T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Ambulance Victoria

Melbourne – Friday 13 June 2025

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Professor Peter Cameron, Academic Director, Alfred Emergency and Trauma Centre.

The CHAIR: Welcome back to the next section of the Legal and Social Issues Committee Inquiry into Ambulance Victoria. Just for the record and for Hansard, could you please state your name and the organisation that you are appearing on behalf of? Thanks.

Peter CAMERON: Thank you. I am Professor Peter Cameron. I am the Academic Director at the Emergency and Trauma Centre at the Alfred, as well as a health services researcher at Monash University.

The CHAIR: Thanks very much, Peter. I am Joe McCracken, Chair. We will go around the rest of the committee and introduce ourselves as well.

Michael GALEA: G'day. Michael Galea, Member for South-Eastern Metropolitan.

Ryan BATCHELOR: Ryan Batchelor, Member for the Southern Metropolitan Region.

Georgie CROZIER: Georgie Crozier, Member for Southern Metropolitan Region and also Shadow Minister for Health and ambulance services.

Anasina GRAY-BARBERIO: Hello. Anasina Gray-Barberio, Northern Metropolitan.

The CHAIR: We have got two online. You may not be able to see their faces because of the presentation that is up, but if you guys can hear me, do you just want to give a quick yell out, please?

Ann-Marie HERMANS: Yes. I am Ann-Marie Hermans. I am also representing the South-Eastern Metropolitan Region.

Renee HEATH: Renee Heath, Eastern Victoria Region.

The CHAIR: Rightio. Thanks very much. I will just read this out, and then we will get into it. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information you provide during the hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and repeat the same things, those comments may not be subject to the privilege that you have here today. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded, and you will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and posted on the committee's website.

Peter, I will hand over to you to talk us through your presentation. We might have 5, 10 minutes, something like that, and then we will go to questions from the committee. Over to you.

Peter CAMERON: Thank you for the opportunity. It is an area of interest of mine, obviously, and I am very keen, I guess, for a bit of a relook at the way we do our pre-hospital care.

Visual presentation.

Peter CAMERON: The main points I want to get across today in 5 or 10 minutes are that we have got to identify what the role of the ambulance actually is and what its hierarchy of priorities is. The governance of ambulance itself results in a lack of integration with community and hospital care. It is in some ways a bridge but in some ways a barrier to those areas of care. Emergency dispatch is not integrated with ambulance, and the funding itself distorts the priorities of the service.

Just to take a sort of helicopter view of history, in the last century we had the rise of the hospital, basically the ivory tower where everything was. All the technology and all the expertise were all centred in a hospital, and that is divorced from community care. The research and education are, again, centred on that institution, with

multiple funders from different health sectors. So we are sort of set up to be an ivory tower, with people trying to get into that ivory tower.

The number of hospital beds across the system is very variable in every country. You go from India, where it is about one per 1000, to some of the Asian countries where it is more like 10 per 1000 inhabitants. We are in the middle there somewhere. But when people talk about shortage of beds, it is all a relative thing. It is not an absolute – you should have three or you should have five or whatever. Of course where I work, in the emergency department, overcrowding is common, and it is an interminable problem, and it is in the newspaper every second day. It seems that despite 20 years of studying this – as well as ambulance ramping, which is a direct consequence of that – we do not seem to have an answer. Really, from a patient safety point of view, it is ridiculous. It has actually been shown to be associated with death and morbidity. It is not a good thing. It is not good from a patient's perspective. Clinically, it is horrendous, the staff hate it and of course it actually results in adverse events, so whichever way you look at it, it is bad. We should be trying to fix it. There is no consensus on what the problem is or the solution and what is acceptable. And I guess it gets to the point where – is our model of care wrong?

On possible solutions, current models of care push patients to this sort of centralised, institutionalised care at the same time as we are trying to cut down the beds, because they cost money. The question is: what percentage of patients need institutional care? What is happening with the expansion of community care, and how can we manage that? How well can we do remote management? And what is the role of AI algorithms and advanced technology in changing that? And then, of course, just a comment at the end about KPIs. I have a particular dislike of KPIs; I actually think they do more harm than good. The classic example is Mao Zedong, who wanted to double steel production over five years, so he did that but at the expense of melting down all the steel fabrication to make that target. That is a bit of an extreme example, but the same sort of thing can happen in a hospital – people are running faster and faster to meet a KPI, but they do not actually improve the care. KPIs are useful at a local level, but driving the system using KPIs is wrong. We can argue about that.

