AMA

SUBMISSION TO THE REVIEW OF THE RURAL, REMOTE AND METROPOLITAN AREAS (RRMA) CLASSIFICATION

AUSTRALIAN MEDICAL ASSOCIATION

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Australian Medical Association Submission to the Review of RRMA

Executive Summary

The Australian Medical Association (AMA) is pleased to have the opportunity to comment on the Department of Health and Ageing (DHA) Discussion Paper, ***Review of the Rural, Remote, and Metropolitan Areas (RRMA) Classification***, of March 2005.

To ensure all Australians have access to the level and quality of health care they need, a robust and flexible classification system is required. Such a classification system would enable Governments to more accurately measure need and implement health policy that addresses inequalities in access. It would ensure the right health programs get to the right places.

The current RRMA Classification, while it has its merits, is not comprehensive enough to allow the Government to assess and address the health needs of populations. Geography is only one factor that impacts on patient need. The Discussion Paper quite correctly identifies the importance of looking at the supply of services as well as other indicators of need.

In 2002, the AMA commissioned ground-breaking work on the supply and demand factors that influence primary health care services in Australia. The findings of that work were that the following factors are statistically significant in explaining the utilisation of GP services:

- Age/gender profile of patients;
- Socio-economic factors, aboriginality;
- Price of GP services;
- Supply of doctors;
- Rurality/Remoteness; and
- State/Territory.

Copies of the relevant reports and an accompanying paper are provided with this submission.

These findings provide a blueprint for the components that should be included in a measure of the need for primary health care services.

This paper conveys the AMA's response to the Department's Discussion Paper.

A key finding is that RRMA should be retained, updated and improved but that the great reliance on RRMA as a single indicator should cease.

The AMA supports the Department's proposal to look at a wider range of indictors but suggests that the cloth be cut a slightly different way with a needs analysis, a supply analysis and some supplementary indicators.

While not necessarily showing the red light to the creation of a composite index, we do have some reservations about the ultimate usefulness of such an index in policy formulation. We do suggest that the component indices would need to be available for analysis by all stakeholders and that if a composite index is created, the structure and weighting of each indicator would have to be completely transparent. Any change to an area's overall ranking must be clearly demonstrable and stakeholders must be able to easily obtain information on the movement of each individual component. Additions or deletions of component indicators should occur after full stakeholder consultation.

Because of time constraints and the fact RRMA is currently used primarily to influence general practice policy this paper places most focus on issues around general practice workforce and access to GP services. We do make some brief comments on issues of patient access to specialist services and would agree that this area requires more attention than it has had in the past.

The AMA would be very interested in an ongoing dialogue with the Department and other major stakeholders. We commend the Department for undertaking this review.

1 INTRODUCTORY COMMENTS

1.1 The need for a review of RRMA is confirmed

The AMA agrees that a review of RRMA is timely. It is clear that RRMA has some flaws. An over arching issue is whether too much has been expected of RRMA as an indicator.

Governments have a particularly important "redistributive" role in health care. Good public health policy will be based on the strongest available evidence about:

- the relative needs of sub-groups within the population; and
- the supply-side issues that affect them.

Ultimately, good public health policy will seek to very substantially reduce inequalities in health outcomes. Inequalities in health outcomes cannot be addressed by health policies alone because, to an extent, they reflect socioeconomic factors which have to be addressed in a wider social policy framework. Health policy can, and must, address inequality in access to health services as a means to the end of reducing inequality in outcomes.

Compared with urban dwellers, people living in rural and remote areas have long had more limited access to services of all types, not just health services. In the view of the AMA, the Australian population accepts that it is fair and just that governments seek to solve these access issues. And, indeed, governments have tried with mixed success. Some of the problems have proven to be intractable. Further efforts to find solutions will be required.

1.2 Not just a rural/remote problem

Problems of access are not limited to rural and remote areas. The landmark study of the GP workforce by Access Economics for the AMA[1] drew attention to GP shortages in outer urban areas. The Access Economics study was based on SLAs and separately analysed GP workforce sufficiency in inner and outer urban areas. Significant differences in GP shortages between inner and outer urban areas emerged.

1.3 Not just a GP issue

To date, the main application of RRMA has been in GP analysis and funding. Issues of access and equity span the entire health system. Access to specialist services is a significant issue for people living in rural and remote areas. While the majority of our comments are directed towards to GP policy framework, we have included some comments on specialist services in Section 2.5.

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[1] Access Economics 2002, Primary Health Care for all Australians: An Analysis of the Widening Gap between Community Need and the Availability of GP Services.

2 COMMENTS ON THE THREE INDICATORS

The Discussion Paper proposes three indicators—a geographical analysis, a workforce analysis and a health and well-being analysis—with the possibility of linking the three indicators into a composite or weighted index.

