Review of the Rural, Remote and Metropolitan Areas (RRMA) Classification

Rural Doctors Association of Australia

April 2005
Summary

The Rural Doctors Association of Australia (RDAA) acknowledges the need to review the RRMA geographical classification system which has now been in use, with little modification, for over a decade. RDAA believes that the time has come to update the system to make it more relevant to current needs and concepts and to utilize other systems and synergies which were not available at the time the system was developed. RDAA believes this to be the best option for developing a robust and balanced geographically based classification system as a basis for resource allocation and planning in the 21st century.

Revising RRMA offers the opportunity to include a range of indicators of health access need. However, rather than combining these indicators into a single index using a particular weighting for each indicator, RDAA believes that these indicators should be developed as a series of templates which can be applied to the revised RRMA on a case by case, or program by program basis. A “weight for purpose” process would enable the flexible application of any or all of these templates according to the principle purpose of the program concerned.

RDAA believes that four sets of indicators are needed to provide an adequate level of multivariate analysis. These templates should include geography (including both distance and transport systems) demography (including population centres as in RRMA currently) health outcomes and socioeconomic status (including generic and health infrastructure).

Recommendations

RDAA therefore recommends that:

The RRMA system should be retained. However it should be reviewed and updated to:

- facilitate accurate and equitable planning and resource allocation through the development of templates delineating the geographic, demographic, socioeconomic and health and infrastructure factors relating to access to health services

- include an appropriate measure of workforce shortage to be used in conjunction with other indices

- include in its generic and health infrastructure template/s indicators of community need and capacity, including the capacity to attract and sustain a health workforce

- utilise the capabilities of the ASGC measure, including building up to Statistical Local Area (SLA) level from CD modules, while maintaining a population density measure and the current classification categories

- align it more closely with standardized and regular generic data collection systems and processes, particularly the national Census of Population and Housing (Census) and Australian Bureau of Statistics (ABS) economic indicators

- ensure ongoing regular review of its data, templates and effectiveness in line with these and related data sets which are updated every five years.
The Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. The autonomous State/Territory associations work and negotiate with relevant bodies in their jurisdictions, while the RDAA Committee of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to provide quality care to the people of rural and remote Australia. Much of its activity therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural birthing services, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support the provision of medical services to rural and remote communities, RDAA has a particular responsibility to ensure that the needs and perspectives of people who live in the bush are heard by decision makers and incorporated into the design and implementation of national policies and programs.

Background

Over the past decade, the Commonwealth Government has provided a range of funding measures to help address the lower health status of country people, and to attract and retain the health workforce needed to do this. The Rural, Remote, and Metropolitan Areas (RRMA) classification was developed in 1994 using 1991 Census data. It was a useful tool which served its purpose in allocating funding well in its early years. However, the increasing size and complexity of the funding programs over the past few years have contributed to a perception that RRMA no longer provides an adequate framework. This illustrates the importance of ensuring that any new or revised classification system has sufficient inbuilt flexibility to remain robust and relevant in future funding environments.

RRMA has been used historically as a proxy measure of access to health services, to help allocate workforce support resources from government. It has been of particular service to those living in rural and remote areas where their inevitably more limited access to health and other services is a factor in their well documented lower health and socioeconomic status.
relative to those who live in urban centres.\textsuperscript{1} The focus on population centres has allowed the style of practice suitable to smaller (< 25,000) communities to be taken into account, to the benefit of these towns and the medical workforce which serves them.

As government comes under increasing pressure to make funding available to outer metropolitan areas to address workforce shortages there, the anomalies in the RRMA classification, particularly in relation to the higher end classifications such as Capital Cities, Other Metropolitan Centres and Large Rural Centres (RRMAs 1 – 3) have taken on greater importance.