Virtual care is one of the solutions that has really taken off, and many clinicians think it is the emperor with no clothes, but I think in this space it has a really important role. At the Alfred we undertook a pilot during and after COVID, and we were able to get to a 70 to 75 per cent diversion rate, which included the 10 per cent re-presentations over the next seven days. It was actually very effective at keeping people out of hospital at the same time as providing patients with high satisfaction, so it was sort of a win-win. In residential aged care it is particularly important, because ripping someone out of a nursing home bed and putting them in a corridor in a hospital is not the best way to treat our older people, and there are many better ways of doing it, and yet we still do not have an integrated way of doing that – integrated outreach, better use of mobile X-rays and CTs where appropriate, of course better advanced care planning and integration with the major institutions. What I am talking about is a community care system as opposed to having the ivory tower – the ambulance transport and community care. That is what we have got at the moment.

The fundamentals for change – the funding model is sort of wrong. We do not reward prevention of institutional care, we reward activity, but the activity is not necessarily the most productive activity in terms of improving someone's outcome. Obviously capitation models are possible, but not in our current environment, but certainly regionalisation of care can help with that. The public needs to be aware of the costs of hospitalisation, both in terms of the actual cost as well as the cost to them in terms of the physical danger of being in a hospital.

In Australia a return ambulance – and this is slightly different to what you will get from AV, but this is the real cost – is something like $2000 for a return trip if you include all the costs. Overnight stay at the Alfred in short-stay, which is what most old people will do – they will come in at 7 or 8 at night, they will stay overnight – is between $2000 and $5000, and multiday stays are $10,000 to $20,000. These are huge costs. An outpatient virtual consult and follow-up is 500 bucks. There is no comparison.

The funding models at the moment push prehospital clinicians to take them to hospital. If you are a paramedic and you have got someone you are a bit worried about, it is much easier to just chuck them in the back, take them to hospital, sit on the ramp for a few hours and then it is not your problem, from a cognitive point of view, from a time point of view or from a litigation point of view. But to enable that to happen, you have got to have the right structures in place, and at the moment we do not have those. The skills of the paramedics may need to change, and it may be that we need other clinicians apart from paramedics. Obviously there is the role of point-

of-care tests and how they are paid for – for example, at the Alfred at the moment we are about to do a trial with point-of-care, high-sensitivity troponins at the scene, which may result in, say, 30 or 40 per cent of chest pain patients not having to be transported, which out of 50,000 patients a year, that is quite a few patients. The point here is that for each clinical pathway, we need to deconstruct them. Whether it is an older person with a fall, someone with chest pain, someone who may or may not have sepsis, the question is: if you deconstruct it, how would you go about assessing and monitoring, how would you go about investigating the treatments, the follow-up and the risks from the time they enter the system to the time that they leave the system, not just what the local doctor or the nurse does, what the ambulance does, what the emergency department does and what the hospital does, but look at it from the whole patient journey, and what would the cost be, relative, community versus hospital care?

This is an opportunity, I think, to relook at what ambulance actually does and to deinstitutionalise a lot of health care. There are good little examples of things going on, but it is all sort of patchy. The pre-hospital, hospital, rehab community paradigm is sort of like last century. Currently very few health systems around the world are set up to optimally manage community needs, and very few consumers understand the unnecessary cost of our current model. I think fundamentally the AV governance model needs to be looked at closely, because it is just another health service. It is the same as the Alfred or Northern or whatever – it is providing a health service. In the past it has sort of been the paramedics and then there are the doctors at the hospital, whatever. It is actually just another health service that is trying to provide services between the community and the hospital, and it needs to be integrated with the governance of the hospitals. Thank you.

The CHAIR: No worries. Thanks very much. We are going to just cycle through questions, and I will go first. There is a lot to take in and there is a short amount of time to get through it, but I will try my best. Firstly, thanks very much for your presentation. I think one of the things you said in there was that activity is rewarded, not necessarily outcomes. Can you talk a bit about that?

