HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr JM Krause MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms K Dalladay (Principal Research Officer)

CLINICIANS ROUNDTABLE DISCUSSION—INQUIRY INTO TELEHEALTH SERVICES IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

MONDAY, 4 AUGUST 2014

Brisbane

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Committee met at 6.06 pm

D'EMDEN, Associate Professor Michael, Director, Endocrinology and Diabetes, Royal Brisbane and Women's Hospital

DONOVAN, Associate Professor Tim, Neonatal Paediatrician, Royal Brisbane and Women's Hospital

GILHOTRA, Associate Professor Jagmohan, Consultant Psychiatrist, Queensland Mental Health Commission

KIMBLE, Professor Roy, Director, Paediatric Trauma, Lady Cilento Children's Hospital

KORCZYK, Dr Dariusz, Cardiologist, Princess Alexandra Hospital

LIPMAN, Dr Jeffrey, Director, Intensive Care, Royal Brisbane and Women's Hospital

MACDONALD, Dr Graeme, Hepatology and Gastroenterology, Princess Alexandra Hospital

NORTH, Dr John, Orthopaedic Surgeon, Princess Alexandra Hospital

SMITH, Associate Professor Anthony, Deputy Director, Centre for Online Health, Royal Children's Hospital

SOYER, Professor H Peter, Director, Dermatology Department, Princess Alexandra Hospital

YANG, Associate Professor Ian, Director, Thoracic Medicine, The Prince Charles Hospital

CHAIR: Good evening, everybody. I declare open the Health and Community Services Committee public round-table discussion with clinicians. This evening's proceedings are part of the committee's inquiry into the implementation of telehealth in public health services in Queensland. My name is Trevor Ruthenberg. I am the chair of the committee and I am the member for Kallangur. Mrs Jo-Ann Miller will be here shortly. She is the deputy chair and the member for Bundamba. Other committee members with us are: Ms Ros Bates MP, member for Mudgeeraba; Dr Alex Douglas MP, member for Gaven—Alex is a GP and Ros is an RN; Mr Jon Krause MP, member for Beaudesert; Mr Dale Shuttleworth MP, member for Ferny Grove; and Mr John Hathaway MP, member for Townsville.

I welcome the clinicians who have joined us for a discussion about telehealth this evening. We have representatives of the following clinical specialties: cardiology, intensive care, psychiatry, dermatology, orthopaedic surgery, thoracic medicine, endocrinology, paediatrics including trauma and neonatal surgery, and hepatology and gastroenterology. Shortly I will ask each of you to introduce yourselves and tell us very briefly about the type of clinical work you do using telehealth. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Under the standing orders, members of the public may be admitted to or excluded from the hearing at the discretion of the committee.

Mobile phones or other electronic devices should now be turned off or switched to silent, please. Hansard is making a transcript of the proceedings. The committee will use the transcript in formulating its report to parliament and may publish the transcript of proceedings, unless there is good reason not to.

I understand that you have been advised of the format for our round-table discussion this evening, but let me run through it briefly. I will start by asking each of you to introduce yourselves and take a couple of minutes to describe to the committee the type of clinical work you do and your use of telehealth. There will be opportunities later, as we discuss barriers to implementing telehealth and the factors to support it, to tell us more about your experience. At about 6.30 pm, or a little later, we will turn to discussion of those issues, which are part of the committee's terms of reference for this inquiry. We are interested in understanding more about the barriers you see in using or expanding the use of telehealth and the factors that are important to success in telehealth.

Committee members may wish to clarify some of your comments as we go. I would prefer that we spend most of this evening listening to you, and we will try to keep our committee questions to issues we need to clarify, if members would take heed of that. We will finish by asking you to identify one thing you consider most important in addressing any barriers to the effective use of telehealth in the public health services. We will use a whiteboard to record those issues and see if we can understand what your priorities are. Our experience is that sometimes we all find commonality even across the various specialties and subspecialties. Following that, a light supper will be served when we finish around 7.30 pm.

Could I ask that you start by introducing yourselves? We have 11 clinicians here. If you each take five minutes we will be here a long time, so maybe two or three minutes would be good. We will start with Professor Kimble.

Prof. Kimble: I am Roy Kimble. I am a paediatric surgeon and Director of Burns and Trauma at the Royal Children's Hospital and the Mater Children's Hospital, and we will be shortly moving to the Lady Cilento Children's Hospital in November. We perform telehealth services for a variety of specialties. I started in burns in 2000. We hold weekly burns telehealth clinics. We also hold weekly paediatric surgical telehealth clinics and monthly vascular anomalies telehealth clinics, and they are multidisciplinary clinics with multiple specialists involved.

We also do a lot of teaching to medical students via telehealth simply because there are too many medical students to have in one hospital. So we beam out to several hospitals. That way we can actually deliver more hours of teaching than we can with lectures face to face. We also do a lot of education to other hospitals within the state. We beam into up to 20 centres with our trauma education which happens twice a month.

CHAIR: Thank you, Professor. Peter, will you please introduce yourself and then we will just move around the table.

Prof. Soyer: My name is Peter Soyer. I am a Professor of Dermatology at the University of Queensland and the Director of the Dermatology Department. My interest in teledermatology is probably 15 years or even more. Back in Austria I was also involved in some policy agenda. We are currently providing a state-wide store and forward teledermatology service, which we have also published and audited. From our point of view store and forward teledermatology works perfectly well because with images we are able to do the diagnosis. Basically the job is done by our registrars and is supervised 24/7. There are issues around at the moment to do with email. A VET application has been provided from Queensland Health but we have come to a barrier, and at the moment this is not possible because we would need to drive to the hospital to do our teleconsultations which then makes the whole service basically not viable.

My second approach and interest is in mobile teledermoscopy, which basically has to do with mobile health. This has to do with empowerment of patients. We have basically provided through this period quantified self-research projects where people can basically make images of their moles and we provide a second opinion for this, combined with automatic diagnosis and a decision that supports this. It is very much a research tool. But we foresee that in a couple of years, maybe five years, this will be more and more relevant, that people will use mobile phones also for telehealth in our discipline.

CHAIR: Thank you.

Prof. Yang: I am Ian Yang. I am the Director of Thoracic Medicine at The Prince Charles Hospital and an Associate Professor at the University of Queensland. Our consultants at The Prince Charles Hospital have really embraced telehealth to help treat our respiratory patients and other cardiology and other patients state-wide but also through the Northern Territory and New South Wales. So we really have a far reach with our services. Examples of our clinics are sleep disorders; lung transplantation, which is a state-wide service; cystic fibrosis; mycobacterial clinics; and a whole range of others. Just to give you an example of how much we have embraced this service, last year

we had 800 consultations at the Prince Charles Hospital and this year just in the first six months we are up to 900 already—so really an exponential growth and a huge area for opportunity for health care.

CHAIR: Thank you.

Dr Lipman: I am Jeffrey Lipman. I am a Professor of **Anaesthesiology** and Critical Care at the University of Queensland and Director of Intensive Care at Royal Brisbane. The reason I mention the two is that intensive care is a separate specialty in Australia. It is where the sickest of the sick are. Soon after the medicopolitical issues of Bundaberg previously, we were approached to set up formal telelinks with that health district. We now do an hour of telemedicine with Bundaberg ICU each day and with Hervey Bay—when they want each day. So there is a formal link with intensive-care patients in the two hospitals. We have shown that the mortality has decreased in Bundaberg and that the staff satisfaction has improved so they retain their staff. To me it is a no-brainer, it is going to come, and I think it is just a matter of getting over the barriers. Sometimes the sickest patients cannot be transferred and they are kept there and that in itself we have shown to improve outcomes.

