



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)

PUBLIC HEARING—INQUIRY INTO TELEHEALTH SERVICES IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 21 MAY 2014

Brisbane

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Committee met at 9.01 am

CHAIR: I declare open the Health and Community Services Committee's public hearing for its inquiry into telehealth services in Queensland. My name is Trev Ruthenberg. I am the chair of the committee and member for Kallangur. With us today is Mrs Jo-Ann Miller, the deputy chair and member for Bundamba; Ms Ros Bates MP, member for Mudgeeraba; Dr Alex Douglas MP, member for Gaven; Mr Jon Krause MP, member for Beaudesert; Mr Dale Shuttleworth MP, member for Ferny Grove; and Mr John Hathaway MP, member for Townsville.

We will hear today from three witnesses. I expect the committee will hold further public hearings into telehealth. Witnesses are not required to give evidence under oath, but I remind you that misleading the committee is a serious offence. 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 or excluded from the hearings at the discretion of the committee. Mobile phones or other electronic devices should now be turned off or switched to silent. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to. The proceedings today are also being broadcast live on the parliament's website.

SABESAN, Dr Sabe, Director of Medical Oncology, Townsville Cancer Centre

CHAIR: I welcome our first witness, Dr Sabesan, who joins us by video conference. Dr Sabesan is the Director of Medical Oncology at the Townsville Hospital and Health Service. He will give a presentation to the committee and then we will have time for questions from the committee. Dr Sabesan, I invite you to make your presentation.

Dr Sabesan: I will start with the talk. The talk is already on your end. The first slide talks about the Townsville teleoncology network, and then I will go through the terms of reference in the document.

The next slide is the description of the Townsville teleoncology network. All the red dots are the participating sites—Townsville, Mount Isa. There are now about 21 sites and it is continuously expanding over the last seven years.

The next slide is our clinic model. It is the same as any other model described in the literature. In this system we have a couple of models. One is the teleoncology model replacing face-to-face care for Mount Isa. So we do not go and they do not come, but they get all the services that are available in Townsville or Brisbane in Mount Isa in terms of medical oncology or chemotherapy. Because we replaced face-to-face care, we have complex requirements in terms of medical, nursing and allied health on the other end. In this slide we have a patient and then myself and I am just describing—because I have never seen this patient in real life—lung cancer and the patient's CAT scans so the consultation becomes dynamic. Also in this model we use the traditional video conferencing machinery simply because we do much more complex stuff than treatment on the remote end, but if you are doing pure consultations with GPs or home all we require is web based systems like Java. In private I do Skype as well so it does not have to be expensive.

The next slide is a quick history of the Townsville teleoncology network just to show that system evolve. They are not built from day one. For example, we started our model in 2007. Prior to that all Mount Isa patients needed to travel to Townsville for reviews, first doses of chemotherapy and all the complex regimens. We found in that time a lot of the consultations were five minutes or 10 minutes, and it was really heartbreaking to see people travel that far and take that many days with an escort just to see us for 10 minutes. That is what made us look for telehealth models.

At that time simple chemotherapy in Mount Isa was supervised by emergency doctors on a goodwill basis and two part-time chemo nurses only doing selected regimens. In 2007 we started services. The enablers for us were the willing specialists. So we saw the need and also the rural practitioners were ready to receive the service. We had the technology already fortunately invested by Queensland Health and a couple of nurses so that was enough to start a basic consultative service. At that time for the next two years the policy was that people only travel for the first reviews

and for complex regimens, and everything else could be done in Mount Isa. Through some funding we had two full-time nurses and a part-time senior medical officer for oncology. This is to show that if you want to develop and build telehealth services the rural system needs to be propped up. We cannot just dial in and expect the rural site to pick up the pieces when they are not resourced enough. So this is how it evolves, so more resources. There was more funding through accumulated data over time so the business cases were easy to write. There was also a lot of willing people on the other end.

In 2009 throughout this period we did a lot of evaluation—I will come back to that later. Because of the evaluation and quality improvement activities and we learned a lot over the time, the policy in 2009 was that we had a system established comprehensively that no-one needed to travel. So doctors do not have to travel, patients do not have to travel, but they were based on strict governance and it was not ad hoc. At that time through more business cases and growth we have now a cancer care coordinator in Mount Isa, rotating medical registrars, RMOs, nurses and allied health. The enablers for that were upskilled rural generalists—nurses and doctors. The coordinators were important. The table summarises what the service in Mount Isa is. So basically three to four times a week routine medical oncology clinic and also on demand. We now also do new cases, reviews, urgent cases, admissions and ward runs, and all types of select chemotherapy regimens so that means no-one needed to travel. Since that slide which shows savings on the PTS Scheme up to \$120,000 a year for the Mount Isa Health Service District, we managed to divert some of the money to employing a rotating medical registrar. So that is again improving the rural workforce through the savings rather than digging into the bottom line.

As I said, we needed to value it because one is to improve the model and also to show people the successes and failures. The questions were: what have you achieved, is it safe to do business via videolinks, is it acceptable, what are the course comparisons and contribution to survival outcomes? Survival outcomes are difficult to do early in the piece with small numbers, but my feeling is that if you provide a best standard of care service, whatever we provide to urban centres, if we provide the same service to rural centres then you expect the survival to be the same. I am not too fussed on doing a big study and wasting taxpayers' money to prove that teleoncology can improve outcomes. I think it is intuitive. We focused on getting the model right so the service is the same as that which we provide in Townsville.

The first question is: has the teleoncology model improved the access to specialist medical oncology services? Also, we believe in capacity building of rural science. I believe that is the only way you can close the gap between rural and urban disparities in a sustainable or meaningful manner. We had these two articles published in the *Australian Journal of Rural Health*. The next slide really summarises that we are a small subspeciality yet we have seen 200 patients including 30 Indigenous patients in more than 1,000 consultations. The last 80 patients were solely managed on videolink. So they were never seen face to face and for that I have some evaluation, too. We have also seen 12 urgent cases treated urgently in Mount Isa by videolink, avoiding interhospital transfers. So we actually stopped the transfers. Ninety-five patients were treated with chemotherapy. Now we cover locums for Mackay and Cairns. Cairns got it so we do locum cover for Mackay on videolink.

The next question is: are patients and rural health professionals satisfied with teleoncology models? I have a study that one of our trainees did purely on Indigenous perspectives, and we did another study in the *Journal of Telemedicine and Telecare* 'A teleoncology model replacing face-to-face specialist cancer care'. We had to do this study to make sure that the patients are happy with these kinds of models, but intuitively I knew just from talking to people that if you can provide the same service closer to home of course they will like it. But this is just to prove the obvious because some people still ask the question.

In terms of Indigenous perspectives we did not come across any cultural barriers. The only thing that came up was the same issues and themes as non-Indigenous patients about travel inconvenience, care closer to home and savings. My philosophy now when we put together training packages for our trainees is their approach to communication with a human being is regardless of race or colour but is based on individual patient needs. It can be a Caucasian with a very low educational level versus high. It could be Indigenous very low educational level versus high. We just have to find out the information and tailor the conversation according to their needs rather than, 'Are you Indigenous? I am going to treat you differently.' That is a great lesson for us. Again, it reinforced the idea that it is about patients not about a group.