RDAA acknowledges that health workforce shortages and inadequate health and generic infrastructure are not confined to rural and remote areas. However, this does not mean that the negative impact these factors have on people in the bush has decreased. Country people experience risk factors and higher rates of morbidity and mortality than people in metropolitan areas, and tend to be hospitalised more often in remote and very remote areas.\textsuperscript{2, 3} In addition, many rural communities have to contend with a continuing decline in health and social and economic infrastructure brought about by the closure or downgrading of local hospitals, aged care facilities, airports, banking and service industries and small to medium businesses.

The strength of a community’s social and economic infrastructure can have a significant impact on the health of that community’s population, as well as influencing the community’s capacity to recruit and sustain an appropriate health workforce.\textsuperscript{4} In spite of relative disadvantage on some counts, people in metropolitan and outer-metropolitan areas still generally have more choices and alternatives than country people, because of their comparatively easier access to public transport, jobs and social services and other public infrastructure and support systems.

While RDAA acknowledges the need to respond to health workforce pressures in outer metropolitan areas, it essential that initiatives and programs to support the health of rural communities are not diluted by re-channelling funding to other areas. Support for others must not be at the expense of rural communities.

RDAA believes that while RRMA requires updating, and other indicators of health access need to be developed, these should not be combined into a single index using a particular weighting for each indicator. Rather, RDAA recommends that the other indicators be applied to the revised RRMA on a case by case, or program by program basis, and a “weight for purpose” be applied according to the principle purpose of the funding program.

\textbf{The RRMA review}

RRMA was generally well accepted when it was first introduced, and has served doctors working in the bush, and rural communities well. One of the key reasons for its ready acceptance was that it was simple and practical to use.\textsuperscript{5} RRMA based programs, such as the Rural Other Medical Practitioners Program, the Rural and Remote General Practice Program,

\begin{itemize}
\item Australian Institute of Health and Welfare 2004. \textit{Australia’s Health 2004}. Canberra: AIHW. p 208
\item \textit{op cit}, p 212
\end{itemize}
the Nursing in General Practice Program and the More Allied Health Services Program have played a vital role in contributing to the health workforce in country areas. This in turn has improved the ability of communities to recruit and retain doctors in the bush.

There is no doubt that RRMA requires reviewing and updating. The RDAA view is that the greatest gain would come from reforming RRMA rather than abolishing it. Given the better geographic information systems and technology, and the capacity to add templates covering demographic and health and well-being indices for particular purposes, RDAA believes this review offers a valuable opportunity to build a RRMA II system which is robust, flexible and balanced, while retaining the simplicity and practicality of the original RRMA.

RDAA sees that all three of the currently available geographic classification indices have weaknesses and anomalies. Many of these issues may be resolved by incorporating the best features of all three systems into a stable and accepted geographic index.

Geographic Classification Index

While RDAA acknowledges that RRMA is now out of date, and suffers from a range of other anomalies, it maintains that RRMA, with its 7 categories, is preferable to the five of ARIA and ASGC.

All three classification systems account for the majority of the population in their first classification category, with RRMA 1 (capital cities) estimated to account for 64% of the population, ARIA’s Highly Accessible category accounting for 81%, and the ASGC’s Major Cities estimated to account for 66%. This is hardly surprising, as it is an accurate reflection of where most of the Australian population lives.

The barriers to health service access in metropolitan areas are not primarily related to geography and distance, but usually to a complex mix of social and economic factors. These factors are also an issue in country areas, exacerbating already reduced access to health services which do relate primarily to geography and distance. Therefore RDAA maintains that a revised geographical classification index should also provide improved sensitivity to other factors through the use of indices which can sharpen focus on particular aspects of health need and access.

The Discussion Paper which accompanies the Terms of Reference for this review emphasises the benefits of the Australian Standard Geographical Classification (ASGC) over ARIA. RDAA holds that ARIA is certainly the least acceptable of the three options set out in the Paper. A classification system based on ARIA (as distinct from ARIA+), would wrongly class many rural areas as Highly Accessible, particularly in Victoria. Other areas in Queensland, NSW, SA and WA would also be wrongly categorised as Accessible by the ARIA methodology.

