



Priorities for the next Victorian Government

➤ TIMELY CARE. THE WORKFORCE TO DELIVER IT. A HEALTH SYSTEM THAT WORKS TOGETHER.

October 2026

Introduction

Health policy is ultimately judged where care is delivered: in general practices, consulting rooms, operating theatres, emergency departments, hospital wards, and community health services across Victoria.

It is there that patients experience the health system, and doctors see the practical consequences of government decisions. They see where care works, where a shortage in one service becomes a crisis in another, and where policy intent does not survive contact with daily practice.

None of the priorities set out here is new, and none has been devised for the election. They reflect advocacy AMA Victoria has pursued over months and, in many cases, years, informed by concerns repeatedly raised by doctors across Victoria. The election provides an opportunity to bring those priorities together and seek clear commitments from each party.

Victoria enters the 2026 election with persistent pressure on access to care, an overstretched medical workforce, and major reforms still being implemented. Patients wait too long for specialist appointments, inpatient beds, mental health care, and other essential services.

Regional communities face the same pressures with fewer services and greater distances. General practices, community health services, and private specialist practices absorb work and costs transferred from elsewhere. Public hospitals struggle to train and retain the doctors on whom their future capacity depends.

At the centre of these pressures is a shortage of usable capacity. A building is not a service, a nominal bed is not a staffed bed, and a new model of care does not add capacity when it simply moves work elsewhere. Victoria needs sufficient people, services, and infrastructure to provide care, and it needs to use the capacity it already has well.

The observation that everything in health is connected is hardly original, but it is true. When people cannot obtain timely general practice or specialist care, some become sicker and present to an emergency department. Without an inpatient bed they remain there; without rehabilitation, aged care, disability, or community support, patients who no longer need acute treatment cannot leave. The next patient waits, while workforce shortages, fragmented information, and poorly designed regulation run through the sequence.

The headings are useful for organising a document. The challenges themselves are less obliging. Chronic pain belongs to hospital care, community care, workforce, funding, and data. Regional health depends on training, digital systems, transport, and statewide service design. Private practice affects public capacity. Prevention affects everything that follows. The categories are guides, not boundaries.

Victoria does not lack health plans. It has statewide plans, workforce plans, mental health plans, and reform blueprints. Where the problem and remedy are already clear, the time for planning must stop. The next government should fund the capacity, train and retain the workforce, remove avoidable friction, set dates, and report honestly on results. A new document is not delivery.

AMA Victoria's priorities are organised around three connected responsibilities: delivering timely care for every Victorian, supporting the medical workforce and medical practice, and building a connected and equitable health system. The asks vary in scale. Some require sustained investment. Others ask

government to remove a needless process, publish information it already holds, or apply a sensible rule consistently. Small reforms should not be mistaken for small gains. Every unnecessary hour returned to clinical care matters.

AMA Victoria asks every party to say clearly what it will fund, when it will deliver it, how progress will be measured, and how clinicians will be involved. The following ten commitments are the tests against which the detail in this statement should be read.

10 COMMITMENTS FOR THE NEXT VICTORIAN GOVERNMENT

1. End dangerous delays in hospital care.

Beginning with its first budget, fund the staffed acute, subacute, and rehabilitation capacity needed to reduce access block, require clinical and executive review and corrective action for every emergency department stay of more than 24 hours, and publish results for each hospital.

2. Make specialist care visible and navigable.

Publish standardised quarterly waiting data, ensure one clinically appropriate referral is enough, and fund the public specialist positions and networked services needed to reduce delay.

3. Restore capacity for severe and acute mental illness.

Fund additional acute, subacute, and rehabilitation care and its specialist workforce, identify where genuinely new beds are operating, and publish meaningful access and outcome data.

4. Give chronic pain proper priority.

Expand public multidisciplinary pain services, particularly in regional Victoria, strengthen the pain medicine workforce, and report demand, waiting times, and outcomes.

5. Keep general practice, community health, and private specialist practice viable.

Stop transferring unfunded work, protect community health general practice services for vulnerable patients, and provide a full payroll tax exemption for general practice and private specialist services.

