GP LINK Lunches | Dr Michael Wright

Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.

Dr Michael Wright

Dr Ken McCroary

Ken McCroary - As part of the ongoing advocacy for South Western Sydney general practitioners chairing Sydney South West GP Link I also chair the NSW AMA Council of General Practice and as part of this role I recently attended the Australian Medical Association conference on the Gold Coast where I ran into Dr Micheal Wright.

Dr Wright shares a great deal of similar goals and concerns that we do at GP Link. He is particularly interested in the workforce and renumeration for general practitioners now and into the future.

I have worked with Michael over the years in various roles particularly for the Royal Australian College of General Practitioners again advocating for the profession and the need to find solutions for the ongoing difficulty in primary care and particularly general practice.

Dr Michael Wright is a general practitioner (GP), health economist and health services researcher based in Sydney. Michael currently combines clinical practice with strategic appointments and academic research analysing the effects of current health policy on the quality and performance of primary care. Michael is currently the Chief Medical Officer of Avant Mutual, and is board chair of Central and Eastern Sydney Primary Health Network. Michael is RACGP National President elect and during the campaign stepped down from his other roles as Chair of RACGP's Reference Expert Committee on Funding and Health System Reform, and Deputy Chair of RACGP NSW/ACT Faculty Council.

Michael completed GP register training in Queensland and previously worked in London as a GP, where he was also a researcher at the London School of Hygiene and Tropical Medicine. Michael completed his PhD in health economics at the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney (UTS) in 2019. His PhD investigated the impact of continuity of general practice care on health outcomes, and his research interests include growing the evidence base about the value high-quality primary care, and health policy research into quality, efficiency and sustainability of health services.

Ken McCroary: So Michael, funding reform, I know it's a passion of yours. Explain.

Michael Wright: I think what we've seen over the last decade is repeated talking about the need to strengthen general practice and a lot of attempts to describe what should happen and there's still discussions. There's a number of taskforces and reports still coming out. While we've been talking about changing the system what's been happening on the ground is the funding going into general practice and general practices has been dropping.

So over the last decade we know that in 2013 over 70% of the health budget went to general practice, it's now dropped down to about 5.6% last year and so that represents, if we think that it's getting harder to provide care for our patients, our patients are thinking it's harder to get care, it is because less money is going to support general practice services. And that's a part of what I'd like to bring about with the health funding reform change.

Ken McCroary: **It seems like a catch 22 issue sort of that the patients are getting more complex and complicated but the funding available to primary care is diminishing. How do we get the message across to the people making the decisions?**

Michael Wright: I think it's a real challenge and I don't think it's going to be easy but it's something we just have to lean into. As you say, our patients are getting older, they're also living with complex health conditions and we need more time with them on average, at the same time less money is coming in and that just doesn't make sense. And that's one of the messages I want to get to government. I think we've made the message from a clinical point of view how important it is for providing care but as well as being a GP I've got some background training as a health economist and I feel like I can explain the message in terms that health funders and policy makers will better understand and I think that's what's been missing until now.

Ken McCroary: You segued for me. My next question was tell me about life as a health economist and the journey through London, the PhD, and what you are doing now with Advant and everyone else?

Michael Wright: I've been a GP for over 20 years. The first 10 years of that I was a GP on the Gold Coast working with my Dad. We're back on the Gold Coast now and we had a practice together so we grew it from a little solo paper-based GP, where Dad was bulk billing everyone, to a larger multidisciplinary care team, shifting towards mixed billing which was really difficult for Dad. He felt like he couldn't charge these people, he'd never charged people, but eventually he realised that for the quality of the care and in order to keep the practice open we had to charge those costs and so I learnt that lesson fairly early on. Even at that stage I'd tried to talk to policymakers about how we needed to put more money into general practice, that it was an investment and then increasingly I got a message from that "oh well you would say that, you're a GP, you just want more money" and I was, "no it really is important and of value for the whole health system", but they wouldn't believe my message.

That's when I thought I need to understand the language that they're speaking and that was the language of funding and economics. I then took myself on a journey. I did a Public Health degree in Health Economics at the London School of Hygiene and Tropical Medicine, lived in London for four years, worked in the NHS, realised there are other ways to do things and I don't really want to do them that way, so came back to Australia and over the last 10 years in Sydney I've done a PhD in Health Economics and my PhD was all about the value of continuity of care. We hear a lot about, we know it feels good for the doctor, I like seeing patients who I've seen before, but do we actually have economic evidence it improves the quality of care, the answer, is yes and that was my PhD.