The three maps below, taken from the Australian Institute of health and Welfare (AIHW) 2004 publication *Rural, regional and remote health: a guide to remoteness classifications* offer telling comparison.

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6 op cit p76
Figure 1: RRMA areas of Australia

Figure 2: ARIA areas of Australia
The main purpose of a geographic classification system is to provide sensitive and accurate information about the distance people have to travel to gain access to health services, and the number of people the various types of health workforce in rural and remote communities of various sizes as a guide to the size and distribution of the health workforce needed. Thus decisions can be made about levels of funding support required to help ensure an adequate health workforce is available in rural and remote communities.

Ideally, a geographic classification index should be a simple and practical tool to:

- ensure appropriate workforce coverage in rural and remote Australia
- ensure appropriate service capacity, including the provision of emergency and procedural services
- address the specific burden of disease in different areas
- address underspends in health funding systems including Medicare and Private health Insurance subsidies in particular parts of the country
- ensure equity to the population\(^9\)

RDAA believes such a classification must therefore include population and geographical measures that help identify both the size of a particular area as well as the population density within that area. It must also include information about service infrastructure to provide a better understanding of patient drainage patterns and transport systems.

Statistical Local Areas (SLAs) provide a convenient unit of measurement for this purpose. Given the more powerful measurement capacities now available, it is possible to build a more robust and accurate set of measures than those in the original RRMA classification. SLAs

\(^9\) RM, rural medical practitioner, \textit{pers. comm.} April 2005
built up from the Census Collection Districts (CD) of the ASGC could be used to construct the 7 classification categories of the revised RRMA measure.

The Australian Bureau of Statistics uses this approach for the National Regional Profile and many other indices. While it uses CD level information to build the index, it provides the data at SLA level. It is also worth noting that the SLA measure would be sensitive enough to pick particular areas of disadvantage in large metropolitan centres as well.10

It is essential that the revised geographic classification must be based on a measure small enough to be sensitive but large enough to be practical in determining the equitable allocation of resources to areas of need. However, the measure must be a standardized unit to deter instability and potential interference on the grounds of specific interests.

Therefore RDAA recommends that the revised RRMA utilise the capabilities of the ASGC measure, including building up to SLA level from CD modules, while maintaining a population density measure and the 7 classification categories.

The ARIA and ASGC use of road distance to a range of service centres is not the improvement on the original RRMA that many claim it is. This measure makes no distinction between good and bad roads, highways or narrow, winding roads and does not take into consideration patterns of air travel or other transport systems.

A preferable approach would be to create a measure of a community’s social, economic and health infrastructure to use in conjunction with the revised RRMA index. This would provide a more accurate way to identify barriers to health service access in particular communities. These infrastructure measures would also provide credible indicators of a community’s capacity to attract and support, and therefore retain, a health workforce of doctors, specialists, nurses and other health professionals.11

The following comment from an RDA member summarises the issues facing any revised classification system well.

"I have finally seen the break down by postcode on the ASGC measure of remoteness that seems to be the preferred standard. I don’t see it as much of an improvement on the North Coast - perhaps it works better in western NSW. In our region on the North Coast there are some improvements with Byron becoming Inner Regional (IR) from its previous RRMA 5 status, but Kyogle RRMA 5 becomes Inner Regional. Kyogle I see as genuinely a challenging place to fill with GPs and Registrars. It is seen as less remote than Coffs Harbour RRMA 4 becomes OR (Outer Regional). Tumut is Inner Regional. Wollongong is Inner Regional for goodness sake! Kempsey is Inner Regional. Grafton is Inner Regional. It is all a bit of a joke really. Lismore, where the Base Hospital is, is Inner Regional, too, which is fair enough, but working in Lismore is very different from working in Kempsey or Kyogle."

From my point of view it is a lot easier working in a town with a base hospital than in a town with no hospital or a hospital staffed by yours truly only. It seems this classification is not able to make this distinction and as such will lead to people moving out of these towns to work in towns with the back up of a base hospital and specialist services if ASGC is used to incentives rural practice as RRMA has been.

