palliative care support received by respondents was information about palliative care (17.8%), symptoms management (13.3%) and pain relief medication or administration (13.3%).
5. Almost two thirds of respondents felt their cultural needs and rituals had been acknowledged in their palliative care experience (64.3%).
6. Just over half of respondents felt palliative care was adequately accessible during business hours (55.8%), but only 14.0% reported adequate access to after-hours palliative care.
7. Key needs for people receiving end-of-life care were the reduction in physical suffering (32.8%), home nursing care (20.2%) and specialist medical care (16.0%). Meanwhile, the key needs for carers of people receiving end-of-life care were home nursing care (24.6%), 24-hour specialist care (23.7%) and grief counselling (17.5%).

4.1 Characteristics of survey participants

Analysis of the demographic data from the survey[45] of 49 residents both within and outside the WSPHN region indicated that:

- **Respondents were more likely to be older, within the WSPHN region and women:** The median age of respondents was 62.5 years, with three quarters residing in the WSPHN region (66.7%). Furthermore, just over eight in ten were women (82.6%); see Table 17.
- **Smaller proportion of respondents were born overseas and spoke a language other than English at home:** 40.8% of respondents reported being born overseas compared to 59.2% who were born in Australia. Meanwhile, 40.8% reported speaking a language other than English at home compared to 59.2% (see Table 18).
- **Most respondents were non-Aboriginal:** 98% of survey respondents identified as non-Aboriginal, while two per cent identified as Aboriginal (see Table 18).

[45] Source: Western Sydney Primary Health Network, 2025a

Table 17 *Demographic characteristics of survey respondents from within and outside the WSPHN region*

	Community respondent demographics				
	Gender[46]		Age	Residential location	
	Male	Female	Median age	Within WSPHN region	Outside WSPHN region
Number	8	40	49	33	16
Percentage (%)	15.2	82.6	62.5 years	67.3	32.7

Note: Total survey responses = 49.
Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

Table 18 *Cultural characteristics of survey respondents from within and outside the WSPHN region*

	Community respondent demographics					
	Country of birth		First Nations status		Speak a language other than English at home	
	In Australia	Outside Australia	Aboriginal[47]	Non-Aboriginal	Yes	No
Number	29	20	1	48	20	29
Percentage (%)	59.2	40.8	2	98	40.8	59.2

Note: Total survey responses = 49.
Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

4.2 Palliative care awareness

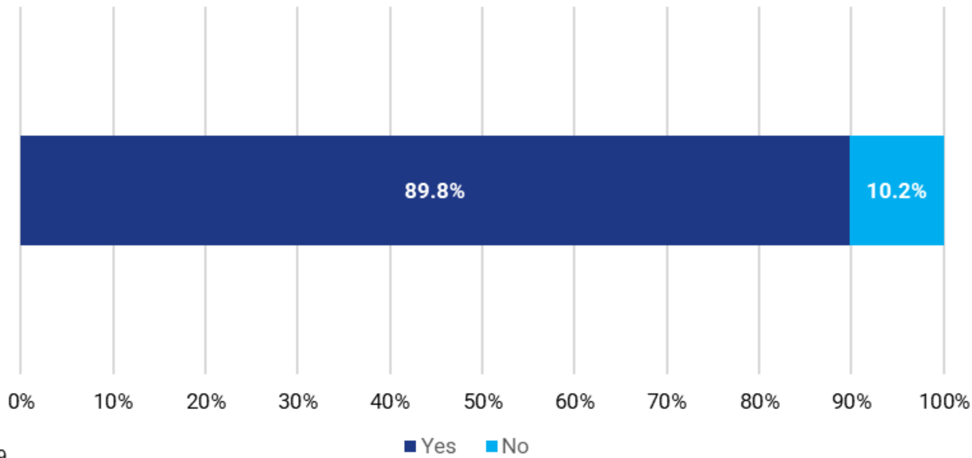
Analysis of the survey data[48] on respondent awareness of palliative care indicated that:

- **Most respondents had heard of palliative care and believed it permitted patients to continue living as comfortably as possible:** 89.8% of respondents from within and outside the WSPHN region had heard the term palliative care, while 10.2% had not heard term. When asked to describe palliative care, 81.8% reported that it permits patients to continue living as comfortably as possible. A further 13.6% believed that palliative care improves a patient's quality of life, while 4.5% were unsure (see Figures 10 and 11).
- **Just over half of respondents were familiar with the end-of-life planning process and the NSW Advance Care Directive:** 56.8% of respondents reported being aware of the end-of-life planning process, while 43.2% were not aware. Similarly, 52.3% of respondents were aware of the NSW Advance Care Directive, while 47.7% were not aware (see Figure 12).
- **Respondents placed a high level of importance on discussing their preferences for care if they were seriously or terminally ill:** 88.6% of respondents reported that it was very (22.7%) or extremely (65.9%) important for them to discuss their preferences for care if they were to become seriously or terminally ill. Only, 2.3% reported it being not at all important to them (see Figure 13).

[46] One community respondent selected 'prefer not to say'.
[47] Response options in the survey included 'Torres Strait Islander' and 'both Aboriginal and Torres Strait Islander'. However, these response options were not selected by community members.
[48] Source: Western Sydney Primary Health Network, 2025a

- **The hospital was the primary source of information about palliative care, along with a family member and print or digital media among the top three:** 22.2% of respondents indicated that the hospital was their primary source of information about palliative care, followed by a family member (16.7%) and print or digital media (13.3%); see Figure 14.

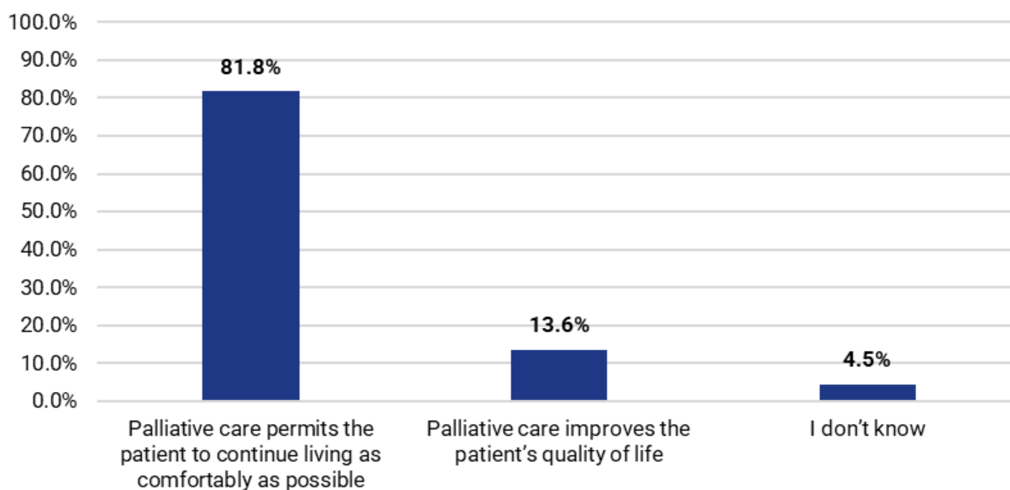
Figure 10 *Proportion of community respondents who have heard of palliative care*



n = 49

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

Figure 11 *How community members describe palliative care*[49]



n = 44

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

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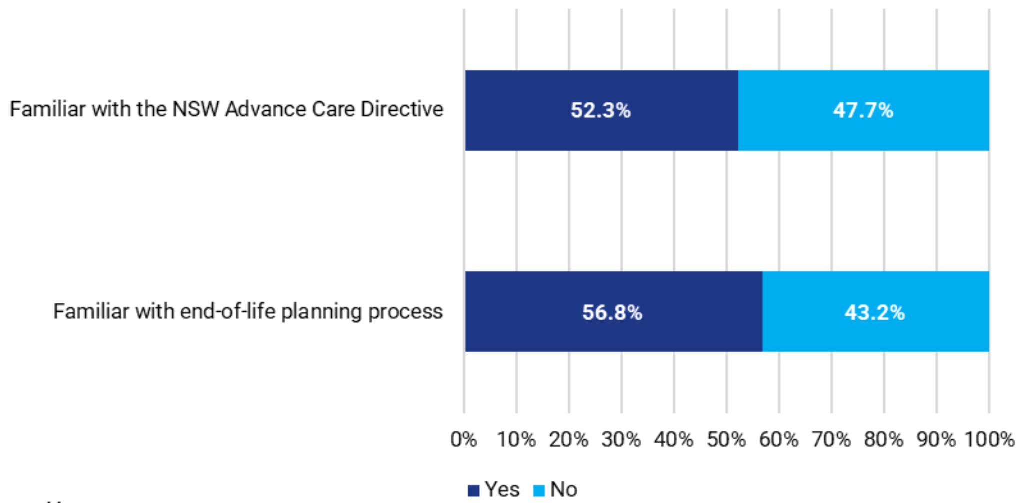
[49] Other response options included in the question but not selected were 'palliative care speeds up end-of-life'; 'palliative care delays end of life'; 'palliative care calms the patient'.