One of the over major benefits of Indigenous telehealth is that it allows the families to attend the video consultations. Under the current models a nervous escort will come with one patient, whereas here pretty much 10 to 15 people attend the consultation. In terms of compliance I can rely

on a couple of family members to make sure they are looking after them. Also now we take on preventive education through telehealth because we have families. That is a big advantage of telehealth over face-to-face care for rural and Indigenous people.

The next slide is the qualitative study on our teleoncology, replacing face-to-face care. There are five major themes. In view of time, I will skip through this. Quality of the consultation: there are no problems with that, because we have a good system. Communication relationship: really one of the major benefits of telehealth is bringing the rural clinicians and the urban clinicians together, so they can see each other rather than talking on the phone. That relationship is important for continuity of care. Technology and fears is an issue, but if it is explained properly I think everyone will get used to it.

The next slide: local services and support is important. One of the concerns of rural people is whether the care is as good as they are going to get in Townsville. So we actually have to sell the rural models and say, 'Actually, if you come to Townsville you are going to hear from me the same thing and you are going to get the same treatment, so it is the same service'. Then they accept it. That is an important aspect, to convince the people that the service you are providing is good enough, if you believe that it is good enough. If you think it is substandard, then either you should not do it or tell them it is not good enough.

The next one: always it is the coordination of care. There is always an issue in a public system or government system of coordinating too many people. But that is something that we work on continuously, so that the system is smooth.

The next question is: is it safe to supervise chemotherapy in rural towns via video link, because of the concern that chemotherapy causes a lot of side effects and some people die of it? We thought we should really compare Mount Isa with Townsville. That study is completed. I got the final results yesterday. What we found was the doses and the intensity of the doses between Townsville and Mount Isa are the same and also the side-effect profile and the admission rates are the same between Townsville and Mount Isa—no deaths. Basically, that tells us that the Mount Isa telehealth model is not inferior. It gave us great confidence in the system, that it is a safe model.

The next question is the cost comparison. Again, people talk about whether it is costly and how much? I am not a health economist, but we did do some analysis. At the end the day, it is establishment costs versus the costs prevented by telehealth. It is going to be flawed by certain assumptions. One of the assumptions is that you have accounted for all the costs, but in public life a lot of people do service in goodwill and they are not counted towards this. Nevertheless, the bottom line is that the total establishment cost for the four and a half years was \$442,000 and the total savings was \$762,000. That is allowing for travel accommodation for patients and escorts, and also avoiding urgent aeromedical retrievals and also specialist travel. In that \$300,000, that is about \$75,000 a year at that time, so now it would be more. We were able to use that for a medical registrar. My observation and interpretation of this is that the higher the volume of activities, the higher the savings and the return. Also, if you do more complex services, you are able to do more activities on telehealth, so that will again give you more return.

One of the other things is that there is a controversy in the literature about whether or not it is really cost effective. We cannot really compare the literature with our models. We have mixed reports in the literature about cost savings and one of the meta analysis shows there is no net savings. But two studies in Queensland—they are the only two studies in Australia—both of them showed net savings. One was Len's study or Anthony Smith's study on the pediatric services. They showed a net savings and we showed a net savings. My feeling is that we showed a net savings because we deal with people from faraway places. So the longer the distance, the higher the savings. If you compared a study in Germany or the UK where the travel distances are short, obviously you may not see the difference in savings. But for us in an Australian setting, I think if you purely look at Australian studies, it is going to show savings because patients travel from faraway places.

The next one: as I said, in-kind support not included; the longer the distance the larger the savings; may not generate the same savings from shorter travel distances. But at the end of the day, that is only the savings for the health system. We have not factored in the savings and the inconvenience and the nuisance and the nonsense for the patient and their families.

The next one: this is my pet topic. It is really changing service capability and scope of practice. I do not believe in dialling in and just dumping the service on someone else. If I am going to provide a service, it is my responsibility to make sure that the capabilities are met and the scope of practice is expanded.

This slide, you may not see this clearly, but what it is showing is that over time, through lobbying and funding and shifting specialist services gradually to Mount Isa, the Mount Isa Cancer Care Unit has become an independent or stand-alone chemotherapy unit with full staff and full services. They have medical oncologists available 24\7 through telehealth. That is really a comprehensive rural service. That is the model we want to create for every system, so that all of our rural partners are well resourced.

In summary, with the Townsville teleoncology model, it is feasible to provide comprehensive services, acceptable to patient and health professionals, safe to supervise chemotherapy, saves money. Also, it expands the rural scope of practice and workforce.

This picture is basically showing a vicious circle of limited access to specialists locally, that leads to a narrow scope of practice, that leads to rural workforce shortages and then that leads to limited access. The end point is that patients have to travel.

The next slide: through telehealth, you get improved access to specialist services locally, it broadened the scope of practice and if you broaden the scope of practice you have to improve your workforce and if you have an adequate workforce you can provide more services and that means you cut down the travel. That is what I want to achieve and I think the system needs to aspire to achieve it.

My conclusions were that telehealth models facilitate the provision of specialist care closer to home and we can build rural health systems through telehealth models by shifting specialist services. These opportunities need to be taken advantage of for building systems. Rural resources need to be adequate in order to receive the services from tertiary centres. It needs to be part of core business and it should not be left to champions anymore. Because the government has invested so much money into telehealth through incentives and programs, I think now it is time that someone says, 'Actually, every hospital is expected to provide telehealth. That should be part of their core business and it should have appropriate KPIs for the CEOs, middle managers, clinicians and departments'. Until we get to that level, it will be: 'If I like it, I'll do it; if I do not like it, I will not do it'. For me, that is where the drive needs to be.

Also, one of the problems is that when you shift services to rural towns, the urban centres do lose their activity based funding. That can be a deterrent. Somehow, these new models of care may need to be incentivized, so the tertiary centres may need to be incentivized to make up for the loss. Also, the savings on PTSS need to be reinvested in building rural capacity, rather than just putting it into the bottom line.

I think I am almost done. The next slide: this model I describe is good for larger towns, whereas the smaller towns are going to miss out. We actually now came up with this model called Q-ReCS, Queensland Remote Chemotherapy Supervision Model. It is a state-wide model. We are working through the rural network and the cancer network. The purple represents a patient in a small town like, say, Biloela. Nursing, medical, pharmacy is all done through telehealth, so it is the direct supervision model, so we can do simple chemotherapy. At the moment, we are rolling it out in North Queensland. I was in Thursday Island yesterday. That model is actually causing a lot of excitement and I am pretty sure we can do chemotherapy in many towns through that model. That is really the extension of the previous work. That is all I have to say.

CHAIR: Thank you, Dr Sabesan. Can I say it was very comprehensive, thank you. Committee we have time for a couple of questions, but before that, can I welcome a delegation from the Parliament of Vanuatu: Mr Louis Kalnpel, the Clerk of the Parliament; Mr Leon Teter, Committee Officer; Ms Arielle Tary, Chamber and Procedures Officer. Welcome to this hearing. Committee we have time for a couple of questions.