CHAIR: Fantastic. Thank you and welcome.

Prof. Gilhotra: I am Dr Jagmohan Gilhotra. I am an associate professor with the University of Queensland and I am working as a consultant psychiatrist with the Queensland Mental Health Commission. In our work what we have found out is that the clinical access to mental health services in rural and remote areas is very difficult at the moment and telehealth is only one of the issues that will certainly make it better. The barriers that we have looked at are quite a few, but the most important one is that at present there is no clinical guidelines for telehealth in mental health. There are a lot of clinical guidelines in telehealth in many places like colleges, but in mental health the Queensland Mental Health Commission is now leading a working group which will come up with recommendations for the clinical guidelines in mental health telehealth. The other things that are involved with telehealth in mental health that are important are transport and the workforce.

CHAIR: Thank you.

Dr North: John North, orthopaedic surgeon at Princess Alexandra Hospital. For my sins I am also the clinical director of the Queensland Audit of Surgical Mortality which looks at all the surgical mortality across the state, public and private, and in the Northern Territory as well. So we cover a fair area. That is nothing to do with telehealth, though. My main telehealth interest has been in the North West Hospital and Health Service—HHS, if you do not mind me using that from now on—where a relationship has been built between Princess Alexandra Hospital and Mount Isa to do a fracture clinic at Mount Isa every week. This may not seem so wonderful because Mount Isa is in the modern age but it is a long way from where somebody might get reasonable orthopaedic care. We have published on this several times and shown that for every hour that I spend on the telehealth at Princess Alexandra Hospital we save the North West HHS $33,000. This is mainly in transport and accommodation. And if you think that RFDS takes $12,000 to get one patient from Mount Isa to Townsville, and there will be times when it needs to and I am not knocking RFDS, then this is a much less acute process that allows enormous savings for the HHS. We have delved into the South West as well, but there does not yet seem to be the same enthusiasm that North West and their team have shown. We have published on it several times. Cost-effectiveness is enormously useful for the local group and if you are the parent of a child who does not have to go to Townsville it is incredibly cost-effective.

CHAIR: Thank you.

Dr Korczyk: I am the senior consultant cardiologist from Princess Alexandra Hospital. I am also the head of the heart failure unit at that hospital and a representative of the cardiac network of Queensland. I think that cardiologists have embraced the new technology. I think we have been increasing the amount of throughput using telehealth. We are using telehealth in all our subspecialties, including heart failure, transplant medicine and electrophysiology. We have got clinicians involved with running telehealth clinics, including specialist cardiologists, specialist nurses, pharmacists and physiotherapists. We are recognising some problems with telehealth. We are looking forward to actually working and trying to find the niche of telehealth in cardiology and cardiovascular medicine.

CHAIR: Thank you.

Prof. Donovan: I am a neonatal paediatrician at the Royal Brisbane Hospital. We have used telehealth applications in newborn care. There are about 65,000 newborns in Queensland in a year. Three hundred or so of them are brought down to Brisbane for their care. We focused on this and

saw it as a problem some time ago because we realised that the mortality, if you were under a thousand grams and born outside Brisbane or Townsville, was double that of being inside a tertiary centre. We speculated that telehealth might be helpful for this and we then worked through a research program, which is in the submission. Essentially, some of the issues in acute care are very different from my colleagues at the table when you are looking at a head-and-shoulders outpatient consultation and telehealth, but they were solvable.

With help from the University of Queensland and collaborators we were able to make a system that was mobile, wireless and that the person in Brisbane could operate and see the babies and we then did some research into it which I am sure is available to you. We showed that it was cost-effective and we showed, by an independent assessor who looked at each of those consultations, that we were able to reduce the number of babies that were retrieved by 26 per cent and that 93 per cent of the infants received new information that was clinically important. We feel that we have validated the clinical use of telehealth and there is an economic advantage in it as well.

As far as the barriers go we will discuss them later, but I think one of the greatest barriers is clinician engagement along the way. I think research that is hard-nosed and gives you evidence that clinicians will agree to and will think is unambiguous is one way forward.

CHAIR: Thank you.

Dr Macdonald: I am a hepatologist, a liver specialist, and I became involved in telehealth for very pragmatic reasons. I look after patients with viral hepatitis through the secure unit at the PA Hospital. That is a place where prisoners will go for medical treatment, either outpatient or inpatient care. For a prisoner to come to an outpatient appointment for management of their viral hepatitis, their hepatitis C or B, it would take two guards to escort them. The prisoners are reluctant to travel because if they, say, came from Maryborough the round trip is around a week and they could spend a couple of days in BCC—Brisbane Correctional Centre—where they may be in an environment that they are not familiar with, with potentially quite dangerous people that they do not sort of have any benchmarks of how they are going to behave. So they find it quite threatening to leave their prisons and they will not come for care. So, we run a clinic on a weekly basis looking after patients with viral hepatitis. I think there is a lot of support from the administrators within Corrective Services. The main problem I have is engagement with the clinicians. The AO staff will make the bookings, the equipment mostly works, but actually trying to identify patients at risk of side effects, and these are potentially quite nasty medications, is difficult. Probably the biggest challenge that I face is trying to have engagement with the clinicians. So although it is seen as a good idea, actually across a number of different prisons it is a difficult issue.

CHAIR: Thank you.

Prof. Smith: Good evening. I am an associate professor with the University of Queensland. I am also the deputy director of the Centre for Online Health which is based in Brisbane at the Royal Children's Hospital and also at the PA Hospital. As an aside, I am the president of the Australasian Telehealth Society as well. I guess one of the most critical reasons behind my involvement in tonight's proceedings is the fact that I also take responsibility for service direction at the Royal Children's Hospital operating the Queensland telepaediatric service and also the telehealth services at the PA through the PA Telehealth Centre.

At the Royal Children's Hospital we run the Queensland telepaediatric service which currently stands as one of the largest reported telepaediatric services in the world. It is about 14 years old. We commenced that service in November 2000. Just recently we passed over 20,000 consultations for children under the age of 16. We cover about 37 different paediatric subspecialties at the Children's. Our general motto is that if it is available at the Children's it should be available to everybody throughout Queensland and throughout other areas such as Northern New South Wales. We run routine clinics. We also run and provide ad hoc consultations for more urgent and acute cases. We provide telemedicine services into the home. In 2008 we also established a novel community based program for Indigenous patients in Central Queensland in Cherbourg which is running extremely well and is now supported and funded by Queensland Health. We also support and operate a critical-care telemedicine service originally at the Royal Brisbane and Women's Hospital and currently at the paediatric unit at the Royal Children's. Some of our major specialties are also represented tonight in the areas of burns care, endocrinology and diabetes, ear, nose and throat, neurology, psychiatry and paediatric surgery.

At the PA Hospital it is a newer adventure. Two years ago we officially opened the PA telehealth centre. We had a tremendous opportunity in Australia to actually build a telehealth centre correctly. With appropriate design and planning we put into place what we believe is one of the best

facilities in the country. This service now provides around 1,500 consultations to patients all around Queensland incorporating a range of different specialties, including geriatrics, endocrinology, dermatology and orthopaedics. This service is relatively new compared to our experience in the Children's but we are growing. We have a strategic plan in place to basically focus on some of the major objectives that need to be put into place to grow this particular service. Thank you very much for the opportunity.