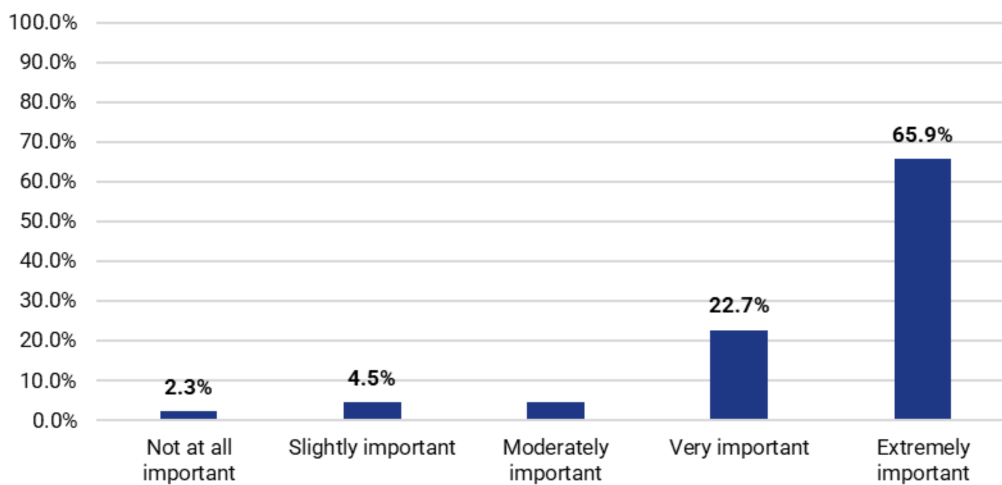
Figure 12 *Familiarity of community respondents with the NSW Advance Care Directive and the end-of-life planning process*



n = 44

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

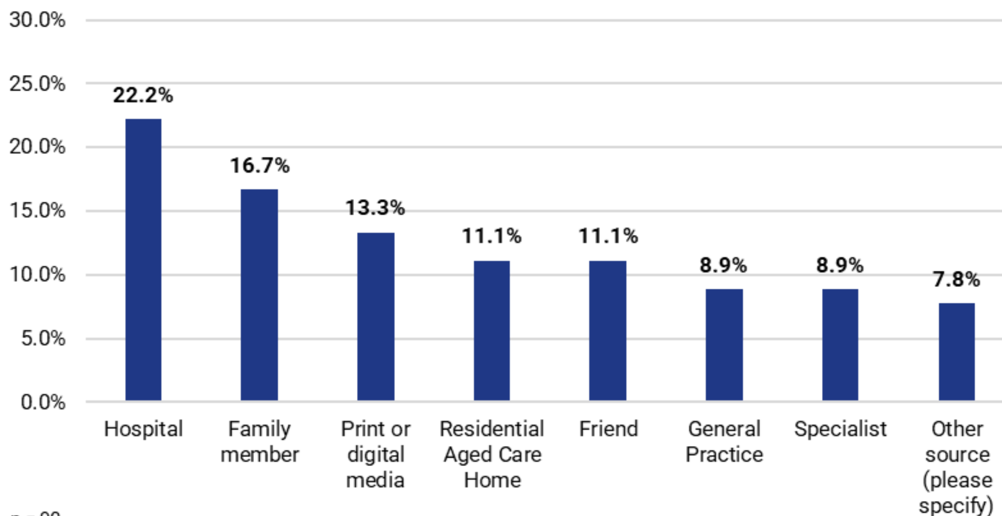
Figure 13 *Level of importance of discussing respondent preferences for care if they were seriously or terminally ill*



n = 44

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

Figure 14 *Sources of information about palliative care that respondents accessed*[50,51]



Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

4.3 Palliative care planning

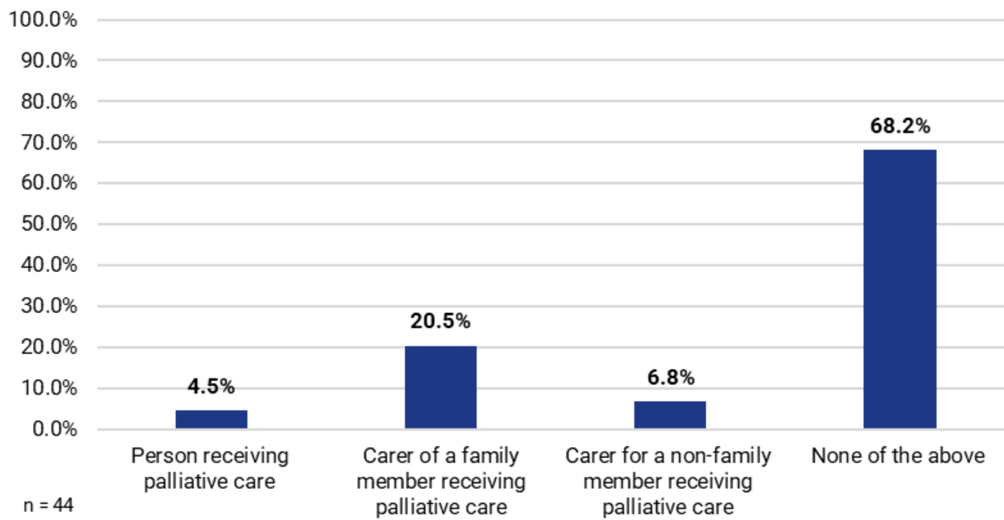
Analysis of data[52] on palliative or end-of-life care planning and utilisation indicated that:

- **Higher proportion of respondents were caring for a family or non-family member receiving palliative care than receiving palliative care themselves, however most were neither.** 20.5% of respondents were caring for a family member receiving palliative care, with a further 6.8% caring for a non-family member. Only 4.5% of respondents were receiving palliative care themselves. Meanwhile, 68.2% were neither receiving palliative care nor caring for someone receiving this care[53] (see Figure 15).
- **Between 20% and 30% of respondents engaged in some type of palliative or end-of-life care planning.** 28% of respondents had an Enduring Power of Guardianship, while 20% had implemented an Advance Care Plan, Advance Care Directive and/or care goals. One in eight respondents (12.0%) did not have any of these in place (see Figure 16).
- **Information about palliative care, symptoms management and pain relief medication administration were the most common types of support received by patients or their families.** The top three types of palliative or end-of-life care support received by respondents or one of their family members was information about palliative care (17.8%), information about symptoms management (13.3%) and pain relief medication or administration (13.3%). Meanwhile, the bottom three types received were support with advance care planning (2.2%), an Advance Care Directive (2.2%) and Mental Health support (2.2%); see Figure 17.