6. Build the medical workforce Victoria needs.

Conclude a fair public hospital doctors' enterprise agreement, fund training places in line with graduate numbers and service need, create sustainable public specialist positions, and publish the data needed for sound workforce decisions.

7. Give doctors' time back and support safe, sustainable careers.

Make Getting Rid of Stupid Stuff an ongoing partnership, remove duplication, and protect doctors from fatigue, occupational violence, and exploitation.

8. Deliver regional and rural health equity.

Establish a parliamentary inquiry while acting now on extreme hospital waits, medical training and retention, statewide digital access, and the real cost of travelling for care.

9. Protect prevention and act earlier.

Reconsider the dissolution of VicHealth, preserve dedicated prevention funding and an independent public health voice, and improve equitable access to proven programs.

10. Connect the system and make reform work.

Deliver a statewide electronic medical record and interoperable referrals, put medical leadership at the centre of reform, and ensure new models of care are safe, connected, and properly evaluated.

PART ONE

Delivering timely care for every Victorian

Every Victorian should be able to obtain timely, high quality care, regardless of where they live or which part of the system they enter. That requires investment across the patient journey, not an isolated response to whichever pressure is most visible on a given day.



1. End dangerous delays in hospital care

Emergency department access block occurs when patients who need admission cannot reach an inpatient bed, or when patients ready to leave hospital cannot obtain rehabilitation, aged care, disability, mental health, or community support. Patients receive prolonged care in unsuitable spaces, treatment is delayed, clinical risk rises, and the hospital has less capacity for new demand.

An emergency department stay of more than 24 hours is an extreme failure of patient flow. Each case should trigger clinical and executive review, corrective action, and public reporting so recurring problems are not hidden in statewide averages.

Ambulance performance matters, but moving a patient from a trolley at the hospital door to one inside the emergency department does not resolve access block. Nor does a capital announcement create a staffed bed. Facilities require recurrent funding, workforce, diagnostics, theatre capacity, and connected services beyond the hospital. The same applies to planned surgery: additional theatres do not add capacity without the staff, diagnostics, beds, and postoperative services to use them.

Patient flow must respect the rights and preferences of older people. Patients who no longer need acute care but cannot enter a preferred residential aged care facility should receive safe interim care and a later transfer when a suitable place becomes available. Capacity pressure should neither keep people in inappropriate acute care nor displace consent, safeguards, or proper review.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

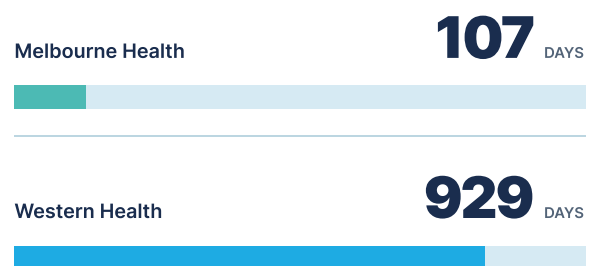
- beginning with its first budget, fund a hospital capacity package covering staffed acute, subacute, and rehabilitation beds, Hospital in the Home, planned surgery, diagnostics, workforce, and recurrent operating costs
- require clinical and executive review and corrective action for every emergency department stay of more than 24 hours, and publish results for each hospital
- fund whole of hospital patient flow, including timely rehabilitation, transition care, disability, mental health, aged care, and community services, and pursue joint action with the Commonwealth where responsibility is shared
- require every major infrastructure commitment to identify the workforce, operating funding, and connected services needed to use the promised capacity
- expand planned surgery and procedural capacity and publish consistent data on waiting times, postponements, and the reasons care is delayed.

2. Make specialist care visible and navigable

Public specialist waiting lists remain among the least transparent parts of Victoria's health system. Patients can wait months or years without knowing their place in the queue. Conditions deteriorate, tests expire, and GPs manage the uncertainty without reliable information or ready access to specialist advice.

A routine appointment. A vastly different wait time.

Days to a routine first general surgery appointment in Victoria's public specialist system.



Source 1 · AMA Victoria, Policy and Advocacy Update: 27 August 2026. See also the original reporting in The Age.