Peter CAMERON: Yes. I mean, the problem with activity-based funding is, you know, when you are the ambulance, how many transports you do or whatever is a sort of sign of how much work you do. In the emergency department we are not paid directly as the number of attendances, but with an emergency department seeing 100,000 versus one that sees 50,000, you are going to give them more money just one way or another. Certainly once you get to hospital admissions, they are all casemix funded, so the WIES or whatever, the casemix payments, are basically the revenue that the hospital gets. If they were to, say, not do the operation or not admit the patient but send them home with two weeks worth of follow-up, that would be at the expense of the hospital. And even worse, for a place like the Alfred, let us say you have a referral from a country hospital with a broken leg, or even better a broken spine, you might decide not to operate, but you will not get any money if you just say, 'Oh, I've looked at the scans, I've looked at the person. I don't think it's appropriate in this case.' It might take you a couple of hours – there is no revenue for that. Whereas if you admit them and operate on them, you get a lot of revenue. I am not saying that that is what drives the doctors, but what I am saying is the system does not reward the hospital for having a better system for preventing that admission.

The CHAIR: One of the things you also talked about was costs, and I know you put up the example there of virtual 500 bucks, I think it was from memory, and others that cost $2000 to $3000, up to $20,000, I think.

Peter CAMERON: Yes.

The CHAIR: You also spoke about the general community not having a command of the costs. I guess the question is: how do you get to a position where you can maximise taxpayers money that is going into this while at the same time prioritising patient outcomes? I know that is a really hard balancing act, but it should be the ideal.

Peter CAMERON: I do not think we are very honest with the public. Why don't we have an honest discussion – forums or whatever – to ask the public what they want? Because when you speak to people at a pub or something, they are not stupid, most of them.

The CHAIR: Getting there.

Peter CAMERON: But we do not have honest conversations. We sort of whitewash it all, and we do not say, 'Well, if you had the choice, what would you prefer?' Most of the time people are pretty sensible.

The CHAIR: In terms of the costs, though, how do you transition to a model which tries to provide the right care for the right person in the right situation at the best value for the taxpayer? Because your example that you put up there, $500 for virtual consultation in most cases – I mean, it depends what it is. That would seem to be at least a low-cost option compared to the other ones, but you are saying that does not happen all the time.

Peter CAMERON: No, and part of that is because each health service is not part of a health system – they are part of a health system, but they do not act like they are part of a health system. So the problem is that – I can give an example of the Alfred because I work there – for the Alfred to provide advice, say, to a community provider that a more appropriate patient journey would be to manage that as an outpatient and we will provide the backup, there is no funding model for that. So in the end the registrar or whoever says, 'Oh, well, come in here and we will sort it out,' as opposed to 'Well, we're going to map out that patient journey, and there will be someone that is coordinating that.'

The CHAIR: Yes. My time has finished, so I will pass on to Mr Galea now.

Michael GALEA: Thank you, Chair. Thank you for joining us today, Professor Cameron. It has been very interesting, and I am sure we could spend a lot more time, but I am also limited, so I will just start by asking you about the role of paramedic practitioners. Talking about different models of care and going outside of the traditional way of doing things, do you think that there is a big place for this, noting that Victoria has, I would say, probably been at the forefront of this? Is there a big scope for this, and what do you think of these programs?

Peter CAMERON: I think there is a place for it, but I also think there is a place for nurse-led practitioners as well. I think whatever it is it has to be multidisciplinary. My concern, I guess, with whichever models we come up with is that they are efficient in delivering the right care to the right person at the right time. That is where I think it is very important that we monitor and analyse and do not just say, 'Oh, we're going to have a thousand paramedic practitioners, and that's going to solve the problem,' but maybe pilot it in a region and see how it goes. But whichever way it goes it should not be – my problem at the moment is that the ambulance acts as an independent authority which does not seem to integrate with the surrounding health services. I would rather see, whether it is a rural region or an urban region, regionalised care where the ambulance was really just another part of that. I have not directly answered your question, but the point is that we have had all sorts of practitioners and they have not necessarily resulted in better or more efficient care, so whatever it is it has to be integrated and it has to be monitored, and we have to make sure that it provides the outcome that we want. The good thing about paramedics is there are more being trained than there are positions in AV, so there may be a sort of a gap for their employment, which is good. Like nurses, for example – in the past there have always been shortages of nurses. So having a mix probably gives you a bit more flexibility.

Michael GALEA: Yes. But I guess would it be fair to say your point then is that it all needs to be multidisciplinary – it needs to be paramedics and it needs to be the virtual EDs, which you mentioned in your presentation as well, and the traditional EDs and everything else and then the lower levels of care, so the primary intervention as well? I think a key thing that we heard today is working together and not in silos as well.