So I thought I've got more evidence about the value of general practice, I'll still keep practising as a GP but then had a number of roles with the college, I'm now Deputy Chair of the NSW/ACT Faculty Council and I've chaired the college's Funding and Health System Reform committee for six years where we are coming up with ideas for the college that they can use for their advocacy. And then 2.5 years ago I started with Advant as their Chief Medical Officer and that came about, I'd been doing some work trying to assist Medicare to make their systems clearer so that doctors could be more certain that what they were doing was compliant and then I went into Advant and at Advant I had the division called Advocacy, Education and Research, so I'm trying to identify problems that doctors have in the health system and advocate for change as well as provide education so we know what we're doing and we're not getting into trouble and basically advocating for the needs of 80 000 doctors and medical students there.

Ken McCroary: **Yes, it's a very large organisation. You mentioned introducing mixed billing and then not wanting more money, that's one of my courses, I don't want more money I just don't want my patients in South Western Sydney having to pay the increasing gap so I can provide quality care. Now you've also got an interesting passion for providing universal healthcare for everybody, holistically and how do we deal with that increasing gap and what Medicare, even with triple bulk billing, is having, as compared to say AMA rates of whatever it costs to run a practice?**

Michael Wright: And I think that's the fundamental problem. There are a number of solutions. I mean I think we know that the current Medicare is underfunded, it doesn't cover the costs of what we need to support our patients and provide high quality care. In some areas people have been able to introduce private billing, that's not going to be universal. Essentially it does come down to the government providing better funding for these services. Particularly in rural and remote areas there is not enough funding from Medicare that would allow you to bill through that so we need other funding and whether that comes through funding from states and territories, we need to look at how other people fund it, we can't just say the most vulnerable in our community they just have to slump it up because that's not going to pay. And so the message of what we need to do needs to get through the government, not just the federal government but also the states and territories.

Ken McCroary: And like everyone amongst our colleagues that do realise this issue with remote medicine, working in outer metro in areas that actually have lower socioeconomic determinants compared to rural and remote, not every area but most, I still see that as a separate issue as well. Are you on top of that?

Michael Wright: I think you're right. I think rural and remote have always almost been like, I call it, the canary in the coal mine, but the problems are more spread now where in outer urban areas it's very hard to get workforce, the tripling of the bulk billing rate was a lot smaller so that hasn't been a solution for funding so we definitely need more funding going in. The funding needs to go towards more vulnerable people potentially that's people who have got chronic and complex conditions, maybe it's kids, but it's also going towards those GPs that are providing that care so people that do have a higher burden of people from culturally and linguistically diverse backgrounds probably do need additional funding to support that community because of the increased complexity of the care that those people need.

Ken McCroary: Now I've also been really interested in some your research particularly those that will reinforce those messages that you've been talking about particularly primary care funding being so cost effective and beneficial compared to the 94.3% we spend on the rest of the health budget and also that bonus and benefit of continuity of care with the same GP or the same GP practice for decades create much better outcomes. Do you want to just mention some of that research?

Michael Wright: Over the last decade I've used my clinical practice to inform and I've kind of had questions going how many people go and see multiple GPs? How much of the health budget goes towards general practice? And more recently what's the impact of the pandemic on the financial viability of practices? And I've been producing research and evidence based on that.

So particularly we know that 80% of patients actually do have a regular GP and close to 90% have a regular practice so most people do have a place that they prefer to go to. We know that less than 6% of the budget goes to general practice services so we need to probably look more at the other 90% and look at savings because I don't think you can get many more savings out of what general practice is doing and even in that last year there's been a billion dollars less in Medicare funding going into general practice services so we are already very stretched.

And then when we look at the impact of the pandemic, say if we look at the vaccine roll out I think most GPs were really proud of how they responded during the pandemic, that we thought we stepped up and did a great job at keeping our community safe but we do feel that we weren't really looked after by government in the way that

the funding was rolled out and we were often treated as almost second class in the health system in terms of access to things like PPE compared to hospitals. And so I think they are all bits of evidence that we have that I've just tried to bring into these discussions and that will inform the discussions when we go and talk to government policy makers.

Ken McCroary: You do mention a good point. We were sort of neglected in terms of decision makers during COVID, frontline health workers were vaccinated first but that didn't include general practitioners who weren't considered as frontline even though I preconceive that we are yeah?

Michael Wright: I think you strike on a good point. It's about this value of general practice. I think as a GP I know our patients know that value of that interaction we have but unfortunately policymakers, funders, they don't see that, they can't see the evidence of it unless they are sitting in a consult with us and that's the thing we've struggled with is actually articulating the range of things we do in every consultation. I suppose that's one of the reasons why I'm excited about maybe the use of artificial intelligence and how we've got these AI scribes that increasingly being available that help us sort of recording our consultation notes. Now they are not without their downfalls, there are some issues around privacy and consenting people and checking their accuracy but I'm quite excited to think that they might actually provide a more comprehensive record of our consultation which will be great for ongoing care but also will be great in terms of documenting what we are doing in practices so we can actually go and say look this is the complexity that we are dealing with, this is the diagnostic uncertainty that we're dealing with and that's all in the important stuff we do and that's all in the scope of general practice and that needs to be better valued.