Mr HATHAWAY: Thank you very much, Sabe, for a good presentation. I take it that your Mount Isa caseload is increasing as it draws its patients across a shorter distance, and that is how you develop that as a node. What is the college's view on you providing supervision remotely to potential specialists coming through? How do you achieve that with the registrar based in Townsville?

Dr Sabesan: That is actually one of the issues we are working on with the college, to support this trainee who goes there. He is a basic trainee, so the requirements are less. You can have one local physician there. That is the remote supervision that ticks the box. But if you are going to have advanced specialist registrars, the colleges do not recognise telesupervision models. I am taking part in a college project to come up with a framework so that it is accreditable. There is some work to do, but that should not be a deterrent to these kinds of models.

CHAIR: Dr Douglas, would you like to ask a question?

Dr DOUGLAS: No, not at the moment.

CHAIR: Right at the very start you mentioned that you do some of this privately and sometimes you use Skype, for example, so technology is very cost effective. How do you deal with patient records when you are dealing with that technology, if you are working outside of Queensland Health networks and the security of that? How do you deal with patient records?

Dr Sabesan: I do private outside. I do not do the private work inside the Townsville Hospital. That is a private system, so we do not have the same firewall issues. I do Skype. Really, the documentation is the same as the face-to-face documentation. I see them and I write it on the chart, whether it is public or private. We use a web based system in public as well, to the GPs. A lot of the GP practices do not have VC machines, so we dial in using Java to GPs. It is the same thing: I write it on the medical chart and I dictate a letter and the letter goes to the GPs, whether it is via telehealth or face-to-face.

CHAIR: So you are acting as a consultant in that process and the GP remains as the primary provider?

Dr Sabesan: Yes. I mean, it is a contention, but my feeling is that it is a specialist case and I am actually calling the shots and I have prescribed the medication, so I take full responsibility. I would not expect the GP to know all about that drug. My feeling is, yes, the GP is to make sure that they can do physical examinations, they can ask questions, fill in the gaps and give them some forms, but really, for me, I take full responsibility.

CHAIR: We will take one more question.

Mr HATHAWAY: Thanks, Sabe. You also mentioned how, as your project developed, you went from doing initial consultations or complex consultations and now that is all being handled out at the Isa. Are you now doing ward rounds? For example, if you have an initial or a complex patient that comes into Isa, are you now doing teleconference on an iPad as you go around remotely to the wards?

Dr Sabesan: No. I mean, the thing is that is a bit difficult and I do not know whether that system is necessary, because then you have to have a mobile system. I know in some of the rural hospitals their corridors are really small and things. So what we had decided is if they can be stretchered out to these VC machines—or most of them can actually sit in a wheelchair so they can be pushed to the video conferencing. So the doctor comes with the medical chart, the nurses come with a medical chart, and they have a medication chart, and I can access all the bloods and X-rays, so basically we do a ward round in that room. That means I could provide a service on demand immediately and address the needs of those patients. So yes, that is our ward round.

CHAIR: Thank you, Dr Sabesan. Unfortunately, we have run out of time. Would you mind if we, as a committee, had a couple of follow-on questions in writing? Would you mind if we sent those to you just to follow up with you?

Dr Sabesan: Yes, okay.

CHAIR: Thank you, we appreciate that. Thank you for your time.

McGRATH, Associate Professor Pam, Senior Research Fellow, Griffith Health Institute, Griffith University

CHAIR: Thank you, Professor. We appreciate your time and your submission. I will invite you to make an opening statement, and that will give us some time to speak with you. We are looking at being done at about 9.50, so it is over to you.

Prof. McGrath: Thank you. Can I just say that it is a real privilege to be following Dr Sabe Sabesan. His work is brilliant in this area and he is what the literature calls a champion of telehealth, so I am in awe of his presentation. It is also most appropriate, because in my discussions with him (we work on a CRC for Indigenous health), he tells me the uptake is least in haematology, and this is the area that I am presenting. So although he has been doing oncology broadly, my submission is specific to haematological malignancies and it is from a consumer's perspective. It is researched based, and that is what I think is the brilliance of his work. He is not only developing the model; he is also assessing and evaluating it through research.

This research was funded by the Leukaemia Foundation of Queensland. The point of the research, or the focus question, was to look at the impact of relocation, which is the need to travel to specialist centres for specialist treatment, and we were looking at the experience of relocation, and in particular the financial impact and the whole idea of telehealth and telemedicine, which is very primitive in this area, was specifically explored. So it was not an outcome of the data; it was actually a focus area where specific questions were asked, and there was a consistency throughout it.

The first point I would like to say is that it was qualitative in-depth research, so we had the opportunity to hear the fullness of people's stories and it was a purposive sample which went throughout Queensland. I think it is really important to say that we sampled, in terms of gender, across the broad spectrum of age and across every diagnostic group. In haematology there's a wide range. We go from leukaemias, myelomas, lymphomas and a range of other related conditions, and they all have their own stories. So it was quite comprehensive with that, and also it was geographically comprehensive in that we not only looked at—and we based it on the PTSS model, which is calculated in a 50 km radius from treating hospitals. So we also looked at within the 50 km radius in the metropolitan area, and then in the regional areas and then in the rural, and we also had a very exciting sample of remote, which is a challenge for any researcher.

The other important issue that I would like to say is that in qualitative work there is a methodological phenomenon called saturation. In other words, you keep going until you could almost tell the person you are speaking to what they are going to tell you before they tell you. So I got very strong data saturation on this, which then gives me a level of confidence to say, you know, that phenomena I am talking about is quite real and probable out there, and then if I pretty well picked up the phone and talked to anyone I would be hearing the same story. The evidence is overwhelmingly that the consumers—you know, the patients and the carers—would welcome the fostering and the development of telehealth. It is very much, unfortunately, at a primitive stage at the moment. I think it needs to be set in the context of the major problems of relocation for people dealing with haematological malignancies.

It is very exciting, the development of haematology, in that really only a couple of decades ago a lot of those conditions were fatal—and quickly fatal. They were quite acute. Now we have moved in many areas, whether it is the lymphomas—the myelomas have even caught up—we are now looking at pretty well chronic conditions, which is very exciting. But in haematology, even though you get the benefit of chronicity, there is also an enormous amount of intensive treatment and follow-ups. Follow-ups can be monthly, bimonthly, six-monthly and, if you are really lucky, you end up with yearly ones, so this is an area where there is a lot of treatment and follow-up on a regular basis. If you live a long way away from where that treatment is, one of the biggest considerations for your treatment is going to be all the travelling to access that.

The fact of relocation has numerous stressors on not only the patient, but their family. It means leaving home; it means who is looking after home while you are down there. It means do you bring children with you? Do you leave them at home? Do you interrupt work? Do you want to interrupt schooling? The list is extensive. It comes at a huge price, accessing treatment, with what you have got to do. The further away you are, the bigger that price is.

The problem for a lot of the families from the rural and remote areas is that they are too far away. They cannot visit or access treatment on travel over a day, so it means that even carers cannot come with them because somebody has got to stay home and look after the farm, or the

children or whatever. So they are doing it really tough. And the treatments for haematological malignancies can be quite tough. We are talking about bone marrow transplants, high-dose chemotherapy, total body irradiation—they are not easy treatments. So often because of these relocation issues, people are travelling alone because that is their practical situation.

