Specialist care reform blueprint

Putting Victorians at the centre of their specialist care

VICTORIA State Government | Department of Health

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Koori' is retained when naming the unit in a hospital.

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Minister's foreword

Victoria's public specialist care system is already the largest part of our health system, supporting millions of people all over the state with assessment, treatment and ongoing care.

But as our population grows and Victorians' needs continue to change, this system must be able to meet current and emerging challenges and anticipate future demand.

Victorians deserve a public specialist care system that anticipates and keeps pace with these changes, a system with patients and their families at its heart, that provides equitable, high-quality care from the middle of Melbourne to the edges of our state.

Significant changes in the ways we can deliver health care – including through unprecedented advances in technology and evolving models of care – are already enabling us to deliver more convenient, accessible, coordinated, and person-centred care. But there is always more work to do.

This blueprint adds to the many reforms already underway in the health system, including the *Planned surgery reform blueprint*. It reflects the voices and stories of patients, carers, clinicians and communities across Victoria who generously shared their lived experiences and ideas. These contributions now enable us to build on what works, to become more responsive and innovative, to better understand and remove barriers, and to drive continuous improvement.

Our goal is to improve patient experience and outcomes by making specialist care easier to navigate, more consistent, and more connected. Achieving this requires collaboration and partnership across the health system – with primary care, with community organisations, between all levels of government, and, most importantly, with patients and families themselves.

Continuous improvement is a hallmark and a responsibility of Victoria's health care system.

It will take hard work, focus, and the ongoing commitment, expertise and compassion of our extraordinary health workforce, with and for our communities. With a shared commitment to this goal, I am optimistic that we can achieve meaningful, lasting change that saves and improves Victorians' lives now and for generations to come.

My thanks and respect to everyone who shared their stories, perspectives and expertise that have shaped this blueprint. Together, we are building a specialist care system that is modern, sustainable and defined by what matters most to Victorians.

The Hon. Harriet Shing
Minister for Health
Minister for Ambulance Services
Minister for Water

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Preface

The *Specialist care reform blueprint* puts Victoria's specialist care system at the point of transformative change. It paves the way for a new era of specialist care in Victoria, built on strong partnerships, innovation and a drive for excellence.

To develop the blueprint, we have undertaken a rigorous, evidence-based approach over 12 months, drawing on detailed data analysis, comprehensive literature reviews and statewide engagement with more than 500 stakeholders.

We listened to many different voices across the health system, conducting 21 targeted interviews with health service executives, 13 health peak bodies and 4 inter-jurisdictional and international partners.

For me, some of the most enlightening engagements came from facilitating nine place-based workshops, which offered a unique opportunity to connect directly with clinicians and others involved in the patient journey. The workshops allowed me to hear firsthand the genuine enthusiasm and readiness for reform across the sector.

The need for change is clear. For too long, the way care has been delivered has remained largely unchanged, relying on outdated models that no longer meet the needs of patients or clinicians.

The blueprint sets out a clear and ambitious approach to change this, a pathway to move beyond legacy approaches and create a system that reflects modern health care and innovation.

It aims to deliver improvements for patients and the system through six key reforms: patient-driven care; virtual care embedded; better connection with primary care; efficient and consistent processes; regionalised access to specialist care; and stewardship and continuous improvement.

Together, these reforms will improve patient experience and outcomes, strengthen partnerships between health services and embed innovation into everyday practice. This will create a system that is more connected, equitable and responsive to what patients value the most.

I would like to acknowledge the significant improvements already underway across Victorian health services. This blueprint builds on that momentum, aligning and amplifying efforts statewide so more Victorians can benefit.

As a clinician, I know that real progress happens when we work together and the blueprint is built on that principle, creating a shared vision for specialist care. It is about turning ideas into action and making collaboration the foundation of better health outcomes.

Your insights have created the reforms that will put Victorians first in every specialist care journey. The task ahead is clear – now let's work together to bring these reforms to life.

Professor Ben Thomson
Chief Surgical Adviser
Department of Health

Acknowledgement

The department acknowledges the strength of Aboriginal and Torres Strait Islander peoples across Country and the power and resilience shared as members of the world's oldest living culture.

We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's First People and recognise the richness and diversity of all Traditional Owners across Victoria.

We recognise that Aboriginal and Torres Strait Islander people in Victoria practise their lore, customs and languages and nurture Country through their deep spiritual and cultural connections and practices to land and water.

We are committed to a future based on equality, truth and justice. We acknowledge that the entrenched systemic injustices experienced by Aboriginal and Torres Strait Islander people endure, including in our health system, and that Victoria's ongoing treaty and truth-telling processes provide an opportunity to right these wrongs and ensure Aboriginal and Torres Strait Islander people have the freedom and power to make the decisions that affect their communities.

We express our deepest gratitude and pay our deepest respect to ancestors, Elders and leaders – past and present. They have paved the way, with strength and fortitude, for our future generations.

Terminology

Admitted care

Care for patients who undergo a formal admission process to a hospital to receive treatment or care (AIHW 2025).

Local Health Service Networks (LHSNs)

Officially established on 1 July 2025, Victoria's LHSNs group health services within a geographical region. They are responsible for supporting collaborative care for their community, as close to home as possible. There are 12 LHSNs across Victoria. For more information visit the department's website <www.health.vic.gov.au/health-services-plan-reform/local-health-service-networks>.

Non-admitted care

Health care provided to patients who do not undergo a formal admission process and do not occupy a hospital bed.

Planned surgery

In 2023, the department began using the term 'planned surgery' instead of 'elective surgery'.

Unlike emergency surgeries (for example, following an accident), planned surgeries do not usually require urgent action. However, they are medically necessary and are often not an 'elective' choice. The term 'planned surgery' is a more meaningful description for many people.

Primary care

Primary care is generally the first service people go to for health care outside of a hospital or specialist, for example, general practitioners (GPs), physiotherapists and pharmacists.
It includes diagnosis and treatment of health conditions and long-term care (Australian Government Department of Health, Disability and Ageing 2023).

Primary Health Networks

Primary Health Networks are funded by the Australian Government to improve the efficiency and effectiveness of health services, particularly primary care for their communities and improve the coordination of health services within their regions.

Specialist care

Specialist care (also known as outpatients) refers to planned, non-admitted health care at public health services. It includes consultations for time-limited assessment and advice, ongoing treatment for complex conditions and pre- and post-surgery care, delivered by medical, surgical, nursing and allied health professionals. It may include mental health services provided in outpatient settings, such as consultation liaison psychiatry, but excludes community-based mental health services.

System and steward

In this document, we call the 2 leaders of reform the 'system' and the 'steward'.

The 'system' refers to public health services and hospitals, LHSNs and the wider health sector such as primary care (for example, GPs). The system delivers safe, high-quality care to Victorians, as close to home as possible, while working within integrated networks to provide timely access to more complex and specialised services when needed.

The 'steward' over the Victorian healthcare system refers to the Victorian Department of Health (the department) and government. The steward leads and manages Victoria's public health system, ensuring safe, high-quality care and better health outcomes through policy, accountability and regulation.

Value-based health care

Value-based health care is an approach that aims to deliver the best possible health outcomes for patients using the resources available. It focuses on improving health results that matter to patients, rather than the volume of services provided. Success is measured by clinical results, patient experience and efficient use of resources.

Virtual care

Virtual care refers to the use of digital technologies to deliver health care remotely, such as telehealth (telephone and video-enabled consultations) and remote patient monitoring (using simple devices to monitor and send patient's health data to the patient's health care team such as heart rate).

Summary

Reimagining specialist care

Specialist care is essential to the health and wellbeing of Victorians, particularly our most vulnerable community members.

Specialist care is still delivered in the same way it has been for decades. Outdated and fragmented care processes are making it increasingly difficult for the system to keep pace with rising demand and to operate effectively and sustainably. Patients and clinicians are navigating inefficient processes that add burden without improving outcomes.

These growing and compounding challenges mean we must think differently and address longstanding issues to strengthen and modernise the system. The Victorian public health system has shown its capacity for meaningful reform through the *Planned surgery reform blueprint*. We must now build on this momentum and the strong appetite for change to ensure our public specialist care system can deliver timely, high-quality and patient-centred care.

Although the Victorian health system provides quality care, there are clear examples where we can do better:

- A parent of a 4-year-old described waiting more than 12 months for an ENT (ear, nose and throat) assessment. The parent is increasingly anxious that reoccurring illness and hearing difficulties are affecting their child's early development – impacts that could shape their child's education and future.
- A casual worker shared that every appointment costs them a full day's income. Despite being asked to arrive at 9:00 am, they often wait 2 to 3 hours, and sometimes find that results are not available, forcing them to rebook and lose yet another day of pay.
- Rural patients who are driving up to 5 hours for an appointment and navigating metropolitan Melbourne face medical and financial pressures, including carparking fees, which can reach up to $70.

The *Specialist care reform blueprint* sets a clear, practical, future-focused plan to reshape specialist care.

Developed collaboratively with the people who deliver, access and support specialist care, it outlines how we can build a system that is more efficient, easier to navigate and centred on what matters most to patients.

Our ambition for a better specialist care system

Our aim is clear: *All Victorians should be able to access integrated, responsive specialist care that consistently delivers safe, high-quality and equitable outcomes.*

This new blueprint, grounded in extensive research and engagement with more than 500 stakeholders, has 3 components:

- **a system-wide aim** that defines the future we are working towards
- **3 pillars of change** that identify where sustained effort is needed to achieve the aim
- **6 interrelated reforms**, designed to work together to drive change under the pillars.

The pillars of change are the foundation of the transformation needed:

1. **Responsive and high-value care:** a system focused on outcomes that matter most to patients and families.
2. **Efficient and integrated services:** a connected, effective and efficient public specialist care system.
3. **Strengthened stewardship and continuous improvement:** strong oversight to guide and scale innovation for lasting impact.

Across these pillars, the **6 reforms** shape a unified program of change. Each reform supports the others. Together they reinforce patients as partners in their care, normalise virtual care, improve the connection between primary and specialist care, streamline and standardise processes, improve access across regions and strengthen stewardship.

Many health services are already progressing specialist care improvement initiatives, but scaled and full implementation will take time. The case studies throughout this document highlight some of the example actions that can start straight away, while others will need more planning and a phased implementation.

A shared commitment to a better future

This blueprint is built on the local innovations already underway across Victoria and is grounded in evidence about what works. But delivering meaningful reform will require collective leadership and coordinated action across the system. Success depends on strong partnerships between the steward, health services, clinicians, primary care providers, patients and communities.

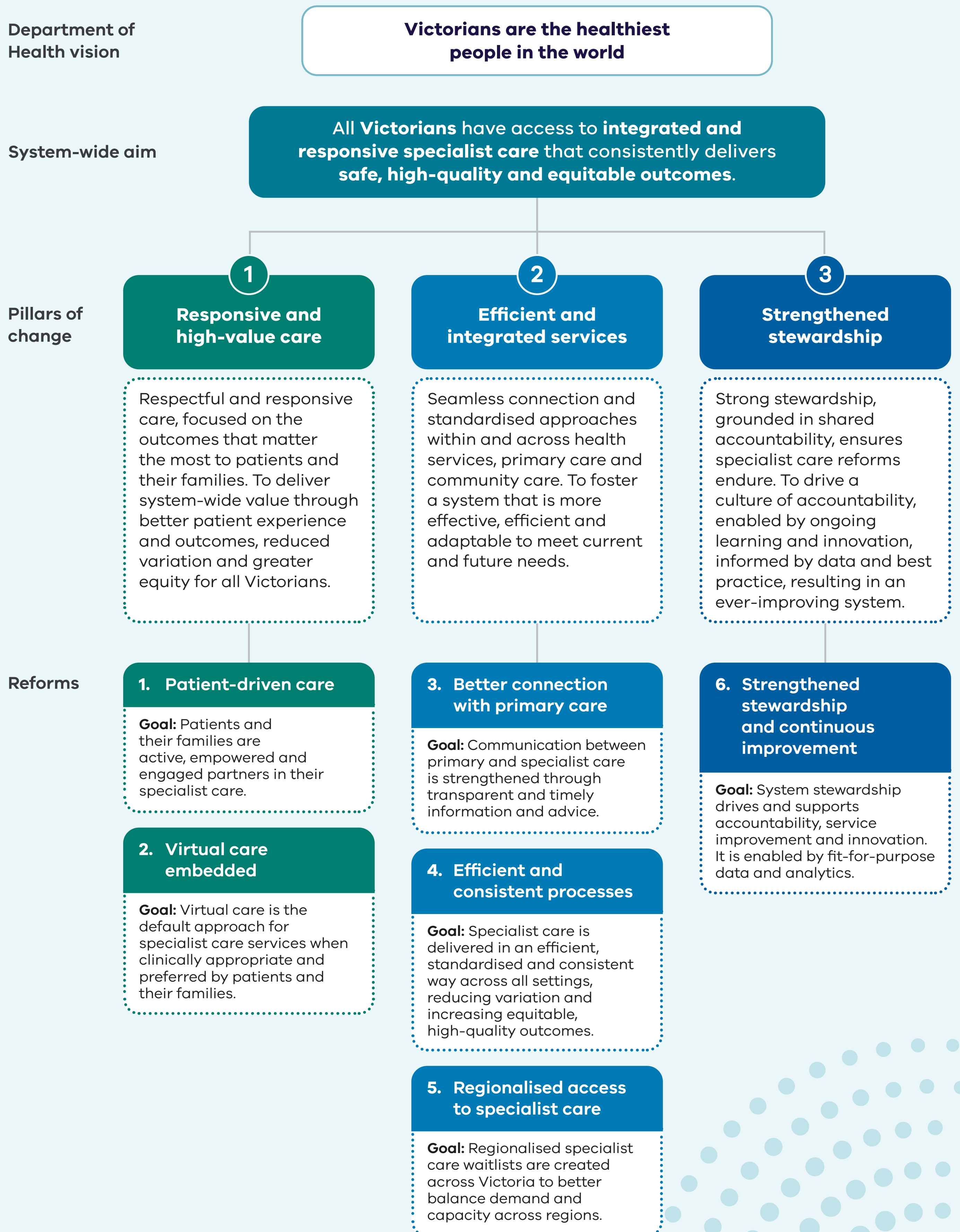
This is the moment to set a new direction – to build on what works, change what no longer serves patients or clinicians and embed reforms that endure.

Together, we can create a specialist care system that truly reflects what Victorians need and value, ensuring care is centred on what matters most to them.

Immediate actions that can be delivered now include:

- increasing the number of virtual appointments, offering patients more flexible choices
- developing patient-initiated follow-up approaches so patients can better control their own journey
- designing scalable nurse-led and allied health-led models of care.

Figure 1: Specialist care reform blueprint on a page

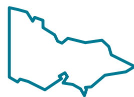


Specialist care in Victoria

Demand on services

↑460k referrals **↑250k** appointments

From 2020–21 to 2024–25, **referrals increased by an average of 460,000 per year**, while appointments increased by only 250,000.



↑16% population

Victoria's population grew by 16% between 2016 and 2026 and is **projected to grow a further 17% by 2036**.

↑30% multiple chronic conditions

The number of Victorians with **multiple chronic conditions increased by almost 30% between 2011 and 2022**.