Ken McCroary: And that also leads me onto integration of digital information and records and overall that will probably improve health outcomes to won't it?

Michael Wright: Definitely. I think it's one the issues, you know we hear about a patient's hospital will send them off with some information, don't hear anything, the patient reappears, you know often weeks later, and they come in assuming that we have complete knowledge of what's happened when we haven't heard anything. And often if we're lucky they'll have a scrunched up bit of paper in their handbag that details what has happened and that's the sharing of information. So we really need to get better at integration, the information that comes out of the hospital really needs to go somewhere and it needs to come to our desktop and the technology is there, we just need the willingness to do it.

Ken McCroary: Yeah. This morning I heard from the Health Minister who did mention the multidisciplinary facet of primary care and he did say GP land which I was surprised and pleased by. Now my colleagues locally have issues with workforce as you mentioned and not just GP workforce, nurses, allied health professionals and then they've also got this concern about fragmentation of primary care when we see things like pharmacy trials prescribing, what are your thoughts on those sorts of issues?

Michael Wright: I'm really concerned about these new models of care, whether it's pharmacy prescribing, whether it's nurse practitioner-led clinics providing additional access to services which is confusing for patients because they don't particularly know which ones they are supposed to use but which fragment care.

Basically, the patient gets pieces of care in multiple silos and those silos don't talk together. Now that is, I'll put my medico-legal, that is risky because things are happening in isolation they are not going to get followed up, it will be more expensive because things will get missed, it's bad for health outcomes and it's bad for costs and the sustainability of the health system. So that is the series of logic and facts that says these models are not good and we need to keep making the message around quality and safety being more important than convenience and access. Now I know that these new models are rolling out but I think we do need to work with our patients as well so they know what they're getting and they are not getting a general practice service.

For the last 40 years Australians have benefited from being able to access their GP that knows them for comprehensive care and that is rapidly being stripped away. And if they are now only going to be offered partial care or a lower comprehensiveness of care by seeing these other providers we are going to get worse health outcomes and to me I think near enough isn't good enough. We've got a good system where patients do get good access to GP care and it's been taken away.

Ken McCroary: Excellent. Now one of the things that has come up since we planned this talk was the presidential campaign for the Royal Australian College of General Practitioners. Now there's some pressing issues we've talked about funding reform, workforce for me in the area that I work in is a really, really big issue. We did touch on it a little bit but do you have any ideas about finding a solution. Like Mr Butler today spoke about importing another 5000 GPs from overseas which as a global citizen it's not grand and it's not a long term solution either. What are you going to tell them?

Michael Wright: I think we realise we've got a workforce shortage in all the health professions particularly in general practice. I think the figures are we need another 10,000 GPs over the next decade so we need to train more hopefully, we need to make general practice more attractive for them and there are a number of barriers along the way that make it less attractive to go into general practice which is getting continuation of your entitlements when you move from the hospital to GP registrars.

There's a pay difference between working in the hospital and working in general practice and there's also more broadly a need to get an earlier exposure to general practice so whether that's as medical students or as interns or PGY2 in actually getting experience in what general practice is because I've been talking to a lot of registrars over the past few weeks and what I hear from them is that they are really excited and enthusiastic about being GPs and they would have done it earlier if they hadn't of thought it was such a difficult thing and probably if they hadn't have heard as much of the negative narrative about there is no future in general practice.

I think we need to put initiatives around supporting doctors going from medical students into GP Registrars up until when they get into the fellowship and there are a number of areas along the way that we need to put more funding in to support GP Registrars during their training and the supervisors who are training them. We need to get a consistent training experience so that we actually create this pipeline of well trained, supported GP Registrars and Fellows and then we also will also have an increasing number of international medical graduates and they also need to be supported through that system as well so whether its systems like the Fellowship Support Program which needs to be supported by government, in those programs too that by the time they've finished their program they feel they are ready to work in Australian General Practice and feel up there as a supported member of our community.

Ken McCroary: Yeah I was reading about that on some your information that your awareness of the fact that just like the rest of society, the college is changing membership with women, with overseas doctors as well, we're a diverse group of doctors particularly in South Western Sydney, I think 70% or more of our 1000 GPs were born and trained overseas. The numbers are fairly high and I think having someone aware of that would be a comfort to my colleagues.

