# THE VIRTUAL HOSPITAL SYMPOSIUM
# Key Themes & Strategic Insights

January 2026

## BACKGROUND:

In mid-January 2026, New Zealand hosted a two-day Virtual Hospital Symposium to "reimagine care through innovation." The hybrid event spanned 14–15 January 2026 with in-person hubs in Auckland, Wellington, and Christchurch (and full online access). Co-hosted by the NZ Telehealth Forum, Whakarongorau Aotearoa (National Telehealth Service), and partners (HiNZ, Spark NZ, Mobile Health), it gathered over 100 clinicians, health system leaders, and digital health innovators from New Zealand, Australia, Canada, and the USA. The goal was to share lessons from virtual care initiatives and co-design a "virtual hospital" model for Aotearoa New Zealand – a model to better integrate telehealth and in-person care to improve access, equity, and system resilience. Day 1 focused on storytelling and problem-framing, with keynotes and panels highlighting current challenges and innovations in virtual care. Day 2 featured facilitated co-design workshops in six thematic breakout groups, using a structured Nominal Group Technique (NGT) to identify and prioritize key principles and actionable recommendations for building a national virtual hospital (hybrid care) approach.

EVENT DURATION
**2 days**
14-15 January 2026 (hybrid format across Auckland, Wellington, Christchurch & online)

PARTICIPANTS
**111+**
Clinicians, health leaders & digital innovators from NZ, Australia, Canada & beyond

THEMES
**6**
Breakout workshops on clinical workflows, cultural safety, funding, technology, workforce, and evaluation

KEYNOTES
**4**
International experts from Canada, USA, Australia & WHO shared virtual care insights

# Day 1 - Global & Local Perspectives on Virtual Care

**Day 1 ("Grounding Innovation in Experience")** featured a mix of international and Australasian speakers who offered real-world insights into virtual health. Through keynote addresses, case studies, and panel discussions, participants identified pressing challenges and inspiring successes in virtual care implementation. Several core themes emerged from these presentations:

## INTERNATIONAL KEYNOTES:

**Equity & Reaching Underserved Communities: Dr. John Pawlovich** *(Keynote speaker from British Columbia, Canada)* described how the Real-Time Virtual Support (RTVS) network has transformed care for remote Indigenous and rural communities. He emphasized that equity must be the foundation of virtual health programs, deliberately targeting underserved populations (e.g. rural, Indigenous, lower socio-economic groups) – in contrast to early telehealth that mainly benefited more privileged, tech-savvy patients. In his region (northern BC, an area "the size of France" with sparse population), virtual support lines connecting rural providers to specialists and patients to clinicians 24/7 have averted emergency department closures and saved an estimated NZ$76 million in patient transfer costs for urgent care by treating people closer to home.

Dr. Pawlovich stressed the importance of a "culture of kindness" and trust – clinicians on virtual support lines approach each call asking "How can I help?" rather than questioning why the patient or rural provider reached out – as a key ingredient in successful virtual care uptake. Going forward, he outlined plans for a Hybrid Health Network that tightly weaves together on-the-ground teams with virtual support, including innovative ideas like using drones to deliver medical supplies to remote areas (supported by a recent $14 million grant). His core message was that "virtual hospitals" must not be separate from physical health services – they should strengthen and connect with local care, forming a hybrid model that improves accessibility without losing the human touch.

**Telehealth for Specialist & Emergency Care: Dr. Jim Marcin** *(Keynote from UC Davis, USA)* shared two decades of experience using telehealth to support hospitals without onsite specialists, particularly in paediatric critical care. He showed that when used appropriately, telehealth can improve clinical outcomes and efficiency. At UC Davis, about 15% of ~1 million annual ambulatory visits occur via video, with behavioural health leading the way (≈85% of psych visits now virtual). Telehealth networks link rural clinics and small hospitals to specialists: for example, patients can attend a local clinic while an urban specialist joins by video – an approach that educates local providers and spares patients long travel, though payment models in fee-for-service systems remain a challenge.