[50] Other responses = 7. These responses were unique and could not be back coded to existing responses. Other reported sources included church, library, community nurses at the Western Sydney Local Health District (WSLHD).
[51] Respondents were asked to select the sources of information they have accessed. As such, the n value in the chart reflects the number of responses rather than the number of respondents. This has also been reflected in the results for this chart.
[52] Source: Western Sydney Primary Health Network, 2025a
[53] Of the 44 people who had heard of the term palliative care, 30 were neither receiving palliative care themselves or caring for a family or non-family member. As such, only 14 people were asked follow-up questions about palliative care planning and utilisation.

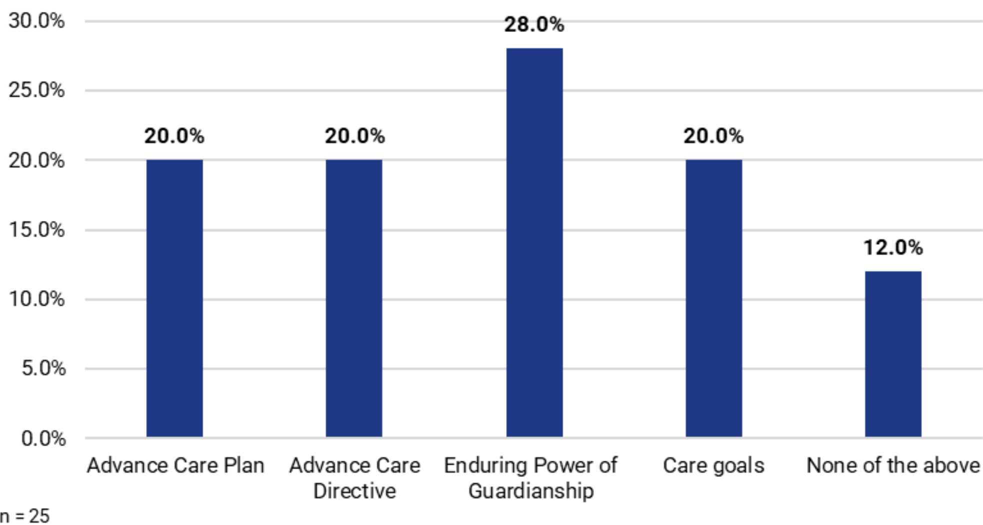
- **Higher proportion of respondents felt their cultural needs and rituals had been acknowledged and included during the palliative care journey.** 64.3% of community stakeholders reported that their cultural needs and rituals had been included as part of their palliative care experience (see Figure 18).

Figure 15 *Proportion of community respondents who have heard of palliative care*



Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

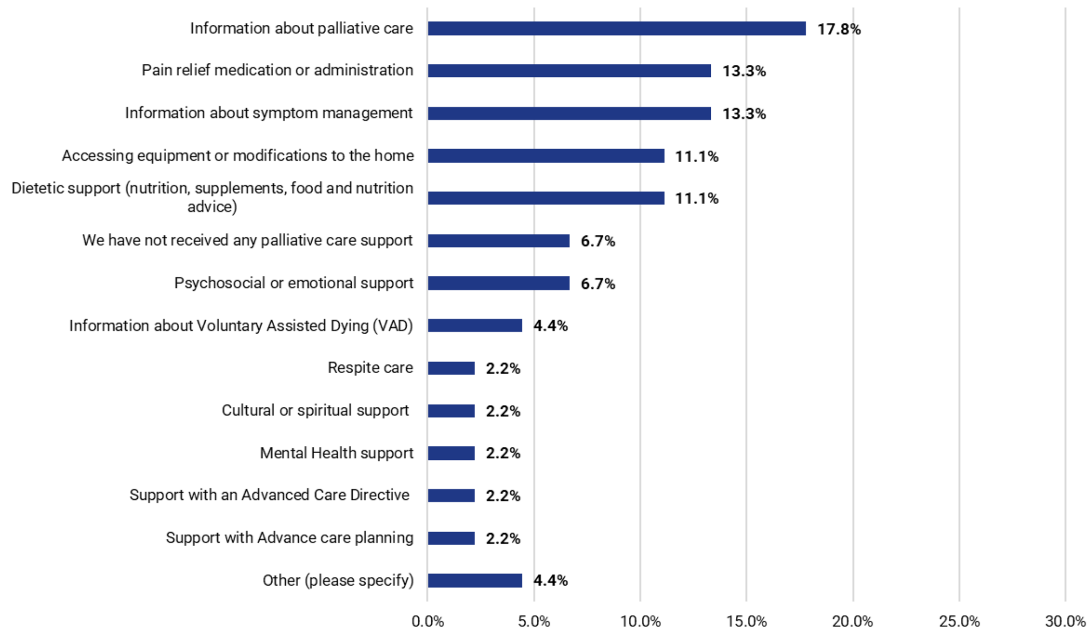
Figure 16 *Respondent engagement in palliative or end-of-life care planning*[54]



Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

[54] Respondents could select more than one response. The n value of 25 represents the number of selections made by 14 individuals

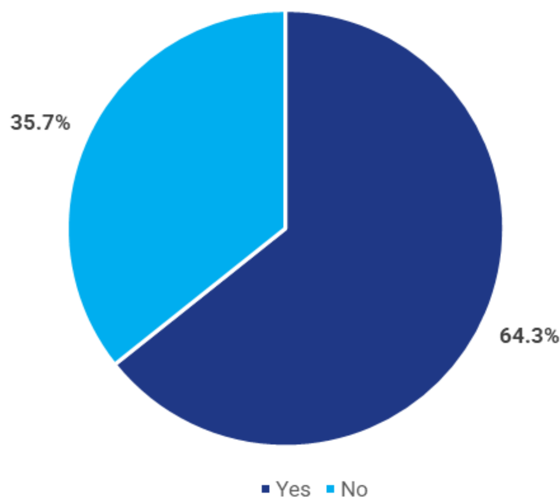
Figure 17 *Types of palliative care or end-of-life care support received by individual respondents or their family members*[55,56]



n = 45

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

Figure 18 *Respondent perceptions about whether their cultural needs and rituals have been acknowledged in the delivery of palliative care*



n = 14

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

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55 Other responses = 2. One respondent indicated that palliative care was provided at home, while the second did not provide a written response.

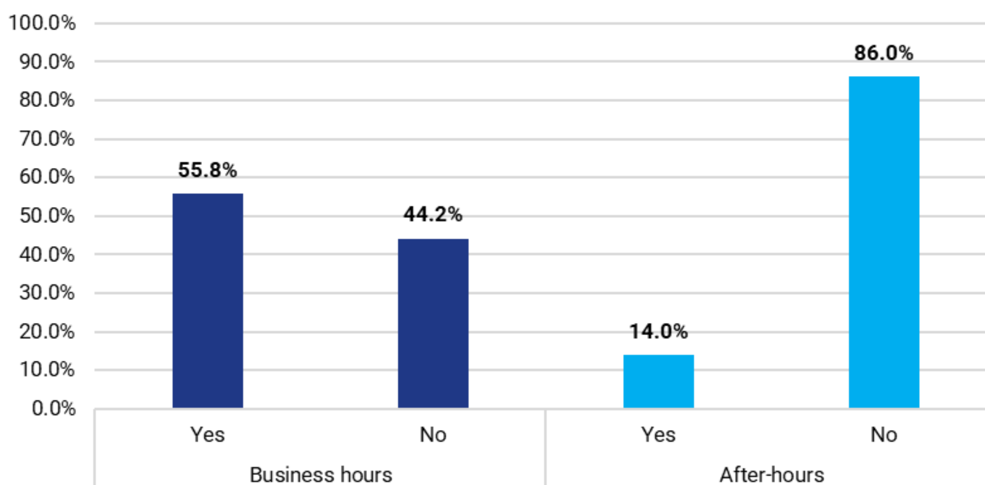
56 Respondents could select more than one response. The n value of 45 represents the number of selections made by 14 individuals

4.4 Palliative care needs

Analysis of data[57] on community stakeholder perspectives about the needs of people receiving palliative care and carers of palliative care patients indicated that:

- **Access to palliative care was considered more adequately accessible during business hours than after-hours.** 55.8% of community stakeholders reported that palliative care was accessible during business hours, while 44.2% felt that access was inadequate. Meanwhile, only 14.0% reported that palliative care during the after-hours period was adequately accessible, while 86.0% believed it was not (see Figure 19).
- **Reduction in physical suffering was considered the primary need for people receiving end-of-life care, while home nursing and specialist medical care were among the top 3 needs.** 32.8% of community stakeholders reported the reduction in physical suffering as the primary needs for palliative care patients. This was followed by the home nursing care (20.2%) and specialist medical care (16.0%); see Figure 20.
- **Home nursing care, 24-hour specialist care and grief counselling were among the top 3 needs of carers of people receiving end-of-life care.** 24.6% of community stakeholders reported home nursing care as a primary need of carers of people receiving end-of-life care. This was followed by 24-hour specialist care (23.7%) and grief counselling (17.5%); see Figure 21.