Access to care in 2024–25

5.3m appointments

Specialist care is the **largest activity in Victoria's public health system**, with 5.3 million appointments delivered.

29% aged 65 or older

Victorians aged 65 or older accounted for 29% of specialist care appointments.

↓26% virtual appointments

Virtual specialist care appointments declined to 26%.

33% offered choice of appointments

Only 33% of patients were **offered a choice between face-to-face and virtual appointments**.

11% unattended appointments

11% of specialist care appointments were not attended (**around 600,000 per year**).

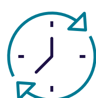
20% new patient appointments

Only 20% of specialist care appointments were for **new patients**.

Inequitable outcomes in 2024–25

24% rate of unattended appointments

Unattended appointment rates were higher for patients who identify as Aboriginal and/or Torres Strait Islander, at 24% **compared with the Victorian average of 11%**.



60 day median wait for first appointment

Median wait times for routine first appointments differed by as much as 60 days within one metropolitan LHSN.

20 day longer wait for under 18s

Victorians aged under 18 years waited an average of 20 days **longer than adults for routine and urgent specialist care appointments**.

Source: Health conditions prevalence (Australian Bureau of Statistics 2023), Victoria in Future (Department of transport and Planning 2025), Victorian Integrated Non-Admitted Health (VINAH) dataset (Department of Health 2025b).

The Victorian specialist care system

Specialist care (also known as outpatient services) accounts for the highest volume of activity within Victoria's public health system, with a delivery of 5.3 million appointments in 2024–25.

Specialist care is the non-admitted services provided by medical, surgical, nursing and allied health specialists in hospital outpatient settings.

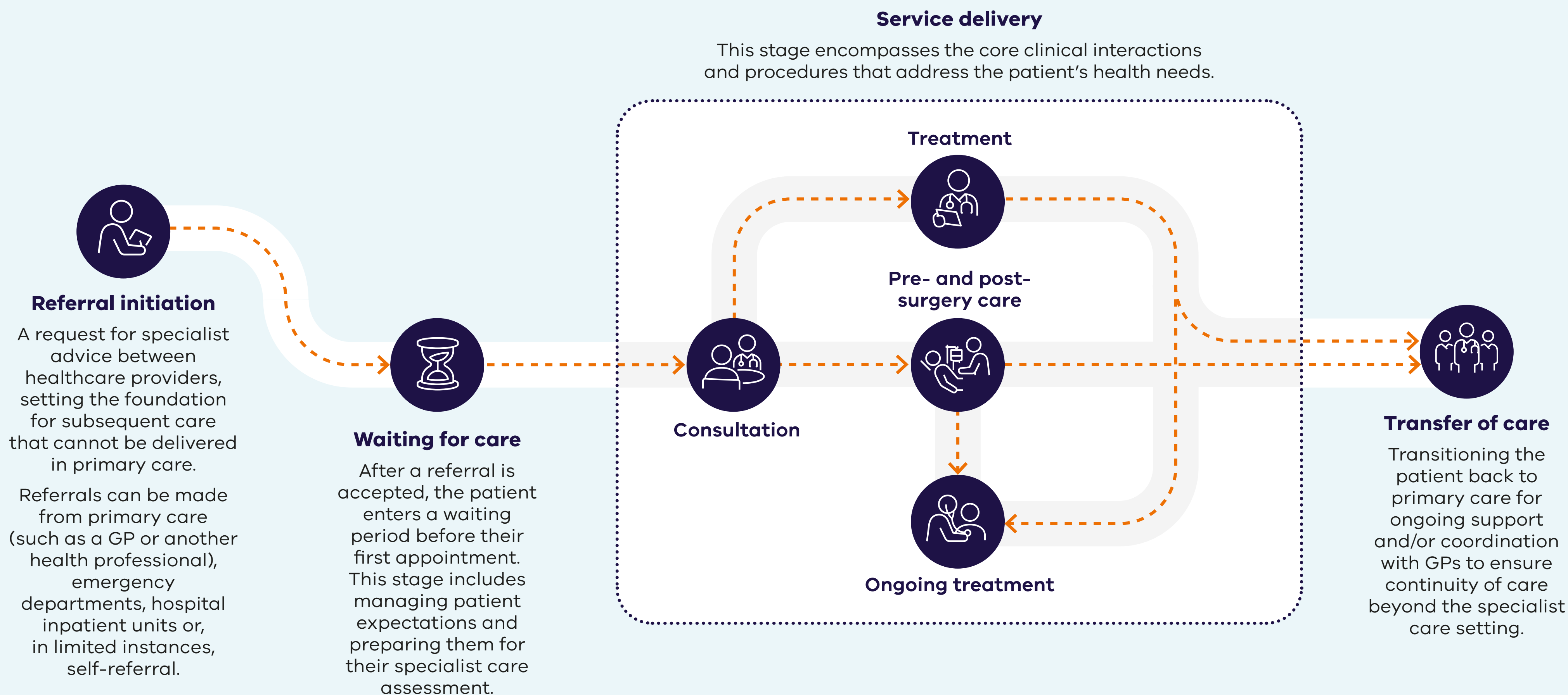
Patients access specialist care services via a referral, typically from a GP, when their condition needs expertise beyond what a GP or other primary care services can provide (Figure 2).

Victorians access specialist care for clinical assessment, diagnosis and treatment. For some Victorians, longer term specialist care is needed – for example, when complex investigations are needed to confirm conditions such as cancer or to manage chronic and progressive diseases like neurological disorders.

Access to specialist care in Victoria is guided by the Managing access to non-admitted services in Victorian public health services policy <https://www.health.vic.gov.au/patient-care/access-to-non-admitted-services-in-victoria> ('the non-admitted policy') and statewide referral criteria <https://www.health.vic.gov.au/statewide-referral-criteria>. Together, these set clear expectations for how and when Victorian public health services accept and manage referrals and prioritise patients.

Referrals, as set out in the non-admitted policy, are either categorised as urgent (appointment required within 30 days) or routine (appointment required within 365 days).

Figure 2: Referral and specialist care delivery pathway



Service delivery key	Consultation:	Treatment:	Pre-and post-surgery care:	Ongoing treatment:
	Specialist assessment, diagnosis and advice, with patients often referred back to primary care for ongoing management.	Time limited and goal oriented.	Assessment before and after surgery to prepare patients, support recovery and monitor outcomes.	Continued specialist care for complex conditions.

Activity growth and modes of delivery

Over the past 2 years, specialist care activity has grown by 9% and 8% respectively (Figure 3), reflecting health services' response to rising demand. In comparison, admitted services and emergency department presentations grew by only 3% in 2024–25.

The COVID-19 pandemic changed how care is delivered across Victoria. It led to a rapid move to virtual care, such as the Virtual Emergency Department. Virtual care uses digital technologies to provide health care remotely and includes telehealth (telephone and video consultations) and remote patient monitoring.

Virtual specialist care appointments increased from 4% in 2018–19 to 45% in 2021–22, enabling continued access to specialist care during the pandemic. It also underpinned efficient use of resources and improved system sustainability. The volume of virtual specialist care appointments has since dropped to 26% in 2024–25 (Figure 3), highlighting a return to in-person care.

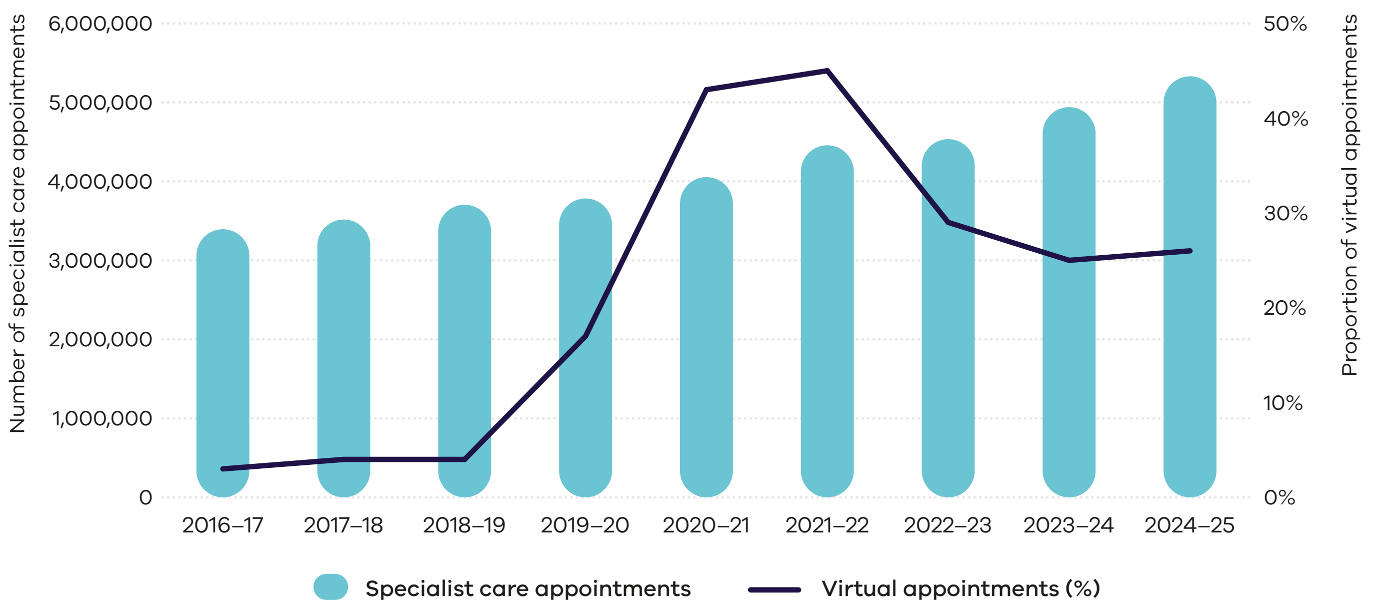
While face-to-face appointments are needed for many specialist care appointments, other barriers affect community and clinician confidence and trust in using virtual care when it is appropriate for them (Department of Health 2023).

Demographic groups experiencing a lower uptake of virtual care include:

- older people
- those with unstable housing
- those with limited access to technology
- people living with disabilities
- those living in remote areas.

> **'For years, my husband and I travelled from regional Victoria to Melbourne, twice a year, to see his haematologist. Each check-up meant 2 separate trips – one just for blood tests and another to see the specialist in the following week. The driving, taking time off work and managing the logistics around hospital schedules, was increasingly difficult.'**
>
> – Sally, Barwon South-West patient

Figure 3: Specialist care appointments and proportion of virtual appointments



Source: Victorian Integrated Non-Admitted Health (VINAH) dataset (Department of Health 2025b)

Demand and access challenges

Our public health system is working hard to meet community needs.

However, demand for specialist care is growing faster than the system's capacity to provide specialist appointments.

This is due to several factors:

- **Population growth:** The Victorian population increased by 16% between 2016 and 2026 and is expected to rise a further 17% by 2036 (Department of Transport and Planning 2025).
- **An ageing population:** In 2024–25, 29% of specialist care appointments were provided to Victorians aged 65 years or older (Department of Health 2025b). This is an over-representation relative to population (Department of Transport and Planning 2025). As the number of older Victorians continues to grow, the pressure on the system will be compounded by the high service needs of people in their final years of life.
- **High service needs:** Evidence shows that people in their last year of life access health care at much higher rates. On average, annual Medicare-subsidised service use (including specialist care) for people in their final year of life is 5.7 times greater than for people not in their final year of life (AIHW 2022).
- **An increasing prevalence of chronic disease:** The number of Victorians with multiple chronic conditions increased by nearly 30% between 2011 and 2022 (ABS 2023).
- **Increasing costs in the private system:** Fees for private specialist appointments increased by 73% from 2010 to 2025. These rising costs, coupled with a general cost-of-living crisis, is shifting specialist care demand from the private to the public health system (Grattan Institute 2025).

The gap in Victoria between service demand and supply becomes clearer when the number of referrals is compared with the number of new appointments delivered (Figure 4).

Between 2020–21 and 2024–25, the number of referrals into the public specialist care system grew by an average of 460,000 each year, while the number of appointments delivered only increased by an average of 250,000 (Figure 4).

The main barriers of specialist care appointment access (supply) are:

1. **Funding:** Health services are funded flexibly to meet the needs of their local community within a set budget. The number of specialist care appointments offered can depend on demand for other services such as emergency care and planned surgeries.
2. **Workforce challenges in some locations and some specialities:** Victoria's health workforce increased by 33% between 2011 and 2021, but, like other jurisdictions, the health sector continues to experience shortages, particularly in rural Victoria. Specialist care relies on having access to a 'specialist', that means that even one or two gaps in a local workforce can diminish local access.
3. **Infrastructure and time:** The system is physically limited by available space and infrastructure. Health service appointments, particularly in-person appointments, occur within traditional '9 to 5' business hours. This reflects a highly traditional care model, rather than a model designed around the contemporary needs of patients and families.

Just like in our emergency departments and surgery system, patients with urgent clinical needs are prioritised in the public specialist care system.

In 2024–25, 15% of first specialist care appointments were classified as urgent and about 80% of these patients were seen within the clinically recommended timeframe of 30 days.

While it's comforting to know that those with the most pressing needs are being seen relatively quickly, those deemed to have less urgent needs are often waiting for extended periods.

Extended wait times are stressful and worrying for patients and can increase the risk of conditions becoming more complex and needing even more intensive and expensive care, including admissions to hospital.

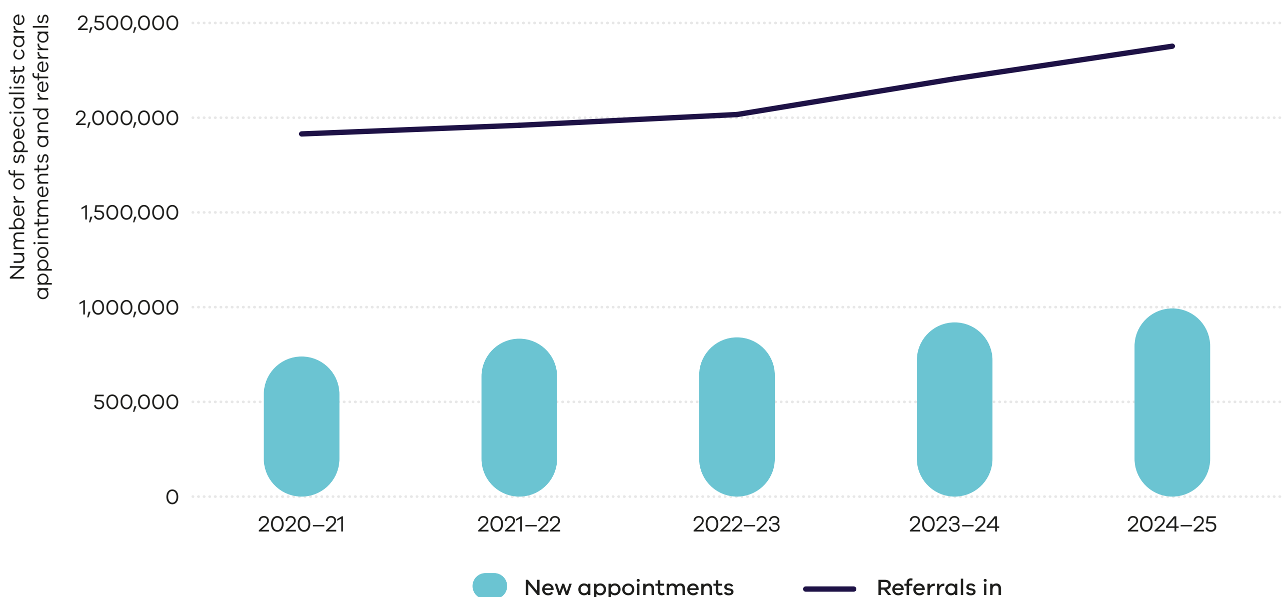
Demand for specialist care varies across different specialties. For example, obstetrics and oncology together account for 27% of all public specialist care appointments, reflecting high demand in these areas compared with other specialties (Department of Health 2025b).