They are doing this at a time when most of us really want the comfort of our family and our home. For most of us confronted with a life threatening condition, the first thing we want to do is go home and talk to a loved one or be in the comfort of our home. There is a lot of loneliness and homesickness that that they are experiencing, the separation from children, all of that sort of problem. That is the big picture on relocation, and again there is very little work done on this. This is not a big uptake area and it needs a lot more further work, but the one issue that I want to present and focus in on today is all the travelling that is happening for just purely follow-up routine assessment. We are not talking here about your major—because I think at this point in time your really acute treatments like your transplants and whatever have to be done. That is where the expertise is, in the metropolitan area. But the follow-up is, as I said, constant and ongoing and time-consuming and involves a lot of travel. That is the process that I really want to focus in on today: travelling down for follow-ups.

One of the important issues that quickly came out—and the data saturation was enormous on this—is that at any particular point in time, all throughout Queensland there will be people travelling everywhere over extremely long distances with great hardship. It takes a great deal of time to go from point A, which might be Augathella—and I interviewed out at Birdsville, Charleville, you name it. I will give you some examples: up to a six-hour flight each way; a 17-hour car trip each way; an eight-hour trip each way; a 18-hour bus trip each way; a four-day return trip by car—they are just some examples. They are doing that to come down for a 10-minute conversation with their doctor with all of the cost of the PTSS and whatever, and then they will be going back. I am only talking here about follow-up visits where you walk into the doctor, you have your five- to 10-minute conversation and you walk out. But that is the level of hardship.

I want to stress too—and it was quite a worry for me, the more I learned about this one—the hardship with which they were doing it. I mean, a lot of haematology is the older age group, you know, the 60 plus. Now, they are travelling at night, tired, sick and nauseated; people travelling after bone marrow aspirations where the travelling creates bleeding. There is enormous wear and tear on the car, so they are wearing their cars out. The cars are not in good condition. There is a huge financial impact, so that people after a few years with a haematological malignancy, especially if they were not well off in the beginning, will be really feeling the financial impact. Some of those cars they are driving are a bit of a worry. So it is not only that they are doing those huge distances; they are doing it under conditions where one would wonder if that is appropriate. Then there are all sorts of worries about, 'Do we bring the car down?' They bring it down because they cannot navigate the city and the transport, so they are forced into that. Some then come from just too far away and so they have to then organise flights, and then that has a whole set of practical problems. Some just cannot. Because of blood clots and things that is not an option, so you have to get in the car. Others, the flight might come in on the Tuesday morning, and the clinic is not until the Wednesday afternoon and the flight does not leave again until the Thursday morning, so you then have a whole week even though you are flying down. These are very real, palpable, practical problems that people were speaking in great detail about.

For some people there starts to be this balance, and I have the data on that. They're saying, 'It is just too much to continue.' We have seen it in areas such as breast cancer, and now the research is showing that real women will go and have a double mastectomy rather than engage in chemotherapy and follow-up because they cannot do it. There was a level of that problem here where people were saying, 'That is undermining our family. We cannot keep the farm going.' There is starting to be a balance here: is treatment an option, or do we say no to treatment and take another path? That balancing act was something they were considering.

Often patients were travelling these distances and the hospitals did not know about it. That is a phenomena because you have got busy hospitals, and patients and carers do not put their issues out there. That's not a problem with professionalism; that is just a communication problem that happens in hospitals. Some hospitals do know because there are more assertive patients and they will flex for them. One of the things that first flagged the importance of this issue is that some of the patients were so stressed, they were engaging in what we call self-advocacy. So they were saying, 'This is too much. I cannot do this system.' They were doing very creative things like one woman organised and liaised with the Royal Flying Doctor Service so they would take over flying her down and flying her back, and also at the end she has got them now that they do the follow-up. But that

did not come from the system; that came from patients saying, 'Look, we cannot do that,' and then the doctors being forced into finding ways around it. So there were some excellent examples of self-advocacy. Also there were examples of people engaging in local campaigns to keep the haematologists local and things like that. It was a strongly-felt issue.

I do want to stress that because we interviewed rural and remote patients, we found particularly important and acute issues for rural property owners and farmers. They really have another set of issues. They have got a high workload and constancy of care that they just cannot walk out of. If you go and leave your property with your cattle that can break down the fences and get loose and you are not there and all of that sort of thing, there are no options like if you are in work where you can take leave or something. They cannot, and even the idea of outsourcing and bringing someone in is not cost-effective for them. They do not have that sort of money. So there is a whole problem of the patient having to relocate by themselves.

There is again strong data that came from that that says because of those acute problems for rural property owners and farmers, the conflict then becomes quite acute about the 'do we risk going financially broke, having to sell the farm that we really have had in our family for generations and not pass that onto our family, or do we say no to treatment'. They were quite realistic issues they were facing. There is a powerful pull to remaining in the home for treatment. Rural people do have a very strong connection with their land and that gives them an energy that they do connect with. They require the comfort of home. They find that just being home is physically and emotionally nourishing to them. The relocation process is not just arduous and difficult and has practical problems in terms of their recovery and coping with treatment, it has problems in how they recover and how emotionally they feel they can deal with it.

I have done a lot of work on relocation in Australia. I was recently asked to do some in New Zealand and what came out of that was that there was not just accommodation based relocation where people come and stay in the accommodation, in New Zealand, maybe because the distances were closer, people were doing travel based relocation where they would come and go to great lengths, even if they had to travel five hours, to get back home. So when I was doing this study I was mindful of that. We have a lot of travel based relocation here in Queensland where people are literally travelling incredible hours just to get back home. I am saying that to say this is not a little issue for them, they really are walking their talk. Whereas previously we thought it was all accommodation based relocation, even at this point in time there would be people travelling all over Queensland just to get back home.

I also want to put in a mention that we did include the under 50 ks that the transport and accommodation scheme leaves out and there are real issues for them because some of them live on the islands. They have to get the boat to her, then they have to get up to the hospital, and they do all of that and some of them are travelling four or five hours by train or bus to get to the hospital and then get back. So even though they are within the 50k they are funding all of that without any PTSS relief. I was quite surprised to find that even within the 50ks there are issues.

There is the need and the desire for telehealth. One of the things we were interested to find out is what is happening out there and what is the way forward. What we found is that there was not a lot happening, but that what was happening was pretty well driven by one in particular but only a couple of haematologist. In the literature they are called the champions of telemedicine. What they were doing was extremely low cost, incredibly practical, applauded by their patients, saving an enormous amount of all of that distress I have just talked about and was incredibly cost effective. That is what I would like to present to you now. It is not just the problems but there are solutions. Most of it would fit under what AMA would call technology assisted consultations. Remembering the focus is on routine follow-up. This is sort of almost then a practice in haematology. They take the blood tests locally and they are sent to the metropolitan area. The patient can do the 18 hours travelling back or what these champions of telemedicine were doing were just skyping and having the exact same conversation. Skype is free. Sometimes that would be done in consultation with the GP. They would go to the GP. But that meant that that person was not travelling all that distance and it also meant that the PTS scheme was not covering the travel, the kilometres, the overnight accommodation. Some of these patients were coming so far that we have got overnight accommodation halfway, then we have got the accommodation down here and then they have to stay overnight and go back. They are saving all of that just by the blood test taken locally, sent down, the haematologist skyping—some use texting and some use teleconferencing—some involved the GPs and some did not. But that model was incredibly cost effective.