Figure 19 *Perceptions of adequate access to palliative care services during normal business and after-hours*

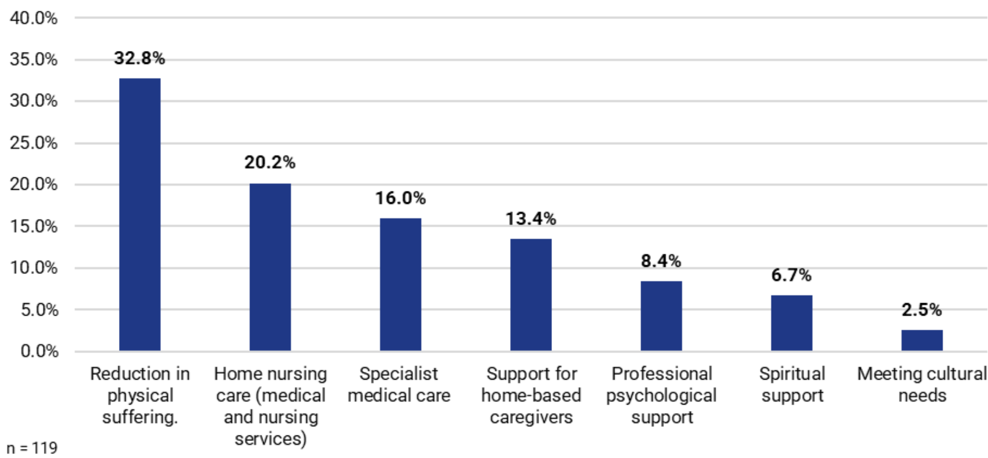


n = 43

Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

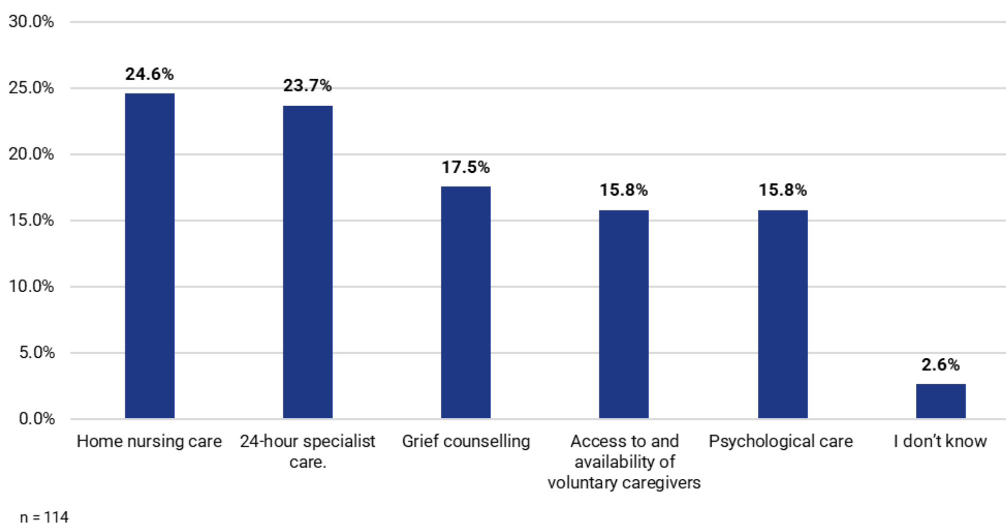
[57] Source: Western Sydney Primary Health Network, 2025a

Figure 20 *Top three most important needs of people receiving end-of-life care*



Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

Figure 21 *Top three most important needs of carers of people receiving end-of-life care*



Source: Western Sydney Primary Health Network. (2025a). Compiled by WSPHN.

5 Palliative care workforce capacity and capability

This chapter provides the results from a survey of health professionals (n=82) in the region about their confidence in providing palliative care, the barriers and challenges they face and the type of support that would assist them in their roles and how they can best be delivered.

Summary of palliative care workforce capacity and capability in the region

1. Most palliative care services were provided within General Practice (33.3%), residential aged care (31.3%), or in a person's home (26.0%).
2. Palliative care providers were most confident about case conferencing (at 53.0%), managing pain for clients (at 53.1%) and assessing a patient's cognitive ability in deciding end-of-life care (53.1%). However, they were least confident in coordinating community-based palliative care (16.0%) and preparing advanced care plans (13.6%).
3. The most significant barriers faced by palliative care health professionals was having sufficient staff to ensure high quality care (37.6%), the availability of local services (at 11.0%), integrating palliative care with their patient's active treatment (9.6%) and time pressures (9.6%).
4. The key social and emotional challenges faced by palliative care health professionals were talking to patients about death and the dying process (13.6%), initiating conversations with patients and families about the transition to end-of-life care (13.3%), supporting the patient's family or carers (10.3%), preparing the patient for end-of-life (10.3%) and supporting the psycho-social aspects of care (10.0%).
5. Palliative care health professionals are best supported through educational and learning opportunities delivered online (19.3%) or face-to-face (15.6%), and by a palliative care specialist (22.6%). The key topics of interest among health professionals were best practice in palliative care (30.1%), information on allied health support (25.1%) and understanding the regulatory and legal framework for palliative care (23.0%).

5.1 The palliative care workforce

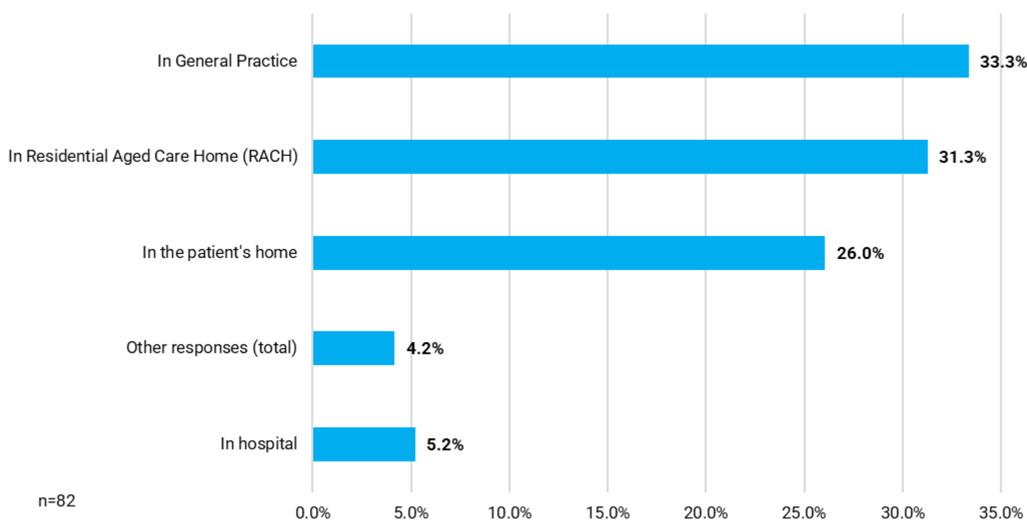
Analysis of data[58] about the composition of the palliative care workforce in the region indicated that:

- **Palliative care is primarily provided in general practice, aged care or a person's home:** Nine in ten health care professionals reported providing palliative care in either a general practice setting (33.3%), residential aged care home (31.3%) or in the person's home (26.0%). Only 5.2% of respondents provided palliative care in a hospital setting (see Figure 22).
- **More GPs among survey respondents than other palliative care professions:** 37.8% of respondents providing palliative care services were GPs. A further 28.1% were primary care nurses (17.1%) or in a managerial role (11.0%). The remaining 34.1% were residential aged care nurses (9.8%), allied health professionals (8.5%), community health workers (7.3%) or in other health roles[59] (8.5%); see Figure 23.

