



The Royal Australian
College of General
Practitioners

RACGP Submission to the Minister for Health and Ageing

Federal Budget 2011-2012

Supporting our communities

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Introduction

This submission

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health and Ageing for the opportunity to contribute to discussion regarding the Health and Ageing Budget for 2011-2012.

The RACGP seeks Federal Government consideration of its proposals, which aim to facilitate the delivery of safe, efficient, coordinated, and comprehensive general practice and primary health care.

The College is committed to work with all levels of government to improve access to high quality care to better meet the needs of our local communities.

About the RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

Key messages

The RACGP advocates that the Federal Government should:

- Continue significant investment in e-health
- Build the capacity of general practice
- Enhance health outcomes for regional, rural, and remote communities
- Enhance the health of Aboriginal and Torres Strait Islanders communities
- Recognise and reward for general practice
- Support international medical graduates.

1. Investing in the future of e-health - readiness for a Personally Controlled Electronic Health Record (PCEHR)

The implementation of an efficient and effective e-health system is a long-term undertaking across the stages of planning, implementation, and financing. The effective up-take and implementation of e-health initiatives requires investment in information, communication, and technology systems as well as education and training. The method of delivery of general practice services will need to evolve in order to incorporate nationally established guidelines and solutions, ultimately achieving safer, more accessible, and efficient health services.

The RACGP supports and encourages a national standards based approach to e-communication, and acknowledges the work of NeHTA in establishing standards that will build consistent messaging and communication between different software solutions. However training and support is required to up-skill the general practice profession in the technical and functional interoperability of e-health solutions.

A Personally Controlled Electronic Health Record (PCEHR) will be available from July 2012. Expansion of investment in e-health, to include support to develop user skills and knowledge in the importance of quality patient information, will be well received by health care providers.

To prepare general practice for the PCEHR and to be e-health 'ready' will require an investment across:

- Change management within the practice
- Training and education of practice staff
- Implementation of systems (technical systems).

Recommendation:

- Invest in the national implementation of e-health guidelines and standards and ensure access to e-health communication tools and decision support solutions.

1.1 Technically ready for the PCEHR

An essential pre-requisite for an efficient and effective e-health system is the electronic exchange of accurate and relevant patient information across the health sector, including different health care providers, private and public sectors, and patients. General practitioners require access to technology that allows clinical communication to be timely, meaningful, and secure.

General practice requires investment in development or enhancement of existing software systems to better address patient identification and authentication, and investment in hardware infrastructure to securely share patient health information via the PCEHR.

Recommendation:

- Invest in general practice software and hardware to ensure that practices have the technical capability to support implementation of the PCEHR.

1.2 Functionally ready for the PCEHR

Uptake of the PCEHR by health care providers will be aligned to confidence in the quality and usefulness of the PCEHR in being able to support continuing care across geographical and professional boundaries.

Further investment is needed to deliver change management and education and training in general practice to ensure rapid dissemination of new knowledge, support change, and guarantee adoption of the new technologies and systems.

Recommendations:

- Invest in education and training for general practice staff in the use and benefits of the PCEHR.
- Provide incentives for general practices to dedicate human resources specifically for the quality analysis, and quality improvement, of data in GP e-health summaries outside of the patient consultation through either Practice Incentive or Service Incentive Payments.

1.3 Information Security

Increased use of e-health initiatives must be combined with effective security measures. These security measures must be designed to ensure that highly sensitive and confidential information relating to: individual patients; the health professionals who provide care; and the business component of the general practice is securely managed.

General practice has specific needs for computer and information security, as it can often be a challenge for general practices to find security experts and technical service providers who understand the business of delivering care in the general practice environment.

Some issues contributing to this challenge include:

- Inadequate risk analysis and identifying gaps in security
- Lack of designated authority (person) to ensure robust security processes are documented and adopted
- Poor data management processes to ensure that information is backed up and can be recovered easily if there is a system failure
- Inadequate business continuity and disaster recovery planning
- Lack of and/or poor password security
- Lack of security 'culture' and leadership.

Recommendation:

- Introduce a national strategy aimed at providing ongoing education and training for general practitioners, practice nurses, and practice staff regarding data security in primary healthcare.

