Australians facing 4.7-year wait for life-saving medical technologies

Public or private status can determine access, new report warns

Run time: 41.31 mins

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Stuart, 54

Consultant, father & grandfather whose answer to one question saved his life: "Public or private?", ***SYDNEY***

00:26 – 00:40
Self-introduction
My name is Stuart, I live in Sydney, I'm 54 years of age and I had an aortic dissection.

00:36 – 01:06
What type of lifestyle were you leading before your cardiac emergency?
I played rugby till I was 45. Went to the gym four to five days a week. I don't drink, don't smoke. My family, my wife and I eat super healthy food. Don't eat junk food, did all the right things. Went to the doctor once a year. Had a full health test, blood test. My cholesterol was perfect. My blood pressure was perfect. And then just one morning, got up on a Monday morning and out of the blue, had an aortic dissection.

01:06 – 01:33
What transpired on July 18, 2022?
July 18, 2022. Normal day at work. I was at work, it was about 9:15 in the morning and something just didn't feel right about my body. And then just in the blink of an eye, my aorta tore. I didn't know that at the time because I had no symptoms, no warning signs, no sore arm, no shoulder, no pins and needles, no headache, nothing that would relate to heart.

01:33 – 01:55

What happened when you realised something was seriously wrong?

So we called for an ambulance. It was in the last wave of COVID. They told us it was going to be two-and-a-half hours for an ambulance. Right there and then, one of my work colleagues aid, "No, you can't wait that long. How do you feel" I said, I need to get to a hospital. That saved my life. if I hadn't got to a hospital and my work colleague didn't drive me to hospital, I wouldn't still be sitting here today.

01:56 – 02:11

What symptoms did you experience that day?

The only two symptoms that I actually had were dizziness and I couldn't stand up. For me, that was extremely strange.

02:11 – 02:24

What made the biggest difference in your survival?

The reason I did survive is because that day the device I needed had been approved in the public system, but not the private system.

02:24 – 02:41

Had someone informed you that your chance of survival was only 10 to 15 per cent at the time, how would you have reacted?

But if you had said to me right there and then, I had about a 10 to 15 per cent chance of living, I would have looked at you with just, there's no way.

02:41 – 02:59

How did the hospital receptionist's question, "public or private?" help save your life?

The reason why the woman asking that question "public or private" that day saved my life by going public is the valve that I had put in my heart that saved my life was not available to private patients on that day.

02:59 – 03:27

How did you feel when you were told that your choice to be admitted as a public patient may have actually saved your life?

I felt amazing when I knew that I had gone public purely because it ended up saving my life. I didn't realize that at the time, but obviously waking up in hospital with a 10 to 15 per cent chance of living and then being told that it was because you chose public or private still doesn't sit right with me, but it's the truth.

03:27 – 03:51

What specific changes do you propose to ensure every patient, regardless of their postcode or insurance status, can access the latest medical technology?

Every patient, it shouldn't matter their postcode, their status in life, or if they're privately insured or in the public system, they should have the only priority should be access to the latest and greatest medical technology that Australia has to offer in the world. And it shouldn't matter the system you're in.

03:51 – 04:15

What did you discover later regarding the disparity in life-saving medical technology available to public versus private patients?

I was really surprised when I found out that my private health insurance didn't offer me the latest and greatest medical technology that the world has to offer. I just assumed that being privately insured was my only answer that day and it should have been my only answer. But there's inequality in the system

04:15 – 04:45

Can you describe the procedure you underwent & how the medical technology used that day helped save your life?

So I had a seven-hour operation. It was an aortic dissection, which is basically their, it's the valve and it's your ascending aorta. And it's the whole root of the aorta. So it's really important. It's an operation that needs to go perfectly. And that's why there's normally only a 10 to 15 per cent chance of survival. So just, that medical device saved my life that day. It didn't just buy me more time. It gave me my life back.

04:45 – 05:08

When the doctor told you that you only had a 10-15 per cent chance of survival, what went through your mind?