[58] Source: Western Sydney Primary Health Network, 2025b
[59] Of the 23 other responses, 9 were added to a new response options 'manager/CEO) and 7 were back-coded into existing response options. The remaining 7 other responses included social worker, paramedic and consulting.

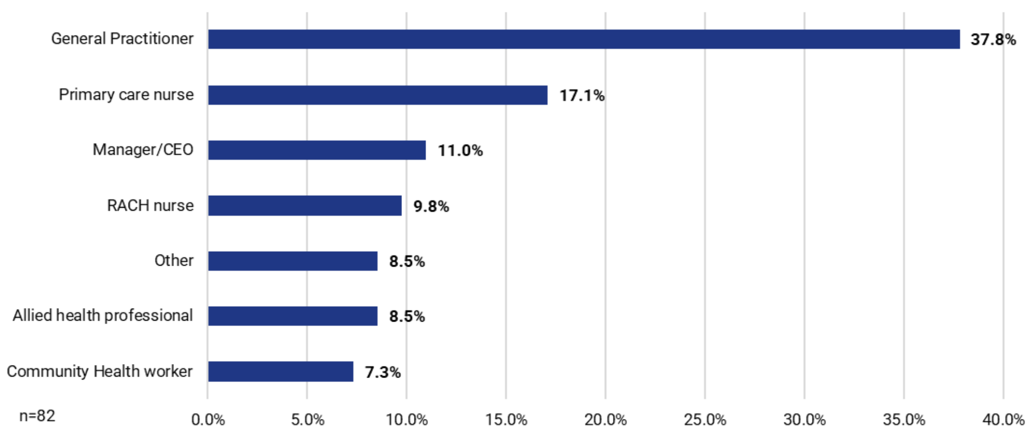
- **Most palliative care health providers have been working in palliative care for more than five years:** 84.1% of respondents reported working in palliative care for five years or longer. This was followed by 11.0% with three to four years of experience, 3.7% with one to two years of experience and 1.2% who had provided palliative care for less than a year (see Figure 24).
- **Four in ten palliative care providers are active in Blacktown:** 39.2% of survey respondents indicated they provide palliative care services in Blacktown LGA. This is followed by the Hills Shire LGA at 25.0%, Cumberland LGA at 18.3% and Parramatta LGA at 17.5% (see Figure 25).

Figure 22 Health care *settings in which health care professionals reported providing palliative care services*



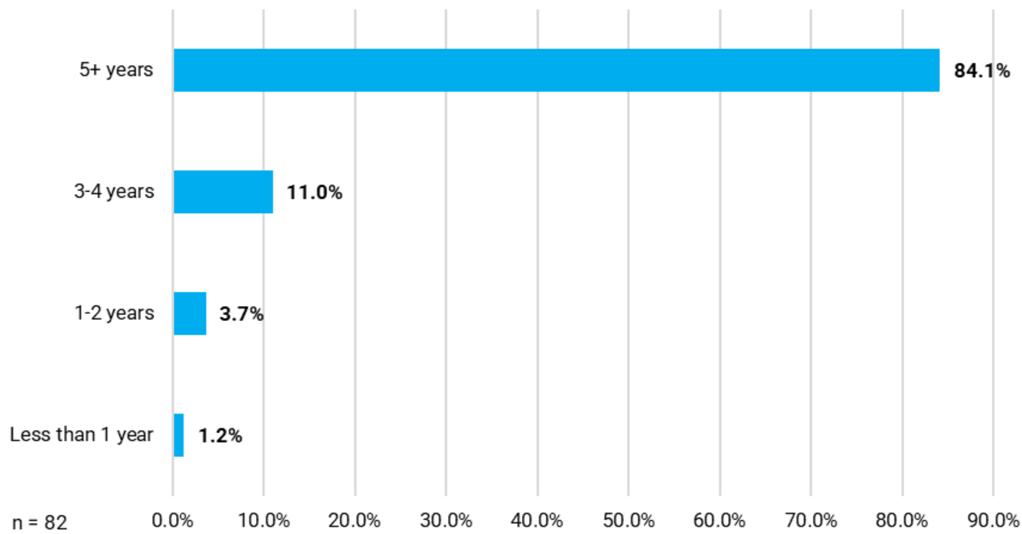
**Note: participants were able to choose up to all responses provided. A total of 96 selections were received for this question.*
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

Figure 23 *Professions and titles of health care professionals providing palliative care services as a percentage of the total survey respondents*



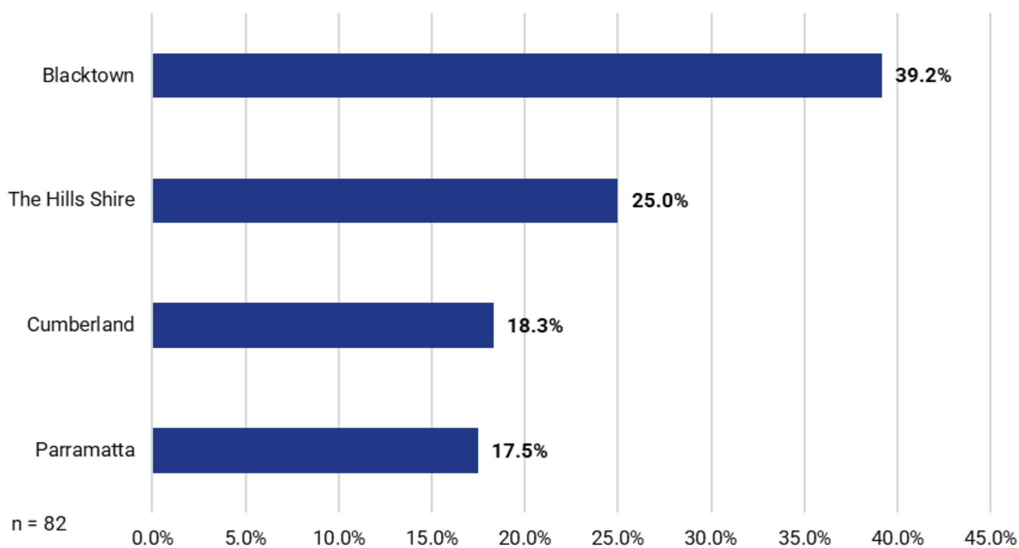
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

Figure 24 *Proportion of health professionals providing palliative care services for less than one year, one to two years, three to four years or five years and more as a percentage of the total survey respondents*



Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

Figure 25 *Proportion of health professionals providing palliative care across the four LGAs of WSPHN as a percentage of total survey responses*