Referral rules can add another obstacle. Royal Melbourne Hospital's reported decision to return some referrals because another service was geographically closer exposed the problem. When AMA Victoria raised the issue, published figures showed waits of 107 days at Melbourne Health and 929 days at Western Health for a routine first general surgery appointment.¹ A postcode is not a referral management system. A referral returned to a GP without an accepting alternative is not coordination.

The health system knows more about its capacity than an individual patient or referring doctor. It should use that information to route a clinically eligible referral, confirm where it sits, and provide a clear route for escalation when the patient's condition changes.

Access also depends on funded specialist service capacity. New clinics, specialist advice, outreach, and longer operating hours require sustainable public specialist time. Without it, referral reform can redistribute a queue but cannot reduce it.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- publish standardised quarterly data on the number of people waiting for a first public specialist appointment and their waiting time, by specialty, urgency, health service, and Local Health Service Network
- implement a one referral approach under which a clinically eligible referral is not returned because of residence, the receiving service arranges any transfer to a suitable accepting service, and the patient and referring doctor receive confirmation and an expected wait
- fund specialist service capacity linked to demand, including additional clinics, outreach, and specialist advice and guidance services
- deliver secure electronic referral tracking and a clear route for clinical escalation when a patient's condition changes
- align referral criteria and testing requirements with expected waiting times so that GPs are not required to repeat investigations merely because the queue outlasted the result.

3. Restore capacity for severe and acute mental illness

Victoria has undertaken considerable reform since the Royal Commission into Victoria's Mental Health System. Community services and Mental Health and Wellbeing Locals have value, but they cannot substitute for acute beds, specialist medical care, rehabilitation, or a clear pathway for someone who is severely unwell.

Published totals tell two different stories.



Source 2 · Mental Health and Wellbeing Commission, Status update, June 2026.

The Mental Health and Wellbeing Commission reported in 2026 that 174 additional beds or equivalent places had been delivered against the interim target of 170, including 139 allocated to public settings and 35 to private settings. It also found that only four of the at least 100 further

beds recommended by the Royal Commission had been delivered.² Other public statements have used different totals. Victoria needs one account distinguishing genuinely new, open, and staffed capacity from replacement beds, Hospital in the Home places, private beds, and transfers from forensic services.

Capacity must also follow need. Melbourne's rapidly growing south east is under particular pressure, while rehabilitation and step down care are inadequate across Victoria. Every additional service requires psychiatrists, doctors in training, nurses, allied health staff, and a safe clinical environment.

Independent oversight is also essential. The Mental Health and Wellbeing Commission cannot provide rigorous public oversight without institutional independence, specialist expertise, access to information, and secure funding.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- beginning with its first budget, fund additional acute, subacute, rehabilitation, and step down mental health capacity and the specialist workforce required to operate it, with priority for areas of greatest unmet need
- publish a reconciled account of every bed claimed as delivered, identifying its type, location, opening date, workforce funding, and whether it is new, replaced, or transferred, and report separately against the recommendation for at least 100 further beds
- publish service and regional data on referrals, thresholds, waiting times, emergency department delay, people awaiting a mental health bed, occupancy, readmission, outcomes, vacancies, and turnover
- ensure new community and emergency mental health services have clear referral and escalation pathways to specialist and inpatient care and medical leadership appropriate to clinical risk
- provide the Mental Health and Wellbeing Commission with the independence, expertise, and funding required for rigorous public oversight.

4. Give chronic pain proper priority

Chronic pain affects around one in five Australians aged 45 and over. It is a major cause of disability, lost participation, and pressure across general practice, hospitals, and mental health services. Only a small minority of people living with chronic pain receive best practice multidisciplinary care, and AMA Victoria has heard of waits exceeding years for public pain services.³

The problem is not a lack of knowledge. Multidisciplinary assessment, appropriate medicines, psychological support, physical therapies, and specialist procedures can improve function and reduce reliance on crisis care. The barriers are inadequate public capacity, uneven regional access, workforce shortages, and funding and data systems that fail to recognise chronic pain properly.

Access is also shaped by state funding and administrative settings. Theatre banding, procedure classification, device funding, and data rules can determine whether evidence-based treatments are viable and whether services can provide the training needed to sustain the workforce.