Peter CAMERON: It is part of a system, yes. And monitoring that system is very important. But I think one of the problems at the moment is we see prehospital care as being paramedics, hospital care as being nurses and doctors. I say use whichever clinician can provide the service.

Michael GALEA: Yes.

Peter CAMERON: That is why you need to deconstruct the patient journey to work out what it is – what skill set is required. Obviously a heart surgeon has to do a heart operation, but for a lot of other lower level stuff, many different clinicians could actually do it.

Michael GALEA: Thank you.

The CHAIR: I will now pass on to Ms Crozier.

Georgie CROZIER: Thank you, Chair. Thank you very much, Professor Cameron, and it is a very interesting discussion. I would like to just ask you about your own experience. You have been working in

emergency departments around the world, I understand. Has any one system worked more effectively and more efficiently and been more integrated – as you say needs to be done here – than what we are experiencing here in Victoria?

Peter CAMERON: It is a good question. I have not seen any system where I would say 'We just have to copy that one', unfortunately. Otherwise it would be –

Georgie CROZIER: And there lies the problem, doesn't it?

Peter CAMERON: Yes. I mean, we have one of the most expensive, one of the most highly skilled systems – and to be fair, a high level of patient outcomes – in the world, so it is not like we are starting from a low base. However, for the amount of money we are investing and the resources that we have got, I do not think we are anywhere near where we could be. I think going into the future we need to make use of the technology that is available and also the ability to use that technology to integrate the system. For example, at the Alfred at the moment they are introducing a command centre, which you may or may not have heard of, which is sort of like an integration model which relies on AI. Basically it sucks in all the data and allows you to track what is happening to the patient across the patient journey. Now, there are still hospitals in Victoria where they have not even got an electronic medical record.

Georgie CROZIER: I was about to say, that is all very well, and you describe the fragmented system – that is the system. But we do not even have a proper IT system. We do not even have any money in this year's budget to be looking at integrating any of those things, so it is not going to happen anywhere soon in terms of trying to bring it all together. The other thing I would say in terms of that community care that you speak of is there is no resourcing in preventative health, in community health, so when you want to keep your patient out of hospital, which is the aim, and leave acute systems for the sickest, we need to be looking at that investment, and I think there is a failure there. Do you see that failure, at that end of government funding, contributing to the pressures that we have got through Ambulance Victoria and into the emergency departments?

Peter CAMERON: The technology side of it in Australia has been underinvested in. In the US they spent trillions, and they have still got a few trillion dollars worth of debt. We have started to invest a bit, but it is very patchy. But I think we do have to invest in that, because that is going to be the backbone of the future health system. We cannot expect all the hospitals to do everything all at once. I think one of the good things that is starting to happen is the sort of more networked approach. If you look at the Bayside group, for example, I think that is a good development, which allows the technology, the expertise, to be spread amongst –

Georgie CROZIER: But they do not have any IT systems. I have asked the CEO. It is not there.

Peter CAMERON: No, no, no, but –

Georgie CROZIER: I have asked in PAEC. It is not there.

Peter CAMERON: No, I understand.

Georgie CROZIER: They are setting it up without the IT system in place.

The CHAIR: Ms Crozier, time is up, I am afraid.

Georgie CROZIER: I could not resist.

Peter CAMERON: But I think the point there is that there is not that much expertise in Victoria as a whole, and –

Georgie CROZIER: Don't we need that before they set up, though?

Peter CAMERON: No, no, no, but what I am –

The CHAIR: I am going to have to hand it over. Ms Gray-Barberio, over to you.

Anasina GRAY-BARBERIO: Thanks very much, Chair. And thank you, Professor Cameron, for your presentation. You have spoken a lot about the lack of integration. In your opinion, is there an us-versus-them with regards to Ambulance Victoria and other actors in the hospital landscape?

Peter CAMERON: I think at an individual level, you know, 'I love my paramedic mates' and all that sort of gear – it is fine. At an organisational level, when things are bad, where you have got 20 ambulances lined up and another 20 coming, it is inevitable there will be tension between staff because they are not all working for the same organisation – one lot are working for ambulance, one for the hospital. There is no doubt across Victoria there have been tensions, and that to me is inevitable whenever you have got a system under stress. But that is not to say that it is us-and-them across the board. It is just that the nature of it can create that sort of tension.