Prof. d'Emden: I am the Director of Endocrinology and Diabetes at the Royal Brisbane and an associate professor at the University of Queensland. We run a telehealth service out of our department really catering for the needs of people in Central Queensland predominantly around Bundaberg. The telehealth service can be divided into two forms: first is a diabetes and endocrine service to adults primarily based around Bundaberg, but it does get patients coming up from Maryborough or down from Gladstone, and to a large extent it is working seamlessly with our face-to-face clinics in Brisbane and our face-to-face clinic that we fly into Bundaberg. Our telehealth service is actually conducted within our department. We do not have to go off to any special facility to do it. Patients flick from face-to-face to telehealth services seamlessly within our department. The advantage of it is that we never have patients actually losing contact with the physician that is looking after them even if they are living up in Bundaberg or Maryborough.

The second service is our very important and successful diabetes and pregnancy service. There is no endocrinologist in a public hospital between Nambour and Townsville. The management of diabetes in pregnancy is a very intensive and specialised service. It requires incredibly important and tight care to achieve good maternal and foetal outcomes. We have shown quite dramatic improvements in glycemic control and improvement in neonatal outcomes of all the women in the service. We would do in our department somewhere between 20 and 25 telehealth antenatal clinics a week and we would do somewhere between 10 and 15 diabetes and endocrine patients a week. It is a very busy component of our service.

CHAIR: Thank you very much. Thank you all. What I would like to do now is turn to our first question. Our first question is: what are the barriers you face in using or expanding your use of telehealth in public health services? Instead of just going around the room, I think there is some value in trying to build the conversation off each other. I will probably just ask Professor Smith to start the conversation and if any of you want to chime in could you, just for the purposes of Hansard, state your name before you make a comment? That just helps us make sure that we keep accurate transcripts because we will probably use some of this during our report-writing process. The question is: what are the barriers you face in using or expanding your use of telehealth and public health services? Again, I remind members to write your questions of clarification down and we will have a short time once that discussion has drawn to a conclusion to ask those questions. Professor Smith, if you would commence?

Prof. Smith: Thank you very much. There are going to be a long list of barriers, and I have made a couple of notes. Telehealth is a process and telehealth implies a change in practice. I think one of the important things that we must realise is that we are trying to do telehealth in an environment where, organisationally, change is very slow and difficult to manage. So I think the difficulties for changed management are associated with the uptake or low or slow uptake of telehealth. When you do telehealth, telehealth by its very nature implies that we are basically involved with patients and clinicians in one or more locations. That is very different to an outpatient environment where a patient appears at a desk with an appointment card and they go into a room and see you in person. Telehealth is much more complicated than that and what I have seen is that we are trying to squeeze telehealth into an environment where we have not got the appropriate systems in place to support a different type of interaction.

Examples of systems that we do not have in place and appropriate systems are the need to link into mechanisms of referring patients, strategies to schedule clinics in more than one location and also strategies to appropriately document activity and organise billing procedures appropriately. The other very important thing is looking at the availability of clinicians. Because clinicians are involved in multiple locations, scheduling can be a challenge, and that just reiterates the importance of telehealth coordination. Again, you do not have an environment where the patient comes to you. In many cases you are dealing with multiple locations and timing is certainly a challenge to ensure that not only the specialist or clinician at a specialist centre is available but also the person at the receiving end with the patient is also available. So lining all of that up takes skill and requires systems in place to be able to do that adequately.

I also believe that there is really a genuine lack of training and education associated with uptake of telehealth, so that is a very important feature. We in Queensland have a large number of people involved in operating and running telehealth and in my experience I have recognised and

noticed that many of them lack experience in telehealth. Some of them are on a very steep learning curve. They are in very responsible positions around Queensland. They are responsible for strategically trying to grow telehealth services, and I think education and training is an absolute essential for them. There is also a reluctance to, I guess, fund some of the very important elements of telehealth, and a very important element which I will allude to later is in relation to telehealth coordination. In my own experience I have sensed that the cost of telehealth coordination is often seen by organisations, particularly at management level, as an overhead or an additional burden whereas for the last 14 years I have been able to demonstrate that if you put the appropriate systems into place and provide the appropriate incentives for clinicians to do telemedicine and have the correct procedures in place you can generate a very effective telehealth service, and that has certainly been our experience at the Royal Children's Hospital.

The other barrier that I will allude to is one that I have experienced on many occasions and more recently just last week. I was out in the south-west visiting the towns of Dalby, Chinchilla and Miles and the experience I had in these three towns confirmed my suspicion that there is a real lack of awareness of what telehealth is from a general public perspective. I personally believe that we need to enhance that knowledge, particularly for people who are going to be involved and participating in telehealth. We need to actually improve public awareness and knowledge of telehealth so that we can create a little bit of a driver. So for telehealth to be growing in areas such as general practice or in remote hospitals, I think what it will also take is we need our patients to be walking in asking for telehealth. One of our programs of work at the moment is trying to generate consumer awareness and basically we have a theme: ask for telehealth. We want people to walk into general practice and say, 'I want telehealth.' That is all fine provided you have the systems in place, so I think having those systems in place is absolutely essential.

CHAIR: Thank you. Does anyone else want to chime in?

Prof. Kimble: I just want to backup what Anthony just said. Certainly with children it is not just the child; it is the entire family which you have to displace for a face to face. For example, in burns we may in one clinic go to 10 different centres throughout Queensland. That takes an enormous amount of coordination behind the scenes to get the right patient into the right room in the right hospital at the right time with the right therapist or clinician. We are dealing with some of the most disadvantaged families in the state and you would not believe the amount of extra work that takes, so without the coordination behind the scenes clinicians will not do this. If you supply a clinician with a screen and a dialling system and a list of patients, we will not do it. We just do not have the time to do it. We need the funding for the coordination of this service because, really, the big advantage in telemedicine is for the patient and the disruption to family life. For a clinician it is actually much easier for us just to give an appointment card and get them to travel sometimes two days to come and see us for a five-minute consultation. Just to put it into some perspective, just in burns in the last 14 years since we started we have seen 2,000 patients and the distance saved in travel for these patients—the equivalent distance—is from the earth to the moon six times over. So that is just to put it into perspective, and that is just for paediatric burns.

Prof. d'Emden: I think the barriers depend on what sort of speciality you are and what sort of service you are delivering and what your aim of your service is to provide. From the perspective of what we did in Bundaberg, the service was to try to provide a quality of equity in Bundaberg to what is available in Brisbane, and the Bundaberg Hospital flew us as endocrinologists in over 20 years ago. It is actually a very expensive way of seeing patients because you have the flight up, you actually only stay there for a short amount of hours and then you have to fly all of the way back. It is very disruptive. Replacing that with telehealth has been very good from the position point of view of going up there, and the alternative was obviously getting patients down.

In terms of some of the barriers that you spoke about, we have scheduled telehealth on what is called OSIM, which is our electronic bookings, and there is an OSIM clinic at Bundaberg now, so the two occur simultaneously and we are not finding that to be much of a barrier anymore now that we have the right system set up to communicate between people. For the actual conduct of the clinic, we only need a nurse present at Bundaberg. We do not need a doctor. It can only be an enrolled nurse even, but she coordinates everything. She gets everything done. In fact, when I do the endocrine ones, we do not need anyone at my end but when we do the pregnancy ones, because they are so rapid and, as you have suggested, going to many sites, we need a second person at our site just making all of the bookings so that things work seamlessly, because, yes, clinics go from Gladstone to Bundaberg to Emerald to Roma and all over the place in that three- to four-hour session where we see potentially up to 24 patients. So you have to have it perfect. When one of the persons went on holidays and a staff member came in who knew nothing, the next week was a disaster. So you need trained staff, but they do not necessarily have to be medical staff. You

have the physician there. From our perspective, it is hospital to hospital based. You just need the peripheral hospital to provide one staff member and us to have the systems and the thing can work very well.