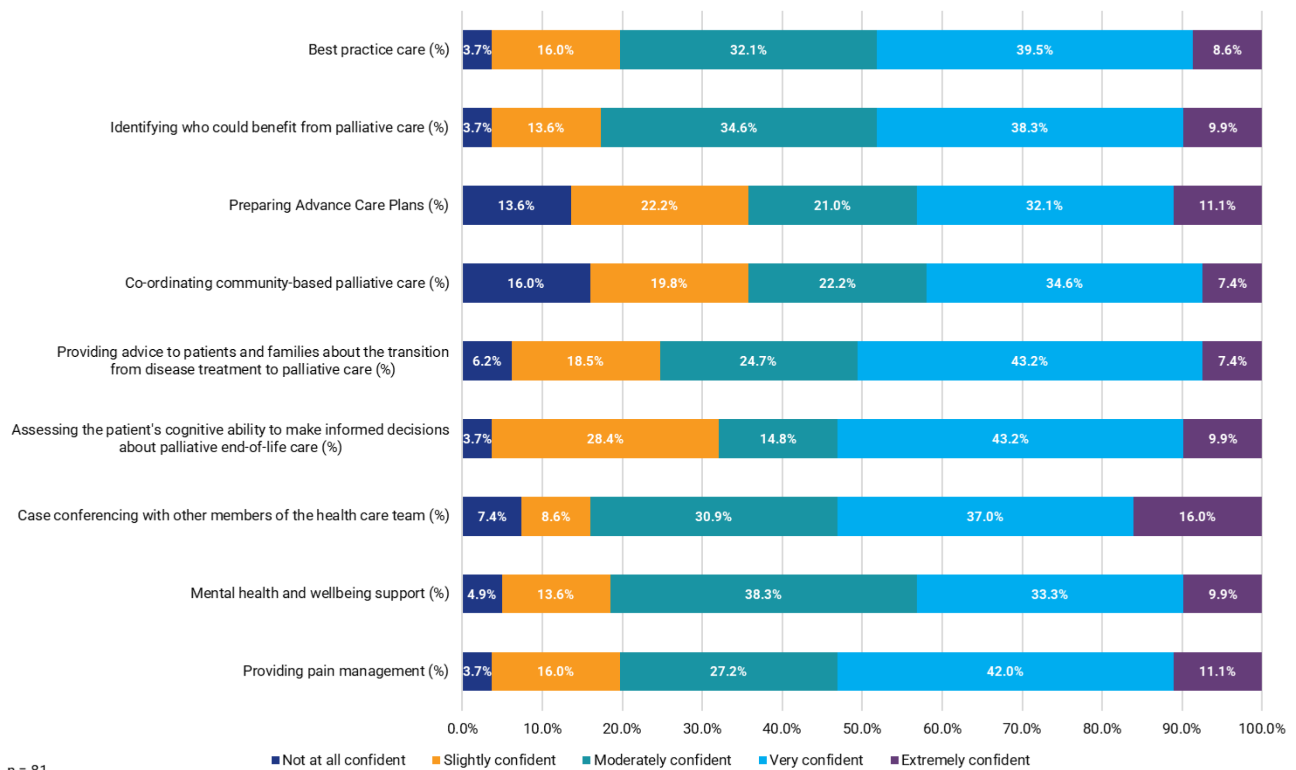
Note: participants were able to choose up to all responses provided. A total of 120 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

5.2 Confidence in palliative care service delivery

Analysis of data[60] about the confidence of health professionals with conducting various activities as part of palliative care service delivery indicated that:

- **Highest levels of confidence with pain management, case conferencing and assessment of cognitive ability.** 53.1% of respondents reported being very (42.0%) or extremely (11.1%) confident with providing pain management to palliative care patients. Similarly, 53.1% also reported being highly confident in case conferencing with other health care team members (37% very confident; 16.0% extremely confident) and assessing a patient's cognitive ability to make informed decisions (43.2% very confident; 9.9% extremely confident); see Figure 26.
- **Lowest levels of confidence in coordinating community-based palliative care and preparing Advance Care Plans and assessing patient's cognitive ability:** 35.8% of the respondent reported being not all confident (16.0%) or only slightly confident (19.8%) with coordinating community-based palliative care. Similarly, 35.8% also reported low confidence with preparing Advance Care Plans (13.6% not at all confident; 22.2% slightly confident); see Figure 26.

Figure 26 *Level of confidence among health care professionals with conducting various palliative care related activities*



Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

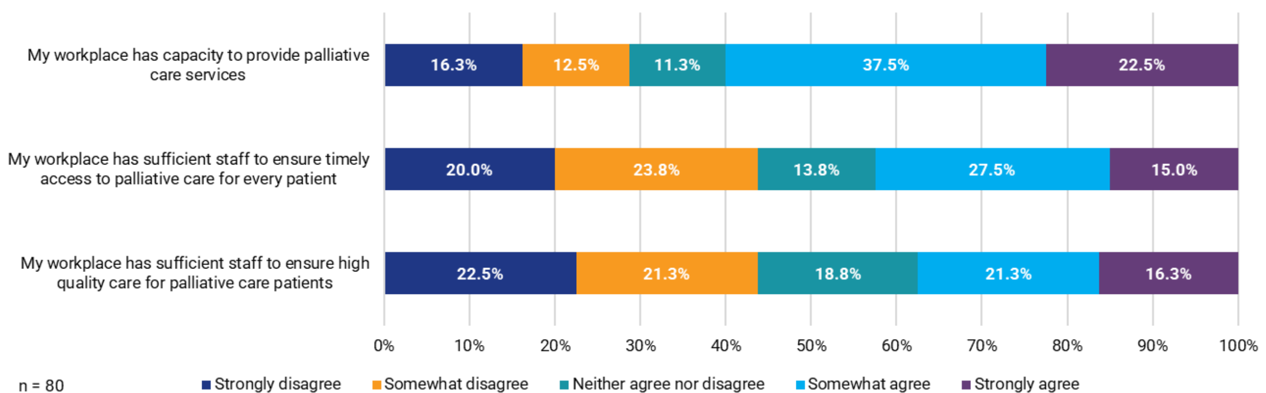
[60] Source: Western Sydney Primary Health Network, 2025b

5.3 Challenges and barriers

Analysis of data[61] about the challenges and barriers experienced by health professionals when providing palliative care indicated that:

- **Six in ten respondents agree that their workplace has the capacity to provide palliative care services, while less than four in ten respondents believe there is sufficient staff to guarantee high quality care:** 60% of respondents indicated that they somewhat (37.5%) or strongly (22.5%) agree that their workplace has the capacity to provide palliative care services. However, only 37.6% of respondents somewhat (27.5%) or strongly (15.0%) agree their workplace has sufficient staff to ensure high quality care for their palliative care patients (see Figure 27).
- **Availability of local services, integrating palliative care with active treatment and time pressures were the top three most common barriers:** 11.0% of respondents reported that availability of local services was a key barrier to care. Additionally, 9.6% reported difficulties with integrating palliative care with their patient's active treatment and their own time pressures as key barriers (see Figure 28).
- **Discussions about and supporting preparations for end-of-life care and the dying process were the most socially and emotionally challenging activities:** 13.6% of respondents reported that talking to patients about death and the dying process was one of the most socially and emotionally challenging activities with palliative care delivery. This was followed by initiating conversations with patients and families about the transition to end-of-life care (13.3%), supporting the patient's family or carers (10.3%), preparing the patient for end-of-life care (10.3%) and supporting the psycho-social aspects of care (10.0%); see Figure 29.