The Commonwealth's 2019 Medicare review recommended longer pain consultations, multidisciplinary case conferencing, and properly funded allied health participation. Victoria cannot implement Medicare changes, but it can press for them while addressing the public service and workforce barriers within its own control.³

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- expand publicly funded multidisciplinary pain clinics and group programs, particularly in regional Victoria, and report demand, waiting times, access, and patient outcomes
- fund pain medicine fellowships and regional workforce measures and ensure pain specialists can work to their full scope with appropriate access to theatres, inpatient beds, and procedural facilities
- correct hospital funding, theatre banding, procedure classification, device funding, and data settings that discourage evidence based treatment or restrict training
- press the Commonwealth to implement the 2019 Medicare review recommendations for pain care, including longer consultations, multidisciplinary case conferencing, and properly funded allied health participation.

PART TWO

Supporting the medical workforce and medical practice

Every commitment in this statement depends on the doctors and medical practices available to deliver it. Victoria needs enough doctors, in the right specialties and locations, with conditions and careers that encourage them to stay. It also needs viable practices and must use doctors' training and time well.

5. Keep general practice, community health, and private specialist practice viable

General practice provides continuous care, manages increasingly complex chronic illness, and helps patients navigate services that are often fragmented. It also absorbs the consequences when another service reduces access, changes a referral rule, or introduces a new model without funding the work that follows.

Victoria cannot repair Medicare, but it can decide whether its own programs, taxes, referral arrangements, and information systems support general practice or shift further cost and work onto it. State-funded urgent and virtual care should complement a patient's usual GP and return clinically useful information to them. Pharmacist prescribing through Chemist Care Now does not.

Community health general practice is particularly important

for patients with complex health and social needs. The threatened closure of cohealth's general practice services in Collingwood, Fitzroy, and Kensington showed how quickly funding, governance, and service decisions can place vulnerable patients and clinicians at risk.

These services have now been extended to July 2027, which provides time but not a durable solution.⁴ No reduction in these services should occur. Their long term future should be secured through sustainable funding, with continuity of care and meaningful medical leadership protected.

None of these services is peripheral to Victoria's health system. They provide care outside hospital, keep patients out of public queues, and sustain capacity the public hospital system could not readily replace. Their viability is a health access issue, not merely a business issue.

The cost of doctoring has risen through staffing, insurance, technology, rent, utilities, accreditation, and regulation. State decisions add payroll tax, land tax, the Emergency Services and Volunteers Fund, the congestion levy, and planning and parking requirements. Each charge may be considered separately inside government. Practices have to pay them together. The consequences are fewer appointments, less capacity to employ staff, delayed expansion, higher patient fees, and closure in some cases.



Victoria's payroll tax exemption applies only to payments attributable to fully funded GP services. It does not provide full relief to general practice or extend to private specialist services. That distinction is difficult to reconcile with keeping care affordable and out of hospital.

Government should not use outliers charging exceptional fees to characterise private specialist practice as a whole or imply that fees alone explain access problems. Affordability must be considered in the context of Medicare rebates, rising practice costs, and inadequate public capacity.

Private specialists can also struggle to arrange multidisciplinary review or allied health input for private patients. Multidisciplinary review and allied health input may form part of accepted care but cannot always be provided within an individual practice. This can fragment care or lead to avoidable referrals to already stretched public services. Government should fund access to multidisciplinary review and allied health services for private patients where this would improve treatment and avoid duplication.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- provide a full and permanent payroll tax exemption for general practice and private specialist medical services and assess the combined effect of state taxes, levies, planning requirements, and regulatory costs on access to care, and subsequently consider reducing state-based cost burdens on medical practices
- when developing state reforms that materially affect general practice with the profession, identify any work transferred to practices, and fund or remunerate the additional work required
- require state funded urgent and virtual services to share clinically useful information with the patient's usual doctor and be evaluated for continuity, duplication, safety, clinical outcomes, disposition, and total system cost
- provide sustainable funding for the multidisciplinary functions of community health, require meaningful medical leadership, and protect community health general practice services from reduction or closure
- fund access to multidisciplinary case review and allied health input for private patients where these are part of accepted care and cannot reasonably be provided within an individual practice.