Michael Wright: Yeah look I'm really alert to it and I think we are the most diverse of all the health groups. We're a big group of diverse people, 1000s of us all around Australia serving every community in Australia, we all come from different backgrounds but we are united in this vision for having high quality general practice as the front door to the health system. I think what unites us is more important than what separates us but we need to acknowledge the diversity of our group. I think the college has done a few good things recently like set up some specific interest groups to help people with specific interests.

They have now set up a national IMG committee which is great but I do think the college needs to be everyone's professional home and everyone needs to be proud, almost like you put your college badge on and you should be proud to be a member. That's what I want to achieve over the next couple of years is actually pointing the direction forward to say general practice is a great thing to do, we provided 166 000 000 consults in the last year, so general practice is far from gone but we just need to fight for it. It will take time.

Ken McCroary: Absolutely. You've also got a strong interest on focus, particularly clinical care vs the ever increasing red tape that we're stuck with, particularly the last couple of weeks with the transition to the new aged care incentive which drove me and my nurse at work absolutely nuts. I know you are going to try your best with that as well.

Michael Wright: Yeah look it's one of my other priorities which is around getting us shifting from dealing with administration and back to what's clinical care and it's going to start off with gathering a list of these things. We mentioned the GP access incentive Ken, the other one that gets me is the real time prescription monitoring which seems like a great idea, allows us to provide safer care for our patients and avoids doctor shoppers and drug users but when rolled out all the implementation costs fall on GPs. And I'm going to push back against all of that.

We need to have clearer systems that don't just add more work to general practice and we need to be consulted in these things early on through the design not just after it's implemented. And the Aged Care Incentive is a similar one, there's a lot of administration in that and that is unacceptable for GPs, particularly for the amount of compensation they get in return. So yeah I'm starting a list of the things where we need to start and I'll be prioritising pushing back. This is just taking us away from general practice and providing care to our patients.

Ken McCroary: Yeah. Even like MyMedicare, well just over a million people have been registered and there's another 26 million to go and it takes time from us in our practice, our geriatric patients, our dementia patients, our chronically mentally unwell patients, they don't have access to computers and aren't digitally savvy so it's up to us to enroll them and all that takes time and effort and pulls us away from day-to-day work doesn't it?

Michael Wright: And look that's the issue. Whether it's what we were talking about previously with the bulk billing or things like MyMedicare I think a lot of people have relied on the altruism of general practice that we just do it for our patients and we do but we need to be recompensed for it.

Ken McCroary: Yeah. Particularly I mentioned this before, over 30 of our practices are likely to close down in because they cannot afford to remain open, particularly in a region that doesn't have the ability to pay for increasing gaps and there is no other way to manage this rather than try and provide free care but you can't do that.

Michael Wright: As I said that's a similar issue in some of the rural areas as well but it is a real issue in outer urban and these are high needs patients, high demands patients and their GPs are working really hard and they need more money to support them.

Ken McCroary: Excellent. Now I might finish up by giving you an opportunity to talk about the future and the future GP, what will we look like? What do you envision? The future of the system and how we fund it and how we get to that idea that I think a lot of us share in terms of what's right, what's better. I read that the government's looking at 60% of funding for general practice coming by not from fee for service by 2030 and all that sort of stuff which is pie in the sky stuff and I don't think how it's going to appear but in your crystal ball…

Michael Wright: General practice is the centre and the front door of the health system. That's what we need to retain. So we almost, if image all this money keeps pouring into hospitals and it's trickled down to general practice we really need to tip the whole model up and say let's fund general practice properly and we'll then keep the referrals and costs to other parts of the system under control.

But it's a difficult argument that we have to keep taking so we will I think have more funding for team care or sort of multidisciplinary care. As you say we've got this workforce crises so we're not going to be able to do all this care so they are arguably things we could say you know what maybe my nurse, my physio, my podiatrist is better equipped to do that, and they'll get some funding to do that but I will actually be doing stuff that is interesting. You don't want to be doing all the hard stuff all the time too. That's the other thing we do have complex care but I do want to have the positive experiences as well so I think it's about more team based care, more funding and then I think from a college point of view it's about general practice almost being the future of the health system.

I feel like we can lead a number of things in terms of, we know it's important that everyone has GP, I think that general practice does lead the way in discussions around health and wellbeing and encouraging everyone to look after their own health. I think in terms of the IT issues if they can turn the use of e-scribes and things like that, I mean I'd love it if we trained, had everyone trained in that so that we could actually use that safely and well in our practice and then I think the other one is from environmental systems. General practice is the greenest part of the health system. We know how many resources get wasted in hospitals and if we can get more care out into the community, and I know there's a lot of support for that, and that's another way to get more resourcing back into general practice rather than wasting it sort of down the line.

Ken McCroary: Thank you so much for your time today Michael. I really wish you the best and good luck in the upcoming election.

Michael Wright: Thanks Ken

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