From our perspective we think flying in is very important. We still fly into Bundaberg once every three months, but that gives a face to the name and it also allows us to do a physical examination on patients that we think we actually need to physically examine from time to time. You might say that three months is a long time to wait, but if you actually get a public appointment at the Royal Brisbane or the Prince Charles Hospital you will probably wait more than three months before you get in anyway, so that is not that much of a barrier. I think it is well on the way to overcoming those things. The biggest barrier we have is a reluctance of some of the other major peripheral cities up the coast like Maryborough, Gladstone and Mackay to address the issue of equity of access to people with diabetes and endocrine disorders there. They are quite happy for them to, I guess, continue to be managed at the general practitioner level without much backup and thus we see a lot of poorly managed people with diabetes in those areas which means we have much higher rates of referrals for renal transplants and complications of diabetes from those areas.

CHAIR: Thank you.

Dr Korczyk: I would probably share those comments with the two previous speakers. We also in cardiology seem to enjoy those hybrid clinics when we go and meet the patients face to face and then continue with the follow-up through telehealth. The barriers in our speciality are very similar and I think it is very important that the receiver sites of that telehealth consultation actually buys into that whole system of providing the telehealth speciality, and that seems to work the best. I have been providing telehealth in heart failure to Roma Hospital for the last seven years and we have had several changes in the medical officers and nurses in the hospital and every time that happens—and it has been happening fairly frequently—it just disrupts the ongoing provision of the clinics. So there needs to be a very stable and functioning system on the other side, which always goes with funding. At the moment when we are providing the funding to those sites I think the only funds provision is to the provider and not to the receiver. That may need to be looked at and reviewed in the future because that may actually increase the uptake of those new technologies throughout Queensland. We find the use mainly in patients in remote areas. We are also providing the service to the general practitioners and we find that the service not only helps our patients but also provides education to those medical officers, nurses and pharmacists in those isolated areas. I think it is a great opportunity to actually upskill those services.

CHAIR: Thank you. Dr North?

Dr North: My reason for starting it off almost four years ago was a gentleman that I knew from the Health Quality and Complaints Commission took an interest in quality and safety in nursing and went to Mount Isa. It sounded interesting and I note that there is no-one here from Mount Isa. In fact, I see that everybody here is from pretty close to the coast. What about places like Boulia? Who has been to Birdsville? Who has been to Darwin? Who has driven through Camooweal? My interest was in rural and remote. Although I cannot do surgery over the telephone or telehealth, I can see X-rays fairly easily on my iPhone and whether it is Beaudesert—and I have got them from Beaudesert—or whether it is Camooweal, I can very easily see what it is like and whether it is safe. So we now have a relationship with the north-west where it does not matter whether it is Mornington Island or whether it is Karumba or Dajarra or Julia Creek; I can get those films fairly easily. The key part of this is to then make a consultant decision—not a junior doctor decision but a consultant decision. We need a consultant-led rural and remote medical workforce that does not have to fly in, and I have a pilots licence so I could head off and fly to Dajarra tomorrow. It would take an awfully long time and the potential for injury is small, but it is there.

I think a consultant led service should be our destination. I think we should be creative, however, in making it happen. Like Roy and Graeme, I have been to the jail on telehealth. Why? It saved. I have even been to Woodford on telehealth, and it saved them. They said they saved—I will not say how much—X thousands because of the warders. There was even going to have to be helicopter cover on this particular transfer, and he knows who I am talking about. This sounds ridiculous, but I pressed the button at Anthony's department and we are suddenly into whichever correctional centre. Consultation works well. In terms of surgery, you cannot do it there, sorry. But if we work on being consultant led care, which is Roy's principle, and burns you can see easily—and that is what you would want if you lived in Camooweal or Dajarra—and if we then work on minimum delay, which is what Ros wants as a mother or a grandmother. Grandmother?

Ms BATES: No. Too young to be a grandmother!

Dr North: Sorry, my apologies. But that is what we want. We do not want to sit around waiting three weeks to get an appointment and suddenly find that we have been referred to Townsville but unfortunately Townsville cannot take us for a week because outpatients is too full and they need three more orthopaedic surgeons there. In fact, I have even suggested to Townsville that perhaps employing three orthopaedic surgeons using the contract model that has taken so much time and so much angst recently might include someone who has, say, half a day at Townsville and perhaps two days a month at Mount Isa. All the gear is sitting in the operating theatre and not being used.

Consultant led I think is our first destination. Second is creative approaches to making it work. We have to have Dirranbandi calling me, so how about a virtual booking system? I can go on Google now and book my Qantas flight to Melbourne in two weeks time. How about the GP in Bedourie goes on and says, 'I want a consultation with Kimble or North, or whoever. Yes, there is a spare one on Thursday week.'? He plugs it in with a name and knows that he has to have the X-rays in the box for that time. How about billing this into the contract system so that—and I have actually suggested this, Jon Krause—Beaudesert could even come to the PA? For busy mums who have three kids going to school and the fourth needs to be seen with a forearm fracture, they just plug in. They come up and I see them, using the doctor at the hospital down there. I am sorry to sound a bit passionate about it, but it seems so easy. However, either there is no willingness to fund it or the HHS involved in Beaudesert—it happens to be metro south, I think, which I am in—does not seem to see the value of it. I can tell you there must be 100 mums in Beaudesert who would see the value of it in a minute.

The next rural/remote question, and this is again with Ros's help: if you go to Bedourie or Boulia, guys are driving from there to Mount Isa to get a workers compensation certificate with me, on the other end of the telehealth. That is maybe a 4½- to five-hour drive. What about the RN, with an authority to take X-rays, taking the X-ray in Boulia and I just dial in from Anthony's dialup machine? It works very simply. You can see the patient at the other end with an RN helping you. It works remarkably well. I go to Julia Creek, Cloncurry, Karumba, Mornington Island. It is much easier than flying some mum and child from Mornington Island to Mount Isa, have them wait two nights et cetera. I am just trying to promote consultant led care. Let us get out of the ice age and try to use a virtual online booking system. It does not matter whether it is Kimble or whether it is d'Emden or whether it is Graeme; it could happen anywhere. A consultant led service to rural and remote communities should be a reality.

CHAIR: I appreciate that. Peter?

Prof. Soyer: I completely agree with all that has been said so far. I agree with you about the consultant led service. Obviously, every discipline has its different issues. Dermatology certainly is not so exciting, like quite a few other disciplines, like a mum with a child who is completely burnt and so on. Believe it or not, every weekend two or three people somewhere in this state have a very severe drug eruption—very severe. There are discussions: do they have a slight syndrome, should they be flown in or not? We think that in dermatology a so-called store-and-forward service is the way to go. We do not need, in most cases, videoconferencing. This is logistically too complex. The need is now, on the weekend, not in five days.

Actually, Queensland Health on our suggestion has built a secure web based platform for flowing forward, which can be also used in other disciplines—for diabetes, for ulcers. It is basically a back system like is used in teleradiology. The problem now is the following: Queensland Health has a policy in place that I am only allowed to look at this application if I am sitting on a Queensland Health computer. That means that I would be available probably six hours a week to provide this consultant led service in dermatology, whereas now I am available, believe it or not, 24/7. It does not matter if I am in Europe or in the States. I look on my iPad or I look at my iPhone. It is like when you see a fracture, you know what to do. I look at a rash and I know what to do. I give my registrar the advice. I think this is also quite a good educational tool for our registrars.