Access to specialist care also varies by location, with rural and regional Victorians facing the most significant hurdles, often with limited or no public specialist care available locally. Even within metropolitan Melbourne access can vary significantly between localities.

As a result, patients with the same condition may face very different wait times depending on their address. For example, between April and June 2025, wait times for a routine vascular clinic appointment in metropolitan Melbourne ranged from 182 days to 1,460 days (Department of Health 2025b).

> **'Driving 5 hours for an appointment and navigating metropolitan Melbourne along with medical and financial pressures makes the experience particularly challenging.'**
>
> – Loddon Mallee patient

Figure 4: New specialist care appointments versus referrals received



Source: Victorian Integrated Non-Admitted Health (VINAH) dataset (Department of Health 2025b)

Opportunities for improvement

There are clear opportunities to improve the way we deliver specialist care. Changing models of care can help create more capacity within existing resources to provide more responsive and higher value care to patients.

Every missed or low-value appointment, along with manual and siloed processes, represents wasted time and resources. This costs the system and affects patient wellbeing as people wait longer for specialist care.

In 2024–25, 11% of public specialist care appointments (600,000 per year) were not attended across Victoria, creating inefficiencies in clinical resources and facilities (Department of Health 2025b). This highlights a system not currently fit for purpose for patients.

Also, only 1 in 5 appointments booked are for new patients, with most being for review appointments. Although review appointments play an important role in patient care, feedback indicates many occur by default (Department of Health 2025b).

Some review appointments are also generated because of issues that arise on the day of an original appointment, such as missing test results or absence of an interpreter, which requires the patient to return for another appointment.

There are also outdated and manual administrative processes in the system, creating inefficiency and poor experiences for both patients and the health workforce. These processes require extra coordination, increase duplication and elevate the risk of errors. This administrative burden also reduces the time clinicians can spend on direct patient care.

> **'It is time to put a spotlight on specialist care; it is such an important part of the entire health system.'**
>
> – Phase 2 preliminary consultation, regional health service executive

Specialist care clinicians – including advanced scope allied health practitioners, nurse consultants and nurse practitioners – are underused across the state. In 2024–25, only 14% of review specialist care appointments were delivered by allied health practitioners (Department of Health 2025b). Greater use of these roles could help replace higher cost, traditional models while providing better access for patients.

> **'Waiting in outpatients with the sense my time doesn't matter is a frustrating experience. No one explains the delay, and for older people or someone with a disability, the uncertainty can be harder. I worry about going to the toilet in case I miss my turn. Honest communication about how long patients will be waiting and simple reassurance would help.'**
>
> – Phase 2 targeted engagement, consumer focus group participant

Addressing these issues will create a public specialist care system that delivers better outcomes for patients and ensures the essential workforce and resources we have are used where they create the most value.

A shared challenge across Australia and beyond

Victoria's experience in specialist care reflects broader trends across Australia and internationally. Health systems are experiencing rising demand and seeking more efficient models of care.

In other states, wait times for routine specialist care frequently exceed the 365-day clinically recommended guidelines, as seen in Sydney, Brisbane and Adelaide. Of note, not all states report wait time data, and access metrics are collected differently across jurisdictions (Grattan Institute 2025).

A 2025 inquiry into the New South Wales health system highlighted long wait times for first appointments, workforce shortages (particularly in regional areas) and outdated infrastructure that limits capacity (Beasley 2025).

Queensland and Tasmania both identified fragmented referral and care pathways, and limited integration between hospital-based specialists, primary care and community services. High volumes of review appointments were also contributing to delays for new patients (Queensland Health 2016; Tasmanian Department of Health 2022).

There are similar challenges internationally.

In Canada, long wait times for initial specialist care appointments are a significant issue, but improvements are underway to address this. For example, virtual rapid access clinics introduced in a neurology setting helped expedite care, reducing average wait times by 26.4 days and increasing the number of patients seen each month by an average of 235% (HEC 2026; Rabinovitch et al. 2022).

The COVID-19 pandemic created significant pressure on international health systems and disrupted reforms. In Ireland, public outpatient waitlists grew by 19.1%, creating a large backlog. In response, Ireland now uses data in practical ways to drive improvements, including collecting and publishing wait list data by hospital and speciality. This supports patients and health services to identify delays, monitor performance and allocate resources effectively (NTPF 2025; Parker et al. 2025).

In England, the National Health Service (NHS) is targeting the causes of missed appointments and working to reduce unnecessary review appointments to help manage and reduce growing waitlists. A key initiative is implementing Patient Initiated Review (PIR) models across the health system, enabling patients to decide if a review appointment is needed. Early data from PIR adoption indicates it is reducing the number of review appointments per patient, freeing up capacity for others (NHS 2022, 2023).

Drawing on global best practice, Victoria can build an efficient, equitable and future-ready specialist care system, setting a benchmark for specialist care reform.

> **'At times, I felt lost in the system, unsure who was managing my care. Sometimes my GP didn't have the contact information needed to consult with a hospital clinician to help me get seen sooner or I was transferred between clinics without my GP being updated.**
>
> **Leaving the appointments with only verbal instructions added to the difficulty. When you are anxious it is easy to forget details and this is even harder for patients with language barriers or health literacy challenges.'**
>
> – Nora, West Metro patient

Specialist care reform blueprint

Collaboration to shape reform direction

Developed over 12 months, the *Specialist care reform blueprint* has been shaped by the voices and experiences of those who know what matters most: patients and clinicians.

It has been developed collaboratively and iteratively through our consultation and engagement. It is backed by research and evidence and has been underpinned by a best-practice, proven methodology (Figures 5 and 6).

Across 2025, more than 500 people shared their time, expertise and lived experiences to help inform the blueprint and shape the future of specialist care in Victoria.

This approach brought together diverse representatives from the Victorian community, healthcare workforce and academia, along with peak and professional bodies (Figure 6).

The comprehensive feedback was analysed to confirm the reforms are achievable, align with sector needs and reflect the priorities of providers and consumers.

The Specialist Care Reform Expert Advisory Group validated the reform directions. Expert Advisory Group members were drawn from the healthcare workforce (medical, surgical, allied health, nursing), health service executives, vulnerable populations, peak bodies and government.

This collaborative effort helped strengthen consensus, foster shared ownership of reform directions and ensure the blueprint is both inclusive and responsive to the diverse needs of Victorians.

What we heard

The health sector is ready for reform. Many are already making improvements and looking for broader, system-wide change built on genuine partnership.

Stakeholders consistently emphasised the need to prioritise specialist care and to co-design solutions with clinicians, consumers and communities.

> **'The opportunity to contribute a regional perspective is greatly appreciated.'**
>
> – Phase 2 engagement, allied health clinician, Loddon Mallee workshop participant

Figure 5: Reform methodology

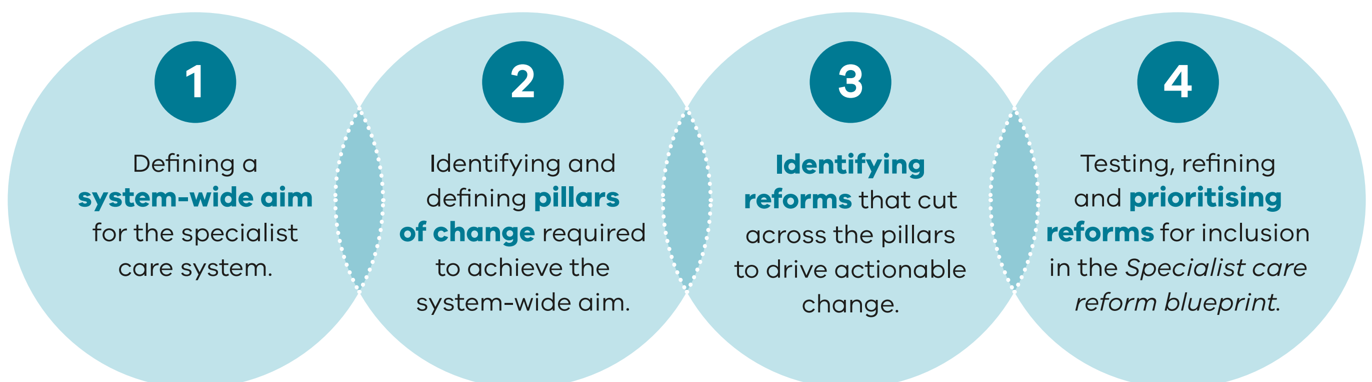
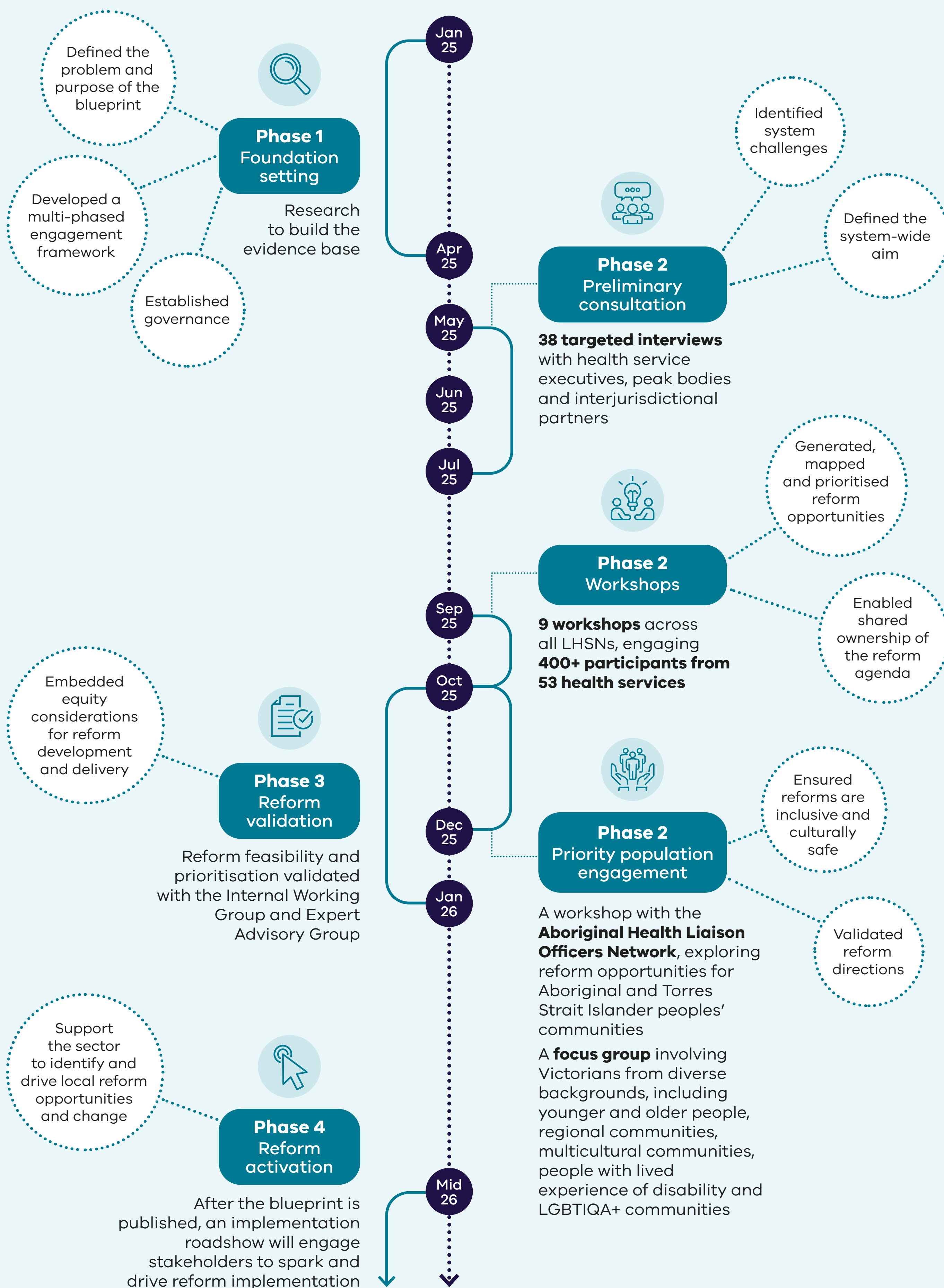


Figure 6: Specialist care reform engagement



Blueprint elements: aim, pillars, reforms

Extensive engagement and expert guidance have shaped a clear and ambitious aim: All Victorians have access to integrated, responsive specialist care that consistently delivers safe and equitable outcomes.

Grounded in the principles of value-based health care, the blueprint identifies **6 priority reforms** to improve access, empower patients and better integrate care.

These reforms are organised under **3 pillars of change**, with each pillar representing an area of policy focus.

System readiness differs across the 6 priority reforms. Some are ready to move into implementation, while others will need further planning and phased development. As such, each reform has been allocated a specific implementation timeline:

1–2 years

2–3 years

3–5 years

Pillar 1: Responsive and high-value care

The specialist care system should focus on the outcomes that matter the most to patients and their families, providing personalised, coordinated care through shared decision-making.

Resources should be directed toward improving outcomes, reducing unwarranted variation and eliminating low-value or unnecessary interventions. Everyone, no matter where they live or their background, should be able to access high-quality, coordinated care that achieves the outcomes that matter to them.

Pillar 2: Efficient and integrated services

Specialist care should be seamlessly connected with primary and community care. Health services should operate efficiently and cohesively within an integrated network, delivering care effectively and sustainably while adapting to evolving needs.

Pillar 3: Strengthened stewardship

Strong stewardship should guide the specialist care system through shared accountability and fostering a culture of continuous improvement and innovation. This should be informed by data and best practice to ensure reform endures.

The priority reforms

1. Patient-driven care

Goal: Patients and their families are active, empowered and engaged partners in their specialist care.

2. Virtual care embedded

Goal: Virtual care is the default approach for specialist care services when clinically appropriate and preferred by patients and their families.

3. Better connection with primary care

Goal: Communication between primary and specialist care is strengthened through transparent and timely information and advice.

4. Efficient and consistent processes

Goal: Specialist care is delivered in an efficient, standardised and consistent way across all settings, reducing variation and increasing equitable, high-quality outcomes.

5. Regionalised access to specialist care

Goal: Regionalised specialist care waitlists are created across Victoria to better balance demand and capacity across regions.

6. Strengthened stewardship and continuous improvement

Goal: System stewardship drives and supports accountability, service improvement and innovation. It is enabled by fit-for-purpose data and analytics.

