PCOC
palliative care
outcomes collaboration

National Overview of Patient Outcomes in Australia 2025

May 2026

1 National Interpretation & Implications

The Palliative Care Outcomes Collaboration (PCOC) now captures outcomes for over 70,000 patients annually, representing approximately 20% of all deaths and around one-third of those estimated to benefit from palliative care. The information reported represents real life outcomes of Australians.

- **Increased coverage:** Although national coverage of palliative care has expanded, the short interval between commencement of care and death indicates that many patients continue to be referred late in the course of illness. This suggests that gains in access have not been accompanied by improvements in the timing of entry into care, which may limit the overall benefit of palliative care.
- **Most referrals come from hospitals:** Referral patterns have remained largely unchanged, with hospitals continuing to be the main source of entry into palliative care. This pattern indicates that access is still predominantly initiated in acute care settings, rather than through earlier identification in primary or community-based care.
- **Shifts in case-mix and implications for care models:** The growing proportion of patients with non-malignant conditions reflects a change in the population receiving palliative care, with increasing clinical complexity and less predictable disease trajectories. This shift has implications for existing models of care, which have historically been oriented towards cancer, and may require adaptation in approaches.
- **Improvements in access:** There has been progress in improving access for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds and those living outside major cities. While representation of diverse populations has improved, ongoing efforts are needed to ensure culturally responsive, equitable, and accessible palliative care for all Australians.
- **Consistent improvement in clinical outcomes following access:** Performance against key benchmarks indicates that care is of high quality once patients enter palliative care services. This suggests that current challenges are more closely related to access and referral pathways than to the delivery of care itself.

2 Acknowledgements

Contributions	PCOC acknowledges that this work represents people who have died an expected death and recognises the significance this holds for each person their families and loved ones. PCOC further recognises the dedication of palliative care clinicians and their commitment to reporting on and improving patient outcomes.
Disclaimer	PCOC has made every effort to ensure that the data used in this report are accurate. Data submitted to PCOC are checked for anomalies and services are asked to re-submit data prior to the production of the PCOC report. We would advise readers to use their professional judgement in considering all information contained in this report.
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3 PCOC's growing reach across Australia

PCOC is a Clinical Quality Registry that enables research to advance knowledge and practice. It is registered on the Australian Register of Clinical Registries as the Australian Palliative Care Outcomes Registry (APCOR).

A total of 191 locations across Australia submitted data to PCOC. This is an increase of 6 (3.2%) compared to 2024. Many of these locations provide palliative care services across both admitted and non-admitted settings.

In the 2025 calendar year, PCOC collected the outcomes of 76,785 patients, having 99,903 episodes of care and 214,340 palliative care phases. Figure 3.1 shows the patient distribution by state and locations of the palliative care services participating with PCOC.

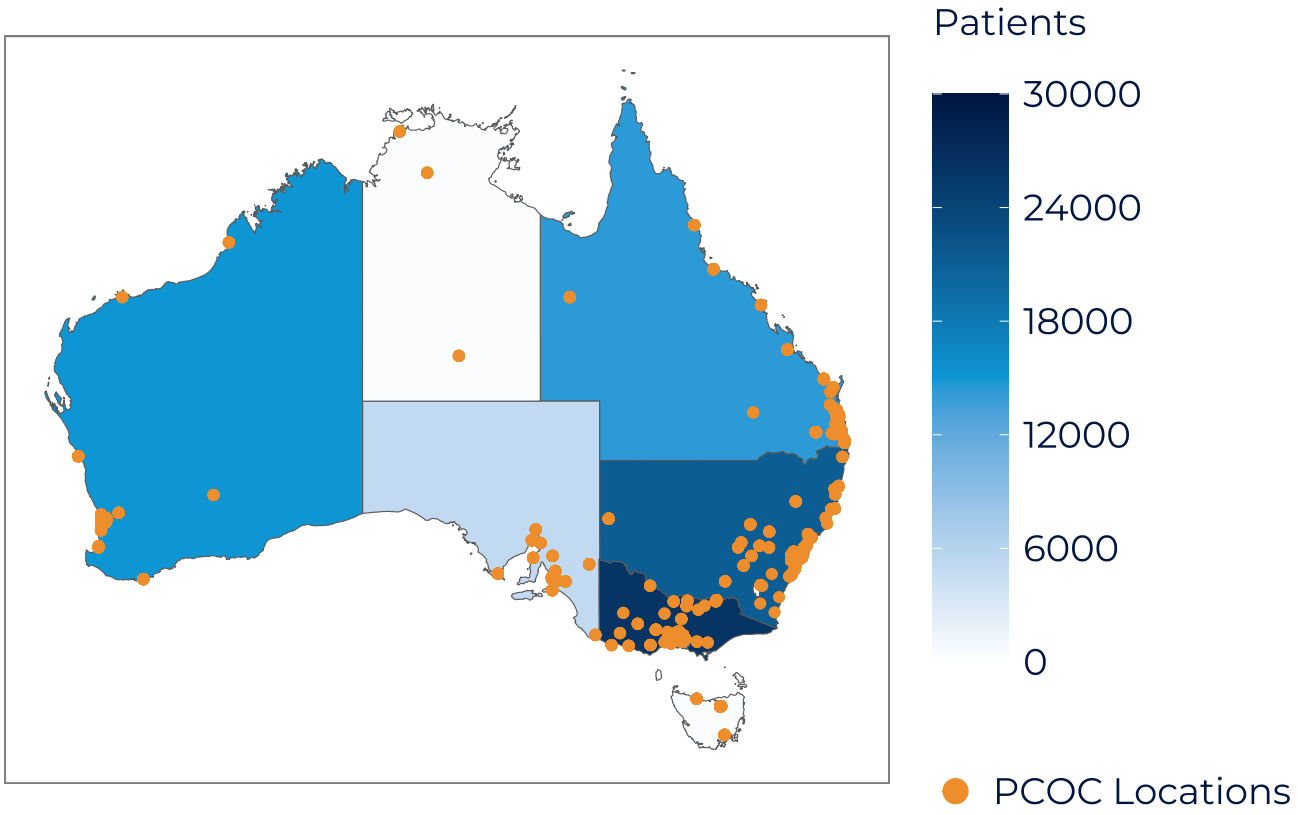

Figure 3.1: The number of patients by state and locations of palliative care services participating with PCOC in 2025

4 Growth in national mortality coverage

One of the key aims of PCOC is to increase the coverage of patients. While an accurate denominator measuring the total number of deaths occurring in palliative care does not exist, trends can tracked over time using mortality statistics collected by the Australian Bureau of Statistics (ABS).

By comparing the total number of deaths captured by PCOC with all-cause mortality, the national percentage of deaths captured can be estimated at 20.2% (see Figure 4.1), representing an increase of almost 7 percent since 2015. Given that an estimated 63.03% of all deaths could benefit from palliative care [4], the proportion of potential palliative care patients captured within the PCOC dataset is substantially higher, at 32.1%. The remaining 67.9% of deaths in 2025 either did not involve palliative care or occurred in services not participating in PCOC.