Anasina GRAY-BARBERIO: Thank you. I want to touch on the solutions that you spoke about in your presentation. You spoke about the role of AI algorithms. We had a submission earlier from the Victorian Ambulance Union around how it is very difficult to override algorithms with regard to call reforms. How do we ensure that AI in a medical and health context maintains integrity?

Peter CAMERON: I think it is a big question, and there is not one answer to that – it could be a whole-day discussion. But whichever way it goes, we are going to have AI – we cannot avoid that – and we are going to have algorithms, but what we need to do is monitor them and analyse them and improve them as we go. To be fair to ambulance, things like cardiac arrest and so forth, we have improved a lot of those over the years. But it is not like you put in an AI model and that is the end of it – it is constantly improving – and there will be problems, and there are dangers. Things like AI can actually – disadvantaged people or people from non-English-speaking areas or whatever can be disadvantaged by dispatch and the algorithms can sometimes even amplify that, so you have got to have a human saying, 'Well, actually that's not right'. That is why it is really important to monitor and improve. But it is not like we can avoid it – we are going to have it. We have just got to make the best use of it.

Anasina GRAY-BARBERIO: Great. Thank you. You mentioned in your presentation that KPIs are not necessarily good for the reason that they can have a negative impact on the work and the outcomes. What metrics do you suggest substituting?

Peter CAMERON: I am not saying we should not have metrics. What I am saying is the way you use KPIs – the worst example of use of KPIs is in the NHS where they used the 4-hour rule to whip CEOs over the head and they did all sorts of crazy things to meet those KPIs because their jobs depended on it. That is bad. Within an organisation you can say, 'Well, we think that we shouldn't have certain things happening, like patients staying more than 24 hours in the emergency department'. That is a good thing to have those internal metrics to say that is a consensus thing that we agree on. But if the government thinks it can control the health services by using KPIs, that is wrong. The health service has to do it and say, 'Look how well we're doing'.

Anasina GRAY-BARBERIO: Great. Thank you very much.

The CHAIR: I will hand over now to Mr Batchelor.

Ryan BATCHELOR: Thanks, Chair. Professor Cameron, thanks so much for coming in. I just want to clarify something in your presentation. You talked about the virtual medicine – it had the emperor –

Peter CAMERON: With no clothes.

Ryan BATCHELOR: Yes. Are you saying you do not think it is a good idea, or you do think it is a good idea?

Peter CAMERON: What I am saying is amongst my colleagues there is scepticism about whether it makes a difference or not.

Ryan BATCHELOR: What is your view?

Peter CAMERON: My view is it has an incredibly important role, but again, it needs to be set up the right way. I do not know that our present model is the right one. I think every major health service should have its

own virtual care and have the capacity to run that, and if they cannot, they should be doing it in conjunction with a major health service that can. So I am a believer in –

Ryan BATCHELOR: You think the principle is the right one, that we should have more virtual care.

Peter CAMERON: The principle is the right one, but I am a believer in a federated approach to the delivery of virtual care.

Ryan BATCHELOR: Okay. You talked a lot about the challenges in the system, the problems with the way it currently works. We are a committee focused on trying to make recommendations; we can critique all we like, but no-one needs another report full of just critiques. What should we recommend that we do differently? What should be the positive recommendations that we make about the changes in the current system – on the interface, for example, between ambulances and emergency departments or between the ambulance service and the health services, for example – that would actually have some concrete change to improve the system?

Peter CAMERON: If you started off with a sort of blank sheet –

Ryan BATCHELOR: But we do not have a blank sheet; we have got a current system.

Peter CAMERON: I am just saying sometimes if you think about that, that might be where you want to get to in 10 or 20 years. You have got to have a goal. You cannot sort of say, 'We're going to do this and we're going to do that, and maybe something will happen.' You have got have something.

Ryan BATCHELOR: You have got to have a vision, yes.

Peter CAMERON: So if you think about it that way, my view is that there obviously should be central ambulance control, but it should also be regionalised so that the regions of the ambulance integrate with the hospital regions, if you like, so that it is actually a shared governance model, because I think at the moment what we have got, as I say, is a health service that is out here – the ambulance – and the other health services all scurry around trying to manage whatever ambulance delivers to them, and it does not actually make sense, because now we are thinking maybe half the patients we are admitting do not actually need to be admitted. We want community outreach programs; we want to deliver this to these people in the community, keep those people at home. People with complex cancers – all sorts of things – can be managed in the community, but we do not actually have the sort of community operator model to do that.