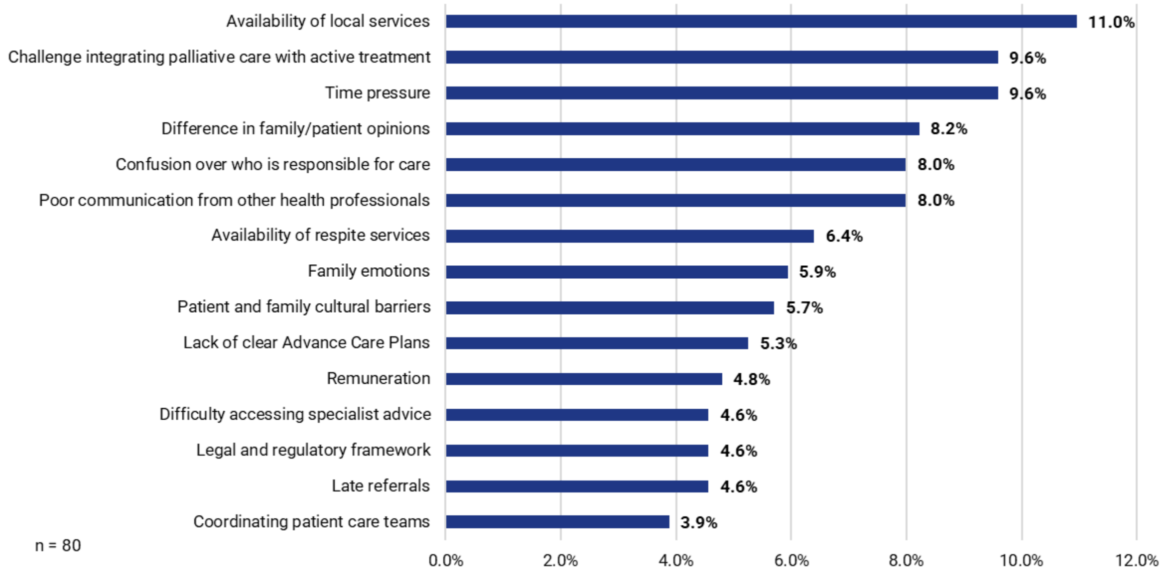
Figure 27 *Perceptions of health care professionals about their workplace capacity and staff availability to provide palliative care*



Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

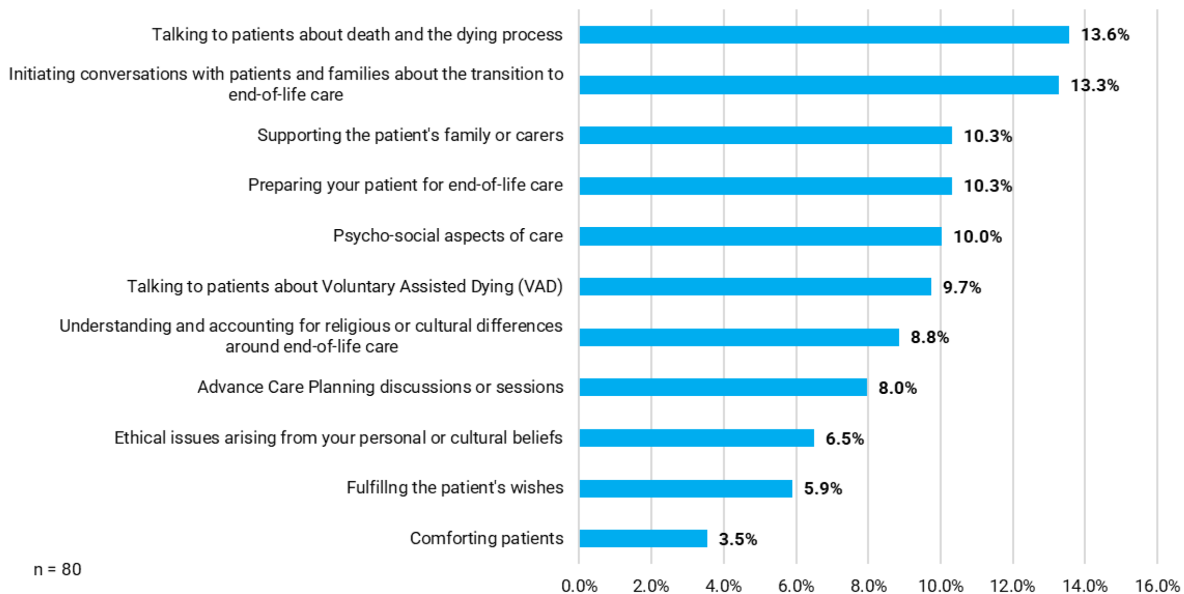
[61] Source: Western Sydney Primary Health Network, 2025b

Figure 28 *Barriers experienced by health professional when providing palliative care*



Note: participants were able to choose up to all responses provided. A total of 438 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

Figure 29 *Top five social and emotional challenges experienced by health professionals when providing palliative care*



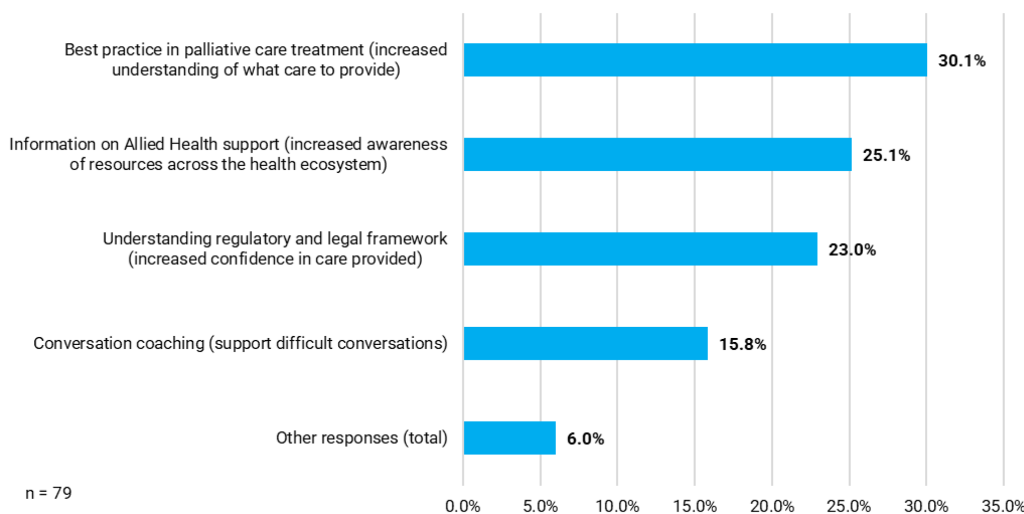
Note: participants chose up to 5 responses each. A total of 339 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

5.4 Support for palliative care health professionals

Analysis of data[62] about health professional perceptions of the types of support and their preferred mode of communication to support palliative care delivery indicated that:

- **Increased understanding of best practice in palliative care, allied health support and regulatory underpinning was of most interest:** 30.1% of respondents wanted to increase their understanding of best practice in palliative, while 25.1% were interested in building awareness of allied health support. An additional, 23.0% reported that improved understanding of the legal and regulatory framework for palliative care would increase their confidence in service delivery (see Figure 30).
- **Webinars and face-to-face workshops were the preferred modes of communication about palliative care with health professionals:** 19.3% of respondents reported webinar/virtual coaching as their preferred method of support in providing and coordinating palliative care. This was followed by face-to-face workshops, at 15.6%. Social media (0.4%) and video (5.2%) were the least preferred modes of receiving support (see Figure 31).
- **Palliative Care Specialists were the most common source of information:** 22.6% of survey respondents indicated that palliative care specialists were currently their main source of information about palliative care delivery. This was followed by government websites (11.8%) and their employer (11.3%). Respondents were least likely to seek information from universities or other relevant educational institutions (2.4%) and other health specialists such as oncologists or geriatricians (see Figure 32).