Research evidence presented by Dr. Marcin underscored the benefits of tele-ER services: in randomized trials, video consultations for pediatric emergencies led to higher parent and provider satisfaction, fewer medication errors, fewer unnecessary transfers, and lower overall costs compared to phone consults.

These outcomes translate to tangible system savings and better family experiences. However, Dr. Marcin also highlighted adoption challenges – even in supportive environments, only ~10–15% of eligible specialist consultations at his hospital use telehealth, largely because virtual consults take extra time and current reimbursement models don't always compensate providers for that effort. This points to the need for aligning incentives and workflow support for virtual care.

Crucially, he stressed that telehealth isn't a replacement for in-person care, but a spectrum of modalities – clinicians must be trained and empowered to choose the "right tool for the right situation," whether that's a phone call, video visit, e-consult, or face-to-face care, based on patient needs and context.

**Digital Innovation in Acute & Emergency Care: Dr. Kendall Ho** *(Keynote from Vancouver, Canada)* spoke about "Digital Emergency Medicine and the Virtual Hospital of Today," drawing on his experience as an emergency physician and Director of UBC's Digital Emergency Medicine Unit. Dr. Ho illustrated how digital health tools – from remote vital-sign monitors to AI-driven triage assistants – can extend acute and primary care beyond hospital walls while maintaining quality and safety.

A key theme of his talk was the importance of continuous evaluation and learning in virtual care: he urged health systems to adopt a "learning health system" approach, where virtual services are rigorously evaluated and iteratively improved using data on clinical outcomes, safety, patient experience, and access. He noted that building this evaluation mindset into "the virtual hospital of today" is essential for maintaining high standards and public trust as digital innovations rapidly evolve.

**Associate Professor Amith Shetty** *(New South Wales, Australia)* presented the "NSW Single Front Door – Right Care, Right Time" initiative, a digital statewide triage and care-coordination platform that ensures patients access the most appropriate care without delay. This "single front door" model – essentially a unified digital entry point for urgent and emergency care – exemplified how integrated virtual triage and navigation can streamline acute care, direct patients to the right level of service, and improve system efficiency. Dr. Shetty focused on breaking down silos so that data and patients can flow seamlessly to the right care setting.

## LOCAL SUCCESS STORIES – VIRTUAL WARDS & INTEGRATED CARE:

### A panel of Australasian clinicians shared "voices from the front line," providing case studies of virtual care in practice:

Leisha Davies challenged the perception of telehealth as a secondary option, demonstrating how a structured, team-based allied health telehealth model can deliver high-quality care to rural communities that would otherwise go without specialist services. Her work highlighted that clinician confidence, workforce design, and quality frameworks — not technology alone — are the critical determinants of success in virtual allied health care.

- Dr. Erik McClain described how a small regional hospital established a virtual ward (hospital-in-home) service that delivered over 325 hospital bed-days of care in patients' homes over 6 months. This not only freed up the physical hospital's capacity but also allowed patients to receive hospital-level treatment and monitoring without leaving their communities.

- In the Northern Region of New Zealand an innovative Hospital in the Home programme that provides an alternative to acute hospital care by enabling patients to remain at home under hospital supervision through a mix of in-person and virtual care. Caroline Ogilivie and Penny Magud described the programme which has treated approximately 20,000 patients and is supported by advanced remote monitoring technology, it has expanded from a single general medicine pathway in Counties Manukau to seven pathways across the Northern Region, with more than 1,700 patients monitored, delivering improved staff-to-patient ratios, fewer home visits, significant bed-day savings, and an estimated $2.7 million in cost avoidance, including 231 bed days freed through a coronary artery bypass pathway and a planned expansion to Northland and Waitematā districts that could support an additional 188 patients and release a further 563 bed days, with future plans to regionalise.

- Isabella Smart presented a hybrid digital midwifery model that expands workforce capacity, improves safety, and reduces non-attendance by enabling midwives to deliver care remotely alongside in-person services. Her data showed particularly strong equity gains for Māori and Pacific women, challenging assumptions about digital access and reinforcing the importance of data-led, patient-centred design.