What I would really like to ask you guys to do is to make it crystal clear that there is a need for a policy change, that telehealth is not just videoconferencing; telehealth is also storing forward. There are a few disciplines in medicine where this is crucial: teleradiology, telepathology, teledermatology, certain aspects of tele-endroconology, telewound care. It is really not rocket science. The technology is all in place, but there is a need for the consultants, and also the registrars, to be formally allowed to access these applications, which of course has to be done by Queensland Health and everything has to fit into the electronic health record. At the moment, we are doing this as a UQ website and, of course, it is not good; you know what I mean? It has to go in the electronic health record of this patient, but it makes really no sense that if I am at home I have to travel to the hospital where the registrars are; do you know what I mean?

You have to make a policy that allows this and, of course, it has to be secure, it has to be VPN and all these things. If I am at home I can go to my Commonwealth Bank account, so why shouldn't I have access to my Queensland Health account? You look at the image and then it automatically goes into the health record. This can be only done with a kind of policy proportion from you. This is basically what I feel extremely passionate about. Teledermatology is dermatology. Telecardiology is cardiology. Teleorthopaedics is orthopaedics. At the end of the day, every one of our disciplines has a specific microenvironment and we have to do it in our microenvironment. I can tell you there is no problem with dermatologists doing this. Everyone is happy. In particular, we have quite a few ladies doing dermatology. They have kids and so on. They love to do it from home. There is no issue at all; there is really no issue. But then driving to the hospital to do it? Come on! This is really anachronistic.

CHAIR: Thank you. We probably have time for one more.

Dr Lipman: I am a small fry in this. Mount Isa and Caboolture are the only two intensive-care units—not the only two, but two of the biggest areas. After that, I have nothing more to say. I think that Anthony and John have done what I could not have done, expressing my views.

Dr Gilhotra: I just wanted to add a couple of things. We were talking about training and education. I think it is also important to look at training and education to do with cultural capability. In rural and remote areas, there are a lot of Aboriginal and Torres Strait Islander patients that we see. It is very important for them to be at least seen once by people who are trained in that kind of cultural capability. One of the previous speakers was saying that there is a reluctance for people to come to telehealth and that is part of the reason why there is reluctance. The second reason for reluctance is from the staff point of view. Again, that has been touched on before. There are, for example, MBS items for psychiatrists or doctors, for nurses or the nurse practitioners to be paid, whereas on the receiving end we have a generic mental health worker, who could be a psychologist or an occupational therapist or anybody, and they do not have any MBS items. It is important for people to be able to have that incentive to come to those telehealth conferences, so that they can be incentivised as well.

CHAIR: Thank you. Prof Yang, we have some time.

Prof Yang: Even though we are very strong advocates—definitely very strong advocates—of telehealth, I suppose there are some patients who we may not be able to use telehealth for, those who we need to physically examine, not just visually but examine hands-on. You could use surrogates, whether there are nurse practitioners or other GPs who could do that. Those where you need the investigations really on hand, that is where the electronic health record in a seamless way is very important. There may be difficult situations, either upset patients or breaking bad news, where it may not be entirely appropriate to use telehealth. I am just saying that we cannot use telehealth for every single patient but for very focused needs.

CHAIR: Thank you. Dr Macdonald, in your introduction you talked about a barrier being clinician engagement. Could you expand on that a fraction for us, please?

Dr Macdonald: We get referrals from doctors in Corrective Services. I understand that a lot of primary-care posts are not filled. It is not a place that is necessarily full of doctors. We get referrals. I might write back asking for some information: 'Does this guy have a history of violence?' 'Does this guy have significant mental health issues that might be exacerbated by the antiviral therapy?' I never hear a reply or very rarely hear a reply.

CHAIR: Is that because of the lack of—

Dr Macdonald: I am not sure why. I write the letters, but I do not seem to get much feedback. I think it is because they are terribly underresourced. We are interested in exploring alternative models of care in trying to involve the nursing staff there. A lot of the antiviral therapy is very formulaic. With consultant input, it would lend itself to alternate models of care, but there needs to be some support for us to actually do that, because it is not as if our days are spent otherwise waiting for things to do. They are pretty full.

One of my suggestions to try to break down the barriers and get input, not so much from the doctors but in Corrective Services more so from the nursing staff, is to engage them and get them as part of the therapeutic team. Currently, it may be a different nurse each week, sitting in the room behind the screen. If I want something, I have to shout out and ask them, 'Can we weigh the patient?' 'Can we do this?' 'Can we do that?' Some support for that sort of innovative model of care would be useful.

CHAIR: Thank you. We will take one more comment.

Prof. d'Emden: I am just making a comment to clarify a couple of things, because I am not quite sure whether you are around all the issues. There are these item numbers, but they are essentially for privately delivered services, which can apply obviously within a private system within a public hospital, but also can apply to a private practitioner or specialist anywhere in Australia delivering it to any patient anywhere. Given that question 3 is coming up, if we are focusing on what Queensland Health can do for telehealth, unless the PA is wanting to pay you a lot of money for overtime for doing telehealth 24/7, we really should be discussing doing telehealth during normal working hours, predominantly, from a Queensland Health public facility to another public health facility. An extension of that is to a patient in their private home, which gets perhaps a little bit tenuous in terms of is that really a Queensland Health patient or not at that stage.

CHAIR: Thank you. Late last week we had the department in and that was one of our questions. They have answered that in some detail for us. We will be exploring that a little. I will ask the members if there are any questions for clarification. I have one.

Dr DOUGLAS: I would like to address the point that Graeme made. Graeme, I did the prisons for nearly 20 years. The problem is that the current model in the prison is not a medical model for the prisons. Bryan Todd was the deputy director in 1990 and 1988. He talked the government into a medical model. The government moved away from it. So the problem you are getting with the lack of acquittal of your processes is because there is not a strict medical model for prisoners in the system. This is despite the fact that the majority are drug addicts or drug addicted. It will not be until we jump back to a medical model, philosophically, that you will start seeing sensible answers to your questions. That problem has happened repeatedly. I have just been to Massachusetts where they have a newer system. They are one of many US states and they have gone back. The sort of things that you are looking for, they are getting. There are many things to solve this puzzle; it is a multifactorial thing.

My point would be that, with most of these things that I am listening to, I do not see tremendous barriers. Michael made a very good point: you just cannot have people doing things all hours. We probably have to have a structure that people can work with, that we can grow from. There is certainly a need out west. I have been a GP. John talked about Quilpie and Birdsville. I have been a GP there and I can tell you how difficult it is. You are up to your armpits in alligators sometimes. You work pretty hard and you do not have a lot of time—like most of you people—to do your running around and trying to coordinate things. How do we get that coordination working? What is the best way to do it? Is there a simple method? There has to be some sort of an online booking thing. That is a great idea from John. Is it a suck-and-see-it thing?

CHAIR: That will be a perfect segue into the final question. I am just going to ask Dr Soyer for clarification. There is an app that we are aware of called Cisco Jabber. I am not completely familiar with it but my understanding is that it allows you to use non-discrete devices on the QH system. So you could use your iPad, for example, and download the application. You could use your iPad in the Queensland Health system. I understand that is available now.