At the moment there is only a small uptake of it, but the data shows that that is very effective and I will soon show that in terms of cost and rollout it is definitely, to be argued, the way forward. It is used primarily for these routine issues. The major benefit is just lengthening the time between the

travel down. A lot of rural patients do want the expertise, because of the cleverness and skill of the doctors in the metropolitan centre, but it is not a trade-off from never seeing the haematologist, it is a trade-off in the number of times you have got to do all those loops. It is not an either/or. The overseas literature would say that people have a high level of satisfaction with this, but they do also want to see the haematologist at some point in time. I am not arguing for an either/or. There are some obstacles at the moment that block the uptake, I suppose. The lack of fast internet connections in some of the rural areas is probably the biggest one. But the process only really requires Skype, which is free. The data shows importantly that it is the preferred option and it is seen as the future option. I have provided in my submission some exact examples of the statements to provide you with the flavour of what has been said.

In summary then, there is enormous hardship without it. It is cost effective with it. I have also provided in the submission very minimal costings. That is based on not only the group that were travelling in this study, but was only based on the group that were travelling for routine follow-up. So you can imagine how that could be multiplied. Then that was projected out to the Leukaemia Foundation group who would be following. Unfortunately we have never had data on the whole haematology group. I have now organised through the Queensland Cancer Registry to get that data, which hopefully will be next year. I am only talking here about the group that the Leukaemia Foundation support, which is very sizeable. So when you project that and then you projected on the total number that would be travelling in haematology you are really looking at \$4 million, \$5 million and that is not factoring in the carers, because there is a problem with carers travelling. So that is purely the savings just on your travel and accommodation scheme. I am sure, as I said, that is quite minimal, the costings that I have done there.

Basically my submission is to say that there are significant problems that telehealth can address, that the move in that direction is applauded, but the caveat to what I have to say is that we need more research in haematology because there are factors in haematology that make it different to other oncology groups and we need to know factors from the haematologist's perspective about what are barriers and facilitators to the uptake of this. I am a researcher, I always just stay purely with what my data says, but the data is a strong affirmation and applause by consumers that this is the direction and the costings indicate that from the Health department's perspective and the health system's perspective that can only be applauded as well.

CHAIR: We have a couple of minutes. I am happy to take a couple of questions to the professor. Go ahead, Dr Douglas.

Dr DOUGLAS: Thank you very much, Professor McGrath. I have to ask the devil's advocate question. I know it is very early in the piece, but what is the evidence to show that a patient that is managed in a telehealth manner as opposed to a patient who is conventionally managed, in terms of managing everything from initial treatment, management of people who have gone out of remission into care, and people who get other illnesses?

Prof. McGrath: My response to that is that the previous presentation by Dr Sabesan went a long way. He is a leader in this area and he is really tackling those issues. I am a researcher and I can only present what my data says and I would say in this area we do not know but we are hoping this is step 1, that we will be moving towards getting more and more of that data. That is just a big area of work to do. I agree with Dr Sabesan's statements that it is very intuitive that the outcome of that work when it is done would be very affirming of that direction, but that is outside the data that I have collected so I cannot really comment.

Dr DOUGLAS: I was going to ask him that question but I knew that time was a problem and he had done so well I thought it was a bit unfair. How about then I get to the next devil's advocate question which is are there any templates for people who are in this situation that are the best practice model templates to follow in managing these types of patients and are we using them?

Prof. McGrath: I think that is the nub of the issue. Here I am talking about Queensland specific. I agree with the previous speaker that you cannot impose work done in Europe. The closest that we can get is work done in Canada because they have vast distances. One of the phenomena that we deal with in Queensland is just the sheer travel. My work would indicate that we now need to focus on developing a dialogue among haematologists that would start to explore where we are at now, what the best model of practice is and the way forward. That work has got to be done. I would be delighted to be in the position to be able to speak knowledgeably about it, but I have to be quite humble and say step 1—we have got a long way to go, but step 1 says this is fertile, we need to go down that direction.

Also my work was talking about routine follow-up. There is some dialogue—I have spoken to another haematologist—that says there is potential for more than routine follow-up to be looked at, but that is all work to be done. I can only stay within the data which is about routine follow-up which really is just a matter of sending the bloods down and having the conversation by Skype.

Dr DOUGLAS: The corollary to that is what you say, which is important, about the follow-up. What about the issue of the responsibility aspect? Dr Sabesan from Townsville was sort of getting there. It is the difficulty of actually the responsibility model. What have you got from your research with regard to defined responsibility when someone is in an outreach situation as opposed to within your confines? It is ill-defined sometimes. Have you got any information on that?

Prof. McGrath: Haematological malignancies are called blood and bone cancers.

Dr DOUGLAS: Soft tissue sarcomas. There is a big group now.

Prof. McGrath: Yes, and it is a growing group, especially the non-Hodgkin lymphomas and that. It really is. But the follow-up, a lot of this assessment is really the mantra of the blood tests. Those who are self-advocated to get that process and those who are receiving that process experience a high level of satisfaction. Instead of the five-minute conversation in the room, you are replacing it with a five-minute conversation on skype. Most follow-up is about blood tests, but you are not eliminating that marker. They are still having their blood tests locally and sent down.

Again, I want to clearly define the limits of what I am saying, because I think there is far more potential. I am saying that this is step 1. If we are looking at something, let us just look at this process of sending blood tests down and having a conversation. But I know that there is the potential for moving further along in the direction that you are taking—I think informed conversations, even that process of experts in this metropolitan area skyping and having telehealth with doctors and experts in the regional areas—but that is outside the parameters of my data.

CHAIR: Thank you, Professor. We are out of time. Do you mind if members of the committee have questions we can, through the secretariat, send them through to you?

Prof. McGrath: No.

CHAIR: Do you mind taking those on notice?

Prof. McGrath: No.

CHAIR: Thank you. I appreciate your time and we sure appreciate your submission.

Prof. McGrath: Okay. Thank you very much.

GRAY, Professor Len, Director, Centre for Online Health, University of Queensland

CHAIR: Welcome, Professor. We have met, obviously. We met you in a much more familiar setting for you than here. We appreciate your time today. Again, I would invite you to make an opening statement and I am sure that we have questions for you after that.

Prof. Gray: Good luck. Like the other two people who have been here, I am a strong advocate for telehealth and I have lots to say about it. I guess, being the director of the Centre for Online Health and having quite a number of years experience, I could say a lot of detail about all sorts of types of telehealth. Clearly, I would use up the time and that would not be particularly productive. However, I have heard things said by our previous two speakers and I would support precisely what they are saying. There is nothing there that I would disagree with and particularly Sabe's interpretation of how they have gone about developing services and all the kinds of learnings from that are completely sympathetic to the views that we have at the Centre for Online Health. So, hopefully, that will reinforce any views that you might have about that.

About myself, I think I should just tell you where I am coming from. I am a geriatrician by training. I have been a geriatrician for over 30 years. I spent the middle of my career as a health administrator, chief executive of hospitals and other things and came to Queensland in 2002 and changed into an academic role. After about five years here, I got tangled up in telehealth and also took on the role of Director for the Centre for Online Health in 2009.