Yeah, so when the doctor told me that I had a 10-15 per cent chance of survival, and really, the first week was critical, it was actually, believe it or not, it was the greatest day of the rest of my life. Well, it's either here or not be here. And so, it really was, to me, the greatest day of the rest of my life.

05:08 – 05:27

How has life changed post- surgery?

Post- open heart surgery, my life is unbelievable. I feel stronger. I feel fitter. My mind is just so clear. I have clarity. Believe it or not, I'm actually the person I always wanted to be.

05:27 – 06:06

What frustrates you most about some patients being unable to access the medical technology they need at critical moments?

What makes me angry, so riled up about patients not being able to access the right medical technology at their life-saving critical moment is that it shouldn't matter who you are, what you are, private, public. We should be looking at it. It's a human life. It's a human being. If you need that piece of medical technology to save your life, there shouldn't be any question. We shouldn't be forcing clinicians and surgeons into choosing the wrong piece of medical technology when the right piece is out there.

06:06 – 06:42

How did your experience change your view of Australia's public & private health systems?

I assumed, like we all do, that I had private health insurance and I thought I would get the latest and greatest of everything. But I found out that not to be true. And all I'm trying to do now is say to people that you shouldn't be forced to say that you're a public patient because you are scared of using your private health insurance. What we need to do is make the system level and equal for whoever you are, public or private, it shouldn't matter. You shouldn't be made to choose to save your life.

06:42 – 07:22

What do you think is the biggest misconception Australians have about private health insurance & access to cutting-edge treatments?

I don't know if a lot of patients realise it takes 4. 7 years for the Australian TGA to approve a new medical device. Now in the US and Europe, it takes one to two years for that same device to be approved. When it hits our shores, we start the approval process from scratch. So even though it's been approved in the Europe and US, we don't take any of that. We start it and we often go through the same process three or four times for that one device. I think it's really important that we start fast tracking medical devices, especially medical devices that will save a human life

07:22 – 07:48

How has this experience shaped your life & outlook?

It's been just over three years since it happened to me. And every day I love getting up and I actually look at the scar on my chest and I'm really proud of it. It's made me the person that I am. I've got to fulfill my life, but even more. I'm excited about what the future holds for me. And it's thanks to medical technology.

07:48 – 8:07

What are your thoughts on the potential value of medical technology?

Twenty years ago, an aortic dissection was a death sentence. No one lived, you know. So what's happened in that time, 20 short years, is the technology is so great now.

08:07 – 08:18

What is your message to Australians regarding the importance of securing access to innovation medical technologies?

Understand that having medical technology in your time of need could be the difference between living and dying.

Associate Professor Colman Taylor

Health Economist, Policy Strategist & Chief Vision Officer, HT Analysts, ***SYDNEY***

00:28 – 08:46

Self-introduction

My name is Colman Taylor, and I'm a health economist working across industry and academia. I'm Chief Vision Officer of HT Analysts, and I have an academic role at the George Institute and the University of New South Wales.

08:46 – 09:05

What motivated you to focus your career on improving patient access to innovative health technologies?

So I'm really excited by technologies and the promise they provide in improving patient lives. And health economics allows us to balance the cost of these technologies against the benefit and deliver real outcomes for patients.

09:06 – 09:27

How would you describe Australia's Health Technology Assessment (HTA) & reimbursement processes?

Australia's health technology and reimbursement processes are extremely rigorous, but they are extremely clunky and slow. Patients wait a very long time for access to innovative technologies, and this leads to inefficiencies and reduce patient outcomes in the system.

09:27 – 09:53

How can patient access to innovative medical technologies be improved?

Improving access to medical technologies in Australia is an urgent area of reform. We have a robust universal health care system, but the delays in access to medical technology create inequities in our system. It should be priority for our government to reform the system, to speed up access and improve patient outcomes.

09:53 – 10:16

How do private insurance schemes influence the pace of technology adoption?