The AMA suggests that the framework actually reduces to:

- An analysis of needs; and
- An analysis of supply-side factors.

In suggesting that, we are in no way suggesting that the geographic analysis ought to be downgraded or marginalised. On the contrary, the geographic analysis will remain a very important input to any needs assessment.

2.1 Geographic analysis

We consider that RRMA has ongoing value as a geographical indicator, particularly as an indicator of proximity to services and as an indicator of the special needs of rural/regional populations. Proximity is a material access issue. The further away people are from the point at which services are delivered, the greater the barriers of time and cost in accessing them. There is a lot of difference between needing to take an hour off work to see a GP as opposed to a day off work.

In short, we believe that RRMA remains a valuable tool for analysis and that it is needed as an input to a more comprehensive assessment of needs (addressed further in Section 2.3 below). Under current policy, a great deal of reliance, we contend that too much reliance, is placed on RRMA for policy purposes.

We therefore recommend that RRMA be retained:

- with some improvements (an inner and an outer urban split of the existing RRMA 1 is well worth considering); and
- updated regularly (5-yearly) after each population census.

2.2 Workforce analysis

We strongly agree that "*medical workforce levels are an important consideration in health policy formulation*". We would urge the Department, however, to see medical workforce analysis as one (but not the sole) component in the analysis of supply factors. We note that other aspects which require consideration and assessment include:

- health infrastructure; and
- the health workforce more generally, including the importance of getting the right mix of health professions and related infrastructure so as to better meet patient needs.

2.2.1 Infrastructure Issues

There are several challenges in relation to health infrastructure. Often these relate to disconnects between patient needs, health workforce and facilities. We see examples of:

- health infrastructure inappropriately under-utilised while patients go without the care they need due to workforce shortages;

- health infrastructure under-provisioned in relation to both patient needs and the willing and available workforce; and
- slow response times in relocating health infrastructure given population movements.

There is no easy way to capture all infrastructure issues in an index.

2.2.2 Doctor supply

The AMA has a number of concerns with the Medicare income-based FWE measures of doctor supply. We propose that the doctor supply be assessed across Medicare, VMO, salaried and non-Medicare work. We further contend that the best "currency" for assessing doctor supply is not income measures but rather the clinical hours that can be provided. The rising body of data about the medical workforce makes such measures more reliable than hitherto. The AIHW and AMWAC have done important ground-breaking work on which there is potential to build stronger measures.

In many areas of medical practice, there is data on average times taken for consultations and procedures to support an assessment of both demand and supply in terms of clinical hours and, therefore, to make an assessment of overall shortage/surplus as well as regional level shortage/surplus.

When demand and supply is brought together in this way, it opens the door to a better informed policy to encourage geographic redistribution of the workforce.

2.3 Health and wellbeing indicators

The Discussion Paper suggests that other indicators of need, apart from RRMA, might be used to assess needs. The AMA wholeheartedly agrees with this sentiment.

One of the keys to properly understanding relative population needs for health care is to avoid seeing people as single dimensional. People may in fact need more health care than the 'average person' because they are older or female or Aboriginal or poor (or several or all of those things).

The Access Economics study referred to in section 1.2 above included a multivariate analysis of need. Other researchers have work of that nature in train.

There is a place for single factor analysis. We can, for example, look at measures of morbidity and mortality to get an overall understanding of health outcomes. Single factor analysis can show that:

- older people need more access to health services than younger people;
- females will seek more access to health services than males;
- people who suffer from poverty and who have low educational attainment (the two often go hand in hand) will have poorer health status than high income/highly educated people; and
- Indigenous Australians have much poorer health status and need more health services than non-indigenous Australians.

Ultimately, however, single factor analysis does not reveal need. Multivariate analysis is the correct scientific tool for that purpose. Single factor analysis will not tell us the relative needs of an illiterate elderly Aboriginal woman compared with a young well-educated non-Indigenous man.

Multivariate analysis of need should be rigorous and based on strong scientific method. There are areas where care is needed. The need for health services is not synonymous with the utilisation of health services. Observed utilisation is itself affected by supply-side constraints (lack of access to services). To use observed utilisation as a proxy measure for need is to invite the risk of engineering disadvantage into the system on an ongoing basis.

Based on previous work by AMWAC, Access Economics and others, a multivariate analysis of the need for GP services would certainly take account of the following key characteristics:

- Age;
- Sex;
- Rurality;
- Ethnicity (Aboriginality); and
- Socioeconomic status (SEIFA is useful for this).

The inclusion of rurality in this list is evidence-based. For example, there are differences in the injuries that rural people sustain compared with those in urban areas. Some of these differences relate to occupation.

There are other potential explanatory variables of need which may be worthy of investigation.