I believe smaller areas will be required and the proposed area boundaries are not sensitive enough to distinguish the challenges of practice to be used as a rural incentive. At least in a region I understand the geography of well.\textsuperscript{12}

RDAA agrees with the Department that a simple geographic index is no longer a sufficiently sensitive indicator of health need. However, it is now widely known that rural people have poorer health status and higher mortality rates than their metropolitan counterparts.\textsuperscript{13} \textsuperscript{14}

Therefore RDAA recommends that a strong and robust geographical measure needs to be the basis of any revised RRMA classification system.

Other measures to support and strengthen the revised RRMA

A revised RRMA classification index should be strengthened by the addition of indices of workforce and health and well-being for particular purposes. RDAA believes that this would best be achieved through a methodology using the suite of indices or templates which could overlay the basic geographic classification using a “weight-for-purpose” approach. There is precedent for this, for example in the way in which some Divisions of General Practice funding has been allocated using RRMA plus a weighting for Aboriginal and Torres Strait Islander populations. The recent Areas of Consideration is a further example of using an additional template (albeit a geographical one) for a particular policy objective.

Health and well-being

RDAA is strongly in favour of using measures of health and well-being in the revised RRMA system. Such systems will also be of use to the Department in differentiating areas of need within metropolitan and other large urban areas where geographic classifications will not produce the levels of sensitivity required to determine barriers to access to health services.

Basic demographic data such as age and sex are important indicators of a population’s health status, as people of different age and sex have different risk profiles, and are likely to use differing levels of health services.\textsuperscript{15} This is particularly so in rural areas.\textsuperscript{16}

RDAA recommends the use of Census data for this index, as it is a standardised data source that is regularly and reliably updated.

\textsuperscript{12} CM, rural medical practitioner, \textit{pers. comm}. April 2005
\textsuperscript{14} Australian Institute of Health and Welfare 2003. \textit{Rural, regional and remote health: a study on mortality}. AIHW cat. no. PHE 45 Canberra AIHW (Rural Health Series no. 2) p 6.
\textsuperscript{16} Australian Institute of Health and Welfare 2004. \textit{Australia’s Health 2004}. Canberra: AIHW. p 208
The Socio-Economic Indexes for Areas (SEIFA) is a robust and useful index of well-being in the population. **RDAA is strongly in favour of using standard classifications systems wherever they are methodologically sound and relevant.** SEIFA offers this and the following extract from the ABS website attests to its applicability in the health sector:

*The health field is one of the most useful areas for the application of SEIFA. Many causes of illness and death are strongly related to socio-economic status, and SEIFA provides a mechanism for analysing these relationships. Health interventions can then be targeted to particular population groups.*

*One useful summary measure of population health is life expectancy. Using ABS mortality statistics, researchers from the Victorian Burden of Disease Study in the Health Surveillance and Evaluation Section of the Victorian Department of Human Services were able to create estimates of life expectancy for males and females in Victoria by Local Government Area (LGA).*

*Using the SEIFA Index of Disadvantage, the researchers examined the correlation between the socio-economic conditions in Victorian Local Government Areas and the average life expectancy in those areas. They found that low socio-economic status was a relatively strong predictor of early mortality.*

*The Victorian Burden of Disease Study also used the SEIFA Index of Disadvantage to examine the relationship between socio-economic status and years of life lost due to specific causes.*

*The study found that years of life lost to diabetes, cardiovascular disease, road traffic accidents and lung cancer were all significantly higher in the more disadvantaged areas.¹⁷*

Other data sources such as those from the National Health Information Framework and the Social Health Atlas could also contribute to the health and well-being indices as necessary. However, given the fact that these indicators are less stable than geographic indicators, it is recommended that only data that is robust and regularly updated (eg every five years in line with other Census based updates) be used for this purpose.

**Workforce**

Caution is required if indicators of workforce shortage are to be used as a matter of course in any index of access to health services which is then used for funding decisions.