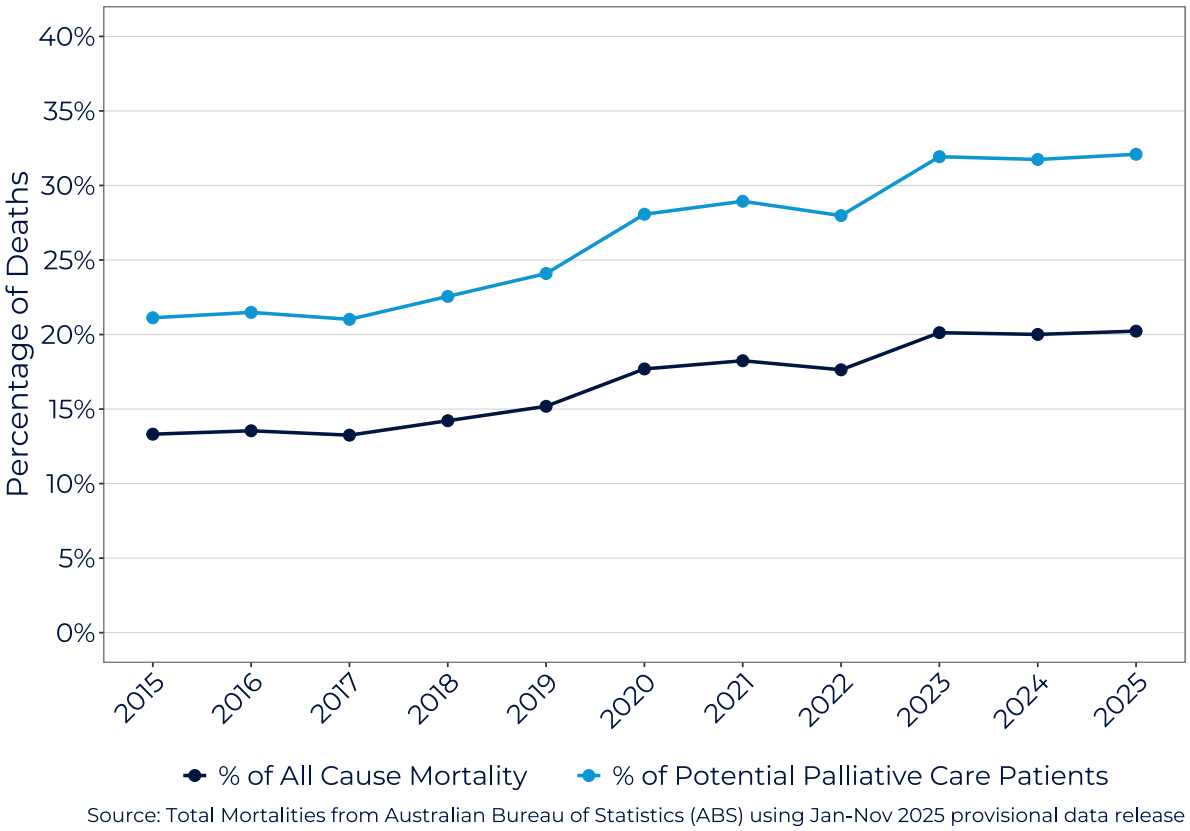

Figure 4.1: Comparing the percentage of deaths captured in the PCOC dataset with all cause mortality statistics and those that could potentially benefit from palliative care

5 Improved reach into rural and remote communities

PCOC also aims to continually expand its reach into rural and remote communities, where access to palliative care has historically been limited. While the number of patients captured in the PCOC dataset almost doubled from 2015 to 2025 (Figure 5.1), the proportion of patients from rural areas increased from 12.3% to 17.1%. Similarly, those from remote areas increased from 0.8% to 1.7%. This, combined with the growth in total number of patients, represents a combined 2.8 times increase in rural and remote area coverage within the last decade.

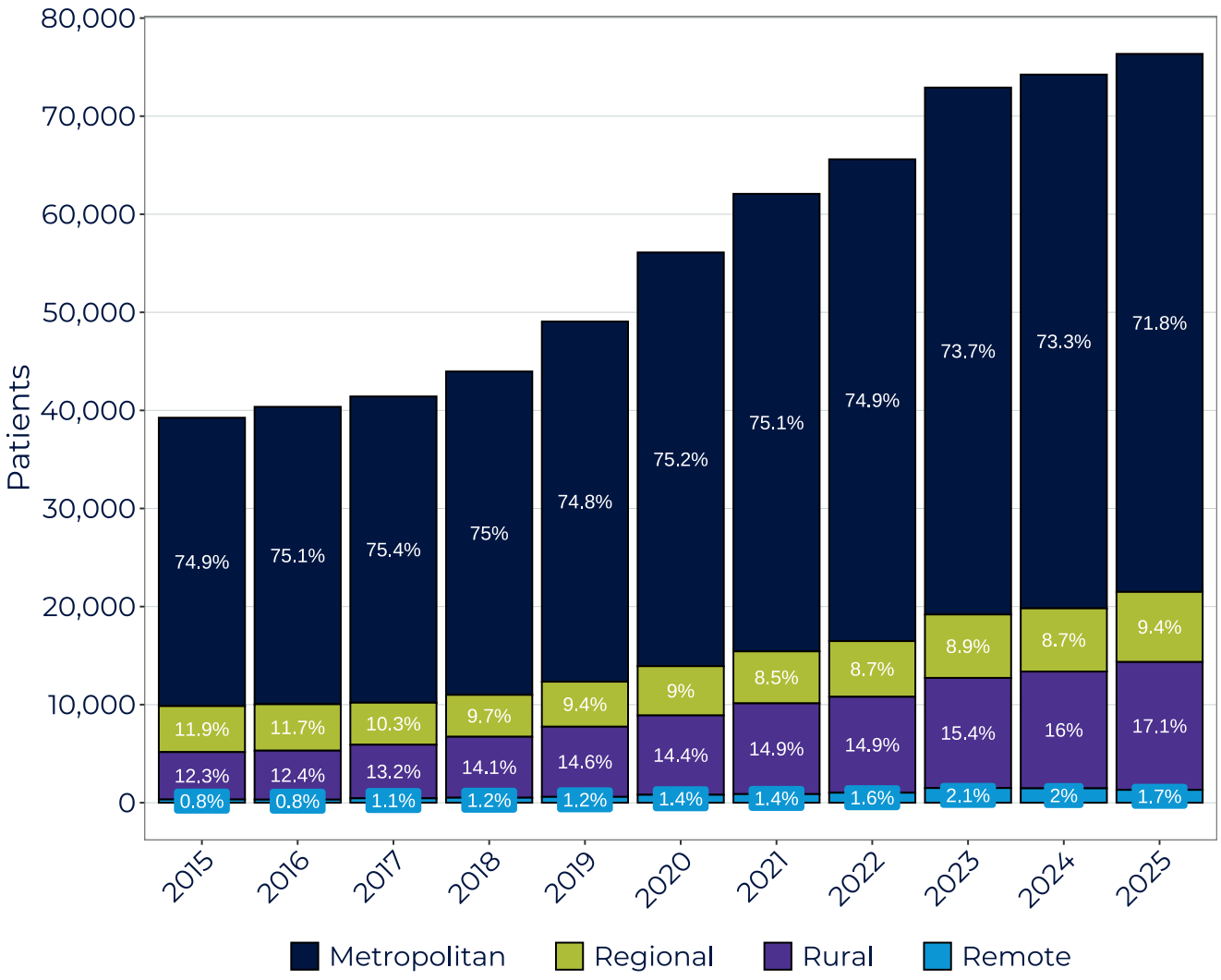

Figure 5.1: The number of patients whose outcomes are captured in the PCOC dataset by remoteness over time

6 Palliative care for First Nations and CALD patients

Maximising the quality of palliative care for Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse (CALD) communities has also been a key focus area for PCOC. Historically, Indigenous patients have been substantially underrepresented in palliative care services participating with PCOC. This has improved in recent years with the difference between the PCOC dataset and the 2021 Census [2] (3.2%) consistently reducing, from -1.91% in 2015 to -0.63% in 2025 (Figure 6.1). If this trend continues, the percentage of Indigenous patients within the PCOC dataset will be equal to the 2021 Census by 2030.