- Dr Raymond Wen described how Telecare Australia delivers virtual specialist and inpatient care as a fully integrated extension of hospital services rather than an outsourced telehealth add-on. By combining a flexible national specialist workforce, purpose-built virtual-care technology, and deep local partnerships, Telecare has dramatically reduced wait times, sustained services during workforce shortages, and demonstrated that virtual care works best as system infrastructure, not episodic intervention.

- Dr Joanna Lawrence outlined the scale and impact of the Victorian Virtual Emergency Department, a 24/7 statewide service that now manages the majority of emergency presentations at home through self-referral and video triage. By integrating with ambulance services, nurse helplines, aged care, and palliative care, the model has significantly reduced emergency department demand while expanding into virtual wards and specialist outpatient care as part of a broader hybrid system.

Common threads from these front-line stories included the importance of integrating primary care and hospital services (avoiding "us vs. them" boundaries), adapting models to local contexts (one rural community's solution may not fit another's needs), and maintaining a strong relationship-based aspect even when using high-tech solutions.

- For example, a rural NZ hospital shared how patients actually appreciated a robotic telepresence doctor (for remote bedside rounds) more than a standard "computer on wheels" – the robot felt more personal – but poor rural broadband and other logistical issues (like maneuvering robots through doorways) remain barriers. These anecdotes reinforced that technology can augment care, but success depends on human factors (trust, training, workflow integration) and supporting infrastructure.

# Day 2 – Co-Design Workshops and Strategic Priorities

On Day 2 ("Building the Virtual Hospital Together"), participants broke into six facilitated thematic workshops to collaboratively define the key principles and actions for making the virtual hospital concept a reality. Using Nominal Group Technique (NGT), each group brainstormed ideas, then refined and prioritized them into a set of top 5 recommendations in their domain. In a closing plenary, these groups' outputs were shared and voted on, yielding a consensus roadmap for implementation. Several cross-cutting imperatives emerged across all groups:

- **"Hybrid care" as the guiding model:** Rather than creating a digital replica of a hospital, **participants agreed the "virtual hospital" should be a hybrid care model – integrating virtual and in-person services into seamless patient-centered pathways. This means designing care that follows the patient across settings (home, community, clinic, hospital) without fragmentation, instead of building parallel digital-only services. The consensus was that virtual modalities (telehealth, remote monitoring, etc.) must be woven into a unified system of care – with clear handoffs, shared records, and standard protocols – so that patients experience "one healthcare system" whether care is delivered physically or virtually. Attendees cautioned that simply rebadging "hospital-at-home" as a separate virtual silo would repeat the inefficiencies of traditional hospitals, whereas true hybrid care can transcend old boundaries.

- **Equity & cultural safety as foundational:** Participants insisted that virtual care innovations must actively narrow inequities, not widen them. This was a recurring theme throughout the symposium. The co-design group on Cultural Safety & Community Engagement stressed co-developing services with indigenous and underserved communities from the start, ensuring the virtual hospital model is culturally safe, builds trust, and respects local values. Practical recommendations included supporting digital inclusion (affordable connectivity, devices, and digital literacy support via community health navigators) so that new services reach everyone. Data sovereignty and privacy were highlighted as non-negotiable – communities must have control over their health data, and transparent governance is needed to maintain trust. Cultural competency of staff, use of local languages, and "whānau-centric" (family-inclusive) approaches were seen as critical to delivering virtual care that people actually trust and use.

- **Technology & digital infrastructure:** The Technology & Infrastructure working group pinpointed interoperable systems and robust connectivity as key enablers for any virtual hospital model. Shared electronic health records and integrated digital platforms are needed to allow information to flow with patients across providers. In the current state, many NZ health IT systems are fragmented – a point echoed by participants who noted that poor interoperability and long delays in approving capital IT investments have hindered progress. The symposium emphasized closing core infrastructure gaps: for example, rural broadband capacity must be improved so that rural communities can equally benefit from video consultations, remote monitoring, and other telehealth tech. Participants also called for

human-centered design of technology: digital tools (from telehealth software to AI decision support) should be intuitive, culturally appropriate, and embedded smoothly into clinical workflows. Technology is an enabler – not an end in itself: as one group warned, an over-emphasis on tech can undermine the human relationships at the heart of care. The consensus was that virtual hospital initiatives must be designed "tech-last" – start with patient and whanau needs, then choose technology that supports those needs. Additionally, building in privacy, security, and data protection by design was seen as essential for public confidence in virtual care.