Pillar 1 Responsive and high-value care

Pillar 2 Efficient and integrated services

Pillar 3 Strengthened stewardship

Embedding equity in every reform

When designing and implementing reform initiatives, equity and inclusion must be at the forefront.

Every reform should actively address barriers faced by vulnerable populations and, regardless of background or circumstances, ensure everyone can access care.

Cultural safety for Aboriginal and Torres Strait Islander peoples underpins all specialist care reforms. It must be embedded in system design, service delivery, governance, data and accountability. Addressing systemic inequities and enabling self-determination ensures policies and practices support better health outcomes and uphold cultural identity.

These reforms must acknowledge the well-established gender bias in health care and the resulting unmet healthcare needs of women and gender diverse people. Gender-responsive care must be a cornerstone of a system built for the best outcomes for Victorians.

Many people experience multiple, overlapping forms of needs. This includes:

- people from multicultural backgrounds who may face language challenges
- people with disability who may experience accessibility limitations
- LGBTIQA+ communities who encounter discrimination.

It is also essential to consider intersectional identities that further compound these challenges.

Applying an equity lens is especially important for children and young people in Victoria. It ensures they can access timely care and fully participate in their education, family life and community.

To embed these considerations, we need to work with communities and adjust based on what they tell us. In doing so, we will make care more accessible, inclusive and effective for everyone.

> **'For Aboriginal and Torres Strait Islander peoples, this is really important work, an opportunity to build trust, connection and care that understands our culture.'**
>
> – Phase 2 targeted engagement, Aboriginal Hospital Liaison Officer Network participant

A message from the Victorian chairs of the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians

Victoria's specialist care workforce – including medical, surgical, nursing, allied health and administrative staff – demonstrates extraordinary dedication, skill and compassion in delivering high-quality care for communities across Victoria. Their commitment underpins every aspect of the specialist care journey and provides the foundation for ongoing system improvement.

The *Specialist care reform blueprint* reflects a shared ambition to modernise and strengthen specialist care for all Victorians. Its focus on patient-driven care, more efficient processes, improved links with primary care, virtual care, better use of system capacity and strengthened stewardship creates a strong framework for impactful and enduring reform.

We recognise that meaningful reform requires collaboration across professions, settings and regions, and we welcome the blueprint's emphasis on more coordinated, modern, multidisciplinary approaches that support equitable access.

As peak bodies representing medical and surgical specialists, we are committed to working together as a healthcare community to deliver these reforms for our patients, colleagues and the future of planned care. We look forward to ongoing collaboration with the Department of Health, health services, primary care and our colleagues across the broader workforce to help deliver reforms that improve patient experiences, strengthen system performance and support clinicians to deliver safe, high-quality care.

Dr Damien Loh
Chair, Victorian State Committee
Royal Australasian College of Surgeons

Dr Rahul Barmanray
Interim Acting Chair, Victorian State Committee
Royal Australasian College of Physicians

A message from Safer Care Victoria

Better health outcomes are achieved when the health workforce and services partner with patients and their families throughout the patient's health journey.

I had the privilege of taking part in some of the extensive engagements undertaken to inform the *Specialist care reform blueprint*.

I saw firsthand the ideas and the desire from clinicians, managers and consumers to improve specialist care.

That gives me great confidence that the Victorian public health system is ready to collaborate to act on this reform agenda.

The blueprint sets out 6 priority reforms, each designed to deliver what matters most to patients and their families, the workforce and the system.

The reforms are designed to build on the efforts of health services to improve patient experience and outcomes, enable a connected model both between primary and tertiary care and across health services and reduce unwarranted variation and duplication in processes and interventions.

There is also a focus on stewardship to improve accountability, data and transparency to enable a shared purpose and continuous improvement.

This is about building a specialist care system that truly puts patients first – one that is equitable, efficient and focused on delivering value to patients and their families.

Safer Care Victoria is proud to champion this reform agenda so together we can deliver the highest standard of care for every Victorian.

Louise McKinlay
Chief Executive Officer
Safer Care Victoria

Reform 1: Patient-driven care

Patients must be active partners in shaping their treatment, empowered with the information they need to make confident and informed choices.

Rationale

Patients often face a complicated specialist care system that is not built for them.

Current pathways from referral to appointment are fragmented and difficult to navigate, leaving patients confused and disempowered.

The current system poses even greater challenges for people with chronic or complex needs, who depend on multiple services and need to attend repeated appointments across several days or weeks.

Patient communication is often inconsistent, with many patients not fully understanding their diagnosis, treatment options or next steps.

In 2024–25, only 66% of patients felt their care options were explained, and almost 22% did not feel involved in decisions about their care (Department of Health 2024). This suggests that many patients feel like passengers rather than partners in their care.

Language and cultural barriers, as well as experiences of racism and discrimination, can significantly impede access to care. In the absence of culturally safe support, patients are more likely to disengage, resulting in poorer health outcomes and increased system costs.

Young Victorians moving from children to adult services can experience delays and gaps in care (RCH and Victorian Paediatric Clinical Network 2025). Planning for age-related transitions of care can begin too late, contributing to delays that can affect younger peoples' development, participation and quality of life.

For example, due to long waits for appointments, some younger patients reach early adulthood (17–18 years old) before being seen in a children's clinic. At this age, their care may not be best met by a paediatric service, requiring a new referral to an alternative service, which causes further delays.

The number of appointments not attended remains too high, averaging 11% across Victoria each year between 2020–21 and 2024–25. This is higher for patients who identify as Aboriginal and/or Torres Strait Islander, at 24%.

By comparison, NHS England reported an average non-attendance rate of 7.6% in 2021–22 (NHS 2023). Contributing factors to non-attendance include missed or no reminders, transport difficulties, competing commitments and uncertainty about the importance of ongoing care (Byrne et al. 2021).

Reform 1:
Patient-driven care

Each missed appointment highlights an opportunity to improve how we deliver care that matters to patients and families. Reducing missed appointments not only increases system capacity by minimising lost clinical time but also ensures limited resources are used effectively.

What can be done

Patients and their families should be treated as equal and active partners in their care.

Delivering care that matters to patients and families requires a specialist care system that supports them to make informed choices about their diagnosis and treatment options. We need to give patients more control of their care through initiatives such as patient-initiated follow-up (Sherlaw-Johnson et al. 2024).

Access should be simpler and more flexible. Patients should be offered real choices to meet their needs. This requires different modes such as self-service digital options to book or change appointments, flexible scheduling, outreach models and virtual options (Reform 2). However, patients should be able to access assisted support, including phone-based or in-person help.

Patients should understand why their appointment matters. When patients are given clear, timely and accessible information, they are better equipped to take part in shared decision-making. This leads to improved understanding, adherence to treatment plans and satisfaction with care.

Care pathways should be streamlined to reduce delays and duplication, especially for people with chronic or complex needs. Transitions between services must be planned early (Reform 4) and supported by shared care and coordination (Reform 3).

Cultural safety must be built into the system. Barriers faced by traditionally marginalised groups in accessing care should be actively and regularly addressed so patients can receive equitable care. Respecting diversity, removing discrimination and trusting patients as partners in their care is needed at every step of the patient's specialist care journey.

This reform presents a pivotal opportunity to build a public specialist care system that responds to what patients and their families value. This will improve patient experience, while also delivering greater value across the public health system.

Goal

Patients and their families are active, empowered and engaged partners in their specialist care.

Reform 1:
Patient-driven care

Objectives

- Care pathways focus on what patients and their families value.
- Patients and families get clear, timely communication and support so they feel informed, prepared and motivated to attend scheduled appointments.
- Care is streamlined to reduce unnecessary interventions while still providing patient choices.
- Services for patients aged under 18 years and their families are age-appropriate and designed to ensure continued patient engagement and continuity of care.
- Everyone can access specialist care equitably. There are culturally safe practices and support for Aboriginal and Torres Strait Islander peoples and others who face cultural barriers within the health system.
- Care delivery continuously improves using patient experience feedback and health outcomes.

'Reform that improves access and gives us more choice will make a real difference for families across Victoria.'

– Phase 2 targeted engagement, consumer focus group participant

What success looks like

Patients and families

- More people report feeling involved in their care through the Victorian Health Experience Survey.
- There are fewer missed appointments.
- There are fewer low-value appointments, especially for people with chronic or complex needs.
- Young people under 18 experience fewer delays when transitioning to adult services.

Clinicians

- Clinicians feel well supported and empowered to provide culturally safe, patient-centred care.

The system

- Culturally safe care is embedded in all services, and staff demonstrate respect for culture.
- Reports of racism and discrimination are reduced.
- Patient feedback is systematically used to improve services and care models.

The steward

- The health system delivers the tailored care that Victorians need, improving patient satisfaction.

Reform 1:

Patient-driven care

Intersectional and complementary reform work

Several dedicated framework guide culturally safe, inclusive and patient-centred care.

The Aboriginal Health and Wellbeing Partnership Forum is Victoria's lead decision-making body for Aboriginal health and wellbeing. The forum's *Victorian Aboriginal health and wellbeing partnership agreement action plan* <https://www.vaccho.org.au/ahwpf/>, as well as input from Yoorrook Justice Commission recommendations, are used to develop each health service's Statement of Priorities and tailored cultural safety action plan.

The *Multicultural health action plan* <https://www.health.vic.gov.au/multicultural-health-action-plan-2023-27> and the *Interim language services policy* and accompanying guidelines <https://www.health.vic.gov.au/publications/language-services-policy> outline our commitment and actions to improve the health and wellbeing of multicultural communities.

The *Managing referrals to non-admitted specialist services in Victorian public health services* policy <https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health> addresses equitable access when access to services outside of the treat-in-turn principle may be needed.

The *Inclusive Victoria: State disability plan (2022–2026)* <https://www.vic.gov.au/state-disability-plan> is Victoria's plan for making the community inclusive and accessible for everyone.

Safer Care Victoria's *Partnering in healthcare framework* <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare> guides health services to actively involve patients and their families in care planning and improvement.

The next phase of reform <https://www.health.vic.gov.au/mental-health-wellbeing-reform/our-next-phase> and the *Victorian alcohol and other drugs strategy 2025–35* <https://www.health.vic.gov.au/alcohol-other-drugs/victorian-aod-strategy> outline the system-wide vision and reforms for the mental health and wellbeing and alcohol and other drugs systems. They complement all reforms in the *Specialist care reform blueprint*.

Case study

Monash Health: Patients leading their own care pathway with patient-initiated reviews

A review of Monash Health's Specialist Clinic service identified that many appointments were used for routine reviews, with some patients returning 'just in case'. Clinicians were often hesitant to discharge patients back to their GP, leading to long review waitlists and inefficient use of specialists' time. To address this, Monash Health saw an opportunity to improve patient transition back to GP care.

The Patient Initiated Review (PIR) pathway was introduced to give patients more control and confidence over their health care as they transition back to their GP from hospital care. This pathway offers a clear process for those who no longer need regular specialist care reviews while still providing timely access to specialist review if needed.

Unit-specific guidelines were developed to support clinicians in identifying appropriate patients for the PIR pathway. PIR suitability is documented in a custom eNote in the medical record and generates letters to both the patient and GP, outlining the symptoms to consider and the process to access a review if required. Patients on the PIR pathway are tracked via a dedicated workflow and flagged when they are ready for discharge.

PIR has empowered junior doctors with a clear framework and given senior clinicians greater confidence to discharge, with a 5% increase in discharge rates over 12 months. More than 850 patients have been placed on PIR pathways across 4 units, with no patients needing to activate a review. Urology, the most advanced unit, is now adjusting clinic templates to reduce review appointments and increase capacity for urgent new cases. PIR will continue to expand to 10 more specialties.

> **'We have patients that demand a review appointment to provide them with comfort. From my perspective, we can reduce unnecessary reviews and provide patients with a straightforward process to access care if they need through PIR.'**
>
> – Urologist at Monash Health

Clear guidelines, lessons from international models, clinical champions and dedicated operational support have underpinned the success of this initiative. Ongoing monitoring and sharing patient uptake and satisfaction data with key stakeholders has strengthened trust in PIR, encouraging other units to adopt the pathway.

Case study

Royal Victorian Eye and Ear Hospital: Asking the Question – a simple step towards better care and the importance of cultural support

The Asking the Question initiative at The Royal Victorian Eye and Ear Hospital (RVEEH) is a simple but powerful change. Every patient is asked, 'Are you of Aboriginal and/or Torres Strait Islander origin?'.

This routine yet important question helps to implement culturally safe, person-centred care and tailored pathways linking into the specialised services of the Aboriginal Health Liaison Officers and the hospital's other culturally appropriate support resources. This approach helps create a welcoming environment where patients feel respected, supported and confident that their cultural needs will be recognised throughout their care.

The impact on patients identifying their Aboriginal and/or Torres Strait Islander status has been profound.

One patient shared how staff went above and beyond to support their family during a stressful hospital visit. After 5 hours of travel and the associated medical and financial pressures, the Koori Unit had organised parking and lunch and took time to sit, listen and offer comfort.

The patient described feeling overwhelmed by the support and respect shown, noting that without the help, they couldn't have attended the appointment. This story highlights how practical support and genuine care can make a real difference, especially for those travelling long distances or facing financial hardship.

> **'It's very daunting driving from a country town to the city. [The Koori Unit] couldn't do enough and made us feel comfortable having a good yarn. The support made such a difference.'**
>
> – Patient at RVEEH

The key lesson is clear: asking the question is just the beginning.

True impact comes from activating meaningful support and fostering a culture of respect and inclusion. Embedding culturally safe practices can create environments where every patient feels valued and supported.

Patient story

Elaine's experience of specialist care

After finding myself in specialist care clinics following an emergency attendance, I've had multiple positive experiences that have shaped how I view specialist care.

Clear communication and feeling supported by staff made a real difference. Efficient systems helped me move through appointments smoothly. It felt like someone was walking me through the process and that took away any isolation I felt while waiting for care.

> **'The health service treated me like an individual, not just a number, which gave me confidence that my health mattered.'**
>
> – Elaine, metropolitan Melbourne patient

Being able to access care when I need it is very important. Being seen quickly reduced my anxiety and helped me focus on my recovery. The staff explained what was happening and why, using everyday language and checking my understanding. This made me feel safe and respected.

Patient education and partnership are also very important, especially as I attend specialist care for a chronic autoimmune condition that requires ongoing treatment.

My specialist often encourages me to ask questions, and my treatment options are explained to me clearly. They provide practical information that allows me to reflect, do my own research and discuss treatment options.

It feels like a true partnership between patient and clinician. Instead of leaving each appointment feeling lost and confused, I feel in control. I feel like a partner in my care.

These experiences show the value of patient education, good communication and shared decision-making. I've learned that tailored support, like interpreters, accessibility assistance or extra time to talk, can help people feel less isolated and more confident navigating the health system.

Specialist care works best when patients are included, informed and empowered to take charge of their own health.

Reform 2:
Virtual care embedded

Virtual care (including telehealth, remote monitoring and mobile health) becomes embedded in specialist care when preferred by patients and clinically and culturally appropriate. It offers convenient access to expert care without in-person hospital visits, saving time and reducing travel. This improves flexibility and efficiency, especially for rural and regional communities.

Rationale

Virtual care is a proven way to deliver patient-centred health care efficiently.