Dr Smith: I think what Peter is alluding to is a web based application for store-and-forward telemedicine. Cisco Jabber allows you do live videoconferencing from a laptop.

CHAIR: I am sorry.

Dr Smith: That is what it was.

CHAIR: So a store-and-forward system within the Queensland Health system.

Prof. Soyer: It is ready. They did a great job. They have gone through with an application for sending images securely—everything in work flow. Everything has been tested. It is only possible to access it if you are on a Queensland Health computer.

CHAIR: Thank you. We have got that. I would like to move to the next question, please. The next question is: what factors have been most important in supporting the successful use of telehealth in your clinical specialties?

Prof. d'Emden: The most important factor by a country mile is having someone at the other end who is actually interested in better outcomes for their patients and embraces telehealth. If you have someone at the other end, the rest is simple. You notice that not a single person—apart from maybe Peter wanting a better store-and-forward system; but that was a Queensland Health system—has talked about technology. Technology is not a barrier; it is people embracing it that is the barrier.

Dr North: I think all of us around the table are fairly passionate, and that is probably why we are here. The encouragements that I have found to keep going are, firstly, thankfulness from the rural and remote health centre. Certainly every time you hear or see someone from Mount Isa they are thankful. Every time you see a patient's mother—say, a child's mother—they are incredibly thankful. To me that is probably the encouragement.

But, I can tell you that there are not more than 20 orthopaedic surgeons in Australia—and I am the past president of the Australian Orthopaedic Association—that do telehealth on a regular basis. That is I think because we have not creatively marketed it somehow. I am very thankful to Anthony and the system that did not need marketing but came in when I had already been up and riding for a little while. It suddenly made it so much easier.

It is only in last two weeks that I have been able to give up my Bigpond personal email—this is Pete's story—and be able to access Mount Isa X-ray facilities. Now, you say, 'That is great, isn't it?' I say it is; however, if it were your son's X-ray of three weeks ago I wanted to see, it has gone into a secure file, been transferred to—guess where—Townsville and it is sitting in a bunker in Townsville Hospital that I cannot get to. This is incredibly frustrating. I am sorry to maybe not answer the question. It is a frustrating fact. I cannot get X-rays from the Redlands Hospital and I live at Yeronga.

We need somehow to have this ability. For radiology and orthopaedics it is a no-brainer. We do not treat discs. We do not treat reports. We treat patients. The patients have investigations so we need to see those. If I cannot see them there is an issue. All this comes outside my normal day. Do I put in for overtime for it? Of course not; that would be ridiculous. The paperwork is changing and it is getting more ridiculous. It starts today. The overtime is much more complex. We have to have access to those investigations if we are going to treat the patient properly. It is ridiculous.

CHAIR: This would be looking backwards if you have them presenting, I am assuming?

Dr North: Well usually you do not. For the person with the very complicated distal radius that I have on here from last week I have his pre reduction films—all Bigpond, remember; this has nothing to do with the Department of Health—and I have his postreduction plaster films and they are all on my Bigpond. It is all deidentified. I have to ring back the operator and say, 'You did a good job there, but this is a slippery one. I need to see it at the clinic on Friday with a new X-ray to be sure it has not slipped.' Even then, we may have to send it to Townsville, if we can manage to get it there.

CHAIR: Just to bring it back to the question, being able to get access to current records is an important supporting factor to success?

Dr North: But records in Queensland Health generally relate to paperwork as opposed to X-rays. A lot of radiology has gone privately, by the way. Usually a medical record is a paper system in the public hospital vault somewhere. Your cardiology, coronary artery investigations are a radiological investigation. That needs data space to get you there. You like to see a moving picture to decide whether that patient needs a stent in the LAD. I need to see a picture to decide whether that patient needs to go to Townsville or can stay and we will watch him and treat him here without an operation. It not only applies to the paper record but very seriously to X-ray, or we call it the radiological record.

CHAIR: So really we are talking about the full extent of patient records. I do want to focus back on the question, which is: what has been important in supporting successful use of telehealth? We will come to you shortly. Do you want to clarify something?

Prof. d'Emden: Once again it is coordination. In endocrinology we have pituitary masses that we need MRIs for. At the end of every clinic we look at who is coming in the next week. We go through them and we get the enrolled nurse up in Bundaberg to pax—that is, transfer radiologically—every single X-ray that we are going to need on the patients coming the week later transferred to the royal Brisbane hospital X-ray facility. We actually have every single X-ray on our system.

We can get all the pathology on the system. There is this great program called the Viewer. We can actually view pretty well every letter that has been written throughout Queensland. Queensland is doing a lot of things very right at the moment. It is making things a hell of a lot easier. You should be very proud, actually. You are well ahead of the rest of the country in that regard.

The IMR, when it finally gets up and running in about six years time, will be fantastic because everyone will see the same information. Once again, it needs coordination.

CHAIR: We had the team in here last week and they talked to us about the Viewer and the fact that that is clearly brand-new technology being rolled out now.

Prof. Kimble: I think everyone is running a different type of telehealth system. For the ones which we run where you are going to multiple centres in every clinic that is difficult. The only reason that I run three different speciality clinics within telehealth is because I was invited to. So Richard Wootton and Anthony Smith developed the system 14 years ago and came to us in burns and said, 'Would you like to run burns telehealth?' We were not really wanting to do it because we were quite happy with the system. So we said, 'If you lay it all on and organise it, we will do it.'

In a system like that where you are going to multiple centres, if all you have to do is toddle down to the telemedicine centre and sit there and be a doctor, it works. But if you are trying to do everything else—trying to get all the images together, trying to get the pictures and collate them—it is not going to work. It is easy enough going from one hospital to another or one intensive-care unit to another—that is fairly straightforward—but so many clinics dot about Queensland and that is very difficult. That needs funding. That needs a lot of resources for coordination.

CHAIR: Thank you.

Prof. Donovan: Since we have an acute-care system, as opposed to one in which you can get an outpatient lead in with a booking system and you might get a at any hour of the night or day; I would like to reflect on the sharing of X-ray images, which remains a problem in Queensland. When you want an X-ray from another hospital there are at least four different platforms for acute care. So a picture is taken of a baby at 11 o'clock at night, the consultant talks to you by telephone, the standard of care is to tell you about the X-ray. But to actually look at the X-ray, it may be available in the private system a bit more easily, but within the public system there are a number of X-ray platforms that do not share between hospitals easily. That is an impediment and not a success. In our system we had to design a way around that so we actually raise the image in the pax system, for instance in Bundaberg, and then we look at the computer with a remote camera and show that you could do that. That is very messy.

CHAIR: So this is the platforms that you are talking about—the various X-ray machines use different compression technology or storage technology for their images?

Prof. Donovan: Yes. The physics are the same but the image storage is not the same. It is quite different. In fact, it is different at the Royal Children's Hospital to over the hill at the Royal Brisbane and Women's Hospital. You have to go to a separate site to look at the images from there. When you go outside there to some of the other places in Queensland there are at least four different image storage systems. For instance, if you acutely need to know that—as in it has been taken and it is half an hour later and you want to know where the endotracheal tube is—then you have to actually ask someone who is IT savvy to come in and transfer the image. You could take a picture of it with your phone and send it. I highlight the issue that if we could address getting images on a simple, single platform then that would be helpful.

CHAIR: That would help for that acute circumstance?

Prof. Donovan: In acute circumstances and maybe in chronic circumstances as well. Then clinicians who say, 'I need the other X-ray which you have not got for me accidentally,' would be easy to get.