2. Building capacity in general practice

There are continued general practice workforce shortages throughout Australia. Though overall general practitioner numbers have increased, due to population growth, general practitioner supply has fallen by 2% since 2002¹, whilst other specialist supply has increased by 17%.² These workforce changes must be reversed as they will increase health costs, and worsen health outcomes.

The RACGP recognises and welcomes the significant increases in general practice prevocational training and vocational training numbers. However, even with these increases in training numbers, there will continue to be a general practice workforce shortage.

In order to combat continued general practice workforce shortages, there must be considerable investment in:

- Building the general practice workforce
- Increasing training capacity
- Building general practice infrastructure

2.1 Building the general practice workforce

Prevocational training

Expanding the PGPPP, or similar prevocational training program, will both encourage medical practitioners to undertake general practice as a career, and provide much needed intern places for the increasing number of medical students.

Recommendation:

- Increase prevocational training places to 1,500 throughout Australia per year by 2014.

Vocational Training

The general practice workforce is ageing, with the average age of vocationally recognised general practitioners now over 50 years.¹ It is essential that, prior to these general practitioners retiring, the next generation of general practitioners are trained and in practice.

Recommendations:

- Establish general practice, and all primary health care disciplines, as careers of choice through incentives and training subsidies
- Increase vocational training numbers to 1,500 vocational training places per year by 2015.

2.2 Increasing training capacity

With the doubling of medical student numbers, and the increasing emphasis on community based medicine, general practices will be teaching double the number of medical students, interns, and registrars – often for longer periods – than previously.

Additionally, there is a growing expectation that other health professionals, such as nurses and allied health workers, may be undertaking some training in a general practice environment.

Currently, there are approximately 7,000 general practices across Australia, yet only about 2,000 of these practices are currently accredited for GP training. With less than 30% of general practices currently accredited for training, there is considerable potential to bring other practices on board to increase training capacity.³

There is a need for overall and coordinated investment in general practice training to ensure high quality and appropriate community based experiences for the doctors and general practitioners of the future.

Recommendations:

- Increase the number of general practice supervisors to reflect increasing training numbers.
- Encourage general practices to become training posts through investment into physical infrastructure and consulting rooms.
- Provide funding to cover the real costs of general practice supervisors' time to encourage general practitioners to become supervisors.

2.3 Building general practice and primary health care infrastructure

Investing in general practice infrastructure has substantial potential returns for Australia's productivity as it will grow the Australian health workforce and enable provision of:

- more general practice services
- multidisciplinary team care
- better management and prevention of chronic disease.

The RACGP recognises and welcomes the significant investment in general practice infrastructure announced in the 2010-2011 Health and Ageing Budget, which provided grants for 425 general practices and primary health care facilities throughout Australia.

However, given that the program was significantly over-subscribed, and that the RACGP and other peak general practice groups have previously advocated for 1,000 practice grants, the College recommends an extension of the general practice infrastructure grants program.

Recommendation:

- Invest \$475M in general practice and primary health care infrastructure, allowing for an additional 575 infrastructure grants.

3. Enhancing health outcomes for regional, rural, and remote communities

One third of Australia's population live in regional, rural, and remote areas. The availability of and access to health services is less in these areas than in urban areas. The National Rural Faculty of the RACGP represents over 7,000 members including 4,400 General Practitioners (GPs) living and working in these regional, rural, and remote communities.

The vital clinical and coordinating role that rural GPs provide in these communities needs to continue to be recognised, encouraged and better funded. Addressing the following areas will support rural and remote communities to receive high quality comprehensive care.

3.1 Infrastructure Grants

The infrastructure needs of rural general practices, primary health care, and community health are essential to ensuring the provision of high quality continuing care.

Recommendation:

- Current Department of Health and Ageing infrastructure grants programs should be targeted and expanded to incorporate larger numbers of general practices and regional, rural, and remote health care providers. These grants should not effect a practice's income tax assessment.

3.2 Accommodation for medical students, junior doctors and GP trainees

Medical students, junior doctors, GP trainees and general practitioners require adequate accommodation while they are undertaking placements in regional, rural and remote communities.