It gives patients choice and flexibility and reduces wait times, travel and financial stress as well as the geographical barriers experienced by rural and regional communities (Capodici et al. 2025; Toll et al. 2022). For people with chronic or complex conditions, it can reduce the number of trips to hospitals. For children, it can mean they don't have to miss a day of school.

Uplifting virtual specialist care appointments from the current rate of 26% to 40%, could help Victorian families avoid approximately an additional 57 million kilometres of travel and save around $50 million in travel costs (ATO 2024; Department of Health 2025b; Redmond et al 2024).

This improvement not only reduces financial and logistical burdens but also supports economic participation by enabling people to stay connected to work and education.

In many specialties, virtual care is as safe and effective as in-person care (ACI 2020; Snoswell et al. 2023). It can improve operational sustainability by improving productivity, reducing overhead costs for health services and freeing clinical capacity (Snoswell et al. 2020).

Use of virtual care grew rapidly during the COVID-19 pandemic but has since slowed.

In 2024–25, only 33% of specialist care patients were given a choice between face-to-face or virtual appointments, even though 84% of those who used virtual care said it was easy to access (Department of Health 2024). Limited uptake means missed opportunities to reduce health service costs and improve access.

However, access to virtual care is not equal. For example, older Victorians, non-English speakers and people with low socioeconomic backgrounds face barriers due to digital literacy, technology access and cultural factors. To ensure equity and inclusivity, health services should offer alternative care options for people who cannot easily access or use virtual care.

Reform 2:
Virtual care embedded

What can be done

While in-person appointments remain valuable for building trust, virtual care should be offered as the default option for patients where it is safe, suitable and preferred by patients, supported by clear protocols to guide decisions. Equity gaps can be reduced through bilingual options, technology support, literacy assistance and telehealth hubs at GP clinics or community health centres (Gallegos-Rejas et al. 2025).

Clinicians must be involved early in the design process to address clinical safety and workflow integration concerns. Training in virtual care platforms, along with protocols, will build confidence and ensure virtual care becomes standard practice (Kho et al. 2020).

Clinical leaders can help build trust and normalise virtual-first approaches by using patient feedback and outcomes to prove virtual care is safe, effective and aligned with professional standards.

Virtual care should become embedded for many specialties, particularly for review appointments. When implemented effectively, it can improve access and reduce costs while keeping in-person care available for those who need it. However, continuous monitoring of safety, quality and experience across virtual care modalities will be required.

Virtual care should be a core part of specialist care services, not an optional add-on.

Goal

Virtual care is the default approach for specialist care services when clinically appropriate and preferred by patients and their families.

Objectives

- Virtual care by default is embedded in statewide policy and clinical guidelines.
- Patients and their families understand and engage with virtual care services.
- Virtual care models are expanded across the system.
- Supports are established for groups who may find virtual care harder to access, such as older Victorians and those from non-English speaking backgrounds.
- In-person appointments are reserved for patients with complex needs, those who cannot use virtual options or those who express a preference for in-person appointments.
- Decisions about appointment types are guided by safety and quality considerations and patient feedback, with ongoing monitoring and reviews of virtual care models.

Reform 2:
Virtual care embedded

What success looks like

Patients and families

- Patients and their families get clear information and education about the benefits and limitations of virtual care.
- Rural and vulnerable populations have shorter wait times for specialist care.

Clinicians

- Clinicians consider virtual care as their initial treatment delivery option.
- Clinicians feel well trained and supported to use virtual care safely and effectively.
- Virtual care is seamlessly integrated into clinical workflows without adding extra burden.

The system

- Health services design and implement 'virtual by default' pathways, incorporating plans to support vulnerable populations.
- More appointments are delivered virtually – particularly review appointments.
- Specialist care waitlists are reduced across Victoria due to efficiency gains (for example, lower did-not-attend rates, clinics running on schedule and fewer short-notice cancellations).

The steward

- More Victorians use virtual care in all its forms and Victoria becomes a national leader in providing virtual specialist care.

Intersectional and complementary reform work

The *Victorian virtual care strategy* <https://www.health.vic.gov.au/victorian-virtual-care-strategy/vision> sets a 5-year vision for virtual care to be used wherever appropriate and preferred by the patient. It helps bring care closer to home and embed virtual models into routine service delivery.

At the national level, the Independent Hospital and Aged Care Pricing Authority released *The Virtual Care Project: Final report* <https://www.ihacpa.gov.au/resources/virtual-care-project-final-report>, which outlines practical steps to make virtual care a core part of Australia's health system.

Also, the *National allied health digital uplift plan* <https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-allied-health-digital-uplift-plan> sets out a coordinated pathway to uplift the allied health sector for digital engagement.

Case study

Bayside Health: The Alfred Care Group's Home Spirometry Program, Respiratory Medicine

During the COVID-19 pandemic, many patients with chronic lung disease experienced reduced access to lab-based spirometry. This created assessment delays and limited the ability of clinicians to make timely decisions about patient management. The Alfred Care Group's Home Spirometry Program was developed to address this gap by offering an alternative model that maintained continuity of care while reducing the need for attending hospital.

The Alfred Care Group introduced a supervised home-based spirometry service delivered through a telehealth platform. Respiratory Scientists guided patients remotely to ensure tests were valid, high-quality and clinically usable. The program focused on providing accurate spirometry outside of the hospital. This helped to support decision-making, especially for patients living far from the health service.

At its peak in 2022, 5.2% of patient encounters in the Lung Function Laboratory at The Alfred were undertaken via the Home Spirometry Program. A 2023 patient experience survey showed overwhelmingly positive feedback, particularly from rural and remote participants who appreciated reduced travel burden. Most patients found the technology easy to use.

Key enablers included strong enthusiasm from medical teams, patient willingness to participate and dedicated support from the local Digital Health team for system setup and training. Initially, the model was time intensive for Respiratory Scientists, however, patient virtual time is now similar to a face-to-face visit, though additional administrative overlay remains.

> **'Great program. It saves me a 4-hour drive, and I don't really like visiting hospitals. Sometimes I have trouble with the technology, but we get there in the end.'**
>
> – Patient involved in the Home Spirometry Program

The next steps include ongoing program audits and contributing to a multicentre study comparing the quality of home versus lab-based spirometry. The service now routinely uses supervised remote spirometry for rural and remote patients.

Patient story

Sally's virtual care experience

After years of travelling from regional Victoria to Melbourne four times a year to see my husband's haematologist, with 2 of the trips solely for blood tests, the COVID-19 pandemic prompted a change. His specialist suggested a new approach: my husband could have his blood tests done in Bendigo and then meet with specialist over a video call for the appointment. It made an immediate difference. The specialist could still see him clearly on screen, talk through the results and check how he was going, without the strain of long-distance travel. It was the first time his care genuinely worked around our lives.

We continued with telehealth every 6 months and it transformed how manageable his ongoing care felt.

More recently, I experienced firsthand how important it is for virtual care to be offered consistently and in the right circumstances. I was offered a virtual appointment, which I declined. When I attended in person, the specialist told me it was fortunate I had come because I also needed a physical examination.

Experiences like this show that while virtual care can make care far more accessible, clinics should have clear guidance on when virtual appointments are suitable and when face-to-face care is essential.

Offering the option of virtual care when it is appropriate, gives patients more choice and makes it easier to get care that fits their situation.

> **'Being offered reliable virtual care options gives families like mine flexibility, reduces travel pressure and helps ensure patients, wherever they live, stay connected to the specialist support they need.'**
>
> – Sally, Barwon South-West patient

Reform 3:
Better connection with primary care

A message from the Victorian chair of the Royal Australian College of General Practitioners

Primary care sits at the heart of our health system, serving as the first point of contact for patients and is key to achieving better health outcomes. As a key reform in the blueprint, better connections with primary care through strengthened, timely and transparent communication pathways will be essential for delivering care that is faster, safer and of the highest standard.

Patients trust primary care providers, especially GPs, to guide them through complex decisions and to provide continuity of care. Enhancing communication and shared decision-making will enable primary care clinicians to manage more conditions locally, reduce unnecessary hospital visits and deliver care closer to home – where it matters most.

Being part of the Specialist Care Reform Expert Advisory Group has been a wonderful opportunity to help shape this ambitious and comprehensive reform agenda. I am proud to have championed primary care as a cornerstone of the patient journey.

A truly patient-centred, equitable and efficient health system depends on stronger integration between primary and tertiary care. Collaboration is the future of health care, and I encourage all of us to play our part in supporting this reform journey so we can deliver the best standard of care for our communities.

Dr Anita Muñoz
Chair, Victorian Faculty
Royal Australian College of General Practitioners

RACGP
Royal Australian College of General Practitioners

Reform 3:

Better connection with primary care

Primary care is often the first point of contact in a patient's specialist care journey. Strong connections between GPs, allied health, medical specialities and other health services enable coordinated treatment plans and seamless communication. This ensures patients receive integrated, high-quality care without unnecessary delay or duplication.

Rationale

Primary care is the first step in healthcare. For patients to get the best outcomes, primary and specialist care must work together.

Currently, communication between GPs and specialists is often disconnected. When information is not shared effectively and efficiently, diagnoses and treatments are delayed.

GPs struggle to access timely specialist advice and hospitals also struggle to communicate directly with GPs. This results in repeated tests and safety risks, leads to more referrals or, potentially, avoidable hospital visits (Fattahi et al. 2025; Grattan Institute 2025). These inefficiencies increase costs for health services and create avoidable system pressures. Ultimately, it also creates a poor experience for patients.

GPs lack visibility of specialist waitlists, referral progress or treatment outcomes, which makes it difficult to support patients to make informed decisions (Reform 1). This can also limit clinical decision-making, leading to duplication and an unrecognised loss of productivity.

Only 62% of Australian GPs report always receiving communication after making a referral (Scaioli et al. 2020). On average, GPs spend 5 hours a week on non-billable work, including arranging referrals and calling specialists, equating to almost 1,000 lost appointments a year per GP (Brown et al. 2021).

What can be done

GPs need better access to expert advice, shared care protocols and comprehensive care pathways. This will ensure patients are referred to specialist care only when it is needed.

Developing collaborative, shared care models between primary care and specialists will reduce unnecessary hospital referrals and improve patient experience (Khano et al. 2022). By having formal shared care and transition protocols, these will define roles and responsibilities between primary and specialist care (Reform 4), enabling care to be delivered in the community, reducing duplication and improving patient experiences (Winpenny et al. 2016).

Using digital tools can make communication easier. Secure portals for shared care plans, messaging and real-time updates on referrals and waitlists will support informed decision-making and manage ongoing care more effectively. These tools can start in one specialty and be scaled progressively.

A highly effective example is 'secondary consults', also known as asynchronous advice, where a GP can send a question or patient information to a specialist via a secure digital platform.

This approach defers unnecessary hospital appointments in up to 60% of cases and saves specialists' time. Patients are kept under GP-led care with the benefit of timely, informed specialist advice (Liddy et al. 2018).

Reform 3:
Better connection with primary care

Mapping specialist care services available within LHSNs and sharing this information with primary care practitioners will increase efficiency by ensuring referrals go to the right place the first time.

Clinician engagement and training (for both primary care practitioners and specialists) are essential to embed these practices into routine workflows and to build trust.

When primary and specialist care work together, in true partnership, to share information and coordinate decisions, patients receive safer and more timely care. This improves patient outcomes and strengthens the whole health system by reducing duplication and unnecessary hospital demand.

Goal

Communication between primary and specialist care is strengthened through transparent and timely information and advice.

Objectives

- There is transparent communication between specialists and primary care practitioners.
- Unnecessary referrals and specialist visits are avoided, with GPs able to access timely asynchronous specialist advice.
- Primary care practitioners understand the specialist care services available across LHSNs.
- Primary care practitioners have access to referral status, waitlist volumes and treatment outcomes so they can make informed decisions for their patients.
- Shared care approaches are expanded for people with chronic and complex conditions, with clearly defined roles and escalation pathways.

'When clinicians, consumers and communities work side by side, we can design solutions that are practical, inclusive and make a real difference for patient care.'

– Phase 2 engagement, medical specialist, Parkville workshop participant

Reform 3:

Better connection with primary care

What success looks like

Patients and families

- Patients can stay in primary care by receiving timely specialist advice without the need for referral.
- There are clear processes for transitioning patients back to primary care, including summaries, progress updates and personalised care plans.

Clinicians

- GPs understand the specialist care system and local services so they can guide their patients confidently.
- GPs are connected to specialist care to manage complex cases, improve clinical knowledge and improve patient outcomes.

The system

- Shared care models, including multidisciplinary case conferencing for complex conditions, become regular practice, with clear roles and pathways.
- Fewer specialist care referrals are received as GPs, supported by specialist care advice, are managing more patients in the community.

The steward

- Across the system, patients receive care at the right time and in the right place.

Intersectional and complementary reform work

Referrals are a vital part of the patient journey and a core function of primary care. Improving referral processes has long been a focus of system improvement.

The introduction of statewide referral criteria <https://www.health.vic.gov.au/statewide-referral-criteria> assisted by setting clear, consistent standards for when referrals are appropriate and what information must be included. Since 2018, nearly 200 statewide referral criteria have been published across 21 specialties, covering adult and paediatric care.

One of the reforms in the *Planned surgery reform blueprint* <https://www.health.vic.gov.au/planned-surgery-reform-blueprint> is to improve how health services and primary care work together to improve patients' surgical outcomes.

The Department of Health has also created *My surgical journey* <https://www.safercare.vic.gov.au/consumer-resources/my-surgical-journey>, a resource that helps patients have informed conversations with their doctors about whether surgery is needed and why ongoing GP management and follow-up is important if they choose surgery.

Case study

Barwon Regional Adolescent and Child Health Shared-Care (BRANCHS) Clinic

Barwon Health's BRANCHS initiative is a multidisciplinary clinic established in response to overwhelmed public referral pathways for paediatric care. A shared care model was developed to bring together specialist paediatricians, trainees, nurses, allied health professionals and a GP in every clinic team.

This collaborative approach allows comprehensive assessment and management planning, with an aim to return patients back to their regular GP when suitable. This model also supports ongoing GP development and ensures management plans are tailored to patient needs.

> **'(I) can help the patient to have the best possible care ... and can get feedback from other team members.'**
>
> – Participating GP, BRANCHS initiative

Participating GPs commit to continuing care after discharge and deliver shared care arrangements. They are supported by a dedicated advice line with direct access to paediatricians. This allows for timely communication and strengthens the partnership between GPs and specialists.

A review of the first 100 patients seen in the clinic found that over half had transitioned back to GP care within 2 years instead of remaining with the clinic. The review identified this applied to patients with complex care requirements as well as to those with less complex needs.

> **'(The benefits of shared care include) ...improved continuity of care, with providers being on the same page with management.'**
>
> – Participating GP, BRANCHS initiative

The success of the BRANCHS model comes from strong specialist clinic–GP relationships and a commitment to shared management. More than 10 GPs have worked alongside the clinic team, building a skilled and connected workforce of 'paediatric GPs' who provide leadership and expert care in the community.

The initiative's success is attributed to close engagement with GPs, especially during periods of change and including them in the specialist workforce to support effective shared care. A 2-year review found GPs were motivated and capable of managing most paediatric patients, regardless of patient complexity.