In summary, therefore, the geographical analysis is one of the key inputs to a multivariate analysis of need.

2.3.1 Further discussion of indicators of need

(A) An updated RRMA

As noted above, we believe that RRMA will be more useful as one of the key components of a needs assessment it if is updated more regularly (5-yearly) and expanded to distinguish between outer and inner urban areas.

(B) Demographic indicators

The ABS regularly publishes demographic estimates and population projections. While the population projections were, as a rule, only published by the ABS at State level, they have now started to introduce capital city/non-capital city data on a fairly regular basis. The ABS publications come out twice in a census cycle, so there was a release in September 2003 and another is due in September 2005. Furthermore, most States now produce regular population projections in one form or another. Therefore, the range of demographic indicators is increasing.

Population estimates are revised after each census. We see scope for DHA/ABS dialogue to see whether population projections by age cohort and sex might be possible on a finer geographic basis than State-wide. Demographic details (critically, the age and gender profile) will be a fundamental input to multivariate analysis of need and for assessments of future ageing effects.

(C) Socioeconomic indicators

We consider that SEIFA is a viable index. This is also key input to multivariate analysis of need. It is possible that there is some room to improve SEIFA but there is no case for trying to reinvent the wheel.

(D) Indigenous/non-indigenous

This is, of course, part of the demography but we have mentioned it separately for emphasis as the extent of Indigenous disadvantage in both access to health services and health outcomes is so profound as to make this one the two areas of greatest failing in the Australian health system (the other being mental health care).

(E) Mortality and morbidity

There is certainly room to discuss how measures of mortality and morbidity might be used to throw light on needs. That said, these are likely to remain well-ensconced in the range of health outcomes measures. They can be difficult to assess as a measure of needs because the links between health services and health outcomes are not well understood. Poor health outcomes may be:

- independent of the care provided: They may reflect the failure of health prevention (eg, people continue to smoke tobacco or use illicit drugs despite the strong evidence that they are harmful substances);
- a reflection of problems in the quality of care rather than access to care;
- a reflection of problems in access to care rather than poor quality; or
- a reflection of the wrong mix of services being provided to that population sub-group. Although health resources may seen adequate for needs, appropriate care is not being provided.

The AMA supports further investigation and research but suggests that the other indicators of need previously mentioned have more immediate application.

2.4 Possible supplementary indicators

While assessments of needs and supply will remain as “bread and butter” issues, there is a role for other supplementary indicators.

One approach is a service-based assessment. A number of services or clusters of services associated with common conditions or procedures could be studied, such as standard GP attendances, services rendered for heart attacks, access to nursing homes, access to maternity services, availability of care for premature babies, and so on.

Were we studying, say, a common procedure such as hip replacement, the indicator might be length of wait for surgery. If the wait is, say, three months in Sydney and five years in Coffs Harbour, that might call for action to pull back the outlier.

Another potential method for condition-based studies is to use morbidity tables to estimate the number of "cases" we would expect for the population of a given area at any given time, and estimate how far people would need to go for all that demand to be satisfied. We might find that in Dubbo, there is capacity to handle 9 out of 10 cases locally with the 10th handled in Sydney, while in Wagga there may be capacity to handle 4 out of 10 cases locally.

2.5 Specialist services

Some particular challenges are thrown up in the analysis of specialist medical services. In some cases, the challenge is to find ways to get more specialists into non-capital city areas. In other cases, the challenge is to attract the workforce needed for outreach (including fly-in fly-out) services. In other areas again, the work is so specialised that it makes no sense to provide the services other than through major capital city teaching hospitals with advanced

facilities and highly specialised teams. And again, there are some major issues about new modes of care to solve access problems including tele-health services in areas such as psychiatry and diagnostic imaging.

What we can do, however, is to study whether there are inequities in access to services. This can and should be done. The needs analysis is not as easily done as for GP services because the factors that determine need vary considerably from disease to disease. What we can say with authority, however, is that some types of specialist services evidence a very strong link to the ageing of the population, ophthalmology being a case in point.

Analysis of infrastructure to support specialist medical practice is also very important.

2.6 Linking the components

The Discussion Paper raises the possibility of linking the three component indices into a single or composite index. As explained above, the framework proposed in this paper is an analysis of needs (combing the geographic, health and well-being indicators into a multivariate analysis), and analysis of supply including workforce and a series of supplementary indicators. The needs and supply indicators would be capable of being linked in a composite index. The supplementary indicators will be much more variable and may be more difficult to handle.

The AMA does have some reservations as to whether a single index will turn out to be an effective tool to inform policy. That said, the attractions of a single index are obvious in terms of apparent simplicity and "cleanliness". In practice, it is like having one red light on the dashboard which may mean engine management system failure, no petrol, no oil, no water, a broken fan belt, brake failure or a door ajar. A single index may indicate a problem. For good policy formulation, it is important to know the nature of the problem.