**Clinical workflows & models of care:** The Clinical Workflows & Virtual Triage group tackled how clinical processes should adapt for hybrid care. They recommended defining clear entry points and triage criteria for virtual pathways – e.g. which patients or conditions are suitable for virtual vs in-person care – along with standardized escalation protocols (for emergencies, transfers, etc.) that are consistent across the country. A major theme was that care pathways need to be redesigned end-to-end: for example, rather than treating virtual care as an isolated add-on, the system should develop complete hybrid care pathways that might start with a remote consultation, seamlessly connect to in-person services when needed, and continue with remote follow-up – all coordinated as one continuum. This requires strong clinical governance and change management: leaders must set standards and support clinicians through the transition so that hybrid care is embedded as a core part of normal practice, not just a trial project. Speakers also noted that New Zealand's rural health experience (where the same clinician often provides primary, hospital, and community care) can serve as a model – it shows the value of flexible roles and breaking down the rigid primary/secondary care divide in urban areas.

**Workforce & training implications:** Every discussion tied back to the health workforce. The Workforce Development & Training breakout group underscored that new models of virtual/hybrid care will falter without a workforce plan. They called for defining new roles (such as dedicated virtual care coordinators, remote monitoring nurses, and digital health navigators) and providing comprehensive training in "webside manner" and virtual clinical skills for all health professionals. A consistent message was that virtual care should enable clinicians to "practice at the top of their scope" by leveraging technology and new team roles, rather than increasing burnout. To achieve this, participants emphasized workforce support and well-being strategies – ensuring manageable workloads, providing supervision for telehealth practice, and recognizing that virtual consultations often require more time and different skills (e.g. more explicit communication in the absence of physical exam). They also noted that introducing attractive new virtual roles must be done hand-in-hand with strengthening the overall health workforce: a hybrid model should integrate with existing teams (e.g. rotating staff through virtual and in-person work) to avoid simply siphoning scarce clinicians away from hospitals or rural clinics. Finally, to reflect Te Tiriti obligations and effectively serve diverse communities, it's critical to invest in cultural competency and diversity in recruitment for these emerging roles.

**Sustainable funding & policy:** The need for aligned funding models was a persistent theme. The Funding Models & Evidence group argued that funding should "follow the patient" across settings – for example, if a patient's care moves from hospital to a virtual home-based service, the funding and accountability should move too. Current siloed budgets and contract structures make it hard to implement cross-sector virtual services (e.g. a DHB hospital might not share funding with a telehealth provider or a primary care team). The symposium's solution was to develop blended and flexible funding arrangements for hybrid care, coupled with value-based payment incentives that reward outcomes, prevention, and equity improvements rather than sheer volume of visits. Participants also highlighted that short-term pilots and piecemeal projects have undermined community trust in the past – rural and Māori communities have seen services come and go with "flash in the pan" funding. Thus, sustainable investment and policy support are needed to avoid raising expectations and then withdrawing services. The participants advocated for removing bureaucratic and contracting barriers that prevent collaboration (for instance, enabling shared budgets or data-sharing across organizations). They also stressed building a solid evidence base to demonstrate the benefits of virtual/hybrid models – capturing not just clinical outcomes, but also patient/whānau experience, cost-effectiveness (e.g. savings from avoided hospital admissions or patient travel), and equity impacts. This evidence should be used to secure long-term policy commitment and funding, rather than relying on time-limited trials.

