Message from the Tonic Media Network Editorial Committee*

Welcome to another edition of *Practice Connect* with topical news and information for you and your patients.

What the recent Budget means for general practice

There are currently many challenges running a general practice - rising costs, reduced income, staff shortages, managing COVID, the list goes on.

The Health Budget has been welcomed for its increased bulk billing incentives but there's been far less discussion about what other spending is planned which could have a significant impact on general practice.

In Tonic Media Network's exclusive GP webinar series, *General Practice in a Rapidly Changing World*, Dr Norman Swan recently interviewed the Federal Minister for Health and Aged Care, Mark Butler about the Budget and provided the opportunity for GPs across Australia to submit their questions.

During the discussion, Minister Butler highlighted that the "backbone of the healthcare system for Australians is their local general practitioner" and that general practice is his "number 1 priority".

There were some large numbers and big commitments to general practice announced in the Budget including the flexible funding of $445 million targets for smaller and medium sized practices, addressing wage challenges, and increasing the workforce incentive payment by 30%.

Minister Butler said he is acutely aware of the current workforce issues and that it's a very competitive global marketplace. "How can we improve our processes as we are being out competed by countries like Canada, Ireland, and the UK".

He is also "terrified by the size of the pipeline in general practice being way too small".

There is increased funding in the Budget for multidisciplinary teams, which aims to provide GPs with the necessary resources to enhance their deliver of high-quality healthcare services to Australians with complex chronic illness.

The Minister also wants to "examine existing billing arrangements to iron out anomalies". Another priority is to eliminate barriers that get in the way of everyone operating at the top of their skill set - doctors, nurses and allied health workers".

Mark Butler also said that a big part of the Budget is “better connecting different parts of the system particularly in a digital sense”.

There is a plan for Primary Health Networks (PHNs) to empower consumers aiming for an efficient, accessible and high-quality healthcare system through engagement and improved services. “My general philosophy of how you do good healthcare policy is to have consumers at the table and there's substantial additional funding in the budget to build consumer capability,” Mark Butler added.

In addition, voluntary patient registration will become a reality under the banner MyMedicare. The system will allow patients to register with a specific general practice, unlocking funding flows to the practice and benefits such as longer telehealth phone sessions.

When asked if the government is going to pay GPs to register new patients on MyMedicare, the minister said they won’t be and that they will “identify patient cohorts and build funding models around their needs”.

Dr Swan asked Minister Butler a range of questions from bulk billing and incentive payments to telehealth and chronic disease team-based care management.

To watch the webinar recording click here

To listen to the podcast click here

Influenza and respiratory syncytial virus (RSV) on the rise

Influenza and respiratory syncytial virus (RSV) are surging in the community.
Doctors are urging people to get immunised against the flu, especially the vulnerable and pregnant mothers, amid growing concerns that vaccination rates have plummeted, and with the start of winter.

At the time of writing, NSW alone has seen a 66 percent increase in influenza across the community in the past week.

Doctors are also warning about a worrying increase in the number of children arriving at hospitals, especially in Victoria, with both the flu and RSV.

Most cases of illness caused by RSV are mild, but it can lead to serious illness for young children, the elderly and people who are immunosuppressed.

RSV can lead to bronchiolitis and pneumonia. It can also cause ear infections and the coughing associated with the illness can worsen asthma symptoms.

What are the symptoms of RSV?

According to NSW Health the symptoms usually begin around 5 days after exposure to the virus and can get worse over the first 3 to 4 days of the illness before an improvement. Symptoms can include:

- runny nose
- cough
- sneezing
- fever
- ear infection (less common).

RSV can also cause wheezing and difficulty breathing.

Meanwhile, the Food and Drug Administration recently announced the approval of the first RSV vaccine for use in the United States. The vaccine, Arexvy, is approved for the prevention of lower respiratory tract disease caused by RSV in individuals 60 years of age and older. Arexvy was

developed by GlaxoSmithKline. Other companies who are seeking official approval of RSV vaccines include Pfizer and Moderna.

Arexvy is also currently under consideration by the Therapeutic Goods Administration in Australia.

Can artificial intelligence predict complications after surgery

Artificial intelligence (AI) has been in the headlines over recent months but its impact on healthcare is already being felt – with some studies finding impressive results for AI programs trained to spot skin cancer, diagnose brain tumours mid-operation, and interpret radiology images.

Another study we can add to the list is a recent paper from a team led by researchers at the University of Western Australia involving cardiovascular complications after non-cardiac surgery.

In the study, researchers tested whether 'neural networks' or computer systems modelled on our human brain could be used to predict complications in people who had surgery.

The study included the information of 25,000 people who had undergone these non-cardiac surgeries and their data was captured as part of the Vascular Events in Non-Cardiac Surgery Patients Cohort Evaluation Study (VISION). All these people had their level of troponin T (a protein found in heart muscle which rises if there's damage) measured postoperatively.

Using this information, as well as routinely collected data such as a patient's age, weight, ethnicity, and more in-depth measurements like intra-operative heart rate and blood pressure, researchers wanted to better understand whether these neural networks could predict whether someone would have complications. Each participant's postop outcomes (complications, death) were also known to researchers, so they could test the accuracy of the model's predictions.