The percentage of those in the PCOC dataset who were not born Australia was in fact around 6% higher than the 2021 Census [3]. This is due to the high number of participating services being located within major cities where more people from CALD backgrounds live.

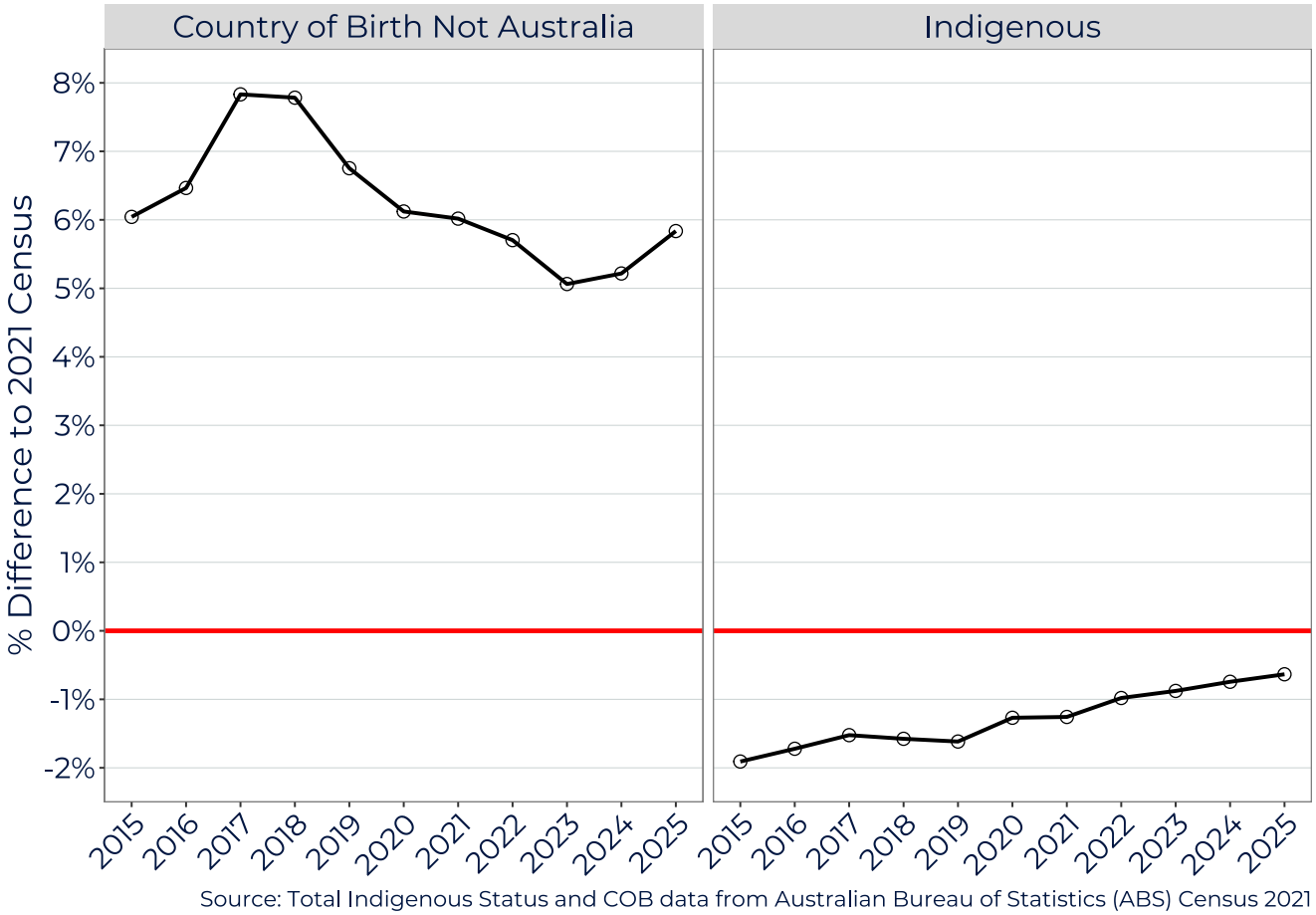

Figure 6.1: The difference in percentages within the PCOC dataset and the 2021 Census data for Country of Birth and Indigenous Status

7 Referral patterns remain consistent with rising volumes

In 2025, the largest referrers to palliative care continued to be private and public hospitals. They have consistently remained around 66% of all referrals over the last decade despite the overall volume almost doubling, as seen in Figure 7.1. General practitioners and Community Services are the next largest referrers which combined make up approximately 15% of all referrals.