6. Build the medical workforce Victoria needs

Victoria's medical workforce challenge is not simply a shortage at the point of recruitment. It is a series of bottlenecks across the career pathway. Graduate numbers must be matched by enough internship and prevocational positions. Doctors seeking specialist training require accredited places and supervision. Newly qualified specialists require sustainable public jobs.

Expanding one stage while constraining the next creates competition and uncertainty without adding the capacity patients need. A junior doctor without a training place, or a specialist without a job, is not a workforce solution.

At the time of publication, no new public hospital doctors' enterprise agreement has been signed. The Victorian Government has allowed negotiations to drag on, leaving doctors and health services without certainty about future pay and conditions. A government cannot credibly call workforce a priority while allowing the agreement governing doctors' working lives to remain unresolved.

Concluding a fair agreement is an immediate test of whether Victoria intends to compete for its workforce. Remuneration matters, but so do safe hours, fatigue protection, payment for work performed, flexible careers, and confidence that employment conditions will be honoured consistently across health services.

Many eligible applicants. Few training positions.

QUEENSLAND

Medi Nav · 2026

► Anaesthesia

404

eligible applications

→ 51

first-year positions

► Orthopaedic surgery

56

eligible applications

→ 17

first-year positions

Source 5 · Queensland Health, Medi Nav: Anaesthesia and Orthopaedic Surgery, 2026.

Doctors and government also need transparent workforce information. Queensland's 2026 Medi Nav figures recorded 404 eligible applications for 51 first year anaesthesia positions and 56 eligible applications for 17 orthopaedic positions. These figures cannot simply be applied to Victoria, but they illustrate the pressure and the case for equivalent Victorian data on positions, applicants, vacancies, and projected demand.⁵

Doctors should not have to infer workforce need from rumours, closed recruitment rounds, or the absence of a job at the end of training.

International medical graduates (IMGs) are an important part of Victoria's workforce and deserve proper assessment, orientation, supervision, and settlement support. Overseas recruitment must complement, not replace, investment in local training and sustainable services.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- conclude and implement without further delay a fair public hospital doctors' enterprise agreement providing competitive remuneration, safe hours, effective fatigue protections, payment for all work performed, and conditions capable of recruiting and retaining doctors across Victoria
- fund prevocational and specialist training positions in line with graduate numbers, IMG intake, and service need, including additional regional and shortage specialty places with funded supervision
- create sustainable public specialist positions for newly qualified specialists and remove funding barriers that prevent services recruiting to identified clinical need
- publish annual workforce data and forecasts by specialty, region, and career stage, and make them accessible through a Victorian service modelled on Medi Nav, covering training positions, applicants, vacancies, projected demand, public specialist employment, and career pathways

- support IMGs through rigorous assessment, orientation, supervision, professional development, and settlement assistance while maintaining high professional standards.

7. Give doctors' time back and support safe, sustainable careers

Duplicated mandatory training, repeated credentialling, avoidable checks, poor forms, and digital workarounds consume clinical time without improving care. AMA Victoria and ASMOF Victoria launched the Getting Rid of Stupid Stuff (GROSS) initiative in February 2025 because doctors could identify the waste immediately, even when the system responsible for it could not. More than 1000 people supported the campaign, and doctors supplied examples from every stage of employment and care.⁶

→ **REMOVE**
duplicated training and repeated checks

→ **RECOGNISE**
equivalent training across services

→ **MEASURE**
the time and cost imposed by new requirements

→ **RETURN**
time to patient care

Reducing duplicated mandatory training was a core ask of GROSS. Doctors moving between Victorian health services have often been required to repeat training they have already completed, even where the subject matter and required standard are equivalent. The Department of Health's statewide Recognition of Prior Learning Framework, announced as a result of the campaign, is intended to allow that training to be recognised across services. It is a welcome and practical win. It should now be implemented consistently and used as a foundation for the next stage of reform. Every unnecessary administrative task removed is time returned to patient care.