Dr Korczyk: From the cardiovascular perspective I would like to share the sentiment of Professor Michael regarding the coordination. I think coordinators are the most important in providing telehealth to patients. But not only that, they can actually get a buy-in from the clinicians, not only those on the receiver side but also my colleagues here who have been looking at the telehealth I have been doing for the last five to six years and are only now starting to warm to it because we have coordinators. We have people who will do the leg work and who will come and organise the clinic and provide you with the data. It is much easier to do that.

The word is coordination to be able to fit telehealth into your very busy practice. All of us are very busy clinicians. Most of us working in the public service are working long hours. You want to have a seamless coordination of seeing patients face to face but also having telehealth clinics to do follow-ups in remote areas. The hybrid model may be the model which works well for cardiovascular.

We all have some similarities however we treat different diseases. In the chronic disease model I think we have some sort of common understanding of where the telehealth could be used. I think the most important thing is the buy in from clinicians. Unfortunately, the one-size-fits-all rule does not work for telehealth and does not work for all the specialties.

CHAIR: I will make some comment on that before we close. That message we have heard time and time again. We very much appreciate that.

Prof. Gilhotra: I just wanted to add one more thing in answer to your question. One of the things in mental health that makes telehealth successful is if it is complemented with face-to-face interviews as well. Telehealth, on its own, at least in mental health, is not going to be successful. We have found that it is successful if it is complimented with face-to-face contact from time to time. It does not have to be every time.

CHAIR: Thank you.

Prof Yang: The other opportunity for telehealth, for example, caring for patients with cystic fibrosis, is to have a multidisciplinary approach where the physicians are there but also the cystic fibrosis nurses, pharmacists, the dietician, the social worker, the physiotherapist, they can all do a telehealth consultation together, not just through one single clinician. That really magnifies and multiplies the benefit for those patients.

CHAIR: Thank you.

Prof. Smith: Sorry, something that no-one has ever mentioned tonight is the fact that telehealth coordination is very important. I just want to say it again: telehealth is very important.

CHAIR: Dr Smith, will you just express your opinion a little bit more clearly, please?

Prof. Smith: Yes, certainly. Just to reiterate, telehealth coordination is very important. Just in terms of operating a good-quality high-standard telehealth operation, you need coordination. I think my point has been made clear. I think a very important point here is that clinicians have to be clinicians and not technicians. I agree that no-one has mentioned the 'technology' word and that is great. Five years ago I think in Queensland Health it would have been all about the technology, all about the number of systems that we have and the number of links that we do. This is about providing clinical services.

One of the very important points that has been mentioned, I think once, is about clinician leadership. As represented around the table here, we have experts in a range of different fields. Telehealth needs clinicians to lead telehealth work. It cannot be run by an administrator or a manager who comes and says, 'This is a great idea. This is what you have to do.' The clinicians have to believe in it and they have to want to do it.

One of the very important features of the service that we have been running—I started this work in the year 2000; it was the basis of a PhD study. I wanted to get in and understand why telehealth was not being picked up as well as I thought it ought to be in a place such as Queensland. Despite having such a large network, it was underutilised and today it still is. But what we wanted to do was simplify it and make it so simple for people to use. Over a three- or four-year period we demonstrated that having such a simple service for staff to come in and be clinicians and provide telehealth services was an incentive for them to do that.

Back in 2005-06, and even up until today, people still underestimate the value of coordination and often still consider it an overhead. I think, as I have said initially, telehealth coordination is the key. Dr North mentioned having multiple systems. In the PAH Telehealth Centre and at the Children's we try our best to make it as simple as possible. It is not completely seamless. Unfortunately, people have a handful of passwords to access multiple systems. We have good systems available in the health department, but they are not fully integrated. So a seamless system is very important.

Another very important approach to the work that we have been doing is that we are not trying to solve all the problems of the world overnight. The work that we do through the Centre for Online Health takes a pragmatic approach. We start small and we gradually develop. As I said, I have taken 14 years to get the Queensland Telepaediatric Service to where it is today. It has taken time. It was not going to happen in two or three years, but it did happen after 14 years.

Having the university input to this approach, so running the service in partnership with Queensland Health, has been invaluable not just for us but I am sure for the whole health department. It has been a collaboration. We have been able to do very important research. As I said earlier, we are responsible for publishing the largest amount of work on telepaediatrics around the world. That has been very important for demonstrating clinical advocacy, user satisfaction and feasibility and clinical cost-effectiveness. In each of the services that we offer, we worked closely with the clinicians and ensured that they take the front in doing this and feel responsible for providing these services. From a researcher-academic perspective, we tend to take the invisible role, which is still a very important role, in helping the clinicians do what they want to do to support their patients.

Another very important successful factor is that telehealth is not a stand-alone application, as mentioned before. It needs to set in with the model and every specialty is different in terms of combining telehealth with the occasionally essential face-to-face consultations and also with work that involves outreach and visiting places. The relationship building is absolutely essential. Telehealth is a partnership. Providing services to regional sites requires building partnerships and there is no better way of doing that than sitting in a tearoom out in the middle of nowhere and working with the clinicians and understanding what their environment is like to do that. That is very, very good.

The last thing I will mention is more a compliment to say that the incentive program implemented by Queensland Health is to be commended. It is a very important program to provide funding. Our only challenge at this stage is not only to build telehealth work but to make sure that the telehealth funding goes to the appropriate areas and gets into these clinical departments allowing our clinicians to employ additional staff if required and to provide these additional services. I just wanted to finish by commending the health department on introducing these new funding schemes for telehealth.

CHAIR: Thank you. We will wrap up that particular point. We are just a fraction behind time but I think we will catch up.

Dr Lipman: Can I just make one point that has come through? The one point that I was going to make is that the success relates to what I think Dr North mentioned. The message that I would like to get across is that it is specialist driven and in the periphery you do not have those specialists. I think that is one of the fundamental benefits of telehealth and successes—that Woop Woop, or wherever it is, can contact the superspecialist in whatever specialty.

CHAIR: Thank you. You are right. I am going to move to the last question. This does not necessarily have to take a long time. Sue is our research director. She makes us look very good, because she substantially writes the reports that we present as our reports and she has a mind for detail. I have asked Sue just to use the board. What is the one most important thing that needs to happen to address barriers to the effective and efficient use of telehealth by the Queensland department of health and hospital services? I am not looking for a whole explanation; I am looking for the one thing that would most benefit encouraging the use of telehealth. Even though there is a bunch of different specialities and subspecialties represented here, we will probably find that maybe we have system issues or systemic issues and that affects everybody. If we can start to address some of those barriers then we can make what occurs in telehealth more effective. So we are really looking for a fairly short, succinct answer. What is the one thing that would really, for you, be a major breakthrough—just the one thing? I will just give you a second to think about that.

I just let you know that our aim is to try to have our report out in late August, early September. That is our aim. We have been to Roma and spoken to various outreach services there using telehealth. We have been to Cairns and Thursday Island. We have interviewed Dr Sabesan in Townsville oncology via teleconference and we have also had Ontario health—OTN—which the Ontario government set up as a not-for-profit and which provides the opportunity for telehealth across Ontario. We have been able to speak with them at some length as well. Theirs is seen as a very mature system around the world. I do not mind who it is, but would someone like to start with the one thing that you think would really be a major breakthrough to help us to better utilise telehealth?