*Using workforce need is fraught with danger. Manilla is not an Area of Need at the moment, but it will only take one partner to leave or get sick and the eggshell will collapse as the other 3 docs live elsewhere, are employees and need an employing entity. Tamworth, on the other hand, is a designated Area of Need at the moment but could lose 5 full timers without anyone noticing.¹⁸*


¹⁸GW, rural medical practitioner, pers. comm. April 2005
While a workforce measure might be able to provide additional sensitivity for some policy decisions, it is crucial that use of a workforce shortage measure does not have the effect of punishing communities that have been successful in attracting doctors and other health professionals to their community.

In addition, workforce figures can change quite quickly, and this could seriously compromise the stability of the proposed index as a whole. The index could easily be accused of being hopelessly out of date if it was not updated regularly, and yet the whole index would be rendered unstable if it was updated too regularly. If, on the other hand, a workforce index were developed separately, it could be updated as required, say annually, and used in conjunction with the revised RRMA for particular workforce initiatives as came under consideration.

A workforce indicator could be developed using a time series approach, so that trends over time could be mapped. Once 10 – 15 years data had been collected in this way, it should be possible to develop a more stable workforce indicator based on trend analysis. Given there is currently insufficient reliable data on which to build such a workforce indicator, considerable investment would be required to develop such an approach.

A community’s capacity to attract and retain a sustainable health workforce is dependent on a range of factors. The programs required to attract doctors to country areas are quite different from those that would be required to attract a doctor to work in Redfern or Cabramatta for example. If the same program were applied in rural and urban areas, it could be counter-productive, as the following communication from an RDA member points out.

For instance, currently Sydney gets $5 bulk billing incentive and rural doctors get $7.50. This was initially an attempt to increase bulk billing (although Sydney already had high rates so all it did was to cost more for the same service) with more money put where the costs were higher and more was required to increase the bulk billing rate; but it was then expanded into Canberra and other workforce shortage areas generally.19

The logical consequence of such action is that even more funding is required in order to attract doctors to rural workforce shortage areas.

While it is accepted that outer metropolitan and some inner city areas have specific health workforce pressures, people in rural and remote communities have a need for ongoing funding to counterbalance present inequities and specifically targeted programs to sustain basic health service infrastructure and workforce.

While it is accepted that current workforce estimates involving FTE and FWE calculations have their limitations, MBS data is the most accessible medical workforce participation data available to government at present. However, this needs to be considered in conjunction with data on the hospital workforce and other sources which delineate non-fee-for-service work. The outcomes of the current Medical Workforce Profile Project will presumably enhance accurate workforce measurement. Estimates of current shortfall or future need should move beyond simple numbers and per capita ratios to include the composition of the medical workforce and the skills mix within it.

19 SP, rural medical practitioner, pers. comm. April 2005
At the moment, a good doctor will do preventative screening and comprehensive patient care, but this takes time and under the current system slow equals less pay so the net result is that we pay our good doctors less. If these doctors work in areas with high percentages of complex patients this pay cut is too significant for sustainable practice, hence the town loses the doctor, or the council/mines/AMS steps in.

Perhaps in future doctors working in areas with poor health outcome codes could have access to loadings for every patient – recognising that to allow the doctor to slow down and do the job properly will increase their ability to do opportunistic screening and early disease detection. Providing such incentives within the FFS [fee for service] structure means they still focus on working to maximum time efficiency. Again, the loadings would be higher if you combine more than one RRMA disadvantage code.  

Workforce measures could be improved by calculating a combination of indicators such as doctor to population ratio, FWE measures, and analysis of doctor or community based MBS item usage. There may be benefit in looking at the range of MBS items used, for example mapping EPC, Health Assessments (aged and indigenous), PIP/SIP and mental health items rather than simply calculating income. Even this approach has its limitations however, as this RDA member points out.