This initiative aims to leverage improved GP knowledge and skills to reduce unnecessary referrals and expand GP support in delivering complex care.

Reform 3:

Better connection with primary care

Patient story

Nora's experience with primary care awareness of public versus private access

When my GP first referred me for specialist treatment, I was advised to go privately, which was costly. My GP wasn't clear on how public specialist care worked and was concerned about potentially long waits. It took persistence and self-advocacy for my GP to learn about public clinic options and then refer me, so I could secure timely care. Not everyone can afford lengthy wait periods or has the funds to cover costly private healthcare fees.

Things could be better. If GPs had clearer information about how the system works, referral pathways and public specialist care options, patients like me wouldn't face unnecessary costs or delays. If GPs could consult a specialist for advice on a patient's condition, lengthy wait periods could be avoided, a referral could potentially no longer be needed and patients would be cared for sooner. I had a very positive experience where, during a clinical appointment, a specialist assisted me with specific treatment instructions, which I followed, and I didn't need to go to emergency.

I always bring a notebook to take notes at my appointments because it isn't always easy to remember everything discussed in any given appointment. Also, as a patient, some medical jargon may be lost in translation. Receiving clear written summaries and medication instructions after each specialist appointment would help me feel confident and in control of my care while reducing the risk of mistakes. It would also be helpful if updates were also sent to my GP so everyone would be on the same page.

It is also important for patients to be connected with community services, not only for medical treatment but also emotional and practical support to manage their condition. Linking to services like counselling, social work and community programs helps patients feel supported, reduces isolation and promotes holistic care.

If it weren't for the compassionate support I received through Victoria's specialist care system, I wouldn't be here today. I call the specialists I've met my guardian angels. My journey has shown me how challenging it can be when communication between GPs and specialists is not supported.

> **'Communication in-between appointments [is] very important for patients and the GP to be on the same page.'**
>
> – Nora, West-Metro patient

Reform 4:
Efficient and consistent processes

Across the patient journey – be it referral or triage, treatment or transition – clinics and associated processes should be standardised and as efficient as possible, ensuring patients receive a consistent experience regardless of their postcode.

Rationale

Specialist care services have evolved to meet local speciality needs often without coordination, creating significant variation in practice both within and across health services. This includes processes such as referral, triage, clinic coordination and discharge.

Patients and clinicians therefore encounter varied experiences depending on where and by whom the care is delivered. This is further exacerbated for patients with complex needs who often have multiple appointments on different days instead of a single, coordinated visit. This increases costs for patients and administrative costs for health services.

Only 20% of specialist care visits are for new patients (Department of Health 2025b). Although review appointments can be essential, the consultation identified that not all are needed to meet patients' clinical needs (Reform 3).

At times, review appointments occur because processes are not in place to ensure test results are available or interpreter needs aren't identified before the patient attends an appointment. This is not only frustrating and a poor use of the patient's time but also means clinician time is not used as effectively as it could be (Reform 1).

More efficient models of care are not used consistently, and the skills of nurses and allied health professionals remain underused. For instance, doctors mostly perform routine review appointments when the evidence indicates the reviews can be both clinically and cost-effectively delivered by nursing or allied health professionals (Connolly and Cotter 2023; Driscoll et al. 2022; Fitzpatrick et al. 2022; Sobb et al. 2022; Stute et al. 2020).

This reduces the capacity of doctors to focus on those with more complex health needs, diminishes overall capacity and contributes to longer wait times for patients.

What can be done

Standardising processes across the patient journey (including referral, triage, patient engagement, new and review appointments and transfers) will ensure patients are prioritised equitably and reduce unnecessary variation in clinical decisions.

It will also strengthen operating efficiency and improve interoperability across services. Most importantly, it will give patients a predictable and transparent experience, fostering trust and confidence in the health system while ensuring that quality of care is not influenced by postcode or service entry point.

Reform 4:
Efficient and consistent processes

Health services across Victoria have already started this reform. One service has dedicated significant time to standardising administrative processes across its clinics to streamline workflows. Another has centralised referral intake across the health service to reduce variation in referral management.

A more evolved approach to specialist clinic design is needed. Setting up integrated chronic disease clinics, rather than siloed disease-specific clinics, will allow complex patients to get the care they need at a 'one-stop shop', saving them time and system resources (Fernandez-Salido et al. 2024).

Technology can also play a significant role in improving efficiency. When applied appropriately, artificial intelligence (AI) and automation can help reduce administrative workloads. These tools should be deployed using a problem-first approach, targeted at specific issues and supported by strong governance to ensure ongoing monitoring and assessment of their impact on access, safety and patient experience.

AI tools can flag urgent cases, predict capacity constraints and help allocate resources effectively. This allows clinicians to spend less time on administrative tasks and more time on higher value activities such as proactive clinic coordination and patient care. For example, a UK trial showed AI scribes gave clinicians 24% more time with patients and reduced overall appointment duration by 8% (Hassan et al. 2025). These improvements have the potential to increase throughput and reduce the costs of administration.

Expanding nurse-led and allied health-led models more consistently across Victoria is also essential to support the specialist care workforce and promote more efficient, cost-effective care. Evidence indicates that nurse-led models can reduce hospital admissions by up to 40% while improving patient satisfaction (Beks et al. 2023). Similarly, successful allied health-led models have reduced wait times from referral to appointment and provided cost benefits for health services (Mutsekwa et al. 2019; Raymer et al. 2024). These models also help fill service gaps.

A strong Aboriginal and Torres Strait Islander workforce across the system is essential to standardising culturally safe specialist care practice through cultural knowledge, lived experience and self-determination.

Aboriginal staff strengthen communication, improve patient trust and reduce barriers to care by ensuring processes reflect the needs and aspirations of Aboriginal and Torres Strait Islander communities.

By embedding cultural safety and creating workplaces where Aboriginal staff can thrive, health services can deliver more consistent pathways, reduce siloed care and support better outcomes for Aboriginal and Torres Strait Islander patients and families (Department of Health and Department of Families, Fairness and Housing 2021).

Standardising care and adopting effective models improves efficiency and helps deliver safe, high-quality patient care, leading to better patient outcomes and a more sustainable health system.

Reform 4:
Efficient and consistent processes

Goal

Specialist care is delivered in an efficient, standardised and consistent way across all settings, reducing variation and increasing equitable, high-quality outcomes.

Objectives

- Practices are standardised statewide to increase efficiency and improve patient experiences, specifically in the areas of:
  - scheduling and management of appointments, particularly review appointments or those needing multiple appointments
  - patient preparation for upcoming appointments
  - patient triage
  - service referrals (intra and interservice).
- Various AI tools are implemented to increase efficiency in administration and broader workflows, where safe and appropriate.
- The workforce is optimised and more supported through innovative care models and clinicians working to the top of their scope of practice.

What success looks like

Patients and families

- The patient experience is more consistent, and the health system is user-friendly.
- There are increased multidisciplinary or 'one-stop shop' clinics providing coordinated complex care for patients in a single visit.

Clinicians

- There are more nurse and allied health-led clinics.
- Appropriate patient information and test results are available before appointments.

The system

- There is less variation in workflows and models of care across specialist care.
- There is a more balanced ratio of new to review appointments.
- There are fewer unnecessary review appointments.

The steward

- The specialist care system is more efficient, effective and sustainable.

Reform 4:
Efficient and consistent processes

Intersectional and complementary reform work

The *Victorian health workforce strategy* <https://www.health.vic.gov.au/victorian-health-workforce-strategy> is a 10-year plan to build a modern, sustainable and engaged healthcare workforce for Victoria. The strategy sets out 5 key priorities:

- Increase supply of priority roles.
- Strengthen rural and regional workforces.
- Improve employee experience.
- Build future roles and capabilities.
- Leverage digital, data and technology.

The Non-admitted policy <https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health> sets requirements for triage, waitlist validation, requirements for review appointments and discharge planning.

AI is a valuable tool that, when guided by strong governance, can help transform health care for the better. The department and Safer Care Victoria have developed an AI governance framework <https://www.vic.gov.au/guidance-safe-responsible-use-gen-ai-vps>. The framework provides a clear and practical path for safely introducing AI into health services. It emphasises careful approval processes, clinical oversight and compliance.

Reform 4:
Efficient and consistent processes

Case study

Eastern Health: AI to support timely triage

Every year, Eastern Health receives more than 140,000 specialist referrals, making timely access to acute specialist clinics a priority.

The health service aims to provide all urgent referrals with an appointment within 30 days, with all new referrals triaged within 5 days. But competing clinical demands and resourcing challenges can affect these timelines.

To address this, Eastern Health implemented an AI tool that supports the timely review of new referrals to their urology acute specialist clinics.

The AI tool does not replace clinical triage but helps clinicians to identify high-priority referrals for urgent attention, with the final triage decision remaining with the clinician.

The AI tool was co-designed between clinicians and the information technology team to ensure clinical safety and quality while maintaining data security and integrity.

The initial round of AI tool training, conducted in October and November 2025 using 130 referrals, achieved an approximately 90% alignment between clinical triage decisions and AI-suggested triage categories. Misaligned cases are being used to refine the model and improve the tool's accuracy.

Following this, Eastern Health will continue training the AI tool through early 2026, with full implementation in urology planned for April 2026. It is expected this will make the triage process more efficient and allow patients to be scheduled for appointments more quickly. Scaling the initiative across other acute specialist clinics is also being considered.

AI is emerging as a key tool to support clinical decision-making and resource allocation. For successful implementation, strong collaboration between clinical and technology teams is essential.

Reform 4:
Efficient and consistent processes

Case study

Western Health – AAPPEAR Clinic

Wait times for ENT specialist clinics are a significant challenge across Victoria, often delaying access to treatment for children.

To address this, Western Health introduced the Audiology Advanced Practice Paediatric Ear (AAPPEAR) Clinic, a new model designed to provide timely and effective assessment for children on the routine ENT specialist care waitlist.

> **'Excellent service from audiologist and very thorough. Explained and showed us everything happening with my son's ear.'**
>
> – Parent of an AAPPEAR Clinic patient

In this service, audiologists conduct comprehensive diagnostic assessments and determine the most appropriate next steps for each child. Children may be discharged without needing to see an ENT specialist, referred for an urgent or routine ENT appointment, or scheduled for further review in the clinic.

This approach ensures children who truly need medical or surgical intervention are identified quickly, while those who do not need medical specialist input are safely managed without unnecessary appointments.

Since implementation, just under half of the children seen in the AAPPEAR Clinic have been discharged from the ENT waitlist without requiring medical specialist input, resulting in a 9% increase in ENT clinic capacity.

Of those referred for urgent ENT review, more than 60% needed surgery, proving the clinic's effectiveness in identifying children who need timely intervention.

The success of the AAPPEAR Clinic is supported by a collaborative ENT specialist team and strong governance and learning structures. The model has improved efficiency in care and waitlist management, allowing ENT specialists to focus on children who need their care.

The clinic is now a permanent part of Western Health's services, with a recent expansion to include post-surgery reviews.

> **'This clinic is paramount to public health care. It allows patients and their families to have earlier access to appropriate services, which may not need any further medical management ... it is absolutely necessary to continue this service as our waitlist continues to grow exponentially.'**
>
> – ENT specialist consultant at Western Health

Reform 5:
Regionalised access to specialist care

Providing patients with regionalised access to care will better direct them to the most suitable specialist and treatment options within their region as well as matching them with available services based on location, urgency and clinical need.

Rationale

Public specialist care waitlists are currently managed by individual health services and clinics. This makes it difficult to match demand with available capacity, particularly in rural and regional areas or high-demand metropolitan growth areas.

Referral pathways and wait times vary significantly between health services for a range of reasons, which can create inequitable access to specialist care based on where people live and which health service they are referred to.

As an example, between April and June 2025, median wait times for routine first appointments within one metropolitan LHSN varied by up to 60 days.

Delays in care can increase the risk of preventable complications (such as liver cancer for patients with viral hepatitis), leading to more severe illness and significantly higher treatment costs for the health system.

Lack of waitlist transparency and demand across regions prevents coordinated planning and leads to inefficiencies. It drives duplicate referrals, as referrers send referrals to multiple health services to secure the earliest appointment.

It also places burden on health services that may already have high demand, when a patient can be referred to a nearby health service that has more capacity.

What can be done

A regionalised and coordinated approach can balance demand across services and optimise use of local capacity, within and across LHSNs, by aligning referrals with available services based on location, clinical urgency and individual need.

This approach can also deliver significant economic and operational benefits. It improves collaboration, reduces duplicate referrals, enhances information sharing and standardises waitlist management (Reform 4).

Regionalised waitlists will also expand patients' options, which can be particularly important for rural and regional Victorians. These patients often face long travel times or limited access to visiting specialists who only come to their area every few weeks or months.

Reform 5:

Regionalised access to specialist care

A data-driven approach to waitlist management is essential for giving patients more timely, appropriate and efficient care. This can ensure patients are directed to the most suitable care and treatment options within their local area.

Strengthening data intelligence and integrity (Reform 6) will enable health services to share accurate, real-time information on available services, waitlists and referral status in their regions to patients and referring clinicians. This will support shared decision-making (Reform 1) and create stronger links with primary care (Reform 3).

Some patients are happy to travel if they have family or social supports near where they will receive care. Regionalised models should include virtual options to reduce unnecessary travel (Reform 2) and ensure patients' ongoing care occurs locally (Reform 3).

A connected and transparent system will give patients more flexibility and choice. This approach strengthens Victoria's health system and ensures resources are used efficiently and sustainably to meet growing demand. Faster access will enable people to resume their lives sooner, be it active participation in their work, study, family or community.

Goal

Regionalised specialist care waitlists are created across Victoria to better balance demand and capacity across regions.

Objectives

- Robust, accurate and timely data systems are developed to support regional waitlists and transparent decision-making and system planning.
- Specialist care waitlists are regionalised to match demand and capacity across regions.
- Health services, clinicians and patients have real-time visibility of:
  - available services
  - referral volumes and waitlists across regions
  - referral status.
- Specialist care referral pathways are consolidated across regions.

Reform 5:

Regionalised access to specialist care

What success looks like

Patients and families

- Patients and families receive clear information about available specialist care and wait times within their region so they can make informed decisions.
- Patients and families experience equitable access to specialist care no matter where they live.

Clinicians

- Clinicians have access to information on available specialist care services, referral wait volumes and waitlists within their LHSN, allowing them to better manage and coordinate patient care.

The system

- Specialist care waitlists are consolidated within each region to guide planning and decision-making.
- Specialist care demand matches capacity, reducing variation in wait times.
- Duplicate referrals are minimised and unnecessary transfers are avoided.

The steward

- Demand flows across the system based on health service capacity at the regional level.

Intersectional and complementary reform work

The Victorian *Health services plan* <https://www.health.vic.gov.au/research-and-reports/health-services-plan> sets a clear vision for a more connected, equitable health system.

A key component is 12 new LHSNs. Each focuses on access, equity and flow by facilitating connected care across logical pathways, making it easier for people to interact with and navigate the health system.

The *Victorian role delineation framework* <https://www.health.vic.gov.au/health-services-plan-reform/role-delineation-framework> defines the capabilities, responsibilities and service levels of health services.