We need to start rethinking about hospital versus community. It is sort of like the patient journey for whatever it is. Most of the patients we have got now – we rarely get young people who come in with one disease, you hit it on the head and they go home. That is not what we do with medicine these days. Chronic disease, whether it is cancer, diabetes, heart failure – they are chronic diseases, and they are in and out of specialist care. That specialist care can be delivered remotely.

The CHAIR: Thank you. I will now go to members online, and I will first go to Mrs Hermans.

Ann-Marie HERMANS: Thank you, Professor. We really appreciate you coming out. I have picked up on you mentioning integrated, monitored and the outcomes that we want, not having KPIs driving the system but improving care, and you have mentioned the use of virtual community outreach programs. Would a virtual emergency department – have you seen that? You have mentioned that you have been to different countries. Have you ever seen a virtual emergency department where people could actually, instead of just ringing up a GP to try to get an appointment or doing it online – would a virtual emergency department work as a form of community care? Has that been done anywhere that you have seen and observed, and do you have any data on that?

Peter CAMERON: In Victoria there is the Victorian virtual emergency department.

Ann-Marie HERMANS: Have you ever seen any care that has been done as a virtual emergency system?

Peter CAMERON: Yes. That is done now, and until the funding got cut at the Alfred we were doing it there – and a number of other health services. Across Australia and New Zealand there are a number of examples where that works. So it is not new – it is just a matter of how it is delivered and how it is integrated

with the hospital and the community services. The big danger with the VVED that we have here is I can sit at home and ring up if I need some pills or something, and I basically get the prescription for nothing. If I ring up my GP, I can pay 50 bucks or something, or if I use the private one, I can pay 150 bucks and get the same service. Or alternatively I can get on the bus and then the train and get to the GP and then get a physical prescription and take it down to the chemist. The danger is it is actually easy – and that is good, but we are sucking, effectively, GP patients into what is an emergency system. That balance needs a lot of thought.

Ann-Marie HERMANS: Yes. So an integrated community outreach program – you are then suggesting, from what I am hearing, that we would bring in the different facets of paramedics, nursing, ambulance and specialist doctor care? Is that what you are actually suggesting for a pilot in a region? Can you perhaps touch on that in terms of how we would be able to drive a different form of KPIs for outcomes and a different form of preventing ambulance ramping through some sort of pilot system?

Peter CAMERON: Yes. I mean, basically what we have shown when we have looked at this in detail is that you can divert a large number of 000 calls. The ambulance does some of that already with the technology that is available now, especially when it is integrated with the hospital system and the hospital records. You can divert a large percentage of patients. Now, obviously we want the heart attacks, the strokes and the major traumas to go straight to hospital as fast as possible. But what we do not want is people with chronic illnesses taking the only lifeline they have got, which is the ambulance, to get a specialist opinion about something that is quite complicated, because that can be done virtually.

Ann-Marie HERMANS: That is really helpful. Thank you. Is there anything else that you wanted to add, based on your research, that you feel you have not covered that is in line with this for today's hearing that would help us to make decisions?

Peter CAMERON: It is a matter of time, I guess.

The CHAIR: If you want to add 10 or 20 seconds, that is fine. Go for it.

Peter CAMERON: Basically what I am talking about here is we need to change the governance structures to align with a different model of care. We need to look at the metrics that are important, and we need to look at the workforce we need to deliver the care that is important for these chronic diseases that are filling up our hospitals at the moment with unnecessary admissions when they could be dealt with more efficiently by an integrated model.

The CHAIR: Excellent. I will now throw to Dr Mansfield. Are you online there?

Sarah MANSFIELD: Yes, I am. Thank you.

The CHAIR: No worries.

Sarah MANSFIELD: Thanks so much for your presentation today. I am interested in digging into the integrated governance model that you are talking about a bit more and I guess understanding what that would practically look like, given, as you said, we have such a fragmented and siloed health system currently. How do you think you would even start rolling that out or tackling that?