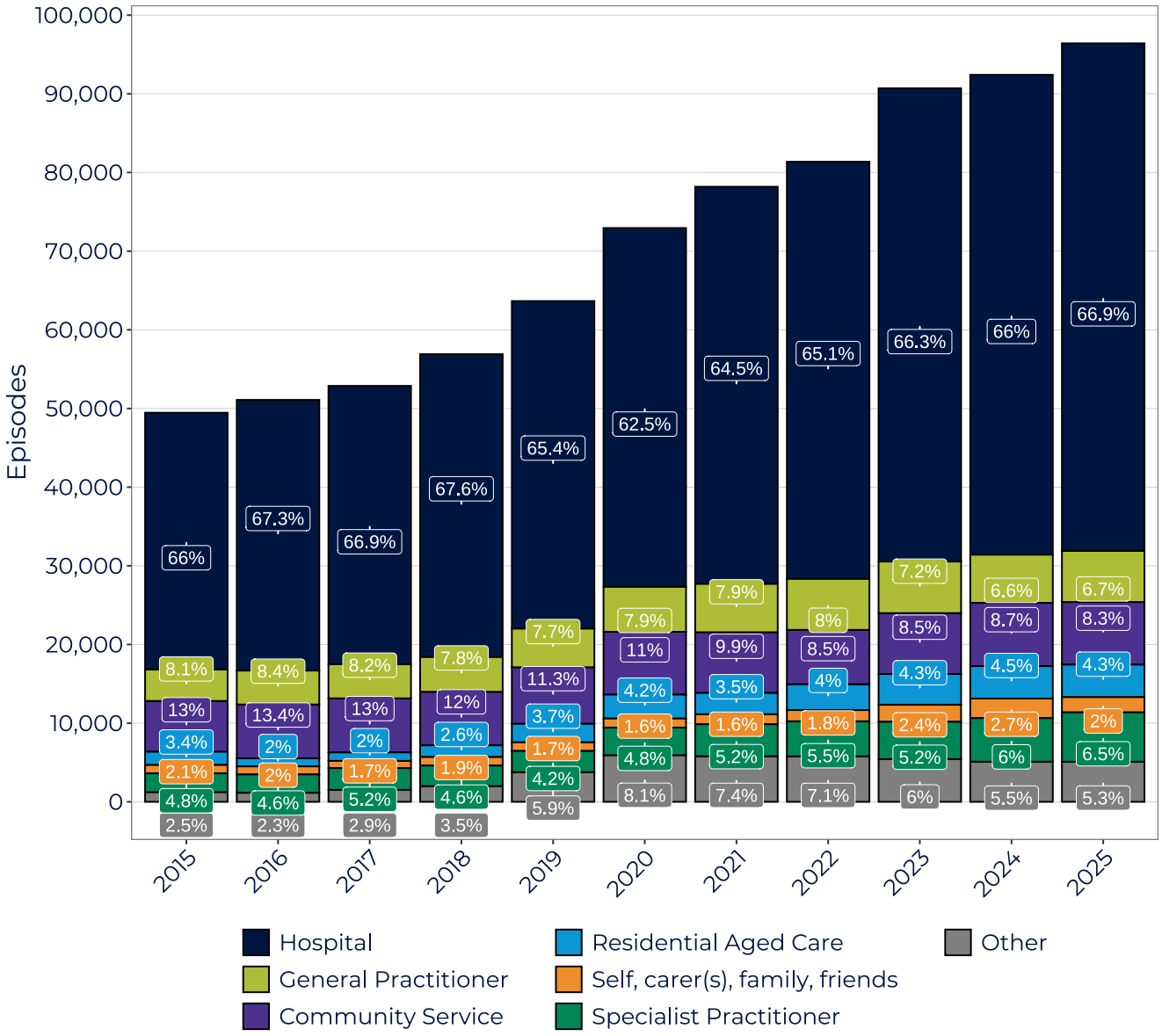

Figure 7.1: Referral sources to palliative care in the last 10 years

8 More patients with non-malignant conditions accessing palliative care

While patients with a malignant (cancer) life limiting diagnoses make up the predominant cohort receiving palliative care within Australia, the last decade has seen a significant increase in those with non-malignant conditions also being provided palliative care. In 2015, non-malignant patients made up approximately 24% of all patient receiving specialist palliative care. This has consistently grown over the last decade to be 41.4% in 2025.

As shown in Figure 8.1, dementia is the most rapidly increasing primary diagnosis of all the top 10 diagnoses, almost doubling from 9.6% in 2015 to 17.4% in 2025. Lung cancer has consistently been reported as the largest primary life limiting diagnosis, although it has slightly decreased in proportion relative to other cancers in the last decade. Pancreatic cancer has steadily increased in proportion from 6.7% of all cancers in 2015 to 8.1% in 2025.

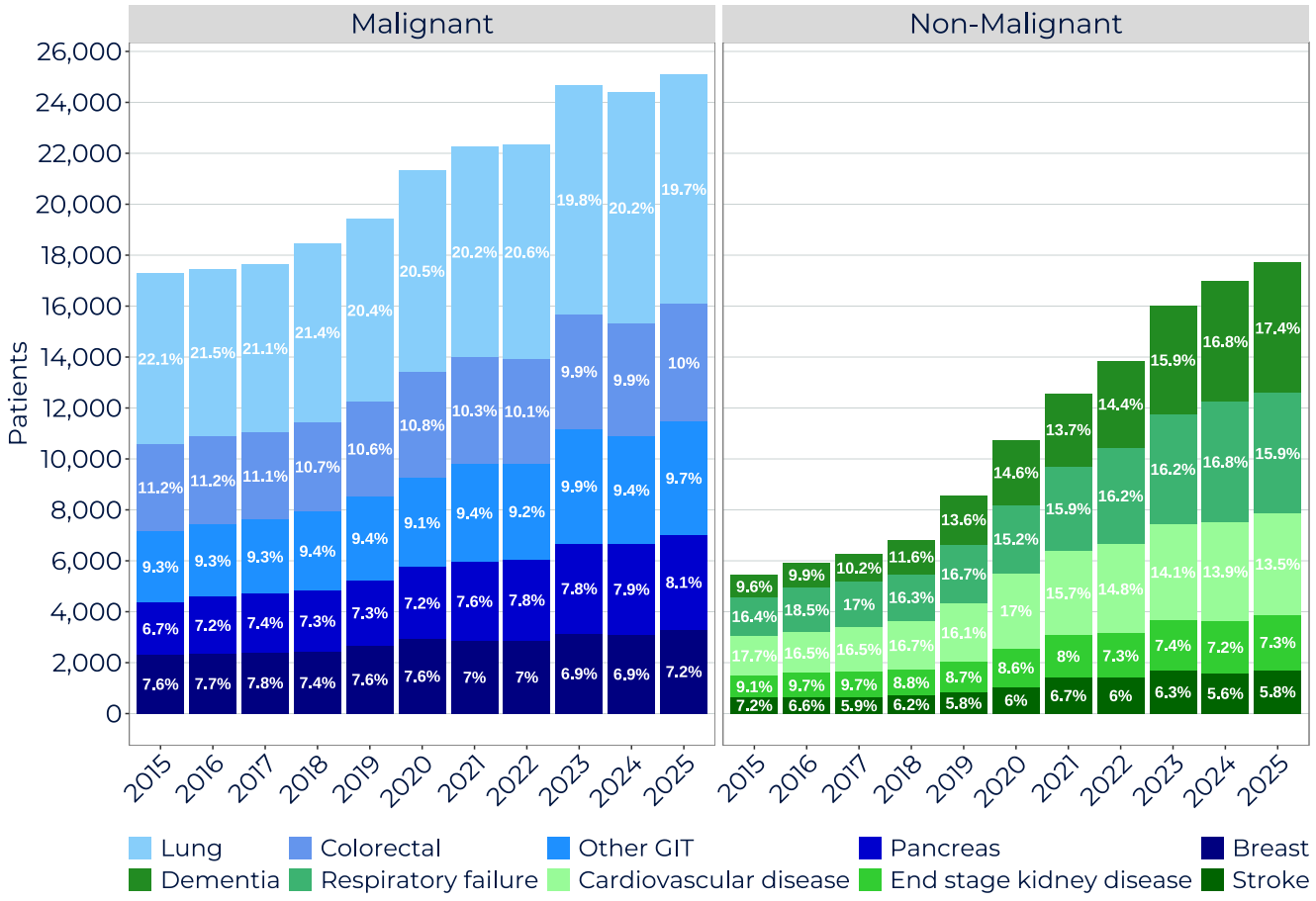

Figure 8.1: The percentages for each diagnosis, relative to the total number of patients given the broad diagnosis

9 Time spent in palliative care

PCOC has the ability to track an individual's palliative care journey, even if they access multiple services. Therefore, it is possible to determine the length of time a patient spends in palliative care, from their first encounter to death.

Since 2015, the median time from first encounter to death has declined from 11 days to 8 days. While this varies by setting, the patient may access multiple both inpatient and non-admitted palliative care services before the final episode ending in death, so Figure 9.1 reflects all settings combined. Over 16% of patients have their first palliative care encounter recorded within 1 one day of dying. This indicates many patients receive palliative care very late.