**Embedding evaluation & continuous learning:** Finally, the Evaluation & Learning Systems group reinforced Dr. Ho's point: any virtual hospital initiative must include an ongoing measurement and learning framework. They recommended identifying a small set of "North Star" metrics encompassing clinical outcomes, patient experience, equity, access, and cost savings to track the success of hybrid care programs. Just as importantly, the symposium advocated for creating a continuous feedback loop – a learning health system – wherein data and frontline feedback are analyzed in real time to refine services and share lessons nationally. This could involve regular cross-region learning sessions and transparent sharing of performance data. Participants also noted the importance of monitoring unintended consequences (like digital exclusion or impacts on healthcare workforce distribution) and making adjustments quickly if disparities or risks emerge. In summary, the symposium's ethos was that the virtual hospital model should always be evolving based on evidence – with a commitment to continuous quality improvement, equity monitoring, and adaptive change built into its DNA from day one.

## The table below summarizes the core themes and key recommendations from the symposium, along with their sources (key speakers or working groups):

| Theme / Session | Source (Speaker or Group) | Key Points & Recommended Actions |
|---|---|---|
| **Hybrid Care Model** (Integrating Virtual & In-Person) | All participants (Consensus) | Rather than a separate "virtual hospital" siloes, adopt hybrid care pathways that seamlessly combine virtual and face-to-face services around patient needs. Avoid duplicating hospital structures online – instead, redesign workflows so care follows the patient across settings with shared records and clear escalation protocols. This integrated model was embraced as the guiding paradigm for NZ. |
| **Equity & Cultural Safety** | Cross-cutting (esp. Cultural Safety Group) | Ensure virtual care closes gaps for Māori, Pacific, rural, disabled communities. Co-design services with these communities from the outset to embed cultural safety and trust. Invest in digital inclusion (affordable internet, devices, digital literacy support) and honor data sovereignty and privacy to build confidence in virtual services. |
| **Global Rural Virtual Support** (RTVS in Canada) | Dr. John Pawlovich (Keynote) | Showcased BC's Real-Time Virtual Support network connecting remote providers & patients to specialists. Emphasized equity: RTVS reaches vulnerable rural and Indigenous populations often left out of traditional care. Demonstrated outcomes like saving NZ$76M in patient transport by treating people closer to home. Recommended creating culture of trust & kindness in virtual services and developing hybrid networks that integrate on-the-ground teams with virtual teams (including innovations like drone medication delivery to remote areas). |
| **Telehealth in Pediatrics** (Critical Care without Walls) | Dr. Jim Marcin (Keynote) | Reported extensive U.S. experience with telehealth for specialist access. Tele-pediatrics yields higher family satisfaction, fewer med errors, fewer transfers, and lower costs in emergency care. However, only ~10% of potential consults use telehealth due to extra clinician time and lack of payment incentives. Recommended aligning reimbursement and training to encourage telehealth use, and treating telehealth as a complementary tool – selecting modality (phone, video, e-consult) based on each patient's situation. |
| **Digital Emergency Medicine** ("Virtual Hospital of Today") | Dr. Kendall Ho (Keynote) | Highlighted how digital tools (remote monitoring, AI triage, 8-1-1 clinician hotlines) can extend emergency & primary care beyond hospital walls without sacrificing quality. Stressed establishing an Evaluation & Learning framework (a "learning health system") for any virtual hospital model. Called for continuous data-driven improvement and research on virtual services to ensure safety, effectiveness, and community trust. |
| **Single Front Door Access** (Digital Triage for Right Care) | Assoc. Prof. Amith Shetty (NSW Health) | Described NSW's "Single Front Door – Right Care, Right Time" platform – a unified digital triage system directing patients to the appropriate service without delay. Illustrated the value of a system-level digital entry point for acute care, breaking down silos between hospitals and community providers. Recommended scaling such integrated triage and care navigation tools to improve patient flow and outcomes. |
| **Clinical Workflows & Triage** | Breakout Group A | Reorient care delivery toward patient-centric hybrid pathways that span virtual and in-person settings. Define clear inclusion/exclusion criteria for virtual services and standardize triage & escalation protocols across NZ to ensure safety and clarity of responsibility. Establish strong clinical governance and change management to support clinicians in adopting hybrid models as mainstream practice. |