Peter CAMERON: Yes, it is a good question. I mean, wherever you go in the world it is very hard to find an integrated system that covers off on the things that we want. As I say, it is not like we can sort of cut and paste. However, I think as a starting point if we have regionalised hospital care, regional networks, and those somehow or another have shared governance with the ambulance – this would require a knocking of heads; it would not come naturally, I can tell you. But if there was some way of even starting that journey, I think it would be good. This is idealistic. At a practical level, I think the only way you could start would be to say, 'We see this as important. We're going to have combined funding for some aspects of care, and you guys have got to sort it out at a regional level.' It has to come with money.

Sarah MANSFIELD: And in terms of that funding model, you mentioned a capitation sort of model before. You would almost have to look at something like that to make something so integrated work, potentially.

Peter CAMERON: Yes. If you look at Kaiser Permanente, for example, in the US, there are some downsides to what they do, but they do have a more integrated model than most. Now, we have not got a

private insurance company, but effectively we have got a federal insurance company and we have got a state insurance company doing different things, so if there was some way of modelling that at a regional level, I think that would be the way to go. But as I say, even a baby step would be to bring that together within a region across prehospital and hospital services.

Sarah MANSFIELD: Yes. To change tack a bit, I know that there have been trials putting a clinician in an ambulance to go out on visits – how have those sorts of things gone? Do you think there is scope to expand some of that to try and improve that pre-hospital transfer clinical support and potentially avoid some of those transfers and admissions?

Peter CAMERON: Yes, 100 per cent. That is where the virtual side of it is really – I can sit in my office and do a really good visual consult and get 90 per cent of the information I need to make a decision and see what follow-up is required. I think it is very expensive to have specialists going out in the ambulance. It is not that expensive to have a specialist consult with a clinician who knows what they are doing.

Sarah MANSFIELD: Thank you.

The CHAIR: I will now pass over to Dr Heath, who is online too.

Renee HEATH: Thank you so much. That was a really interesting presentation. Just following on from Dr Mansfield, if you did have a doctor going out with an ambulance, I guess that saves the referral rights needing to expand. For instance, right now if you needed medical imaging, the patient would have to come into the hospital, and it would have to be a doctor or somebody with those rights to refer. What happens there?

Peter CAMERON: That is exactly what I was talking about with the paramedic practitioner thing. The current paramedics do quite a lot of training. It is not like they know nothing. They actually have enough clinical skills to do a primary assessment of a patient and report that to a higher-level clinician. The patient plan could be made with a visual consult with that assessment, and then the tests and investigations that are required and the medications could all be laid out with minimal change to the training for the ambulance clinician or the specialist. I think there are real opportunities in that integration using the technology that is readily available now.

There is resistance amongst some paramedics. There is resistance with some of my colleagues. But I think as the technology gets better and the integration – because the biggest worry for any of these people is you leave them at home and two days later they die or something, and all of a sudden it is all your fault. That is the worst thing that can happen to a clinician, so the way to avoid that is to just take them in and then it is someone else's problem. But if that responsibility is taken from you and you have got someone holding your hand, then you feel comfortable in doing that.

Renee HEATH: Yes. So they can, in a sense, expand their scope of practising without expanding or changing the training we are giving paramedics at the moment, essentially.

Peter CAMERON: Yes.

Renee HEATH: Yes. The other question I had is: in one of your slides you spoke about mobile CT and mobile X-ray; do you mean in the context of an emergency scenario?

Peter CAMERON: As I say, there are some emergencies that are time critical and there are others that are not. For example, an old lady falls out of bed in a nursing home and may or may not have a fractured neck or femur. If it is obviously a fractured femur, they just need to go to hospital. If it is maybe a bit of a sore hip – not sure – take the X-ray to them.

Renee HEATH: Sorry to get down into the weeds a little bit. So in that situation the paramedic would then liaise with the online doctor, and the online doctor then would provide the referral for that imaging, and then it would be done onsite.

Peter CAMERON: Yes.

Renee HEATH: And then of course it goes through I-MED or some radiologist offsite.

Peter CAMERON: Yes.

Renee HEATH: Okay, that is fabulous, I think. Thank you.

Peter CAMERON: You think of the cost of transporting that poor old lady, who is – the physical cost and the emotional cost but also the actual economic cost. So it is a win–win.

Renee HEATH: Yes.

The CHAIR: You have timed it perfectly, as always. That brings an end to today's session here right now. Peter, thank you very much for coming in and giving your evidence and for your presentation as well. We will close off there. Thank you.

Peter CAMERON: Thank you.

Witness withdrew.