Prof. d'Emden: I love not contaminating my thoughts with the thoughts of others. I would think having a person at the receiving end who is engaged to identify areas where there is inequity of access between that facility and a metropolitan facility and who works at establishing telehealth models to overcome that inequity. I think that if that person is engaged and is enthusiastic and, therefore, potentially has the funds to establish those links, you would go a hell of a long way to solving most of the problems.

CHAIR: Thank you.

Prof Yang: To support and extend that, we have a plea for an accurate and up-to-date state-wide directory of telehealth coordinators in each of the major centres and peripheral centres, because our coordinators take a lot of time to try to find that person to get something going.

CHAIR: Thank you.

Prof. Soyer: From my point of view, clinical leadership to put the policies in place, their assistance and professional marketing.

Dr Lipman: I think you need role models—physicians—like us selling the product to the periphery, which is similar to what Peter says in a different way.

CHAIR: Thank you.

Prof. Kimble: Ours is well established. It is core business for us but to continue we need continuing funding for proper coordination at both ends.

Dr North: I would reinforce that, too, but I think relationships probably will facilitate that. If there is a relationship between Windorah and the PA, or Windorah and Toowoomba perhaps, just as there has been in the Rockhampton coal basin with Emerald feeding back to Rocky, if there is a relationship there, I think that is something that we need to be pushing in a creative way. I am not a marketer; I am just happy to listen to the patients. I am not a marketing expert, but I think creative marketing mixed with relationships—'I can ring that fellow at the PA. I can ring that fellow at the Royal Children's.' I happen to mention at the Lady Cilento that there might be a place for fracture clinics on telehealth. 'Oh, that would be a good idea,' says the EDMS. But nothing had been done to actually make it happen. The person who is doing it at the Royal Children's is retiring from paediatric practice, so it is not going to pass across the river. Relationships and creative marketing.

Dr Macdonald: From a personal perspective, if there was some incentive to try to build telehealth. My week is already full. If there was some incentive to invest the time to overcome the frustrations and try to build those bridges with the different centres—some salary support for someone to actually establish that that could be competitively funded with applications.

CHAIR: Thank you.

Dr Korczyk: If I had two points, one would be stable funding for both sides and the second point is direct recognition by the hospital executives that this is actually extra work that the clinician does. So implementing that extra work in a very busy schedule and recognising that this is something that takes time from the clinician on both sides I think is very important to run a very smooth and successful service.

Prof. Donovan: If I could just speak to acute-care services, which are slightly different from some of the other views. There are not a lot of representatives of stroke and some of the other things that are done acutely. Speaking from that point of view, clearly, funding is part of it, because I have seen services that have started and died without that. But at the core of it, to get clinicians using this service and believing in it is done the same way as we get clinicians to accept any new therapy and that is that you get some evidence that they must listen to. Some of that is coming in Queensland, but it is only in selected areas. I would consider that, if we had that evidence where you could go back to the clinicians and say, 'This is core business,' I would suggest that telehealth, as it is becoming and as you are encouraging, becomes a core business—that trainees, registrars, the college of physicians, for instance, have an interest in making part of what we all have to learn to get to where we want to be, because a part of Queensland Health is going to be it.

CHAIR: Thank you.

Prof. Smith: The first thing is to maintain the funding incentives that have been implemented by Queensland Health. I think they need to be sustained. I think that it is going to take a little bit of time before we jump to conclusions and decide whether they have been a success or not. Also, consideration for expanding that funding into other areas, including the store and forward, which has been alluded to by Professor Soyer and also into areas that are not currently well funded—the non-medical consultations, particularly allied health consultations. They should also be considered.

I think the reimbursement for telehealth—and I was involved in the reports before the government introduced this in 2011—really depends on a patient physically being seen by video. That is unfortunate in a way because telehealth is much more than just video consultations. I think telehealth has the potential to be very disruptive in the way that we change our view on the way that health services are delivered. Therefore, a more open approach to funding and supporting a range of techniques where we can provide a very good service to patients may not involve patients physically being in front of a screen but it could be us collecting some data at a distance.

Ensuring that appropriate telehealth coordination is put into place, I understand that there are coordinators in Queensland supporting the current rural health program, but I am talking about more than strategic advice and support in these regional areas. I am talking about telehealth coordination, the real hands-on dirty work that has to get done for telehealth to work well. So I have been in the trade for now 14 or 15 years. I understand what people have to do to make telehealth work. There is a huge amount of organisation. They need the right personalities. My team certainly have the right personalities. They do everything from referral to complete consultation to follow-up, and they make it happen—absolutely critical. The admin systems all have to be put into place—so integration

of appropriate admin systems. That creates a seamless network for people to provide a good service—so access to all of the information systems that allow you to provide a good service at a distance.

The other very important thing is to introduce strategies that reinforce or promote our interactions not just between hospitals but also with general practice—so primary healthcare providers. So we should be improving our partnerships and relationships with general practitioners where we can and supporting patients so they can really get access to good services as close to home as possible by going to their GP and then having access to a specialist with their GP.

The other one is from my own perspective and ours from the Centre for Online Health, and that is to go ahead and establish a good solid partnership with a research leader. Queensland has the CRE, the Centre of Research Excellence, sitting in its state. So make the most of it and take advantage of that opportunity to partner and recognise and support and perhaps fund that effort. So that would be valuable. We can support a range of studies. We can look at the feasibility. We can examine the initiative over a period of time and partner with Queensland Health to make sure that we are getting the best value for money with this initiative. Thank you.

CHAIR: So that will be three or four subpoints on improving telehealth.

Dr Lipman: You left out coordination.

CHAIR: Are there any other comments before we close? Dr North.

Dr North: Just to use the word 'indemnity'. As clinicians, we all see things—see patients, see X-rays—on telehealth. I am only indemnified in the public hospital system. I am happy to stay that way. But I think sooner or later something is going to happen and I think Queensland Health needs to think about this fairly carefully.

CHAIR: Thank you all. I will make a couple of closing comments. We appreciate very much your time and we appreciate very much the candour with which you have spoken with us. I think probably for all of us sitting here a lot of what we have heard has been galvanised tonight. We got to a point where we were starting to hear some of the same things, so we were at saturation point and what you have done for us is help galvanise some of that from a clinician's perspective. So it will help us certainly as we start to pull this report together.

I think Sue is sick of me making phone calls and us talking about this, because she is actually in the process of writing the report and has to rejig it every time I have some bright idea. But I think you have really helped us this evening. This is a long journey and change never comes easy, especially in very, very large organisations. What is interesting is that if you go to Thursday Island and then go to Coconut Island—allied health has not been mentioned much tonight—in terms of simple things like physiotherapy that we take for granted here in populated areas, a physio gets out there twice a year. Telehealth gives the opportunity for those people to do physiotherapy on a weekly basis until their treatment is done. That is quite substantial when you consider equity in health care and its delivery.

The world is changing. As our population grows older, I think telehealth will be as pertinent to, for example, aged-care facilities and independent living facilities as it is to regional centres. The disruption to an older person having to get a van and come to the hospital, even if it is only three kilometres away, is as disruptive as someone having to travel two days away, except that two days away obviously is two days. So there are real applications for us in the delivery of health care for our population going forward. If we can actually start to crack some of these major barriers, I think it will truly start to unfold in a manner in which we could lead the world. I am quite excited by the potential and we just need to keep focusing on that.

Unless there are any urgent comments that anyone else would like to finish with, I thank you for your participation. It has been very informative and useful for us. For those of you who can, I invite you to stay and join us in the next room for a light supper. I declare this proceeding of the Health and Community Services Committee closed. Thank you all.

Committee adjourned at 7.36 pm