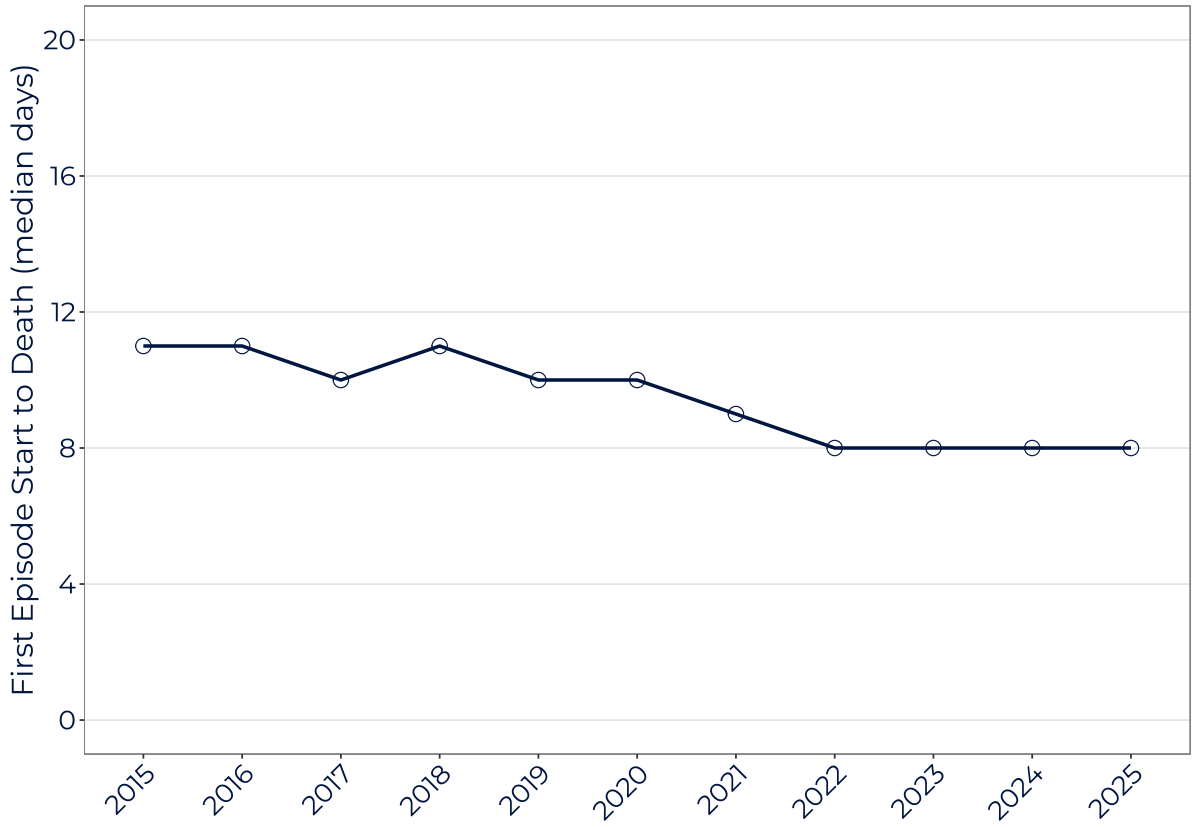

Figure 9.1: The median number of days between an individuals first palliative care episode commencing and the date of death

10 The Australia-modified Karnofsky Performance Status at commencement of palliative care

The Australia-modified Karnofsky Performance Status (AKPS) [1] is a measure of the patient's overall performance status. It is a single score assigned by a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. A score of 100 signifies normal physical abilities with no evidence of disease. Decreasing numbers indicate a reduced performance status.

In the last decade, there has been more patients commencing palliative care with reduced performance status. Figure 10.1 shows trends in the percentage of patients who commence palliative care with each AKPS score (10-50) or lower. For example, in 2025, the percentage of patients who had an AKPS of 40 or less (orange line) at the commencement of palliative was 56.1%. This percentage increased since 2015 by 10.7% when it was 45.4%.

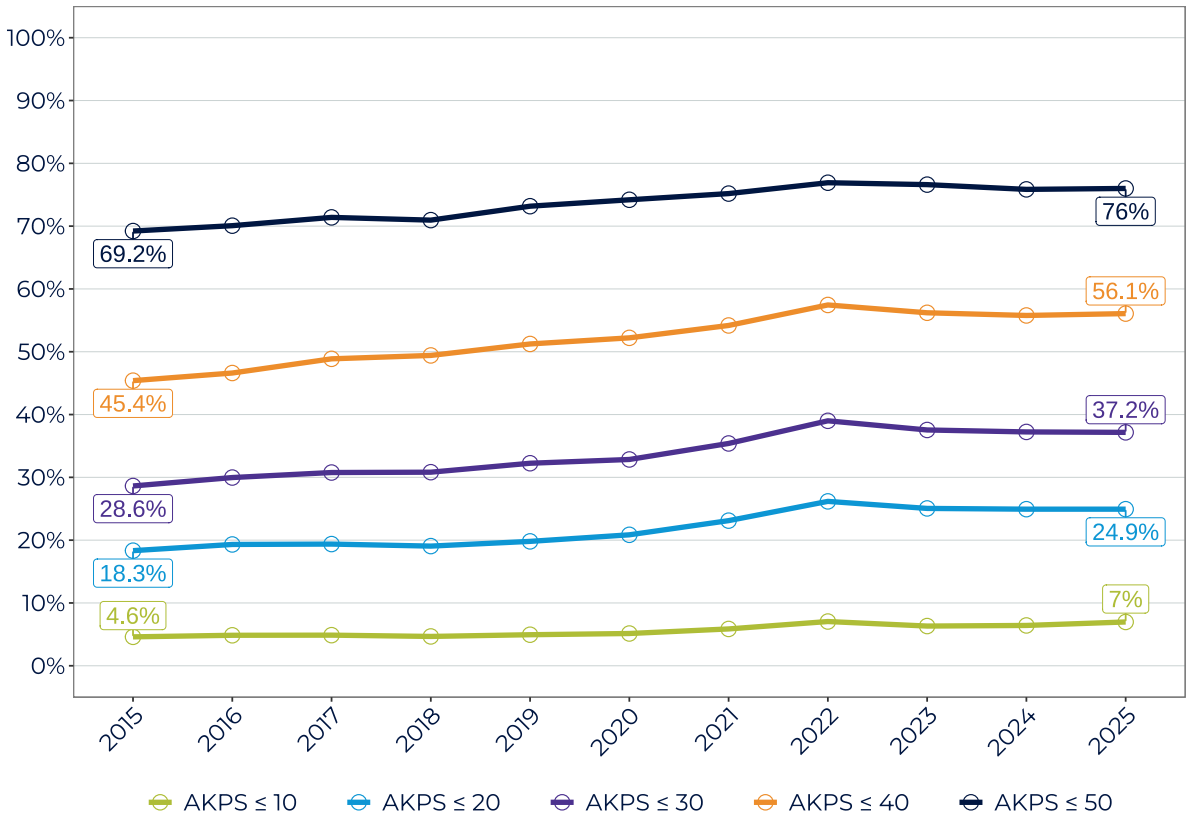

Figure 10.1: Percentage of each AKPS (10-50) or lower at commencement of palliative care

11 Benchmark performance

11.1 Timely Commencement of Palliative Care

At least 90% of patients must have their episodes commence on the day of, or the day following, date ready for care.

As shown in Figure 11.1, the number of episodes where care commenced within one day of the patient being ready for palliative care has more than doubled in the past decade across all settings. The timely commencement of palliative care has consistently performed highly, with well over 90% of episodes meeting the benchmark.