The study found that the multi-layer neural network was good at predicting which people were likely to have heart problems or even die following surgery. It could predict postop myocardial injury with 70% accuracy and forecast which patients would die with 89% accuracy.

The researchers believe these findings prove neural networks can be used to predict post-operative non-cardiac surgery outcomes effectively. They say such a model might be used by a treating healthcare team to determine which patients are at the highest risk of negative outcomes and to allocate resources on that basis. They suggest the models may become more accurate when continually given data that are more relevant to particular areas or subgroups of people.

Treatment choice and survival in men with low-risk prostate cancers

The treatment options which balance harm against good with men diagnosed with prostate cancer after prostate-specific antigen (PSA) screening continue to be a huge debate. Now a major new study from the UK sheds light on the different paths available to men.

In the study, researchers followed more than 80,000 men who were between the ages of 50 and 69, and had received a PSA test in the decade between 1999 and 2009. A localised prostate cancer was diagnosed in 2664 of these men, and of those about 1600 were randomised into one of three treatment groups – active surveillance, prostatectomy and radiotherapy. Participants were followed for a median of 15 years. The primary focus of the study was death from prostate cancer, while secondary outcomes measured include death from any cause, disease progression and metastases.

The researchers found that death from prostate cancer occurred in 45 men – 17 in the active surveillance group, 12 in the prostatectomy group and 16 in the group receiving radiotherapy. Any-cause mortality occurred in 356 men, with a similar split among all treatment groups. Men receiving active surveillance were more likely to have their cancer metastasise and show clinical progression.

Despite this, the main finding of this study is that death rates due to prostate cancer are low and didn't vary by treatment choice. The research suggests men with a diagnosis of localised, low-risk prostate

cancer need to consult with their treatment team about the benefits and risks of each of the options available to them and decide based on their personal values and expectations.

Speaking on ABC Radio National's Health Report, Professor Jenny Donovan from the University of Bristol, who was one of the researchers, said "Our findings are particularly relevant for men with low and intermediate risk prostate cancer, as they're called now, those are the most common after PSA testing. If men have higher risk disease or advanced disease, then they need treatment straightaway. But for men with low and intermediate risk, localised prostate cancers, they have time to decide what to do about their treatment, because they're going to live long lives. We showed 97% survival at 15 years".

Dr Norman Swan highlighted that statistics in Australia suggest that 7 out of 10 men with such a prostate cancer choose active monitoring rather than treatment.

"There are also a large group of men in the intermediate risk group who could also consider active monitoring. They would obviously need to discuss that with their clinicians," Professor Donovan added.

Do vaccine 'champions' influence their peers?

In times of emergency, like during a pandemic, getting accurate information and making informed decisions is crucial. But how do people learn about vaccines and share their experiences with others?

A recent study conducted in Australia investigated how adults who were vaccinated against COVID-19 and those who were not felt about talking to others about vaccines. The aim was to help understand if people felt comfortable sharing their vaccine experiences and opinions with their peers, and if this kind of communication could change people's understanding and behaviours.

Researchers conducted in-depth interviews with 40 people across Australia. Of those participants, 33 had been vaccinated while the rest were either unvaccinated and/or had no plans to get vaccinated.

The study found that those who were vaccinated were open to promoting the vaccine and correcting any misinformation. They felt empowered after receiving the vaccine and believed in the importance of talking to others about it. They thought both peer-to-peer communication and community messages were necessary for a successful vaccination campaign and that communication between family and friends had a strong persuasive power. But something different was observed for those who were unvaccinated. They didn't think community messaging was effective and expressed a desire to make their own decisions instead of following what others said.

The findings suggest that during emergencies like a pandemic, it may be helpful for governments, community organisations and healthcare practices to encourage peer-to-peer communication among people motivated to share their story, who can play an important role in sharing their experiences and correct any misconceptions. The researchers argue this kind of approach might work on other healthcare issues too.

Skin cancer visits to the GP grow

Australia has one of the highest rates of skin cancer in the world. According to Cancer Council NSW, about two in three Australians will be diagnosed with some form of skin cancer before the age of 70.

GPs play a critical role in skin cancer treatment - diagnosing and managing most suspected skin cancers in this country. A major new survey of GPs has found that this role has never been bigger and looks at some of the changes to a typical doctor's caseload over the past two decades.

This study used data from a national, cross-sectional survey conducted from 2000 to 2016 called the *Bettering the Evaluation and Care of Health Study* (BEACH). More than 15,000 GPs from across Australia recorded about 1.4 million patient encounters as part of the research – and a subset of those, 65,000 skin-cancer related conditions, were analysed in this paper. Overall, skin cancer-related conditions were 3% of all conditions managed by GPs in the study.

Researchers found that GPs were most often managing solar keratosis (30% of management load), keratinocyte cancer (25%), naevi (11%) and skin checks (10%). Rates of skin cancer-related conditions presenting to GPs increased over the period of the study, particularly for the period 2000 to 2008. There were also changes in presentation between conditions - things like keratinocyte cancers, skin checks and skin lesions went up, while solar keratoses and naevi were stable over time. People presenting with skin cancer problems were more likely to be male, older, living in remote or regional areas, and from low socio-economic areas.

The authors say these findings can help inform the allocation of resources to particular groups in need and help GPs discern which groups of patients may be especially vulnerable.

Further information

Skin Cancer – Cancer Council

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