Currently in Australia, we have duplication with respect to the evaluation of medical technologies. Private insurers have a process to evaluate value for money, which is very similar to the process that state-based hospitals use to evaluate the same things.

10:16 – 10:45

How does a fragmented approach to reimbursement impact patient care?

The current process for reimbursement results in sub-optimal patient care, because innovation doesn't get to the patient in the fastest amount of time. Currently, patients with private health insurance pay extra premiums, but despite that, they often lag behind public patients in being able to access the newest medical innovations.

10:45 – 11:13

How do current reimbursement policies for medical technologies affect patient access & care?

Current processes for medical technologies results in delays for patient access, which leads to sub-optimal patient care. If patients can access life-changing treatments in a timely manner, this can lead to better patient outcomes, which has enormous flow-on impacts to the Australian economy through productivity and better wellbeing.

11:13 – 11:52

How do current reimbursement policies impact patients living with structural heart disease, particularly those who may benefit from transcatheter aortic valve implants (TAVI)?

Current reimbursement policies in Australia can lead to delays, which in the case of patients with structural heart disease, means they can progress in their disease and no longer be eligible for treatment.

In the case of transcatheter aortic valve implants, there was an at least five-year delay between registration and patient access. During this time, many patients would have progressed in their disease and would no longer be eligible for treatment. This has obvious impacts for the patient, their families, and the broader Australian economy.

11:52 – 12:14

Can you share a patient story that highlights the real-world impact of these delays?

Patients will talk about impact on their lives in terms of daily activities, and in the case of structural heart disease, being able to hang out the washing, being able to undertake chores around the home and play with the grandkids are important outcomes they talk about.

12:14 – 12:35

What is the typical timeline for innovative medical devices to obtain reimbursement in Australia?

The current timeline for innovative medical technologies to obtain reimbursement in Australia is around 4.7 years. That means patients are waiting, on average, 4.7 years to receive innovation that can dramatically change their lives.

12:35 – 13:16

How does duplication within the approvals process influence the speed at which innovative medical technologies reach Australian patients?

One of the biggest challenges with respect to the evaluation of new medical technologies in Australia, is the duplication between the regulatory approval and the Health Technology Assessment process. Once the technology has bypassed regulatory approval, it still has to traverse the Health Technology Assessment process, which answers many of the same questions that have been answered in the regulatory process. This leads to years of delay, and it means patients cannot access innovative medical technologies which can change their lives, and improve the Australian economy.

13:16 – 13:39

What barriers exist within the current system for approving and funding new medical innovations in Australia?

The system is slow, and patients wait years for access to medical innovation. The system is also incredibly risk-averse and doesn't use tools like real-world evidence to underpin funding decisions that could lead to faster patient access.

13:39 – 14:03

Which parties are responsible for funding the reimbursement of medical technologies in Australia?

The current system in Australia involves multiple parties when evaluating new medical technologies. This includes the government at both the Federal and State level, as well as individual hospitals, private insurers and patients increasingly pay out of pocket to access medical technologies.

14:03 – 14:38

What lessons can Australia learn from Health Technology Assessment (HTA) processes overseas?

Other countries around the world face the same challenges as Australia, but have implemented innovative pathways to capture the benefits of medical technologies earlier. Countries like Germany and the US have access pathways whereby reimbursement is provided early, and data is collected to show the impact directly to patients. Australia doesn't need to reinvent the wheel. It just needs to catch up.

14:38 – 15:05

Why is it important for the Health Technology Assessment (HTA) process to incorporate real-world evidence (RWE) alongside clinical trials?

The current Health Technology Assessment process in Australia prioritises clinical trials over real-world evidence. By harnessing the significant amount of data we have in registries and government data sets, we can provide earlier access to patients, and assess the impact of these technologies across diverse patient groups.

15:05 – 15:44

Why does Australia lag behind the UK, Germany & the US despite having a strong healthcare system?