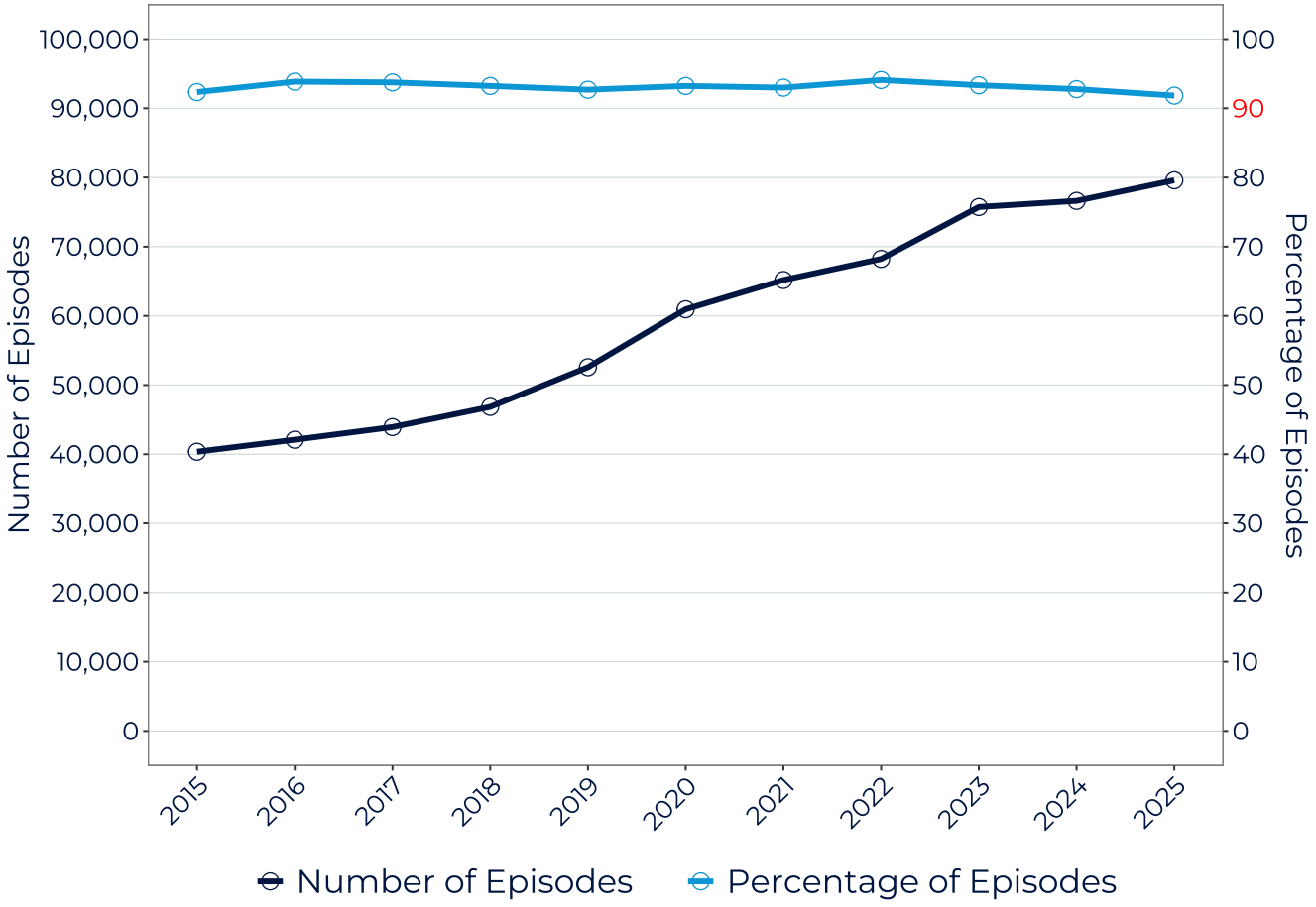

Figure 11.1: Patient's care starts the day of or the day after the date ready for care.

11.2 Responsiveness to urgent clinical need

At least 90% of occurrences where the patient is in an unstable condition must last for three days or less.

The number of occurrences where the time in an unstable condition is three days or less has remained relatively consistent since 2017 (Figure 11.1). When simultaneously considering the consistent benchmark performance and the number of observations meeting the benchmark decreasing, it can be deduced that the overall occurrences of patients being in an unstable condition has declined since 2020.

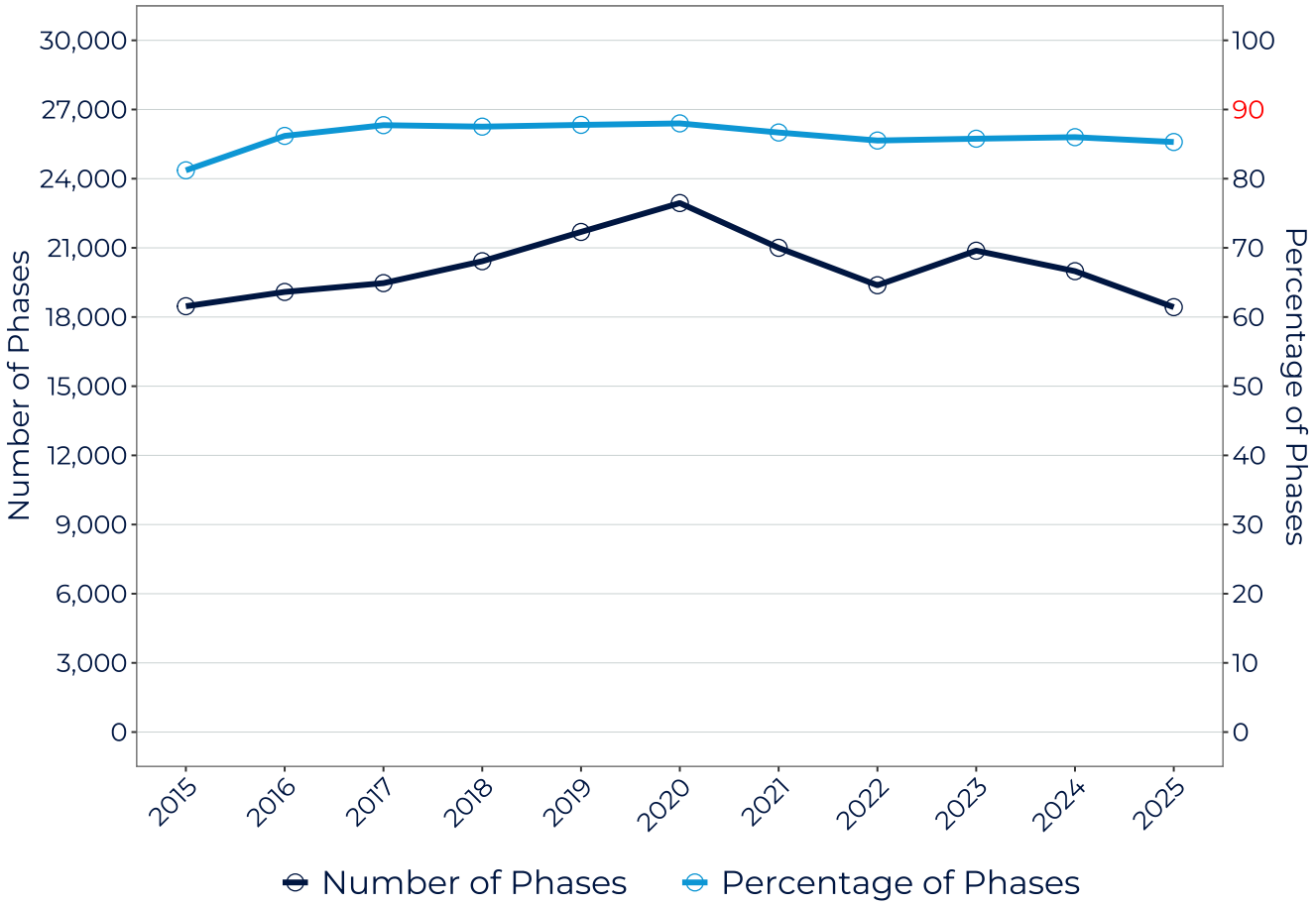

Figure 11.2: Time spent in an unstable condition is 3 days or less

11.3 Absent/mild symptoms remaining absent/mild

At least 90% of observations starting with absent or mild symptoms must end with the patient still experiencing only absent or mild symptoms.