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| **Cultural Safety & Community** | Breakout Group B | Co-design virtual hospital services with Māori, Pacific, rural, and disabled communities to embed cultural safety and trust from the start. Deliver hybrid care in a relationship-centered, whānau-inclusive way equivalent to in-person care. Provide connectivity, devices, and digital skill training to ensure no group is left behind. Uphold data sovereignty and privacy – be transparent and accountable in how patient data is used. |
| **Funding & Evidence** | Breakout Group C | Adopt flexible funding models that allow funding to follow the patient across community, primary, and hospital care, rather than siloed budgets. Align financial incentives with outcomes: reward prevention, equity gains, and reduced hospital usage instead of paying per visit. Fund the necessary infrastructure (technology platforms, workforce training, broadband) to support virtual services. Remove contractual and policy barriers to integrated care (e.g. enable shared budgets and data-sharing among providers). Build a robust evidence base (clinical outcomes, experience, cost-benefit) to demonstrate value and inform future scaling. |
| **Technology & Infrastructure** | Breakout Group D | Invest in interoperable, secure IT systems and shared electronic health records so information flows seamlessly between virtual and physical services. Improve core infrastructure – especially rural internet connectivity – to ensure reliable access to telehealth and remote monitoring tools nationwide. Use human-centered design: make digital tools intuitive and fit for clinical workflows, and ensure they meet cultural and accessibility needs so they enhance care rather than hinder it. Embed privacy, cybersecurity, and data protection from the outset to maintain public trust in virtual health services. |
| **Workforce & Training** | Breakout Group E | Define new virtual/hybrid care roles (e.g., virtual care coordinators, digital navigators) and clarify how existing roles work in a hybrid model. Develop comprehensive training & professional development programs in telehealth skills (remote assessment, "web-side" communication, technology use, etc.) for clinicians and support staff. Protect staff wellbeing and prevent burnout by adjusting workloads – hybrid care should reallocate tasks, not just add more. Foster cross-sector teams and rotations (linking primary, community, and hospital staff) to avoid draining workforce from any one setting. Recruit and train a diverse workforce that reflects the communities served, with strong cultural competency and equity focus. |
| **Evaluation & Learning** | Breakout Group F | Establish a national evaluation framework with key metrics ("north-star" indicators for clinical outcomes, patient experience, equity impact, and system efficiency) to track virtual hospital performance. Create real-time feedback loops (learning health systems) to continuously improve services based on data and user feedback – e.g. use digital tools for rapid patient/clinician feedback and share learnings across regions. Proactively monitor for unintended side effects (e.g., digital divide, safety issues) and address them promptly. Ensure that evaluation results directly inform policy and funding decisions for scaling up successful hybrid care initiatives. |

**In summary,** the Virtual Hospital Symposium built a shared vision that the future of healthcare in New Zealand lies in hybrid care – a model that combines the best of virtual and in-person services to improve access and equity. The event's participants – from front-line clinicians to policy leaders – reached a strong consensus on several strategic priorities for making this vision a reality: invest in integrated systems and data (so care is coordinated across settings), address infrastructure gaps (connectivity and tools for providers and patients), reform funding and governance to break down silos, and put people at the center of design (with culturally safe, community-tailored services and support for the health workforce). They also agreed that continuous evaluation and shared learning must guide the way forward. By focusing on these core themes – hybrid models of care, equity, digital integration, workforce enablement, and iterative improvement – the symposium provided a clear roadmap for health leaders and policymakers to advance virtual care in Aotearoa. The overarching message is that a "virtual hospital" is not a building or an app – it's a new way of delivering care without walls, one that will require co-design, investment, and collaboration across the entire health system with a focus on hybrid care and removing the concept of a "hospital".

**The outcome of this symposium is a set of prioritized principles and actions (outlined above) to inform strategic planning and ensure that virtual care innovations truly serve patients, whānau, and communities across New Zealand.**

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