I began doing my own clinical telehealth work in 2007 and I think I have now done about 3,000 teleconsultations over the last six or seven years. Interestingly, currently, I work at the Princess Alexandra Hospital. My clinical work is at Dalby Hospital, where I am the visiting geriatrician. I go every week and do a ward round by cart and I also consult at two residential aged-care facilities, one of which is in Brisbane and the other is in Dalby. So that is my kind of clinical involvement. Later this year I expect to start doing ambulatory consultations in rural communities—what would normally be in an outpatient clinic in the Princess Alexandra Hospital. We are building the systems and the infrastructure to be able to do that at the moment.

Ultimately, I think we will be back to the start of geriatric medicine, which is home visits. I am guessing that, when the technology, the bandwidth and the systems are in place, it will once again be possible to do home visits as a geriatrician, however you regard that as a valuable thing. Most people think that is a good thing—to see people in their own setting, particularly when they are frail. So we have kind of come full circle in geriatric medicine and it is all possible because of telehealth.

I will just talk about geriatric medicine for a minute, because that is my craft and that is where my own development of telehealth systems is most mature. We see several hundred more rural hospitals in Australia that all have old people in them. If those old people were in a city hospital, they would have a specialist geriatric service to interact with. In a rural hospital, they do not. The evidence suggests that if you get a comprehensive geriatric assessment process, you do get better outcomes. We could argue about that, but that seems to be the evidence. Like most disciplines, there is some evidence that you can do something with a specialist function. It is not intended to displace what is already in place, but rather to enhance it and to do that in a cost-effective way. So with all of these small rural hospitals, the citizens there would in the city get a particular type of service that they do not get. But because telehealth removes the diseconomies of scale problem and it removes the travel problem, essentially, it is possible to provide the same service in a rural hospital as in the city. So we are aspiring to make the service that we deliver currently to about five small rural hospitals in southern Queensland available across the country.

The other world in which we operate is the private world outside of Queensland Health. We have set up a service to deliver telehealth services into residential aged-care facilities where there are an awful lot of people who geriatricians are interested in and who can provide some assistance to. There are about 1,750 such facilities in Australia. Currently, we have built a service that is in seven residential aged-care facilities in Queensland. It will soon be 20. My look at the workforce—the incentives and the systems that we have built—have set me on a path to make this available in every one of those 1,700 facilities within five years. I think it is quite feasible.

I tell you this, because we have kind of gone from Sabe thinking about, 'How can I get my service to one place?' to scaling it up to the nation and figuring out what are all the systems, procedures, financial incentives, enablers and policy issues that you have to tackle in order to get that from an idea to a national program, if you like, where the need seems to be there. It really challenges us with all the ingredients that you have probably been told about that represent enablers and challenges in telehealth. In that particular world, we have very a very intimate understanding of all of those problems.

There are a lot of good things happening in telehealth in Australia: the Medicare item numbers; the disposition of the Queensland government towards telehealth is positive; the new funding arrangements that are being put in place on 1 July to support in-patient consultations are a positive; the support for ambulatory services in Queensland Health is being acknowledged now as an important enabler. All of those things are really quite important to get a good result.

The next little thing that I would like to say—and I hope to be done by 10 minutes, if that is all right; I think you probably want to ask me some questions and we have written most of this stuff in the Centre for Online Health submission—I guess the first thing, and I know others have said this, is that we all think about videoconferencing and we that it is a kind of emulation of standard clinical consultation. We think that people in rural communities should have the same service as what you get in the city, and the distance problem is the big issue. So it is pretty logical to think about video as a kind of substitute for standard care. You can reward it financially in the same way on the medical benefits schedule or through some payment arrangement within Queensland Health.

Those of us who have got embedded in telehealth realise that there is an awful lot more to it than this. That is just the most tangible element. There are all of these other strategies that you can use to deliver health care at a distance, which we call store and forward and telemonitoring. All of those kinds of things need to be thought about. We need to find ways to reward them, because they are all cheaper than standard face-to-face consultations. So whatever you can do that does not involve a direct consultation, but yet does not compromise the quality of care but rather facilitates, for example, health as a primary care to look after a person, if you can do it without actually having to have a consultation, then you can get the price down and you can help more people. That is a really important opportunity that new technology and telehealth offers.

I know that we all kind of struggle with the ‘We put the view out there and nothing happens’ idea. Lots of submissions talk about that. We all hope that there are a couple of ingredients where, if we just tweak things and adjust the policy, it will all kind of happen. I think that, obviously, we have to think about that, because that is how you solve problems. But I think of it much more of an evolutionary thing. If you think about your own personal life—and I see that you all have iPads and mobile phones and you probably use social media and you email people—10 years ago you were not doing any of that. Where was the click that actually made you change? It was a whole lot of things. A new app comes out and it suddenly makes your phone do something completely different. Nobody seemed to make a decision anywhere that really kind of made it all click. It is just happening. Telehealth is like that. There are a whole lot of ingredients that simultaneously need working on and over time more and more bits of the jigsaw actually get fixed. One day, simplistically, the whole jigsaw is finished, but actually it is not, because you have a bigger problem that you can now tackle with another bigger jigsaw. So there is an evolution going on here that we should just realise. You just have to push, push, push.

Why are we doing this? The answer is to tackle the problem of ‘more of the same is completely not going to work’. If we simply say, ‘We have an ageing population,’ lots of people like me are going to get old and die within the next 20 and 30 years and we are going to want the same health care as people have now. You do the maths and it does not work. You run out of workforce. You run out of money. So what are you going to do? Are you going to constrain services? We are seeing the current federal budget trying to tackle this problem. It is really difficult. There is no simple solution. If we cannot figure out a different way of delivering health care, we are going to have to compromise the standard. The only way I can see that you can do that is by changing the systems—rethinking the whole way you do the health care. So if an endocrinologist can look after 500 people instead of 250 through the use of remote monitoring surveillance systems and support staff—in other words he or she manages a system instead of the conventional ‘Come in and I will do everything for you’—then you have some chance of getting the same result at a lower cost. So I think that we have to think about all of those kinds of opportunities.

From the Queensland Health perspective, I think that we need to constantly think about the policy and the funding environments and make sure that these facilitate telehealth. I think recent changes have been positive. They need to be invested in and watched for several years—what is just being implemented. It will not immediately result in a massive uptake, just like the MBS item numbers did not result in an avalanche of uptake. But there has been a steady growth and more and more people are exposed to telehealth. It will take years and you just have to push. You have to push, because the end game—the opportunity—is fantastic. It will not happen one day; it will just be over years. So that is my suggestion to you—that we think long term, that we realise that it is a complex thing that needs lots and pieces of work to really make it work, but the opportunities are enormous. That is where I would like to finish my statement.

It is terrific that you are running this inquiry, because among our community of telehealth people we know that we have an audience of people who are sympathetic to the idea and you are trying to pick out where the problems are and I can see that you are trying to nut out what policy and funding arrangements might facilitate what seems to be a really excellent opportunity. In the process, I can see that you do not want to waste money, but I would say that, when you start anything new, you have to overfund it to make it happen and you have to put in some generous incentives to get all the marginal people to try to give it a go. The zealots will do it no matter what. It is the next guy after Sabe and myself.