As shown in Figure 11.3, the number of these observations where the benchmark was met has continuously increased since 2015, approximately doubling between 2015 and 2025 across all symptoms.

The Breathing Problems symptom has the highest benchmark performance for every year in the last decade. The plateau in benchmark performance is expected as the effort required to achieve further improvements grows exponentially with improvements in performance.

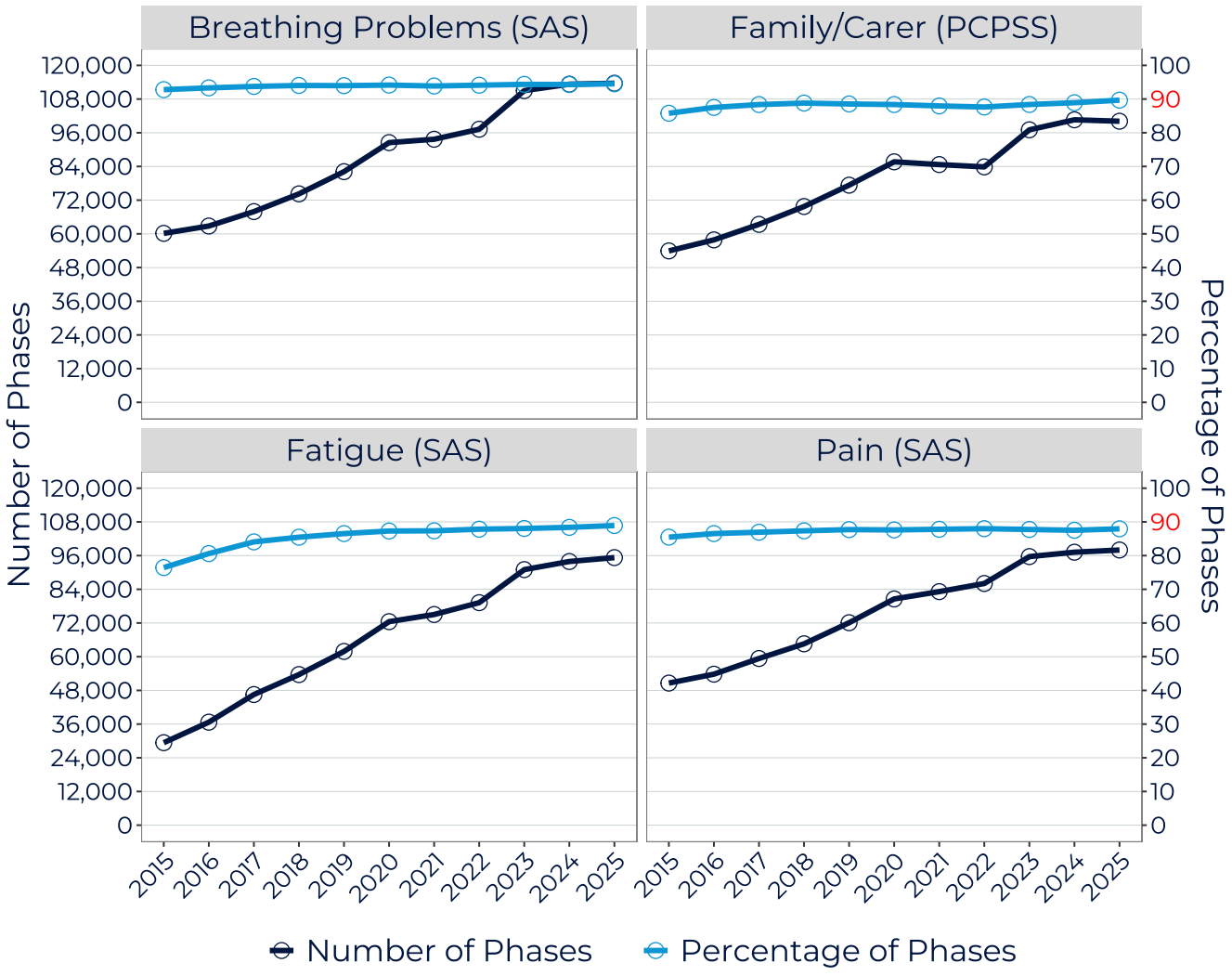

Figure 11.3: Absent/Mild symptoms remaining absent/mild, also known as Anticipatory Care.

11.4 Moderate/severe symptoms reducing to absent/mild

At least 60% of observations starting with moderate or severe symptoms must end with the patient experiencing absent or mild symptoms.

The number of these observations has not increased as substantially across all symptoms measured (Figure 11.4). This is a positive result, as it highlights a decreasing percentage of moderate/severe observations compared to those for absent/mild symptoms. The aim is to reduce the number of these observations, while also increasing the percentage of observations where the benchmark was met. The plateauing effect is less evident here than the absent/mild performance benchmark performance due to there being more room for improvement across symptoms/problems.