Recommendations:

- Allocate \$10M to provide up to 450 transportable modular buildings (similar to those used in the mining sector) to provide accommodation for visiting health professionals at regional, rural, and remote areas health care facilities.

3.3 Procedural Grants

Rural GPs need support and opportunities to gain and update clinical and procedural skills. They also require facilities in order to use and maintain their advanced skills.

Recommendations:

- Maintain the Rural Procedural Grants Program which provides valuable financial support to maintain and enhance the clinical skills of GPs and locums providing hospital based emergency services (\$25M).
- Increase the places available in the Rural Locum Education Assistance Program by a further 165 medical practitioners a year (\$1M).

3.4 e-Health

Rural and remote communities deserve equal access to affordable high speed broadband and the health benefits that can flow from such technology. Technology has the potential to enhance diagnosis, management, referral and continuity of care. The approaches to conducting consultations via telemedicine need further testing and evaluation. Input from general practitioners and practice teams must occur within the next year.

Recommendations:

- Invest in a pilot of telemedicine technologies and general practice consultations in rural Australia.
- Fund initiatives that encourage the development of virtual teams in general practice.

3.5 Multidisciplinary Teams

Health care for rural communities requires effective GP led team based care. Initiatives should continue to be funded to enhance the ability of general practitioners and health professionals to provide team based care to their patients.

Recommendation:

- Invest in initiatives that encourage GP led primary health care teams including virtual teams.

3.6 The next generation

Encouraging and providing financial and professional support for the next generation of rural health professionals is vital. General Practice must be attractive, appropriately remunerated and well supported for the next generation of practitioners.

The Fellowship of Advanced Rural General Practice (FARGP) is offered by the RACGP. The FARGP recognises advanced rural skills and additional training that may be undertaken by GPs in preparation for practice in rural and remote Australia.

Recommendations:

- Encourage and support practicing general practitioners to undertake and complete the FARGP (\$0.7M over 4 years).
- Increase funding for education and mentoring for medical students, interns and registrars in rural areas.
- Provide opportunities for continuing professional development to be delivered locally, in real time, using high speed internet.
- Invest in clinical skill maintenance workshops in regional areas (\$0.5M over 3 years)
- Resource opportunities to celebrate the service of general practitioners to rural and remote communities.

3.7 Easy entry, gracious exit

General practitioners approaching retirement, or those wanting to reduce their clinical activity to undertake a greater teaching role, need to be better supported.

Recommendations:

- Urgently increase the level of financial and academic support for current GP supervisors, examiners and medical educators.
- Provide funding to train additional GP supervisors, examiners and medical educators for regional, rural, and remote areas (\$2.5M over 4 years).

3.8 Response to 2011 Floods

The Royal Australian College of General Practitioners (RACGP) recognises the devastating effect that the flood crisis in Queensland, New South Wales, Victoria, and Western Australia has had on individuals and communities. As a College, we are shocked and concerned at the enormity and size of the floods and recognise that general practitioners in these communities provide essential services, but are facing varying degrees of damage to their practices.

Recommendation:

- Provide additional funds to assist with the reconstruction of general practices and health services affected by the floods.

3.9 Supporting the development of general practice in our near neighbours

The RACGP undertakes to engage with and support doctors in the Asia Pacific region, including supporting the development of post-graduate General Practice (Rural Medicine) training in Papua New Guinea, Timor Leste, and the Solomon Islands.

Recommendations:

- Funding to support the provision of access to teaching and research resources, examiner training, case workshops, conference/seminar attendance, and examination quality control (\$500K over 4 years).

4. Enhancing the health of Aboriginal and Torres Strait Islander communities

The RACGP recognises that improving the health of Aboriginal and Torres Strait Islanders is one of Australia's highest health priorities. The RACGP supports the right of Aboriginal and Torres Strait Islander Peoples to experience a high quality of health that encompasses physical, social, emotional and cultural well-being of the whole community, as outlined by the National Aboriginal Health Strategy Working Party, 1989.

The RACGP supports Aboriginal and Torres Strait Islander People's right to self determination and acknowledges that Aboriginal Community Control in health is a key means of reducing health inequalities. A critical component of this is the expansion and support of the Aboriginal and Torres Strait Islander health workforce to provide comprehensive primary health care.