The burden is not confined to employment and training. Doctors complete poorly designed forms, supply reports and records, enter the same information into systems that do not speak to one another, and meet administrative requirements imposed by WorkSafe, the Transport Accident Commission, and other state bodies. Paperwork either displaces patient care or follows doctors home. Some of this work is necessary. That makes it no less important to design it well and pay for it properly.

Safe patient care also depends on safe workplaces. Doctors continue to report occupational violence, fatigue, excessive workload, and cultures that discourage them from raising concerns. Psychosocial safety is a board and management responsibility, not an individual resilience problem.

Doctors must also be able to seek help and raise concerns without jeopardising their privacy or careers. Independent reporting pathways and doctors' health services need secure funding. Flexible careers and equitable parental leave are practical retention measures, particularly in specialties and regions that can least afford to lose experienced clinicians.

Sustainable careers require flexibility, fair access to training and leadership, and protection from exploitation. Junior doctors should never believe that obtaining a competitive training position depends on unpaid administrative, information technology, or research work unrelated to their employment or accredited training.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- make Getting Rid of Stupid Stuff an ongoing partnership with AMA Victoria and ASMOF Victoria, championed by the Secretary of the Department of Health and embedded in health service Statements of Priorities, with public reporting of time returned to care
- implement the statewide Recognition of Prior Learning Framework consistently across health services so doctors are not required to repeat equivalent mandatory training, create a statewide credentialling and employment passport, and remove repeated checks where existing professional screening provides the necessary assurance and the law permits
- require new state policies and regulations to quantify clinical time and cost, simplify WorkSafe, Transport Accident Commission, and other high-volume processes, and pay doctors reasonably for requested reports, records, and expert work
- introduce and enforce statewide security standards and require health service boards to act on psychosocial hazards, workload, fatigue, and occupational violence
- strengthen confidential and independent reporting pathways and fund independent doctors' health services
- support flexible careers and equitable parental leave, and prohibit health services and training programs from soliciting unpaid work unrelated to employment or accredited training.

Building a connected and equitable health system

Victoria's health system must work across geography, sectors, and stages of care. That requires regional equity, sustained prevention, connected information, and medical leadership. The Health Services Plan, Local Health Service Networks, and Specialist Care Reform Blueprint will shape care for years. Their success depends on whether they are clinically credible, properly resourced, and workable across the public, private, and community services through which patients move.



8. Deliver regional and rural health equity

Place should not determine whether a Victorian can obtain timely, safe care. Yet regional patients face fewer specialist services, longer travel, workforce turnover, and weaker hospital digital infrastructure. These disadvantages reinforce each other.



From January to March 2026, regional and rural hospitals accounted for 2330 of the 3342 Victorian patients who remained in an emergency department for more than 24 hours, almost 70 per cent of the statewide total. Some waited more than 40 hours in environments never designed for prolonged care.⁷

A parliamentary inquiry can provide the sustained, public examination that regional health deserves. It should proceed, but it must not become a reason to defer action on problems already well understood.

Recruitment incentives must reflect real life. A doctor may be willing to move, but the move will fail where their family cannot find housing, childcare, schooling, or work for a partner. Regional careers also require supported training, funded supervision, professional networks, continuing development, and sustainable jobs. Outreach can extend access, but it requires dedicated funding and cannot substitute for a stable local workforce.

A service is not statewide merely because its policy is. Regional clinicians and patients need modern records, reliable referral pathways, and specialist support that does not depend on a fax, personal contact, or avoidable trip to Melbourne.

Distance costs more. Victoria reimburses less.



Source 8 · Victorian Department of Health, VPTAS and Guidelines 2026; Queensland Health, Guideline for the Patient Travel Subsidy Scheme, 2026.