Australia has a robust universal healthcare system. But when it comes to accessing medical innovation, we lag behind other countries we generally compare ourselves against like the UK, Germany and the US. Australia lacks a central policy with respect to innovation and KPIs to measure system performance. We also don't harness the power of tools like real-world evidence to speed up access decisions and improve patient lives earlier.

15:44 – 16:16

What strategies for accessing innovative medical technologies would best benefit patients in the future?

Australia needs to build a system that provides timely access to medical innovation. We can do this by removing duplication and improving collaboration between stakeholders like government, as well as the public and private sectors. We also need to harness tools like real-world evidence that can improve timelines for access to innovation and measure performance using KPIs in our system.

16:16 – 16:38

How could developing a provisional funding mechanism for innovative health technologies create benefits for both the public & the private sectors?

By establishing a provisional funding pathway, we can provide earlier access to patients in both the public and the private sectors. This would allow technologies with proven potential to be put into the hands of patients earlier, rather than waiting for full market approval.

Professor Jayme Bennetts

Professor of Cardiothoracic Surgery, Monash University & Director of Cardiothoracic Surgery, Victoria Heart Hospital, ***MELBOURNE***

16:48 – 16:59

Self-introduction

I'm Jayme Bennetts, Professor of Cardiothoracic Surgery at Monash University and Director of Cardiothoracic Surgery at Victoria Heart Hospital.

16:59 – 17:16

Describe your role in developing the new report – '*Accelerating access to innovative medical technologies in Australia*'

I had the privilege of being involved as a member of the steering committee and also one of the facilitators that led to the report into accelerating access to innovative medical therapies in Australia.

17:16 – 17:35

What is the purpose of the new report?

The overarching purpose of this report is to try and improve ways for us to be able to access new technologies and improved devices earlier in their development phase to allow improved access for patients to better therapies in Australia.

17:35 – 18:32

How can patient access to innovative medical technologies be improved?

One of the major limitations in Australia is the access to innovative technologies as a regulatory pathway that requires assessment and then funding processes around those devices. The money that it costs to develop new technologies is very big, and Australia is actually a small market internationally. So, for us to be able to access these technologies early, and not be waiting for the development of long-term results, which may or may not be the right way to assess them, is part of the problem. Because we currently have a regulatory system, that means that we wait for long-term results to be available, hence, the longer we wait, the more we are missing out on accessing the market, when other international regions are actually accessing the technology earlier than we are, and by the time we get access, we are a long, long way down the order.

18:32 – 18:48

How do delays & inefficiencies in reimbursement & funding processes limit the adoption of new medical technologies & impact patient care?

Ultimately, these delays mean that new technologies, new devices, which may provide better patient outcomes are not being made available to patients as early as they are possible.

18:48 – 19:26

How do differences between the public & private funding & reimbursement systems affect patient access to new medical technologies?

The irony is that public patients often are able to access new devices and technologies earlier because the user pay system in the public means that once it's approved safe through TGA processes, they become accessible if the hospital is able to pay. In the private system, we need to go through the second and third layers where both device efficacy and then device funding is approved through two different processes. So, and until that funding mechanism is in place, these devices are not able to be utilised in the private system.

19:26 – 19:58

How do the barriers identified in the new report affect cardiology & heart surgery patients?

These barriers affect all patients across all specialties. The rapid growth of technology and the improvement in devices that actually allows patients to access lower risk procedures and lower risk therapies that might manage their underlying disease process better is particularly unique to both cardiology, structural heart disease and cardiac surgery, where these technologies are rapidly growing and becoming more available more quickly.

19:58 – 20:34

How do reimbursement delays affect patients with structural heart disease?

Structural heart disease is an area where there's been particularly rapid growth in new technologies and devices, both transcatheter technologies, but also surgical heart valves and coronary stents among three different areas. The issue we have is that some of those devices have taken five years or more to be go through the approval processes in Australia while they've been already available in other jurisdictions internationally. Hence, patients have not been able to access that improved technology and ultimately improved outcomes as early as they have outside of Australia.