4.1 Supporting Aboriginal and Torres Strait Islander doctors and other health professionals

Whilst progress in supporting Aboriginal and Torres Strait Islander People to consider and pursue a career in medicine and other primary care professions has been positive, sustained efforts and appropriate funding must continue to be provided. Agencies such as the Australian Indigenous Doctors Association, the National Aboriginal Community Controlled Health Organisation, the National Aboriginal and Torres Strait Islander Health Workers Association and the RACGP must continue to be supported.

The RACGP supports the recommendations outlined in the National Aboriginal and Torres Strait Islander Health Council paper: *'A Blueprint for Action – Pathways into the health workforce for Aboriginal and Torres Strait Islander people'* and additionally highlights the following specific recommendations to expand and maintain a competent Aboriginal and Torres Strait Islander health workforce.

Recommendations:

- Provide financial support to Aboriginal and Torres Strait Islander medical students, doctors, nurses, health workers and other health professionals who wish to work in Indigenous health, to enable them to receive training and support in the provision of primary care and other clinical specialties required by Aboriginal and Torres Strait Islander communities.
- Increase the recruitment of Aboriginal and Torres Strait Islander registrars into general practice training.
- Provide continuing support for Aboriginal and Torres Strait Islander general practice registrars, including improved educational support, examination preparation, and financial support for examination fees.

4.2 Supporting general practitioners and other health professionals to provide clinically and culturally appropriate health care to Aboriginal and Torres Strait Islander communities

It is essential that general practitioners and others providing health care to Aboriginal and Torres Strait Islander patients and families include consideration of the clinical and cultural issues affecting the health and life expectancy of Aboriginal and Torres Strait Islander Peoples in their clinical care practices. It is acknowledged that significant government funding has already been allocated to address many of these issues, through the Closing the Gap initiatives, including the Practice Incentives Program Indigenous Health Incentive and workforce expansion within the Divisions of General Practice. However the RACGP believes that additional continued education and support for non-Indigenous primary care providers is needed to ensure that they have the competence and confidence to commit to working long-term in this area.

In addition, while the RACGP has already demonstrated its commitment to ensuring the correct and consistent identification of Aboriginal and Torres Strait Islander Peoples in general practices through its 4th edition standards for general practices, a sector-wide collaboration is needed to fully implement this process.

Working with its partners the RACGP has the capacity to implement a number of practical initiatives as follows:

Recommendations:

- Provide training for non-Indigenous primary care providers in the approaches for providing culturally appropriate health care.
- Introduce a nationally coordinated strategy aimed at implementing systems in general practices to identify Aboriginal and Torres Strait Islander patients and optimise access to GP-mediated Aboriginal and Torres Strait Islander specific health interventions.
- Develop an online learning module for general practitioners explaining the Practice Incentives Payment Indigenous Health Incentive (PIP-IH)
- Establish a national support telephone service for general practitioners providing care to their Aboriginal and Torres Strait Islander patients, to optimise access to GP-mediated Aboriginal and Torres Strait Islander specific health interventions.
- Host forums for general practitioners and other primary care providers to provide information on the Close the Gap chronic disease measures and opportunities for collaborations.

4.3 Supporting self determination and community control

The RACGP acknowledges the Close the Gap campaign, and calls on the Federal Government to take action and continue to implement its sector-wide recommendations. In addition, the RACGP urges the Government to continue demonstrating commitment to the principle of self determination in health by sustained support for the Community Controlled health sector.

Recommendations:

- Provide ongoing funding for preventive activities and tools for preventive health care in general practice and Aboriginal primary health care.
- Invest in strategic, policy-driven research that is culturally appropriate and which makes a difference to health outcomes, policy and practice, and the capacity of general practice to engage with Aboriginal and Torres Strait Islanders' health issues.
- Improve infrastructure of Aboriginal community controlled health services and communication and information technology linkages between general practice, community health, public health, mental health, consultant specialists and hospitals and Aboriginal community controlled health services.
- Fund initiatives that address racism and its impact on individuals and communities.