When care is not available locally, patients should not be left to carry the full cost of reaching it. The Victorian Patient Transport Assistance Scheme helps, but its private vehicle reimbursement rate remains 21 cents per kilometre, compared with 45 cents under Queensland's scheme and far short of the real cost of regional travel. Complex claims and support person rules create further barriers for people travelling because the system cannot care for them closer to home.⁸

Regional disadvantage can also be obscured by statewide averages. Government should publish enough information to show where access, workforce, travel burden, service availability, and outcomes differ, and whether the gap is closing.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- establish a parliamentary inquiry into regional and rural health access, workforce, funding, governance, and digital infrastructure, while acting immediately on the measures below
- fund hospital-specific corrective plans for regional services with repeated emergency department stays of more than 24 hours, publish progress against those plans, and ensure action is not deferred pending the parliamentary inquiry
- fund additional rural generalist and regional specialist training positions, sustainable consultant jobs, outreach, and supervision, supported by practical assistance with housing, childcare, schooling, partner employment, and continuing professional development
- give regional public hospitals with the weakest digital infrastructure first priority under the statewide electronic medical record program, with published, funded, site-specific delivery dates and secure links to general practice and metropolitan specialist services

- increase the Victorian Patient Transport Assistance Scheme reimbursement rate from 21 cents per kilometre to the highest comparable rate offered by another Australian jurisdiction, index it annually, and simplify claims and support person rules.
- publish an annual regional health equity account covering emergency delay, specialist access, workforce vacancies, patient travel, service availability, and outcomes.

9. Protect prevention and act earlier

Prevention rarely produces an electorally compelling opening ceremony. The observation is well worn because the political preference it describes is so durable. Sustained investment in immunisation, cancer prevention, cardiovascular health, injury prevention, and healthy environments improves lives and reduces demand for the clinical services more likely to attract one.



The next Victorian Government should reconsider the decision to dissolve VicHealth as an independent agency and absorb its functions into the Department of Health. Prevention should not disappear inside a department necessarily preoccupied with immediate hospital pressure. Victoria must retain dedicated funding, specialist capability, community partnerships, and an expert voice able to give independent advice, including when that advice is inconvenient.⁹

Statewide availability does not mean equal access. Immunisation, screening, and other proven prevention programs depend on practical access, trusted advice, and follow-up. Government should identify where participation is lower and support targeted outreach through general practice, community health, and trusted community organisations.

Skin cancer prevention provides a practical example. Sunscreen policies in schools work only when students have a practical opportunity to apply sunscreen. A targeted primary school trial would test whether scheduled application before lunch improves use without imposing unreasonable work on teachers. It should involve educators, families, public health, and dermatology experts, address affordability, consent, skin sensitivity, and different skin types, and be independently evaluated before wider adoption.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- reconsider the decision to dissolve VicHealth as an independent agency and preserve dedicated prevention funding, grants, specialist capability, community partnerships, and independent expert advice, with annual public accounting of funding and outcomes
- support equitable access to immunisation, screening, and other proven prevention programs, including targeted outreach through general practice, community health, and trusted community organisations where participation is lower
- fund and independently evaluate a targeted sunscreen application trial in selected Victorian primary schools during 2027, with appropriate safeguards for workload, consent, affordability, allergies, and skin type

10. Connect the system and make reform work

CLINICAL LEADERSHIP IN REFORM

Consultation should not end when a policy is published. Doctors need a meaningful role in governance, service design, delivery, and evaluation, with protected time and access to the information required to participate. That includes hospital doctors, GPs, private specialists, community health doctors, and regional clinicians.



Reform also needs a visible line between an announcement and a functioning service. Changes to a role, service, or referral pathway should be clear to clinicians and patients: what is changing, when, and who is accountable. Replacement capacity must be operational before any clinically necessary service or capacity is withdrawn. Clinical risks must be identified and managed throughout the transition.

The creation of Local Health Service Networks makes this particularly important. Larger structures do not automatically produce better coordination. Their value will depend on whether decisions are clinically informed, responsibilities are clear, and services outside public hospitals are included in the design of care.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- establish formal medical leadership and representative clinician advisory structures in every Local Health Service Network, with protected participation by hospital doctors, GPs, private specialists, community health doctors, and regional clinicians
- publish network and site roles, major service changes, funding, delivery dates, workforce requirements, replacement capacity, transition arrangements, and clinical risk controls
- involve general practice, private specialists, community health, and regional clinicians in reforms that affect care beyond public hospital boundaries
- report on the Health Services Plan and Specialist Care Reform Blueprint against patient access, quality, workforce, and outcomes and change course where the evidence requires it.