A critical feature for enabling regionalised referral pathways is giving clinicians access to accurate, up-to-date patient information. CareSync Exchange <https://www.health.vic.gov.au/caresync-exchange> provides this through a secure, statewide health information-sharing system that offers authorised clinicians near real-time access to diagnostic results, discharge summaries and visit history.

Reform 5:
Regionalised access to specialist care

Case study

Western Australia Health: The Central Referral Service

Western Australia's Central Referral Service (CRS) shows how a centralised referral management model can improve consistency, transparency and visibility of demand and service pressures while supporting more equitable access to tertiary services for regional patients.

Established in 2014, the CRS provides a single point of intake for most medical-led public outpatient services across metropolitan health services. The nurse-led service considers all the necessary information to enable patients to be triaged at the most suitable hospital site within a clinically appropriate timeframe. This is supported by Referral Access Criteria developed for several specialities, similar to Victoria's Statewide Referral Criteria.

By ensuring referrals are sent to the most appropriate hospital from the start of the referral process, the aim is to minimise wait times for initial public specialist outpatient appointments.

In 2021, the CRS expanded its remit to include regional health services and continues to bring more services into scope.

The CRS aims to strengthen access and efficiency across Western Australia's specialist care system. It now processes more than 1,250 referrals per day, up from a daily average of 609 in 2014, reflecting a significant expansion in capacity. Urgent referrals are reviewed within one business day, enabling timely assessment for patients who need urgent care while managing substantial referral demand.

Ongoing challenges in referral quality and relying on fax or post for referrals persist, with just over half of the referrals submitted electronically. Around a quarter of referrals are stopped because they are duplicates or are missing information.

Sustained stakeholder engagement with clinicians, GPs and consumers, along with new referral criteria and continued investment in digital platforms, have been key to the CRS's establishment and continued growth and efficiency.

The next steps for the CRS include expanding to regional health services and specialities, transitioning to a fully end-to-end digital referral model and enhancing data use to support service planning and demand forecasting.

Reform 6: Strengthened stewardship and continuous improvement

Enhanced statewide stewardship over accountability and reform will transform Victoria's specialist care system by setting agreed priorities, aligning practices through data-informed decisions and widely sharing innovations.

Rationale

The public specialist care system requires more robust accountability and transparency, with the steward and system working together to manage performance.

The type of data being collected and the measures that assess current system performance need to be adjusted to ensure the right intelligence drives the right improvement. This will ensure existing services and efforts deliver value for patients and align with changing population needs.

Also, while many health services have introduced a variety of improvements across specialist care, these efforts are often delivered in isolation. A more connected approach, driven by the steward, could unlock system-wide benefits of potential innovations and initiatives.

What can be done

A clear and transparent accountability approach will drive performance, enable continuous improvement and build trust in the system. Defined and shared accountability and governance structures will allow timely action and reduce variation. This will be underpinned by deeper partnerships between the system and the sector, driving towards the same goal in specialist care.

This approach will incorporate new fit-for-purpose specialist care metrics – those that drive performance to better patient outcomes including indicators on patient satisfaction and cultural safety. This will ensure patient access and equity is maximised and resources are used efficiently.

Reliable data will provide a clear picture of system performance, enable proactive decisions, improve system responsiveness and strengthen public confidence. The steward should identify the digital solutions and data enablers that set expectations for standardised statewide platforms – for example virtual care, waitlist visibility and shared care. This will prevent fragmented local solutions and ensure data insight tools, such as sector-facing dashboards or a specialist care digital twin[1], are built on consistent, statewide foundations.

The steward will play a stronger role in fostering communities of practice and creating forums for collaboration and insights, allowing health services to exchange insights, embed evidence-based approaches, scale efficiencies and become more connected.

We have a unique opportunity to transform specialist care into a system defined by shared accountability and continuous improvement.

1 A digital twin is the digital representation of a real-world entity or system. It is a digital system that mirrors a unique physical object, process, organisation, person or other abstraction. It is complex algorithmic modelling and is based on real-world inputs at the health service level. For example, the planned surgery digital twin model uses complex machine learning simulation to predict service demand and activity to test performance impacts of reform initiatives to drive optimal care.

Reform 6:

Strengthened stewardship and continuous improvement

Goal

System stewardship drives and supports accountability, service improvement and innovation.
It is enabled by fit-for-purpose data and analytics.

Objectives

- Data collection and reporting systems are fit for purpose, timely, complete and accurate.
- Data-informed insights guide accountability and continuous improvement, supporting health services to implement strategies to improve specialist care.
- Clear reporting is provided on key activity and performance metrics including specialist care waitlists and wait times.
- New specialist care metrics are developed that better measure access.
- Collaboration and continuous improvement are fostered through communities of practice and sector engagement, resulting in shared insights, scaled innovation and strengthened partnerships.

What success looks like

Patients and families

- Patients have access to timely, accurate waitlist information to enable informed decision-making.
- Patients experience better outcomes and benefit from more efficient systems as successful models are scaled across health services and regions.

Clinicians

- Clinicians have access to timely, accurate waitlist information to support informed decision-making with patients.

The system

- The whole patient journey is tracked, with visibility of wait times, equity of access and clinical outcomes to support continuous improvement.
- A fit-for-purpose statewide performance approach is in place, with agreement on what constitutes best practice and how it is measured.
- A strong community of practice exists in specialist care, where health services and regions actively identify, share and adopt reforms, adapting them to local needs.

The steward

- The steward has clear oversight of health system capacity and demand, with appropriate levers to support performance.

Reform 6:

Strengthened stewardship and continuous improvement

Case study

Victoria's planned surgery system: Data and analytics enhancements, clear accountability and a platform for reform

Reform 10 of the *Planned surgery reform blueprint* ('Build robust data and intelligence infrastructure') outlines the reform aims of improving system integration and performance through improvements in accurate, timely and transparent data.

There have been significant improvements since the release of the *Planned surgery reform blueprint* in 2023.

Planned surgery in Victoria is now supported by accurate and fit-for-purpose datasets and performance metrics that monitor demand, capacity and performance trends across the system. The dataset has taken time to develop, but a focus on iterative improvement will continue.

Planned surgery is also supported by a comprehensive set of data dashboards. This enables the department and health services to monitor and benchmark performance and identify reform opportunities that drive service improvements.

Developing a 'digital twin' in planned surgery also provides advanced predictive modelling of the real-world impact of variables or proposed reform initiatives on service demand and performance.

The steward commissioned and developed these tools as a stronger accountability framework for planned surgery. This has enabled proactive demand management by allowing system pressure points to become clear early and has supported effective and responsive service planning.

Setting up a regular platform for services to collaborate on shared challenges and opportunities has also been transformational.

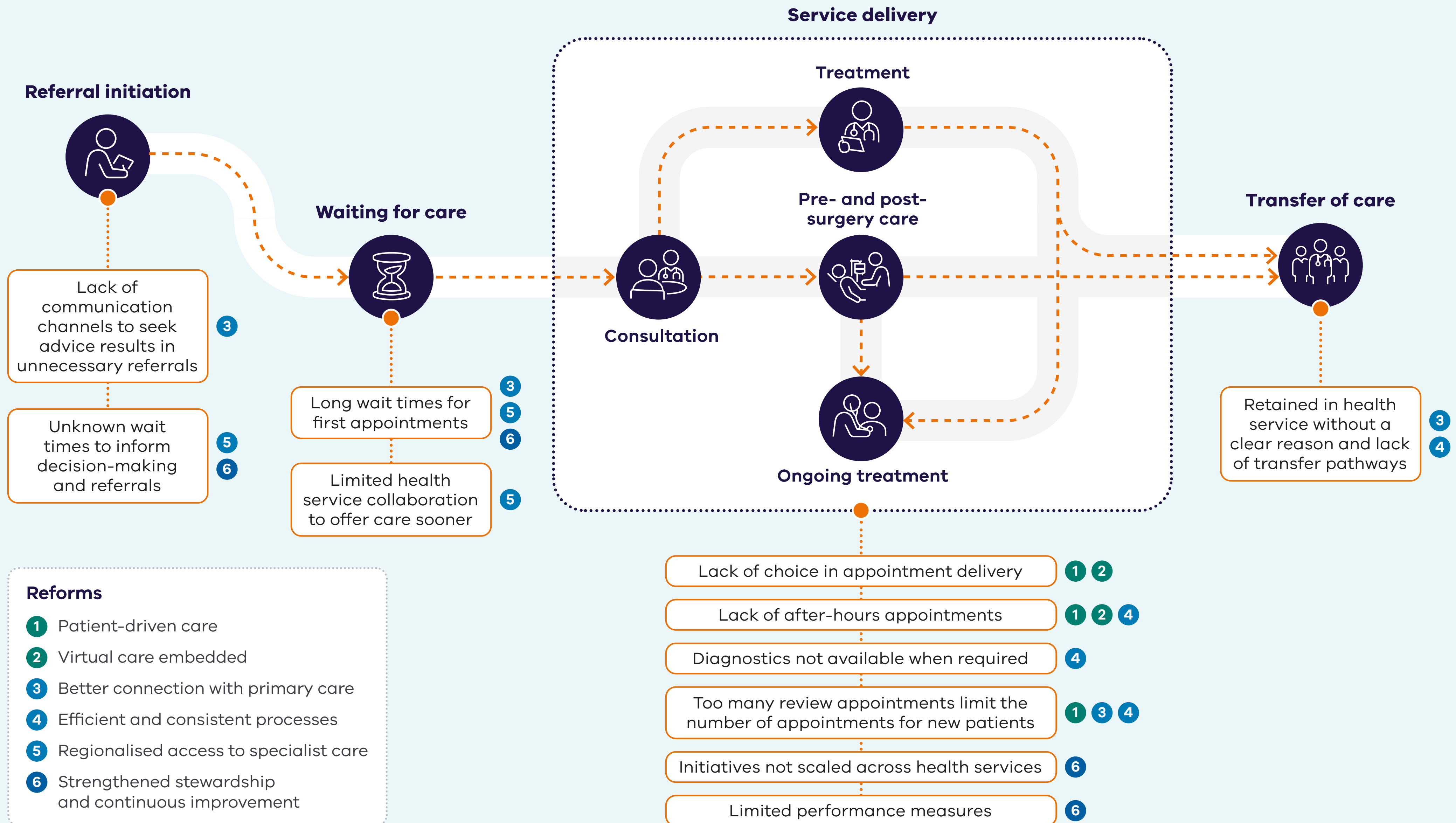
The Planned Care State-wide Community of Practice has averaged attendance of more than 100 health service clinicians and staff from across the state each month since 2022. These forums have helped build awareness and collaboration in addressing local and system-wide challenges in delivering planned surgery.

Collectively, these reforms have helped Victoria achieve record volumes of planned surgery for the past 2 years, with 212,660 planned surgeries delivered in 2024–25 (Department of Health 2025a).

Victoria is now ranked first nationally for timely access to planned surgery. It is the only jurisdiction delivering 100% of the most urgent planned surgeries (Category 1) within clinically recommended timeframes (Productivity Commission 2026).

Specialist care patient journey and the reforms

Figure 7: Referral and specialist care delivery pathway challenges addressed by the reforms



Working together to deliver system reform

A delivery framework for collaboration and success

The *Specialist care reform blueprint* signals the government's commitment to transforming the specialist care system now and into the future.

It sets the pathway that both the steward and system will take to reform specialist care and the overall experience of planned care.

True sustainability in reform comes from partnering with those impacted and empowering those responsible for delivering change.

This approach ensures the blueprint is designed collaboratively, with shared ownership across the sector.

As we deliver the blueprint, we expect:

- **the system** to continue implementing customised innovations and actions specific and relevant to its population under each of the reforms
- **the steward** to set priorities and reform direction as well as enable and support the system to drive towards each goal set out in this blueprint.

> **'I am incredibly excited about the future of specialist care in Victoria.'**
>
> – Phase 2 engagement, nurse practitioner, Hume workshop participant

To guide this approach, a delivery framework with 3 key components has been developed:

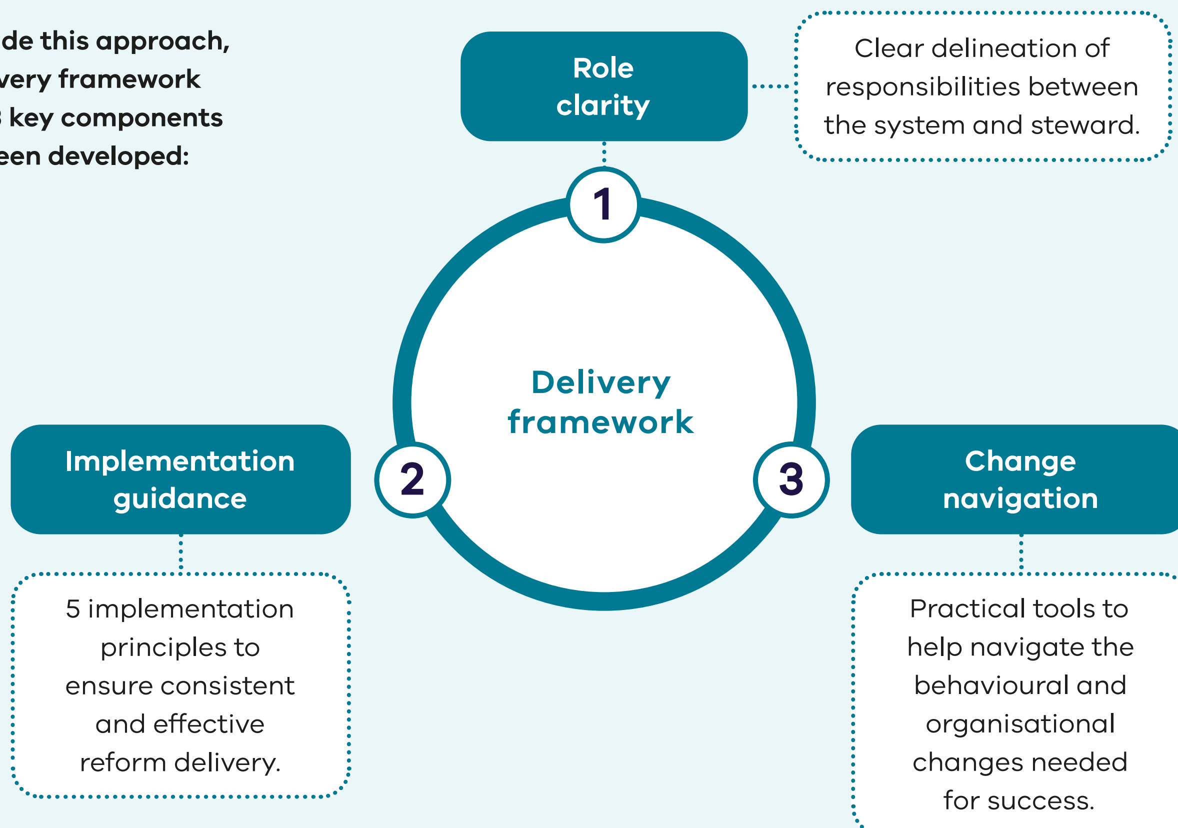
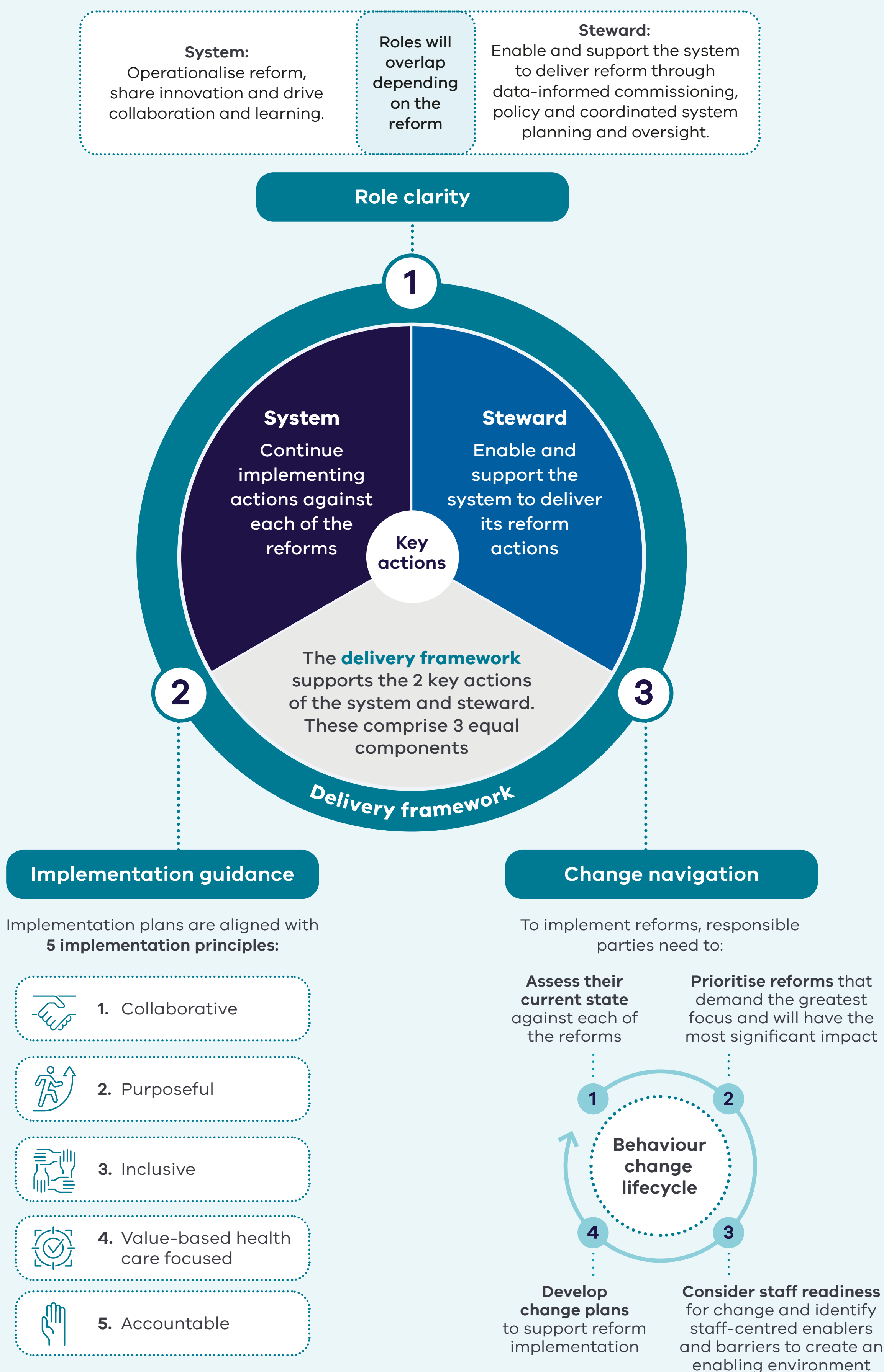


Figure 8: Delivery framework comprising 3 components



1. Role clarity

The success of the reforms set out in the blueprint relies on clearly defining the roles and responsibilities of the system and the steward.

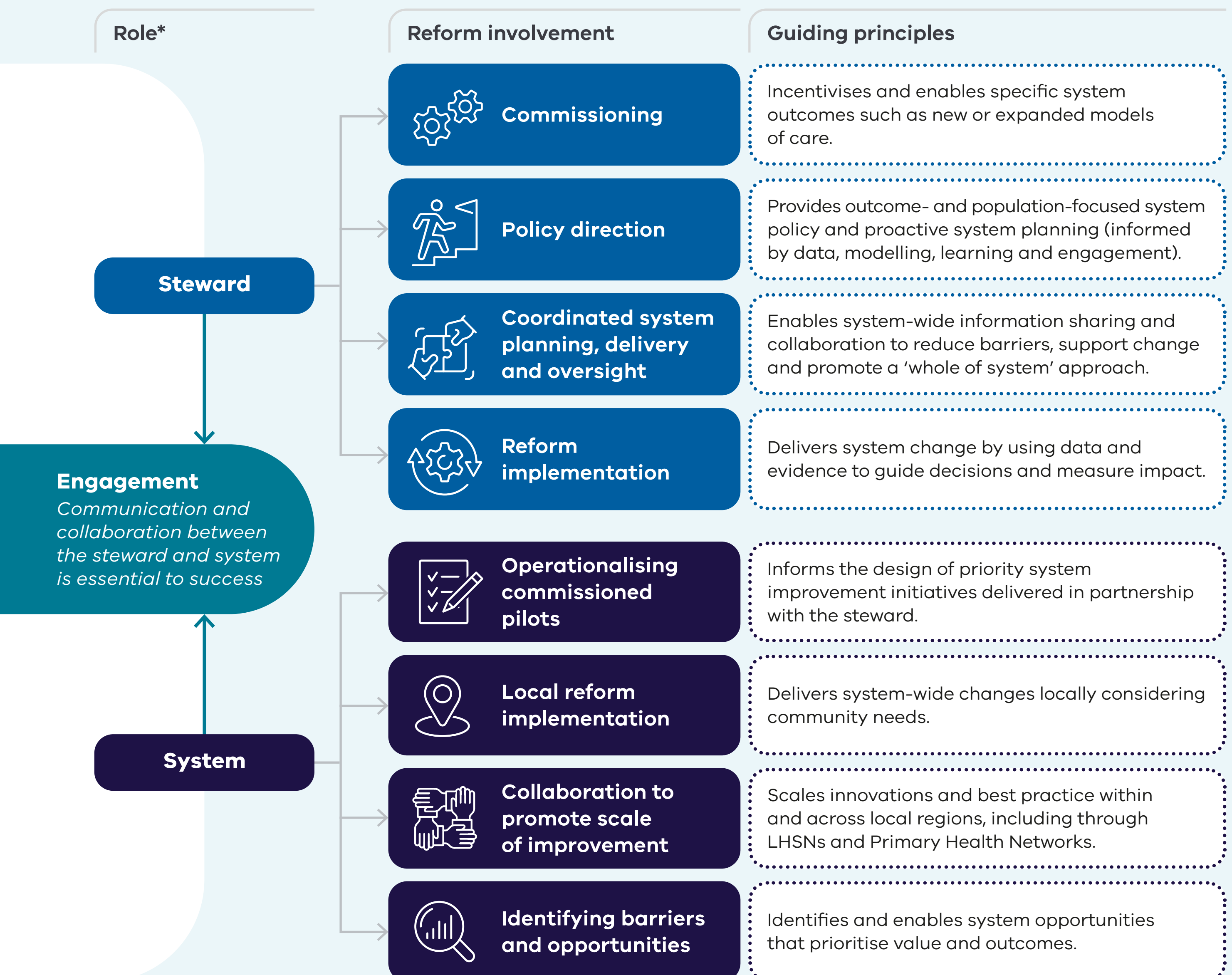
Overall, the system will operationalise the reform, applying an improvement mindset to test, adapt and implement changes locally. It will be expected to achieve reform through collaboration and sharing of innovations, challenges and opportunities.

The steward acts as the 'enabler' of reform. It commissions, sets policy direction and establishes expectations to improve efficiency, outcomes and value across the system.

The steward also supports the consistent and equitable scaling of innovations already underway while driving new reforms. When barriers to implementation arise, the steward is also responsible for providing support to keep reforms on track and achievable.

Successful implementation relies on strong communication and genuine partnership. While the roles of the system and the steward are distinct, they often intersect. Maintaining clear and consistent communication will be critical to driving reform and achieving lasting change.

Figure 9: Roles and responsibilities



* The proposed roles of the steward and system are not mutually exclusive.
Varying levels of involvement will be required across both roles, depending on the nature of the reform.

2. Implementation guidance

While the blueprint is designed to be practical and achievable, implementing reform of this scale is complex and requires everyone involved to embrace a mindset of continuous improvement.

Implementation of the blueprint is guided by 5 core principles that ensure every change is practical, valued, equitable and sustainable.

Shaped through extensive engagement, these principles will help Victoria deliver consistent reform and innovation, as well as the behavioural and system change needed for large-scale reform.

The 5 implementation principles

When implementing the blueprint reforms, both the system and the steward should ensure implementation plans align with these principles:

1. **Collaborative.** All implementation partners are connected and work together with those most affected by the outcomes; opportunities to co-design and test solutions with consumers and the workforce are used where appropriate.
2. **Purposeful.** Consumers, the workforce and the broader health sector understand the purpose of the reforms.
3. **Inclusive.** The reforms focus on equitable outcomes and do not inadvertently disadvantage people or groups of people.
4. **Focused on value-based health care.** Reform design and delivery align with best practice recommendations to achieve outcomes that matter most to patients in the most cost-effective way. On-the-ground implementation is underpinned by access to data and improvement methodology, with the system empowered to test changes locally, supported by strong planning and analysis.
5. **Accountable.** Ownership and monitoring are embedded in implementation approaches, with roles and responsibilities established for the system and the steward.

3. Change navigation in specialist care

Supporting reform implementation in specialist care settings with targeted behaviour change

Reform in the specialist care environment is, at its core, a behavioural challenge.

While policy, funding and structural changes provide the necessary conditions for reform, meaningful and sustained transformation depends on how people think, decide and act within complex clinical and organisational systems.

Clinicians, operational staff and executives will have to adapt established practices, navigate competing demands and collaborate across professional and organisational boundaries to enact true reform that delivers value to patients.

Across all reforms, health services play a critical role in prioritising and designing care around what matters most to patients.

This includes ensuring decisions about service models, workflows and implementation approaches are informed by patient preferences, outcomes, experience and access.

Why behaviour matters in specialist care reform

Specialist care systems are shaped by policies and guidelines but also by deeply embedded professional norms, workflows, incentives and organisational hierarchies.

Behaviour is influenced not only by knowledge and skills but also by habits, cognitive biases, social and organisational dynamics, time pressures and system constraints.

As a result:

- Structural or policy change alone is rarely enough to change practice.
- Implementation challenges often reflect unclear expectations, perceived risks to change, structural and practical barriers or misaligned incentives, rather than opposition to reform goals.
- Various parts of the health service experience different challenges, requiring tailored approaches that reflect local context and patient values rather than uniform solutions.

Behaviour change tools to support implementation

You can use these established tools in your local health service:

- BehaviourWorks Method <https://www.behaviourworksaustralia.org/about/the-method>
- Behavioural Insights Unit EAST tools <https://www.bi.team/publications/east-four-simple-ways-to-apply-behavioural-insights>
- INSPIRE <https://www.behaviourworksaustralia.org/courses/inspire-your-communication>.

Figure 10: Behavioural strategies to support implementation across the 3 reform pillars

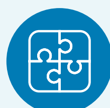
BehaviourWorks Australia has provided strategies to help health services progress the reforms locally by addressing specific barriers.

Pillar 1: Responsive and high-value care

Reforms of patient-driven care and virtual care embedded require shifts in clinical decision-making, communication practices and perceptions of risk and responsibility.

Behavioural strategies can support these changes by:

- **embedding shared decision-making prompts and tools** into clinical workflows that enable choice and flexibility for patients and their families
- **providing appropriate tools and decision-making supports** to assist patients and clinicians
- **normalising 2-way communication** through regular, structured opportunities for questions, feedback and clarification, supported by sufficient time for shared decision-making within care processes.



Pillar 2: Efficient and integrated services

Approaches informed by behaviour recognise that integration is not just structural but also relational and cultural, which require shifts in attitudes and social norms within and between organisations to improve patient experiences and outcomes.

Integration across specialist and primary care means collaboration across the full healthcare continuum. This requires:

- strengthening multidisciplinary teamwork through targeted strategies that address structural and cultural barriers, including **clear role definition** and **shared accountability**
- enabling multidisciplinary teamwork by creating appropriate and consistent **channels for communication** and integrating **ways of working**
- developing reform initiatives grounded in pragmatic implementation approaches that **maximise existing capacity**, **reduce inefficiencies**, promote **integrated services** and can be maintained over time without adding system burden.

Pillar 3: Strengthened stewardship

Effective stewardship is strengthened when health services foster a culture of learning, innovation and responsibility, creating an environment where reform is coherent and purposeful rather than fragmented or burdensome.

To support effective stewardship and continuous improvement, it is important to:

- contribute to a learning system by **sharing data** to enable data-driven decision-making and insights on barriers to change
- design **feedback systems** that are meaningful, timely and actionable
- support leaders to **model desired behaviours**, enable **patient-centred decision-making** and clearly **signal priorities**
- **embed continuous improvement** into routine practice rather than discrete projects
- plan for **scaling improvements from the outset**, ensuring patient value is maintained as initiatives expand beyond pilot sites. Many pilots do not scale because scaling requirements are not adequately addressed during planning.

Refer also to the *Social innovations scaling toolkit* <https://scaling-toolkit.com/>.

Figure 11: Principles and practical actions to guide specialist care reform implementation

Long-term commitment from the steward

Every Victorian should have access to timely, high-quality care that meets their needs, no matter who they are or where they live.

While our health system has achieved much, we know that too many people still face long waits, confusing processes and barriers to getting the specialist care they deserve.

The *Specialist care reform blueprint* is our commitment to change this.

The blueprint sets out a clear and ambitious vision for a specialist care system where health care is coordinated, virtual options are prioritised and patients are empowered to be active partners in their health journey.

It is the result of genuine collaboration – clinicians, health services, the government and consumers all working together with a shared purpose: to improve the experience of specialist care across Victoria.

Central to this vision is strengthened stewardship – responsible leadership and governance that ensures accountability, continuous learning and innovation.

Our proposed reforms are practical and realistic, aimed at ensuring sustainability.

With a focus on care closer to home, fostering collaboration over competition and building a more efficient and sustainable system, we are laying the foundations for a smarter, fairer and more responsive health system.

We recognise that real change takes time. These reforms are a long-term commitment to building a system that will serve Victorians well for generations.

With this blueprint, we are not just improving processes, we are reimagining how specialist care is delivered, creating a system that is efficient, accessible and built to last.

Thank you to everyone who contributed their insights and dedication to this work. Your input has shaped a path that will make a real difference for people across our state.

Together, through shared stewardship and collective action, we are building a health system that delivers the right care, in the right place, at the right time – setting a new benchmark for specialist care in Australia and supporting Victorians to be the healthiest people in the world.

Jenny Atta PSM
Secretary
Department of Health

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