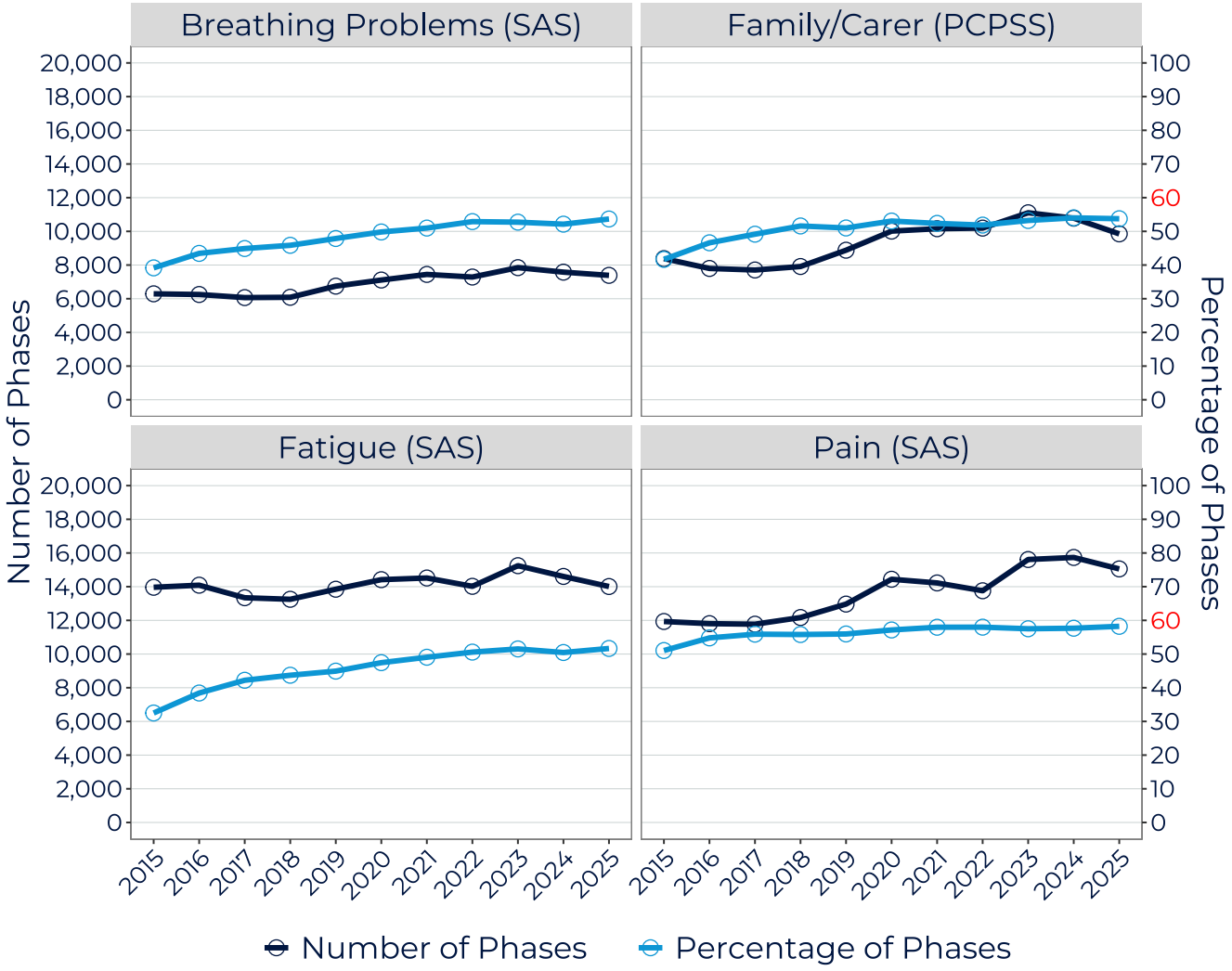

Figure 11.4: Moderate/Severe Symptoms becoming absent/mild, also known as Responsive Care

11.5 Casemix adjusted outcomes

Patients in the same phase who started with the same level of symptom have their change in symptom compared to the reference period.

Positive and negative casemix adjusted scores indicate that a service is achieving above or below the baseline national average, respectively. The highest casemix adjusted outcome performance within the last decade occurred in 2025 (Figure 11.5).

The current casemix-adjusted measure has limitations in accurately reflecting the complexity and diversity of patient populations across settings. We are currently revising these measures to ensure they better capture variations in care needs and outcomes.

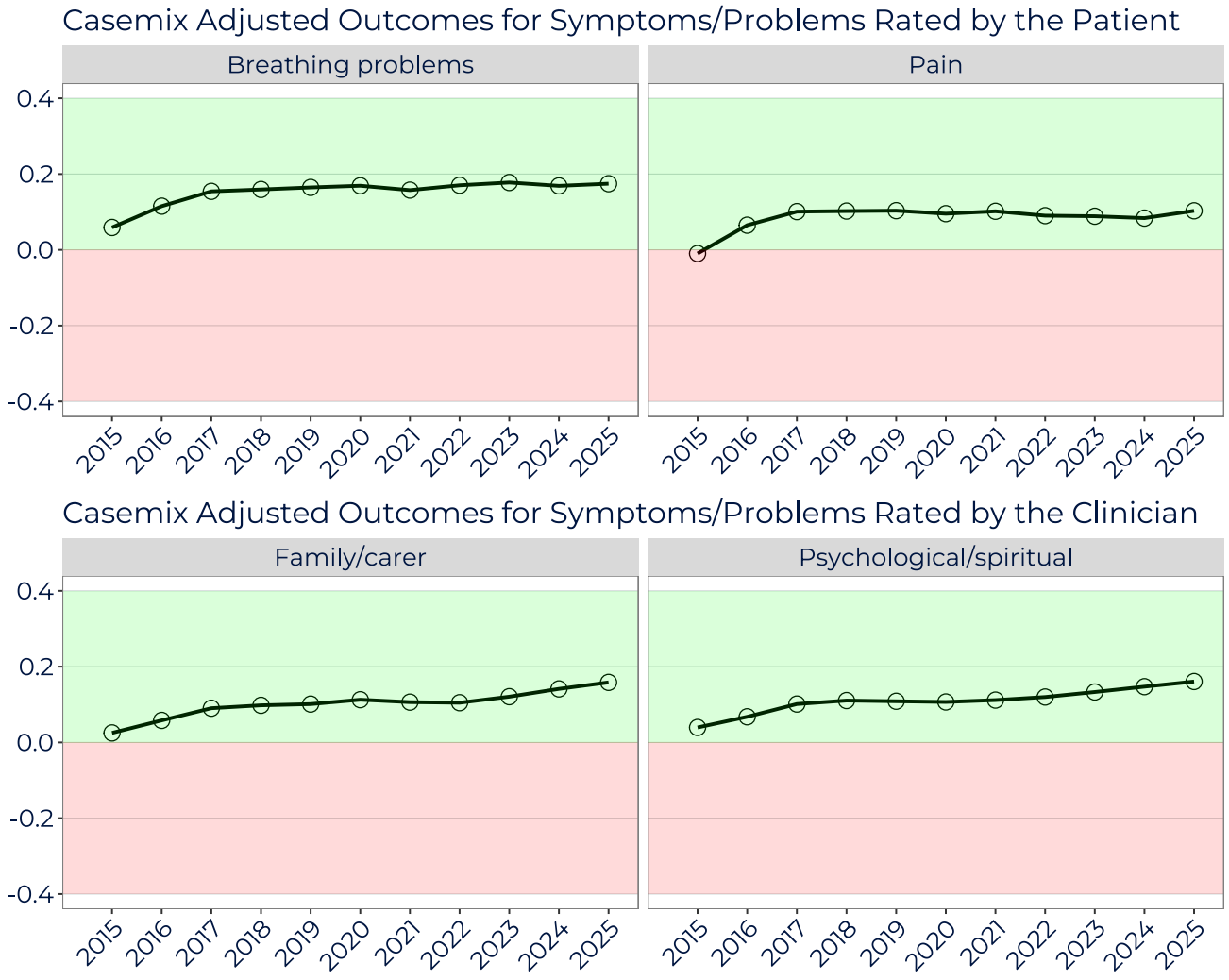

Figure 11.5: Casemix Adjusted Outcomes

References

[1] Amy P. Abernethy et al. “The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice [ISRCTN81117481]”. In: *BMC Palliative Care* 4.1 (Nov. 12, 2005), p. 7. DOI: 10.1186/1472-684X-4-7.

[2] Australian Bureau of Statistics. *Aboriginal and Torres Strait Islander people: Census*. ABS. 2021. URL: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-people-census/latest-release (visited on 05/07/2026).

[3] Australian Bureau of Statistics. *Cultural diversity: Census*. ABS. 2021. URL: https://www.abs.gov.au/statistics/people/people-and-communities/cultural-diversity-census/latest-release (visited on 05/07/2026).

[4] Fliss EM Murtagh et al. “How many people need palliative care? A study developing and comparing methods for population-based estimates”. In: *Palliative Medicine* 28.1 (2014). PMID: 23695827, pp. 49–58. DOI: 10.1177/0269216313489367. URL: https://doi.org/10.1177/0269216313489367.