20:34 – 21:13

Transcatheter aortic valve implantation (TAVI) uptake in Australia is a specific case study addressed in the new report. What can you tell me about TAVI & its impact on patients living with structural heart disease?

Transcatheter aortic valve implantation has been a new technology that has allowed access to a larger number of patients in the population to have treatment for their aortic valve disease that they may not have been offered surgery previously. As a result, we've had a large number of older patients and more high-risk patients that have avoided a major operation that would've been quite impactful from them from a recovery point of view to have a less morbid procedure. In other words, they recover quicker and have less issues with the impact of surgery by having a transcatheter device placed.

21:13 – 21:55

Why has access to the Transcatheter Edge-to-Edge Repair (TEER) procedure for mitral regurgitation been delayed in Australia?

Another area with new technology is the edge-to-edge-device that can allow us to repair the mitral valve percutaneously rather than an operation. And again, it's an area that had took a little while to be approved in Australia when that technology was available well in advance of US internationally. And some of that limitation was that there were some varying outcomes with regards to some major trials that created confusion and some of that confusion allowed the process to be delayed. We now have that technology available and we have patients that are able to be treated with that, but we're probably five to 10 years behind other jurisdictions internationally.

21:55 – 22:39

What is Real-World Evidence (RWE) &how does it compare to evidence from Randomised Clinical Trials (RCTs)?

So real-world evidence Is another term for saying registry or real-life experience that is able to be generated once these devices are in common population use. Randomised control trials are considered the gold standard, but unfortunately the limitation of randomised controlled trials is that you have a very controlled patient group at the selection phase and the inclusion into the trials, which may not actually reflect the population that the devices then ultimately get implanted into. Hence, the real-world experience reference is more of a holistic approach to when the devices are in common use rather than in the trial phase.

22:40 – 23:44

How does Australia's reimbursement system for innovative medical technologies compare to other countries?

So, Australia has three processes that are designed around assessing devices so that they are able to deliver efficacy as described. There is an assessment of safety and cost efficacy with regards to clinical outcomes. And then the third line is the medical procedure that's required to implant the devices. All those three processes together align to make sure that we have devices that are safe, and that are implanted where there is a true and proven patient benefit, and in a manner that the system can afford to continue to function in the way it is. That means that we have a system that takes longer for our new technologies to process through before they become available as opposed to other areas where in Europe and in the US particularly, these devices are available a lot earlier where there's not those same levels of controls around not just the efficacy, but also the cost and the proven benefit at a clinical implant to the patients.

23:44 – 24:07

Can you give a real example of how Australia falling behind countries like Germany, the UK, or the US, has directly impacted a patient's quality of life?

The best example is that with the transcatheter aortic valve implants in Australia it was delayed over five years compared to some jurisdictions. That meant there were a large number of patients that had complex and high-risk surgery that may well have been able to avoid that if we had those devices available earlier.

24:07 – 24:51

What is your key message to decision-makers and what action should they take to improve imbursement?

I think what we need in Australia is a mechanism by which these new devices and technologies can be given approval ahead of some of the longer-term outcome studies that are currently part of that approval process. The US has a model where, some new technologies that, with an appropriate assessment, are thought to be highly likely to be of benefit are given earlier approval and at a funding level that would justify the tech, the research and development that's been put into those technologies. In Australia, we don't have that, and waiting for the evidence to become available means that we are often delayed getting access to these technologies and a similar system would be quite helpful.

24:51 – 25:36

What is heart valve disease, what are the most common types and how common is it in Australia?

Heart valve disease is a form, or one area of structural heart disease, and this is specific to disease processes impacting the heart valves, whether that be a narrowing or stenosis of the valve or whether that be a failure of coaptation so that the valve leaks. Heart valve disease is primarily a problem on the left sided valves with either the aortic valve and the most common problem is aortic stenosis, which is a narrowing of the valve, or mitral regurgitation, which is a leaking of the mitral valve. Both of those affect how well the left ventricle performs, which is the pumping chamber that pumps the blood around the heart, which means the patients get quite symptomatic from both of those processes very early.