Therefore, while not ruling out the creation of a composite index, the AMA would strongly argue for the full sharing of information on the component indicators as well as a completely transparent and properly documented system of weighting the components. We note that when the analytical framework is that of an analysis of needs and an analysis of supply-side issues, there is scope to juxtapose the two analyses when there is a common currency such as clinical hours. Then the composite index can become an indicator of a shortfall or excess of supply of services relative to needs. In that case, it is not necessary to solve the intricate problems associated with trying to attach weights to component indicators.

To illustrate the issues in interpreting a composite index, there may be an influx of well-heeled retirees into a coastal area. The influx of residents may mean that access to GPs becomes more difficult for time. Is a policy response required? Perhaps not. All markets involve some lags in the response times to excesses or shortages of supply. There are market frictions such as the time and cost of relocation to a different city or town. These may mean that an extra GP may not come until someone is certain that practice will be viable. A single index may indicate a need for action when patience is required.

We could give contra examples where intervention in market processes is fully justified. A key objective in analysis is to ascertain where there has been either a failure in the market or a failure in the institutional arrangements. The poor status of health among Aboriginal peoples and Torres Strait Islanders partly reflects institutional failure. For a variety of reasons, these people have very limited access to mainstream programs (Medicare and PBS).

2.7 Practicalities

The AMA does have some reservations about conducting geographical analysis at Collection District (CD) level. The first issue is that the level chosen for the geographical analysis must be capable of being linked or mapped to other indicators. Some factors (such as age structure) cannot be measured in terms of change apart from at census time. Others will change too frequently and the burden of trying to keep them all current will be too large.

We suspect that analysis at CD level is simply too complex and, in our view, unrewarding. The datasets would be absolutely massive and difficult to relate to items in existing data sets (eg, postcode). The experience from the Access Economics study is that there is a recurring need to map from one classification system to another. This can be done by concordances in some cases but in others there is some guesswork required.

Before adopting a very fine geographic analysis, there would be a need for evidence of excessive variation at a higher level analysis:

- Disaggregating down to CD level makes little sense in urban areas as the data is too similar;
- The most remote SLAs such as Willuna and Ngaanyatjarraku have only 1 or 2 CDs anyway so little if anything is gained; and
- Given the size of some SLAs (eg Walgett SLA with some 17 CDs) there may be a case for some disaggregation in situations where an SLA comprises some CDs in the town and the remainder in the surrounding rural area.

There are excellent reasons for avoiding excessive complexity. If stakeholders feel that the measures are opaque and too difficult to understand both as to their operation and the results they generate, the community will not have confidence in what is done. This runs the risk of pernicious political intervention (PPI).

2.8 Can we look forward as well?

The indicators will have wider application in policy development and planning if they encompass measures where robust forecasts and/or projections are readily available. If there is no capacity for some forward looking analysis, then the usefulness of the indicator approach is reduced.

In the case of GP workforce planning, we would argue that the most basic requirement for indicators is for regular robust multivariate analysis of need in conjunction with an assessment of supply and net workforce surplus or shortfall. The Access Economics model demonstrates that it is viable to do this at SLA level. CD level would be far too difficult.

2.9 Clarify the policy purposes

A threshold issue is to better define the policy purposes to which indicators will be applied.

- Is the prime focus primary care?
- Are we also concerned with access to specialist (surgical and non-surgical) services?
- Are we concerned with access to hospitals or is that already well enough covered by other indicators?
- Are we concerned with inadequacies of health infrastructure?

The AMA would appreciate more dialogue on this issue because it is one area where we found the Discussion Paper unclear and because the issues are pertinent to the design of an index or indices.

Another question which arises in the design of an index or indices is whether there should be more concordance between Commonwealth Government measures and State Government measures (such as the “area of need” classifications). This is, however, very much an issue for the longer term.

3 Closing comments

The AMA commends the Minister and the Department for initiating this review and urges further consultation as the ideas are developed. The AMA would be interested in being part of a reference group of major medical stakeholders.

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GLOSSARY

ABS - **Australian Bureau of Statistics**

AIHW - **Australian Institute of Health and Welfare**

AMA - **Australian Medical Association**

AMWAC - **Australian Medical Workforce Advisory Committee**

CD - **Collection District**

DHA - **Department of Health and Ageing**

FWE - **Full-time Workforce Equivalent**

PBS - **Pharmaceutical Benefits Scheme**

RRMA - **Rural, Remote and Metropolitan Areas**

SEIFA - **Socio-Economic Index for Area**

SLA - **Statistical Local Area**

VMO - **Visiting Medical Officer**