5. Recognising and rewarding general practice

General practitioners and general practice teams warrant increased recognition and reward for their contribution as the heart of primary health care in Australia. The Medical Benefits Schedule (MBS) in particular requires refinement so that it better supports this contribution.

The MBS needs to be modified to remove incentives for rapid throughput, and instead facilitate primary health care management of complex conditions through extended teams, advanced skills, and wider delegation to practice-based teams with appropriate support and coordination. This will not be solved by providing further disease-specific item numbers, but by developing a funding model that addresses the growing issues of complex co-morbidities and the workflow systems that support them. The current MBS structure and rebates do not offer patients the opportunity to fully access the range of high quality care options that general practice in Australia should provide.

To better recognise general practitioners' skills, and reward general practice, there must be considerable investment in the following:

- Recognising the value of generalism, as opposed to partialism, including better parity between specialist and generalist rebates
- Developing on-line modules for general practice advanced skills in aged care
- Providing incentives to promote quality primary health care delivered by general practitioner led multidisciplinary teams
- Direct general practitioner referral for MRIs
- Maintaining the real value of patient rebates
- Ascertaining and reflecting the value of general practice.

5.1 Reflecting the real value of patient rebates

General practitioners are not adequately remunerated for all of the work undertaken in the course of their practice. The MBS structure is defined by specific item numbers, many of which do not accurately reflect the often 'hidden' (or non face-to-face) work performed by general practitioners.

The following are examples of unpaid work often performed by general practitioners:

- Clinically relevant services provided when the general practitioner returns to the practice following a visit to a residential aged care facility
- Home consultations that take more time than consultations undertaken in the practice, and for which travel is not reimbursed
- Consultations with other general practitioners regarding patient care
- Consultations with carers regarding the management of someone they care for. Currently the consultation does not attract a rebate as the matter is about a third party.

Recommendations:

- Convene a special GP Taskforce, through the MBS Quality Framework, to conduct a values study of providing patient services in general practice
- Create longitudinal general practice team items in the MBS for general practice care of residents of aged care facilities in addition to an episodic fee
- Refine MBS to allow a rebate for carers who seek support and guidance in their role as carers. The MBS item must extend to carers of all ages and to the carers of people of all ages (including children).

5.2 Provide incentives to promote quality primary health care delivered by general practitioner led multidisciplinary teams

General practitioners should be supported to provide clinical leadership in expanded multidisciplinary teams, where all team members are supported to establish their own leadership roles designed to meet emerging community needs.

Whilst general practice can lead the way in the development of multidisciplinary primary care services, they require the necessary infrastructure to do so. Processes to improve the quality of teamwork that leads to improved patient outcomes should be supported legislatively and financially by the Australian government.

The RACGP supports the role of practice nurses in our practice teams and a clear commitment to building teams within general practices, including the integration of nurse practitioners into properly structured general practice teams. We need to ensure that potentially isolated health practitioners, such as community midwives and nurse practitioners, are also connected to teams, continuing quality improvement, and professional support networks.

Recommendations:

- A generic MBS item number should be established for services provided by practice nurses in the general practice setting or via home visits, or nursing home visits, using the structure of the B, C and D consultation item numbers for general practitioners. This should include any services performed for and on behalf of the general practitioner
- Review the current chronic disease management MBS items for Team Care Arrangements, and simplify as a coordination payment for arrangement and referral of patients to services
- Provide funding for general practitioner clinical leadership training, including funding for dedicated training time
- Invest \$1.4M to develop online educational modules, delivered through *ClinEd*, for advanced GP skills in aged care, including modules for cardiac conditions, delirium, mental health, dementia, renal disease, behavioural management, and diabetes.

5.3 Access to diagnostic tools

New technologies are increasingly emerging in health care which can deliver efficiencies in patient care. However, currently general practitioners are not able to refer for certain procedures that utilise these technologies, such as Medical Resonance Imaging, and instead have to refer patients to specialists.

The management and efficiency of patient care in general practice could be improved significantly if patients were given better access to relevant technologies, such as MRIs, based on best practice clinical guidelines.

Recommendation:

- The MBS should support the capacity for general practitioners to directly refer patients for MRIs.