25:36 – 26:00

What are the potential health risks or complications of untreated heart valve disease?

Ultimately, all heart valve disease produces dysfunction of the heart muscle and the pumping chamber, and that basically means, one, damage to the heart. To a patient, who gets short of breath very quickly on doing even minimal exercise and even tasks like walking to the bathroom or walking to the letterbox can become too hard.

OVERLAY	
Timecode	**Description**
Emergency/Hospital vision	
26:09 – 26:19	Medium, low-angle shot of a clinician pushing a patient on a hospital bed down corridor
26:20 – 26:24	Low-angle, slow-motion, wide shot of paramedics rushing towards ambulance in the rain
26:25 – 26:37	Wide shot of emergency department entrance and sign at a hospital
26:38 – 26:45	Medium, slow-motion shot of clinicians rushing patient on a stretcher through a hospital corridor
26:46 – 26:52	Extreme close-up of hospital Emergency Department doors closing
26:52 – 26:54	Wide shot of clinician walking through hospital
26:54 – 26:56	Extreme close-up of an ECG machine monitoring vital signs
26:57 – 26:59	Medium, panning shot of CT scanner in hospital
27:00 – 27:02	Wide, panning shot of interventional surgery suite in hospital
27:03 – 27:09	Wide, panning shot of cardiac catheterisation lab in hospital
27:10 – 27:13	Medium close-up, panning shot of cardiac catheterisation lab in hospital
27:13 – 27:20	Medium-wide, panning shot of operating room in hospital
Stuart, 54, Consultant, father & grandfather whose answer to one question saved his life: 'Public or private?', ***SYDNEY***	
27:22 – 27:44	Close-up shot of Stuart opening his shirt collar to reveal a scar on his chest from his heart surgery
27:45 – 27:59	Medium hero shot of Stuart looking up at camera
28:00 – 28:12	Medium hero shot of Stuart looking up at camera & smiling
28:13 – 28:28	Medium close-up, panning hero shot of Stuart looking at camera & smiling
28:29 – 28:35	Extreme wide, slow-motion shot of Stuart walking in a park with his family
28:36 – 28:42	Wide, slow-motion shot of Stuart walking in a park with his family
28:43 – 28:50	Medium close-up, slow-motion shot of Stuart's grandson riding a bicycle in a park with his family walking behind
28:51 – 28:56	Medium, slow-motion shot of Stuart walking through a park with his daughter & grandson
28:57 – 29:03	Medium close-up, slow-motion shot of Stuart walking in a park looking at his wife & grandchildren
29:04 – 29:11	Medium close-up, slow motion shot of Stuart's family walking in a park
29:12 – 29:20	Medium, slow-motion shot of Stuart & his wife walking through a park
29:21- 29:29	Medium close-up, slow-motion shot of Stuart lifting his grandson in the air
29:30 – 29:41	Medium close-up, slow-motion shot of Stuart lifting & catching his grandson in the air
29:42 – 29:53	Medium wide shot of Stuart & his family sitting in the grass & playing
29:54 – 29:59	Medium close-up shot of Stuart kneeling & cuddling his grandson
30:00 – 30:04	Medium shot of Stuart's wife spinning their grandson in the air & laughing
30:05 – 30:10	Extreme wide shot of Stuart running through a park with his family
30:11 – 30:25	Medium shot of Stuart & his wife walking through a park, smiling at one another
30:26 – 30:34	Close-up, side-angle shot of Stuart & his wife walking through a park
30:35 – 30:43	Medium shot from behind of Stuart & his wife walking through a park
30:44 – 30:53	Close-up, slow-motion shot of Stuart & his wife holding hands while walking
30:54 – 31:13	Extreme wide shot of Stuart walking up to a park bench & sitting down