By the way, we will have 15 geriatricians doing telehealth in the state shortly. It used to be me—one. I have a vision—and I am telling my colleagues and I think they are buying—that every city specialist should have a rural constituency that they look after and they should allocate a day of their week to a rural community. That might be reflected in as I am doing. I am the geriatrician at Dalby. I see the in-patients. I go to the nursing home and I will start consulting this year in the general practice. They will all know me. I am trying to tell my colleagues, 'You should be relating to one of these communities and building your practice around that at least for part of your week.' We have potentially enough geriatricians in training or existing to cover the whole of Queensland relatively shortly with that sort of arrangement. So I am very positive about it and I am thanking you very much for giving me a chance to talk to you.

CHAIR: Thank you, Professor. I have a couple of questions I would like to ask you. I am sorry team, but it is my turn now. Firstly, in relation to the last statement you made about it being generic and it sort of happens, I was the CEO of a very, very large not-for-profit organisation and we had about 100,000 volunteers and what I found was that often the push came from the bottom. There was a groundswell of demand when people recognised a capability that was not being utilised. That often was the nexus for people in positions that made decisions to actually move in that direction. I am wondering if that is not going to be part of what we see as a significant move toward telehealth.

Prof. Gray: I think success will be achieved when there is both a bottom up and a top down impetus. So if we took Sabe as a case study, I am guessing he got his management team to capture the idea and his CEO or people who can influence things and make some allocations will make it happen. He is not one guy just putting himself out on video. He has a team down the other end there. Someone has to make that investment and someone has to envisage that and take a bit of a risk.

A lot of us scrap around in telehealth trying to get grants and demonstration funds that sort of come off stage somewhere. Actually what you want is the boss saying—well I hope my boss would say, 'We have a relationship with South West. Let's get together and work out what we can offer them and think about a whole package of delivering support.' So that is from the top. Then you have to have the clinicians who want to serve that community and they have to have at least no disincentives to do that. At the moment if they try to do more work they do not get any more budget, so they just work harder. In the current climate, by the way, on the ground, trying to get Queensland Health or DOCS to go the extra yard is really a problem. You may know why that is. So you have to get them enthused and compensated for their time. That is just a temporary thing.

CHAIR: I was very interested in Dr Sabesan's presentation. I have just written some notes down on what I saw. He has been at it now, I think, for seven years, if that is right—from 2007 on. He saw an opportunity and developed that through. What I saw out of that was that after seven years he has documented models of best practice, which goes to Dr Douglas's point previously. The personnel on site are trained. The technology is a tool. It is almost seamless—in other words, the technology is not something that becomes an issue. Then it seems that what that has enabled is a significant increase of his expertise being spread across a much broader region simply because over a period of seven years they have developed this particular model. My assumption would be that for us to have a really mature model across Queensland we would have to develop that sort of model of best practice delivery in just about every discipline of medicine.

Prof. Gray: That is absolutely right. It is customised to the type of practice and the type of service you are trying to provide at a distance. All of this kind of happens—it is hidden when you go into a hospital. You do not actually see this. But as soon as you try to do something different, you find those systems do not work at a distance. You have to re-engineer them.

In geriatric medicine I would have exactly the same story as Sabe. We have worked out how to do a structured geriatric assessment that can be nurse administered. We built a software platform on a web based platform so it can be seen at both ends. We got that software made part of the standard clinical software for Queensland Health, so it is ubiquitously available in all hospitals in Queensland now. Then we train nurses at the other end to prepare cases and host a function, and

that training is ongoing. It is available. There is a contract with Queensland Health to support that in an ongoing way. So everything is standardised. The people at the other end know what they have to do. So that is the geriatric equivalent of what you heard Sabe talk about, and every discipline needs some kind of version of that.

In terms of diabetes, there are 10 things you need to know about a diabetic in order to consult with them. What you do not want to be doing is getting on the video and doing what conventional practice is and start from the beginning. If somebody at the other end can prepare the case for you, what it does is it upskills them and it enables them to implement your recommendations effectively, rather than you just trying to talk through the video and hope that somebody does something at the other end where there is only the patient. You build a team at the other end. So most of the disciplines that we have talked about this morning have all got this problem. Who is at the other end who is actually going to enable what I am doing? Sometimes the GP can be the person, but often there are other people who need to help the GP. It might be their practice nurse, but they have to get skilled up to know. That is very much about how many cases there are. Is it a large volume thing? Is it a rare, one-off thing? So you have to adjust for that as well. You are absolutely right. You need systems. It is not just video. That is why it fails.

Mr SHUTTLEWORTH: My question probably ties a number of these together. A couple of weeks ago we had a conference call with OTN. Do you think further impetus for the take-up of telemedicine across a broad range of clinical types would be more easily undertaken if, rather than as we seem to be doing now—where certain specialties or certain HHSs are grappling with this issue themselves—it be outsourced to an agency, such as a not-for-profit or an agency almost at arms-length but that had an oversight function of all of those things, that drove the scheduling, drove the technology deployment and all of those things? Do you think that we need to look at that? Rather than each individual discipline trying to advance their own, do you think it would be more advantageous if we had someone trying to advance the whole process of telemedicine and then deploying it across the broad spectrum?

Prof. Gray: Yes and no. Some things are best done communally, I guess. If you think about the phone system, we all ring each other up. We used to have one company doing all of that; now we have several. But essentially we can all pick up a phone and talk. We do not even have to think about that. One would hope that telehealth infrastructure was like that. So OTN provides that, for example. In terms of this issue about developing systems for specialties and how that should be crafted or customised, there is a skill in that. It is about system design. Having a group of people who have the capacity to work with clinicians to develop that or help them pick off-the-shelf systems is really quite important. Most of my colleagues do this not very well. They have no idea about that kind of thing, and they make things up that are really of pretty poor quality and not good systems. So we need that function.

On the other hand, you do not want to centralise it to the point where it stifles everything. For example, I think I have been pretty successful. When I came to Queensland Health I went and talked about getting some software to do this. They said to me, 'Well we have a waiting list of 27 projects. Come back and see me in five years.' I would not want to be confronted with that. It would have killed us. So we went away and found some money from grants and did things ourselves. So you do need to have not just command and control central but some kind of mix of ways of doing things to let people get at it. Hopefully your health service CEO might want to make an investment or you can get to an innovation fund. But then you still do need to have a repository of expertise somewhere. It cannot just be project based because you never get anywhere. I think that is where the OTN capability comes in. It needs to be there to draw on but not necessarily the only way in which you can do these things; otherwise you end up with this bureaucratic kind of response that just blocks you.

Mrs MILLER: Professor Gray, what is your prediction in relation to telehealth with preventative health?

Prof. Gray: I should have said a little bit about that. There is an important—well it depends on what you mean.

Mrs MILLER: I am thinking particularly obesity.

Prof. Gray: There is a lot of work going on in that area. A lot of it is about trying to help people help themselves through apps and self-management strategies and then trying to put professionals behind that. So you would have to think that is the hope, wouldn't you? Certainly I think about diabetes like that, for example. It is a kind of lifestyle disease, if you like. I did allude to endocrinology. That is highly specialised. Right down the other end of it, where is telehealth going to take us?