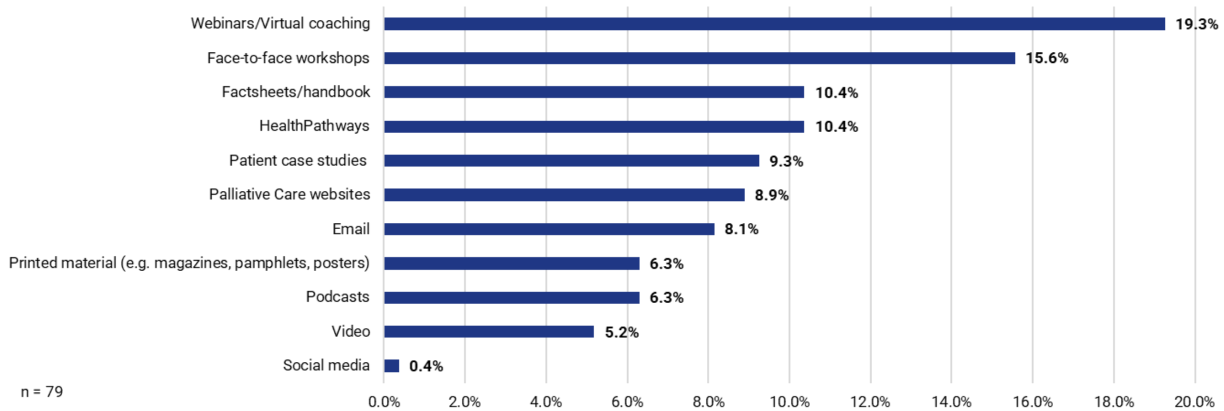
Figure 30 *Palliative care related topics that were most useful to support health professionals in providing palliative care*



Note: participants were able to choose up to all responses provided. A total of 183 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

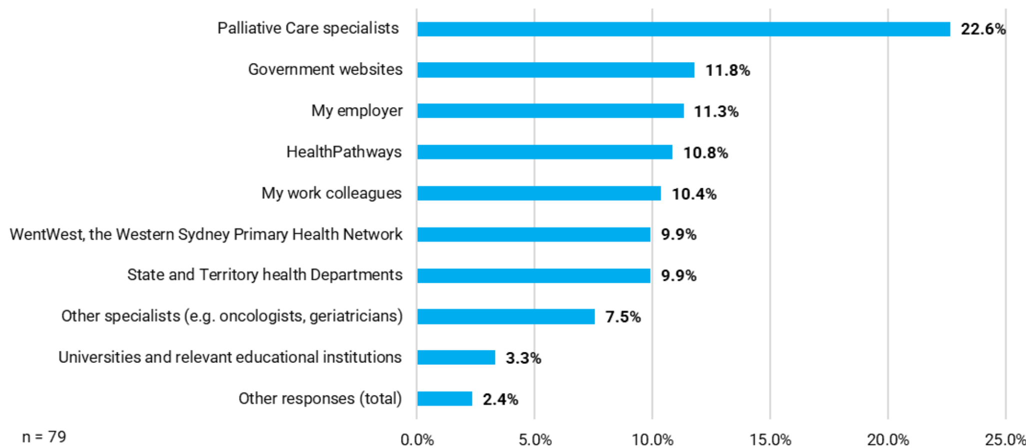
[62] Source: Western Sydney Primary Health Network, 2025b

Figure 31 *Preferred mode of communication to inform and support health professionals in providing palliative care*



Note: participants were able to choose up to all responses provided. A total of 270 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

Figure 32 *Main sources of information about palliative care accessed by health professionals*



Note: participants were able to choose up to all responses provided. A total of 212 selections were received for this question.
Source: Western Sydney Primary Health Network. (2025b). Compiled by WSPHN.

6 Summary of findings

This chapter provides a synthesis of the results from the palliative care needs assessment addressing the following assessment questions:

- What is the demographic and cultural profile of the Western Sydney region?
- What are the current rates of palliative care awareness, service utilisation and care needs among the Western Sydney community?
- To what extent is the Western Sydney palliative care workforce capable to meet palliative care needs in the community?

6.1 Population and cultural demography

The population of the WSPHN region was over one million in 2021 and is expected to increase by 16 percent by 2024. The region is culturally diverse with a high proportion of parents and home-builders, young workforce, children and a growing number of older people residing across four LGAs - Blacktown, Cumberland, Parramatta and the Hills Shire. The largest among these in terms of population is Blacktown LGA which also has the greatest proportion of First Nations residents. As at 2021, one in six residents were over the age of 60 years, while the average life expectancy for the region is 85.2 years. Cumberland LGA is the most culturally diverse of all LGAs in the region with the lowest proportion of residents with English and Australian ancestry, highest proportion who spoke a language other than English at home and a notable proportion who spoke little to no English. While there is a greater proportion of young people in the region, there is forecasted growth among the ageing population which will place more pressure on aged care and palliative care services in the region, particularly with chronic conditions leading to palliative care more than doubling after the age of 65 years.

6.2 Palliative care utilisation

Palliative care services are available across multiple settings in the region, such as general practice, aged care, in a person's home or in a hospital. However, the overall rates of palliative care services provided within and outside of the hospital setting has been decreasing in the region over time and has remained consistently lower than state and national averages. This has resulted in lower rates of palliative care prescribed medications and expenditure compared to NSW.

Yet, upon closer examination of the need for palliative care services within the region there was a high reliance on allied health or clinical nursing interventions among non-admitted patients. Meanwhile, admitted patients were more likely to be receiving palliative care alongside cancer treatment.

This examination also identified age and socio-economic disparities in palliative care needs across the region. People aged 75 years or over were disproportionately more likely to require palliative care both within and outside the hospital setting compared to any other age group in the region. There was also a greater reliance on admitted and non-admitted palliative care services among people from the most socio-economically disadvantaged areas. In fact, the data indicates a direct correlation between disadvantage and palliative care service usage, such that usage declined with a reduction in socio-economic disadvantage. Older people and those from more socio-economic disadvantaged areas in the region have a higher prevalence of chronic conditions than other population groups, often translating to an increased need for palliative care[63].

[63] French, et al., 2021

Furthermore, concerns about the capacity to pay for palliative care coupled with the misconception that it is only provided at end-of-life, leads to increased hospital-based palliative care among people from more disadvantaged areas[64].

6.3 Western Sydney community awareness and need for palliative care

Perceptions gathered from the Western Sydney community indicated that there was a high level of awareness and understanding of palliative care, with information being primarily sourced through the hospital, a family member or print or digital material. Furthermore, most viewed palliative care as an enabler for people to continue living as comfortably as possible. Community members also placed a high level of importance on being able to discuss their end-of-life preferences and were familiar with palliative care planning processes such as the NSW Advance Care Directive.

Despite this, only three in ten people in the region had implemented any type of palliative care planning. Key barriers to palliative care planning include community misconceptions about the settings in which palliative care is delivered (i.e., only in hospitals), when it is provided (i.e., only during end-of-life), and who it is provided by (i.e., only specialists)[65]. This is further compounded by community mistrust of health providers and governments due to perceptions of cultural insensitivity in providing palliative care and language and literacy barriers, particularly among under-serviced and socio-economic disadvantaged communities[66].

In terms of addressing community needs for palliative care in the region, information about the palliative care process, symptoms management and medication administration were the primary types of support received. However, additional service needs were also identified among carers and people receiving palliative care. This included, ensuring adequate access to after-hours palliative care, ensuring care reduced physical suffering and having access to home nursing care, specialist care and grief counselling.

6.4 Confidence, barriers and additional support for palliative care workforce

The palliative care workforce in the region comprises health professionals from primary care, aged care, allied health, community health and clinical and specialist care, and is sometimes provided through specialist multidisciplinary teams. Most of the workforce perspectives provided in this needs assessment were from primary care and allied health professionals with over 5-years of experience in providing palliative care.

The palliative care workforce was most confident with activities that involved the direct care of patients such as administering medication and case conferencing with the health care team. However, confidence was lowest in two key areas of palliative care support. The first was with supporting the development of Advance Care Plans, where health professionals reported social and emotional challenges such as discussing the death and dying process and transition to end-of-life care with patients, their families and carers. The second was the co-ordination of community palliative health care as providers struggled with time pressures and the lack of available local services.

The availability of adequate staff is a common challenge across the health system and was also highlighted by palliative care health professionals in the region. While agreement was high regarding the capacity of workplaces to deliver palliative care, there was much less agreement that these workplaces had sufficient staff to ensure timely access to high-quality palliative care.

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[64] Victoria Department of Health, 2016
[65] Department of Health, Disability and Ageing (previously Australian Department of Health), 2019
[66] Javanparast, Anaf and Tieman, 2022

Health professionals in the region reported that educational and learning opportunities could improve health professional confidence in providing palliative care and address some of the challenges they experience. They were most interested in improving their knowledge of best practice in palliative care provision, increasing their awareness of palliative care resources across the health eco-system and learning about the regulatory framework for palliative care. This information was most effective when delivered online or face-to-face and by an experienced palliative care specialist.

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