5.4 Better parity between specialist and generalist rebates

There is currently a wage disparity between general practitioners and other specialists. Specialists are increasingly performing roles traditionally provided by general practitioners, and are often receiving higher remuneration for similar work and/or directly cross-referring, unnecessarily increasing costs.⁴ Essentially, the value of generalism is not being recognised, and there is a continuing shift towards increased reward for partialism.

Additionally, attempts to redistribute the workforce budget aiming for pay parity via the Relative Values Study have not been successful.⁵ To attract doctors to train for General Practice, pay parity with other specialist colleagues, and a better appreciation for the work performed is needed.⁴

Recommendation:

- Relative values adjustment between generalist and specialist disciplines, commencing with equivalent remuneration for equivalent medical work, needs to occur.

5.4 *Red Book* based preventive item numbers

Evidence clearly demonstrates the benefits of preventive health care, including improved health outcomes, and more efficient use of health spending and resources.⁶ However, even with recent changes and clarification regarding Level Bs, Cs, and Ds, the payment systems for general practitioners in Australia are not appropriately structured to encourage the delivery of preventive healthcare. This has led to relatively less time spent on preventive care at each visit than in other countries.⁷

For adults, preventive activities would include lifestyle management advice, motivational counselling if appropriate (e.g. weight, exercise, smoking, at risk alcohol consumption), blood pressure, women's health (e.g. pap smear and breast exam), skin checks, and mental health wellness as indicated by guidelines.

Recommendation:

- MBS funding for a preventive health item based on the *Red Book*⁸ recommendations, comprising a minimum of specific key preventive activities, with the capacity for general practitioners to delegate activities to practice nurses.

6. Supporting International Medical Graduates

6.1 Recognising and supporting International Medical Graduates

International medical graduates (IMGs) constitute up to 39% of the rural GP workforce in Australia. They provide vital health services to rural and remote communities and will continue to do so for the foreseeable future. The valuable role of IMGs in the Australian medical workforce needs to be better recognised and funded.

Under the 10 Year Moratorium, IMGs, including overseas medical students, first registered with an Australian medical registration board on or after 1 January 1997 are not able to attract Medicare benefits for their services for a minimum period of ten years, unless they hold a section 19AB exemption. A section 19AB exemption requires an IMG to work in a district of workforce shortage in order to access Medicare benefits.

Some IMGs affected by the Moratorium are working in areas of isolation with little support or adequate supervision. Some enter practice without appropriate orientation to Australian general practice, the Australian health care system, or Australian culture. IMGs provide high quality medical care to their communities, often with inadequate professional support.

The RACGP recognises the value to rural communities from the Government funded pilot IMG Peer Mentor Network Project, which concluded in May 2010. The project provided 10 hours of 1-on-1 peer mentoring for 64 IMGs throughout Australia. An independent evaluation of the pilot project recommended the continuation of the project to greatly enhance the quality of care in rural communities (RedTree Consulting, 2010).

Recommendation

- Provide funding for IMG supervision, mentoring, and professional support (\$3M over 4 years).
- Provide funding for research into the feasibility of a cultural awareness campaign aimed at the Australian population which includes key messages regarding the valuable role and skills of IMGs
- Invest in research to explore alternatives to the 10 Year Moratorium
- Fund training for 250 experienced (FRACGP) IMGs in rural areas to become GP supervisors and examiners (\$0.75M over 4 years)

6.2 Professional training and support

The RACGP calls on the Federal Government to ensure IMGs are:

- Better supported to prepare for RACGP Fellowship
- Working to the same standards as those which apply to Australian graduates

Recommendations:

- Provide funding for IMGs to access relevant continuing professional development
- Invest in the provision of cultural and communication training for IMGs
- Reinstate and fund the Rural Outreach Vocational Educational (ROVE) program to enable access to medical educators, for IMGs preparing for RACGP Fellowship (\$2M)

6.3 Support for international medical graduates and their families

IMG are working in areas of workforce need, delivering health care to some of Australia's most rural and remote communities. They should be provided with better support for themselves and their families.

Recommendations:

- Recognise, reward, and support the valuable contribution that IMGs make to the health of rural and remote communities.
- Ensure funding for Medicare access for IMGs and their families.
- Provide funding for the children of IMGs to access publicly funded primary and secondary education.

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