31:14 – 31:22	Extreme wide shot of Stuart walking towards the camera & sitting down on a park bench
31:23 – 31:29	Close-up shot of Stuart's face while sitting at a park bench & looking into the distance
31:30 – 31:33	Close-up shot of Stuart's hands clasped together while sitting at a park bench
31:34 – 31: 41	Close-up, side-angle shot of Stuart's face looking up & off into the distance
31:41 – 31:52	Wide shot of Stuart walking up to his lounge & sitting down to read a book
31:53 – 32:01	Medium shot of Stuart sitting on his lounge & reading a book
32:02 – 32:10	Medium close-up, side-angle shot of Stuart sitting on his lounge & reading a book
32:11 – 32:15	Close-up, side-angle shot of Stuart's face while sitting on his lounge & reading a book
32:16 – 32:22	Close-up, side-angle shot of Stuart's hands flipping through the pages of a book
Associate Professor Colman Taylor, Health Economist, Policy Strategist & Chief Vision Officer, HTANALYSTS, ***SYDNEY***	
32:23 – 32:31	Wide to mid shot of A/Prof Taylor walking in hallway to HTAnalysts branded door
32:32 – 32:36	Extreme close-up of A/Prof Taylor walking into HTAnalysts branded door
32:37 – 32:39	Extreme close-up of A/Prof Taylor walking past HTAnalysts logo
32:40 – 32:53	Mid shot of A/Prof Taylor walking into his office & sitting at his desk, looking at computer monitor screens
32:54 – 33:02	Extreme close-up of A/Prof Taylor sitting at his desk, looking at computer monitor screens
33:03 – 33:12	Extreme close-up of A/Prof Taylor flipping through pages & reviewing new report
33:13 – 33:22	Extreme profile close-up of A/Prof Taylor looking down at new report
33:23 – 33:49	Extreme close-up of A/Prof Taylor's hands flipping through pages of new report
33:50 – 33:59	Panning (L-R) mid shot of A/Prof Taylor at his desk, typing on his computer
34:00 – 34:13	Tracking mid close-up of A/Prof Taylor walking through HTAnalysts office (back shot)
34:14 – 34:24	Tracking mid close-up of A/Prof Taylor walking through HTAnalysts office (¾ – side profile)
34:25 – 34:37	Medium wide shot of A/Prof Taylor going to his colleague's desk & speaking to his colleague
34:38 – 34:49	Low-angle medium close-up of A/Prof Taylor speaking to his colleague
34:50 – 34:57	High-angle close-up shot of A/Prof Taylor's colleague speaking to him
34:58 – 35:05	Mid shot of A/Prof Taylor speaking to his colleague in HTAnalysts office
35:06 – 35:13	¾ close-up shot of A/Prof Taylor looking down at his colleague, speaking to her, & nodding in agreeance
35:14 – 35:21	Wide shot of A/Prof Taylor in boardroom meeting with HTAnalysts staff (from left side of A/Prof Taylor)
35:22 – 35:30	Wide shot of A/Prof Taylor in boardroom meeting with HTAnalysts staff (straight shot)