If they want to use MBS data to look at workload, then the considerable amount of hospital work will not be counted and so seriously underestimates what rural doctors do. The more procedural you are, the less work it would appear that you do, if you just look as Medicare data.

The larger centres and the urban areas have alternative sources of medical workforce for the community to access... hospitals staffed by doctors other than the local GPs, community health, etc. If these issues are not considered, the RRMA 5 towns in particular, will be done down...

It is clear that developing a reliable and relatively stable workforce shortage measure will be no easy task. It is possible that a better measure could be calculated by taking a range of workforce data and averaging it over a time frame of perhaps 5 – 10 years. Whether this would result in a meaningful measure requires expert investigation.

**RDA recommends that if and when a measure of workforce shortage is developed, it should be used with caution, and only in conjunction with other indices.**

Health Infrastructure and Community Capacity

Perhaps the most useful measure to include in the revised RRMA would be an indicator of the community’s social, economic and health infrastructure. These factors have a significant impact on a community’s health and well-being, as well as on their capacity to attract, retain and support a viable health workforce.

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20 Ibid.
21 NM, rural medical practitioner, pers. comm. April 2005
One of the key issues for consideration is the community’s access to transport. RDAA has raised this matter in many forums and it remains a crucial issue for rural doctors, from a wide variety of perspectives, as the comments below demonstrate.

The beauty of RRMA is that it neatly picks up the three groupings, Rural, Metropolitan and Remote, such that living and working in a RRMA 6 setting ie the bigger towns in the Remote setting, is less burdensome with more doctors, bigger better serviced hospitals, more support, more services eg shops and air services than most if not all of the RRMA 5s eg Geraldton, Broome cf Casino.

Failure to understand this leads to poor replacements eg GP ARIA or the even more stupid ARIA itself which irrationally takes no account of whether it is a six lane bitumen hwy joining two towns or whether it is a windy hilly dirt road. It also ignores other transport eg ship to Weipa or flights to Broome which are the normal ways of getting to these places. As the basic premise is wrong, then all of its outcomes will be wrong so it should never have seen the light of day. That’s why it was thrown out...

The supposed main reason in the intro for reviewing RRMA is that it can’t be adapted to urban areas. Who needs it to when you have copious public transport to go from an area of undersupply in Sydney eg Redfern/Parramatta which are a couple of km from huge tertiary Hospitals - RPA and Westmead- respectively.22

Other possible measures of community infrastructure include whether there’s a hospital, aged care facility, or other significant health service that will provide an indication of the community’s capacity to deal with a health emergency and/or support a health workforce.

The ABS has a range of economic and social indicators available at SLA level that could be used to build an infrastructure and capacity index.23

RDAA recommends that the Department consider the feasibility of developing an economic, social and health infrastructure index as a measure of community capacity, including the capacity to sustain a health workforce.

Using a “Weight for Purpose” Approach

RDAA agrees that improving the geographical measure on its own will not improve understanding of access issues influenced as they are by a complex mix of social, demographic and economic factor as well as distance. However, building a single index with a fixed weighting for each of the contributing indices would also face limitations in its usefulness.

To date, funding programs have tended to use RRMA as a fairly blunt tool, with allocation or eligibility generally being available to all doctors in RRMA 4 – 7 or, to a lesser extent 3 – 7.

The development of a suite of indicators, as suggested above, would enable a “weight for purpose” approach, where agreement is reached on the format for each index, but the

22 GW, rural medical practitioner, pers. comm. April 2005
23 www.abs.gov.au (see eg economic indicators, regional indicators and social trends)
weighting applied for each purpose can be used flexibly to help better target specific programs.

Adding templates for desired output as suggested is a good approach, as long as the underlying RRMA is reasonable in the first place. If the guts is no good, adding any number of templates will not work.²⁴

The Department has some experience in doing this already, with overlays of particular data being applied to RRMA (or ARIA) to help target program funding more accurately. Some examples are provided below.

Population health programs – eg, cervical cancer screening, where measures of low cervical screening were used to help target education and support funding for the 2001 cervical screening GP incentives, and population characteristics were added to the general Divisions’ formula to allocate Chronic Disease Management funding for Divisions.