CONNECTED INFORMATION

Victoria cannot operate as one health system while its clinical information remains divided between incompatible records, paper files, faxes, and manual workarounds. General practice, community health, mental health, and private specialists are too often treated as external to public hospital information even when they are responsible for the next stage of care.



A statewide electronic medical record is not an end in itself. The test is whether a clinician can find the information needed, send and track a referral, receive a useful discharge summary, and spend less time recreating what another service already knows.

Artificial intelligence is already being used for administration, documentation, and information retrieval, including to draft discharge summaries. Any AI-generated clinical content should be treated as a draft. A clinician must review it and remain accountable for the final record. Statewide requirements should address privacy, audit, and evaluation.

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- fund and deliver a statewide electronic medical record and interoperability program through a public timetable with milestones for every health service
- connect public hospital systems securely with general practice, community health, mental health, and private specialist practice, with appropriate consent and access controls, and implement statewide standards for electronic referral, tracking, specialist advice, and discharge communication
- require timely, concise, and clinically useful discharge summaries
- establish statewide requirements for the safe use of artificial intelligence in health care, including privacy, clinical accountability, human review of AI-generated content, audit, and evaluation.

SAFE AND ACCOUNTABLE MODELS OF CARE

New models of care can improve access, but access alone does not prove safety, continuity, or value. Through Chemist Care Now, pharmacists can now prescribe or supply medicines under Victorian protocols without the patient first seeing a medical practitioner.¹⁰ AMA Victoria opposed the policy and does not support pharmacist prescribing in retail pharmacies. The expansion should be reversed and access strengthened through GP-led care. Virtual and urgent care and other scope changes should be judged on clinical outcomes, adverse events, continuity, equity, workforce effects, and total system cost. Evaluation should occur before a trial or new model becomes a permanent statewide service, not after the decision has effectively been made.



The same principles should apply across professions. Where prescribing, recommending, and dispensing occur within one service, financial conflicts and clinical governance require safeguards based on risk, not profession.

That consistency has an uncomfortable implication. Government already accepts that these risks can be managed for one profession. It should explain why appropriately regulated GP dispensing should not also be permitted. The proposition is provocative. The principle is not: equivalent clinical and financial risks should attract equivalent safeguards.

Regulation must also pass a practical test: a demonstrated safety benefit proportionate to the clinical time, cost, and complexity it imposes. Requirements should not survive merely because nobody is responsible for removing them.

HOW NEW MODELS OF CARE SHOULD BE EVALUATED

- Patient outcomes and safety
- Continuity and equity
- Workforce effects and total system cost
- Clinical governance and escalation
- Documentation, referral and information sharing

AMA VICTORIA CALLS ON THE NEXT VICTORIAN GOVERNMENT TO:

- reverse Chemist Care Now's expansion into pharmacist prescribing, rule out further expansion, and strengthen access to GP-led care
- publish an independent evaluation of Chemist Care Now and require any new model of care or scope change, before statewide expansion, to demonstrate patient outcomes, safety, continuity, equity, workforce effects, and total system cost, with clear arrangements for clinical governance, referral, escalation, documentation, and information sharing
- apply consistent clinical governance and financial conflict safeguards wherever prescribing, recommending, and dispensing occur within the same service, and explain any differential treatment between professions
- review new and existing health regulation for clinical usability, duplication, patient safety benefit, and the time and cost imposed on care.

Conclusion

Victoria has a highly skilled medical workforce and many excellent health services. It also has persistent problems that will not be solved by shifting pressure from one service to another, relabelling existing capacity, or publishing another plan.

The ten commitments in this statement combine major investments with modest corrections. Some require cooperation with the Commonwealth. Every one includes action a Victorian Government can take.

THREE CONNECTED RESPONSIBILITIES

1

Deliver timely care for every Victorian

2

Support the medical workforce and medical practice

3

Build a connected and equitable health system

AMA Victoria is nonpartisan. We will seek the strongest commitments from every party and tell our members and the community how each has responded. A credible response will say what will be funded, when it will be delivered, who is accountable, and how Victorians will know whether it worked.

The next government will not need another explanation of how the parts of the health system connect. It will need to make them connect.

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