35:31 – 35:37	Mid shot of A/Prof Taylor in boardroom meeting with HTAnalysts staff (straight shot)
35:38 – 35:43	Close-up of A/Prof Taylor in boardroom meeting, speaking to HTAnalysts staff (from right side of A/Prof Taylor)
35:44 – 35:52	Close-up of A/Prof Taylor's hands flipping through pages of new report, then panning (R-L) to him looking down & reading the report
35:53 – 35:58	Over the shoulder mid shot of two of A/Prof Taylor's colleagues in boardroom meeting, nodding in agreeance
35:59 – 36:04	Over the shoulder mid shot of one of A/Prof Taylor's colleagues in boardroom meeting, nodding in agreeance
36:05 – 36:13	Over the shoulder wide shot of all three of A/Prof Taylor's colleagues in boardroom meeting, nodding in agreeance
36:14- 36:20	Wide shot from outside the room of A/Prof Taylor reading new report at boardroom table
Professor Jayme Bennetts, Professor of Cardiothoracic Surgery, Monash University & Director of Cardiothoracic Surgery, Victoria Heart Hospital, ***MELBOURNE***	
36:20 – 36:29	Profile mid-shot of Prof Bennetts walking into frame & smiling at camera in operating room
36:30 – 36:37	Profile mid-shot of Prof Bennetts walking into frame & smiling at camera with his hands on his hips in operating room
36:38 – 36:44	Profile close-up shot of Prof Bennetts looking at camera & smiling at camera with his hands on his hips in operating room
36:45 – 36:48	Tilting (D-U) extreme wide-shot of Victorian Heart Hospital
36:49 – 36:55	Tilting (D-U) close-up of signage of Victorian Heart Hospital outside of hospital
36:56 – 37:03	Panning (R-L) extreme wide-shot of Victorian Heart Hospital
37:04 – 27:07	Panning (R-L) birds-eye wide-shot of Victorian Heart Hospital
37:08 – 37:10	Panning (R-L) birds-eye wide-shot of Victorian Heart Hospital
37:11 – 37:13	Zoom out birds-eye wide-shot of Victorian Heart Hospital
37:14 – 37:16	Close-up of signage on glass door of Victorian Heart Hospital
37:17 – 37:23	Panning (L-R) close-up of signage on glass door of Victorian Heart Hospital
37:24 – 37:29	Extreme wide shot of Prof Bennetts looking at patient CT heart scans at his office with his signage
37:30 – 37:37	Panning close-up of Prof Bennetts' signage outside of his office to him looking at patient CT heart scans
37:38 – 37:47	Over the shoulder extreme close-up of Prof Bennetts looking at patient CT heart scans
37:48 – 37:52	Panning (L-R) extreme close-up of Prof Bennetts looking at patient CT heart scans
37:53 – 37:57	Close-up shot of Prof Bennetts' qualifications
37:58 – 38:13	Mid-shot of Prof Bennetts' colleague & Prof Bennetts walking into frame & handing her patient files, then walking out of frame
38:14 – 38:22	Mid-wide-shot over the shoulder of Prof Bennetts entering waiting room & greeting patient
38:23 – 38:28	Mid-wide side angle (right) shot of Prof Bennetts entering waiting room & greeting patient

38:29 – 38:38	Mid-shot of Prof Bennetts & patient walking through waiting room & into consult room & sitting down
38:39 – 38:50	Mid-close-up over the shoulder shot of Prof Bennetts with patient in consult room discussing cardiac issues
38:51 – 39:11	Close-up panning (R-L) high angle shot of Prof Bennetts with patient in consult room discussing cardiac issues
39:12 – 39:34	Mid-shot of Prof Bennetts standing up, putting on stethoscope, checking pulse of patient on patient's wrist, then using stethoscope to listen for heart pulse
39:35 – 39:47	Extreme close-up of Prof Bennetts using stethoscope on patient's chest (high angle)
39:48 – 39:55	Extreme close-up of Prof Bennetts using stethoscope on patient's chest (low angle)
39:56 – 40:09	Wide shot of Prof Bennetts walking through hospital room to surgical recovery unit & talking to a patient
40:10 – 40:16	Close-up of Prof Bennetts talking to patient in hospital bed
40:17 – 40:28	Extreme close-up low angle shot of Prof Bennetts greeting patient in hospital bed
40:29 – 40:40	Wide panning (L-R) shot of Prof Bennetts & his colleague exiting room & walking in front of reception at hospital then discussing patient cases
40:41 – 41:10	Mid-panning (R-L) shot of Prof Bennetts & his colleague discussing patient cases, then tracking to a mid-shot of Prof Bennett talking to group of his colleagues followed by tracking mid shot (from behind) of Prof Bennetts walking through hospital, putting on his scrub cap & talking to his colleagues

ends#

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