Workforce Recruitment & Retention Programs – eg, ROMPS: Areas of Consideration, OMPS: Areas of Workforce Shortage, and OTDS Section 19AB exemption: Districts of Workforce Shortage.

Updating the indices
It is clear that one of the key issues with RRMA is that it has not been updated, despite being used for over a decade. Any future system must have an inbuilt update and review process established, not only to keep it up-to-date but also to maintain its credibility.

RDAA recommends that the Department use currently available standard measures as far as possible in developing the revised classification system. Most of these standardised measures (eg Census, ABS economic indicators) are updated every five years, which would provide a regular framework to update the revised RRMA.

Regular review is not without its challenges however, and may have the effect of increasing the uncertainty of funding for a few areas at risk of changing classifications from one update to the next. This becomes more likely if unstable measures, such as workforce patterns are built into a single index with a range of weightings, and could have the effect of punishing areas that have been successful in attracting new doctors to the area since the last update.

A transparent system for dealing with such issues and inevitable anomalies must be developed in consultation with stakeholders, including doctors, consumers, community leaders and other health professionals.

Moving to a New System

There are a number of issues that need to be taken into account when considering changing to a new system and appropriate risk management strategies put in place. These issues include:

- Existing programs may have to be withdrawn
- Withdrawing or changing workforce initiatives could lead to a loss of workforce in some areas
- A workforce index will alter over time and is subject to extreme variation. RRMA is currently used to deliver services to patients (eg MAHS). Services could be withdrawn on the basis of the new index in one period, only to be reinstated in the next period.²⁵

²⁴ GW, rural medical practitioner, pers. comm. April 2005
It is strongly recommended that the revised system be subject to extensive testing and trialling to assess the impact of any proposed changes, before the revised system is implemented.

It will be very important to consult widely before implementing any new system, particularly with the communities that will be most affected. To this end, RDAA recommends that a broadly-based panel be appointed to make decisions about the final format of the revised RRMA classification system, and to advise on implementation arrangements including:

- Consultation
- Phasing – in arrangements
- Update timeframes
- Monitoring arrangements
- Review and evaluation.

Consideration should be given to a five year phasing in period, and/or a commitment that no rural community will lose funding from current programs as a result of the new system.

Change management techniques should be utilised to minimise the impact of the introduction of the revised system to help make stakeholders aware, keep them informed, and promote the feeling that they are being consulted and part of the process.

Transition arrangements should also be put in place following each update, particularly for any communities likely to be affected by changed circumstances.

**Conclusion**

The government has made clear its intention to develop a new classification system which will look at geographic isolation, health outcomes and SEIFA, as well as workforce indicators. These indicators should not be combined into a single index. Separate codes allow more flexibility, and also allow for towns to become bigger without losing their benefits if they still have workforce and health outcome needs, and extra money to be allocated to workforce initiatives while still maintaining a differential where 2 or 3 disadvantage codes are combined for particular policy objectives.

*Is a town with a Hospital and 2 doctors more or less attractive to work in because of the Hospital? Depends how sick of seeing other doctor's patients, transients and tourists at 2am you are doesn't it? This is unmeasureable. Do local education facilities matter - of course IF you have kids and of course NOT if you don't. How can you track this? My point is that NO system is ever going to be perfect.*

RDAA agrees that there is a need to revise and review the RRMA, but maintains that the greatest gain would come from reforming RRMA rather than abolishing it, with the addition of a range of templates covering demographic, workforce, socio-economic as well as social, health and economic infrastructure indices for particular purposes. RDAA sees the review as an opportunity to build a RRMA II system which is robust, flexible and balanced, but retains the simplicity and practicality of the original RRMA.

RDAA looks forward to working constructively with the Department on this important project.

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25 RM, rural GP, *pers. comm.* April 2005
26 GW, rural GP, *pers. comm.* April 2005
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