What we are just starting at PA now is that we want patients to have a glucometer and upload all their blood glucose readings into the cloud and, with their permission, allow their GP and specialist to look at all of that. I am imagining it would eliminate half the outpatient appointments that you need. What on earth do you go to the outpatients for? You just want someone to have a look at your results and then ring you if it is not right or have a free monthly review. You can build a whole lot of toolsets to go around that that help people manage their lifestyle, knowing that in the background there are people watching this that you are happy with—you sort of know them—and they will support you. So that kind of way of thinking is going to—and I think this is really important—push the boundary where the person can help themselves and reserve the use of the paid health professionals for the complex, messy things that go on and thus reduce the total cost of the thing.

One of the other themes I want to push is that all of this help yourself kind of stuff reduces demand on our conventional institutions. As Sabe said, small rural hospitals can look after more complex patients. You need less city hospitals. You do not have to transfer so many people. But you are still using your specialists. It is the same idea between the health professional and the patient—how much can you get them to help themselves versus when do you have to intervene? This does not mean you are out of business; you will not be because there is going to be so many of them. You are going to add value where you really can add value. So for the simple stuff where they can look after themselves they will look after. You come in when you are really needed. So your practice is going to get more intense and more about the most difficult things. That is the sort of vision I have with all of this—that is, trying to push it in a very positive way back to self-efficacy both at the patient level and in terms of the organisations.

CHAIR: Thank you. We have time for a couple more questions.

Mr HATHAWAY: I do not pretend that this is an oversimplification, but from listening to you just now I think back to the days of pre-telephone or when blood results were sent out by a doctor by post and referrals were sent by post and then we got fax and emails and all of that sort of stuff. Is that an oversimplification that this telehealth medicine is just part of that process to when eventually, looking at *Star Trek*, they have a holographic doctor who just appears? That is what I am trying to say, that people's reticence to take this up is that it is new technology, but it is now so pervasive that this will just become the standard tool.

Prof. Gray: I believe that that is partly a generational thing and partly an adaptation thing. I absolutely agree. It is a whole lot of ingredients that are making it possible to be more able to manage yourself but to know that you have the backup of really well-trained professionals. You do need to feel confident that you are not making stupid decisions. We do not want people to make decisions about really important things. You have probably heard the melanoma discussion. You could take a photo of your black spot and it can almost be automated in an app. Now you want to know that you are not making mistakes, and you as a health professional want to engage with that person when they really have a problem that you have to do something about. If you are time poor, that is when you want to be involved. So I think that is the idea. I agree with you exactly. That is what we are trying to do here. That hopefully solves our workforce problem and our health budget problem.

Mr HATHAWAY: I particularly like that approach. This is the equaliser of geographical disadvantage as far as I am concerned.

Prof. Gray: I did not make the point about disabled people and frail older people. I did tell the previous federal health minister, 'If you live in a nursing home in Brisbane, you may as well live in Roma as far as getting access to health services is concerned.' That was one of my better moments, because they did make exemptions for the telehealth MBS item numbers for people living in RACFs in cities. So I was really pleased about that. That has enabled us to roll out these nursing home initiatives. That was a good policy decision in my opinion. Quite frankly, I think the MBS item numbers should be for everybody. Eventually we will find a consult by TV with your GP will be a rewarded interaction, probably at the same rate as normal. You do not need a loading. I would imagine that is going to come, and should come.

Mrs MILLER: Plus the \$7.

Prof. Gray: Plus the \$7, yes, with a discount for telehealth.

Dr DOUGLAS: That was a great presentation. It is curious. I was listening to all of this today. It is almost like there are three separate things going on with the same tool. You are aiming to enhance the system, which is fantastic. For medicine that is great, but I would add that the psychiatrists are going the opposite way. They do not want to see patients. I am a GP and I can tell Brisbane

you that they do not want to see complex problems, and the orthopods are doing the same thing. They are going in the opposite direction. We probably need to work around that. They do not want to talk about anything other than the mechanics of doing something. They do not even look after their patients post-operatively and sometimes even pre-operatively.

Prof. Gray: We need to have about a big chat about proceduralists and where they make their money.

Dr DOUGLAS: The reality is that, whilst you are seeking to grow it, remember there is a broad part of the profession moving in the opposite direction and we probably need to address that. It is very difficult to bring a person who is actually going in the opposite direction into this model because, to be honest, they are not interested and they have nothing to add.

Prof. Gray: That is a big discussion about proceduralists and probably outside the scope of telehealth actually.

Dr DOUGLAS: It limits the possibility. Whilst what you are saying is fantastic, it does limit the way things are going. If you get that type of person involved, they do not add anything to the equation at all. They are actually useless. Anyway, be that as it may, the presentation from Townsville today was really a management thing—an existing problem. I have worked in Townsville. I remember Damien Meagher was their regional oncologist there. They had connections with all of those people. What was actually lost was the connections to knowing the individual GPs. What this is building on a system—it is a generic model—and being able to enhance it but using some advanced tools using the same system. I think that is a fantastic thing. Really what we would be seeking to come from people like yourself is templates. Are they on their way? Can we see them? Are they coming?

Prof. Gray: Yes. I think that is what we are trying to do: build systems or platforms on which people can operate. That is not just the administrative platform but the clinical, informatics side of it: who is collecting the clinical information, how is it distributed, how is it presented to the clinician to make their consultation effective—all of those kinds of things. I do think relationships are really important. When we try to deploy people in telehealth, we think about what geography they would physically be servicing as well as their telehealth responsibilities. You want alignment. If you need to see the person, you want to see the same guy, like Sabe. You see these telehealth online kinds of things—Friday afternoon I want to see a geriatrician. I will get one at four o'clock and it will be some guy in Perth. He will probably do a good job but then he will say, 'You need an examination. You will have to go and see your local guy,' and that is hopeless. We have to try to design it so that everything is aligned. The other thing is this kind of partnership/relationship that many GPs have with particular specialists. We have to try to reinforce those sorts of relationships even when you are operating in a telehealth setting. You actually get to meet the guy periodically—

Dr DOUGLAS: Yes, that is right.

Prof. Gray:—as opposed to just writing letters to them and seeing them every three years. So it actually matures the relationships a lot. I have some good GP relationships now. I would never have dreamt of having a relationship with a primary care doctor out at Chapel Hill or Dalby. You start to get friendly with them. It is terrific.

Dr DOUGLAS: For a lot of doctors, remember—and you would know this—it is shared responsibility. What that does is you are sharing the responsibility. In terms of that example you gave about a guy in Perth, the problem is that the people say, 'Look, all I do is consult over the airwaves'—all care no responsibility stuff. The problem we have is from our perspective how do we stop that?

CHAIR: I am sorry, Dr Douglas, we are out of time here and we are on a time schedule. Professor, do you mind if we have questions that we shoot those through to you?

Prof. Gray: Of course.

CHAIR: We appreciate your time. We appreciate you sharing your expertise with us. It has been beneficial for us. I declare the hearing of the Health and Community Services Committee closed.

Committee adjourned at 10.35 am