

## **NSW Rural Doctors Network 2008**

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## **NSW Rural Doctors Network Minimum Data Set Report – 30 November 2007**

### **1. Introduction**

During the 2001-2004 triennium, as a part of their contractual agreement with the Australian Government Department of Health and Ageing (AGDoHA), Rural Workforce Agencies (RWAs) in all states and territory were required to collect and report a minimum, specified set of data in relation to the rural and remote general practice workforce in locations classified RRMA 4 through RRMA 7.

Undertaken individually by each RWA, de-identified data were compiled nationally through the Australian Rural and Remote Workforce Agencies Group (now Rural Health Workforce Australia) to provide a comprehensive portrayal of the Australian rural and remote medical workforce.

The requirement to collect and report a minimum data set and compile these data through ARRWAG were not included in AGDoHA's specifications for the 2004-2007 triennium. However, the RWAs in all states and territory appreciated the utility of maintaining a core set of data in relation to the rural and remote medical workforce that was current and based on operational information systems maintained by the RWAs. As such it was decided that the RWAs would continue to collect and compile a national Minimum Data Set for RRMA 4 to 7 locations.

The data were first compiled at a national level in December 2001 and are updated on an annual basis as at 30<sup>th</sup> November each year. Data in relation to numbers of GPs, age, gender, procedural skills and length of stay in current location are largely derived from databases maintained by each RWA. Data in relation to primary income source, models of service provision, hours of work and types of practice are largely self-reported.

Each RWA normally surveys rural and remote medical practitioners in their state or territory in the third quarter each year. Core questions for the Minimum Data Set have been developed and standardised among the states and territories. In addition, states and territory have the flexibility to incorporate additional questions should they wish. While the annual MDS survey is a major component of the data reported, all RWAs utilise additional resources to verify and validate their data. It should also be noted that the number of doctors reported reflect the more stable elements of the rural and remote medical workforce and do not normally include transient, short term service providers (e.g. locum tenens).

Data provided in this report are a compilation of core data in rural and remote NSW and was current as at 30th November 2007.

### **2. Demographics of the rural and remote GP workforce**

This section will enumerate the rural and remote medical workforce by RRMA, age and gender.

Data indicated that as at 30 November 2007, the number of medical practitioners practicing in RRMA 4 to 7 locations was 1185. This represents an increase of 12 practitioners (1%) compared with numbers reported as at 30<sup>th</sup> November 2006. Table 1 presents the total number of medical practitioners working in RRMA 4 to 7 as at 30th November 2007. Note that there are no locations in NSW classified as RRMA 6.

Table 2 provides a breakdown of this distribution by gender and RRMA.

**Table 1 Practitioner numbers by RRMA**

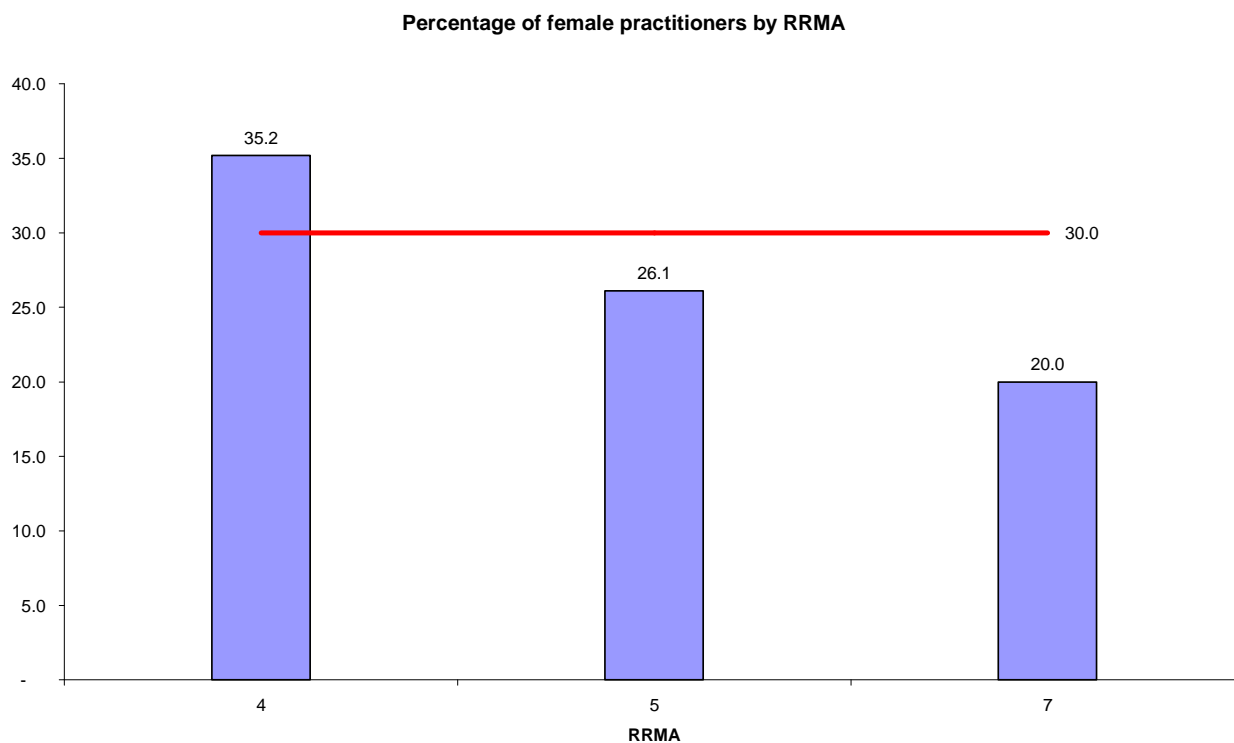
RRMA4	RRMA5	RRMA7	Total
523	632	30	1185

**Table 2 Gender by RRMA**

RRMA	Male	Female	%Female	Total
RRMA4	339	184	35.2	523
RRMA5	467	165	26.1	632
RRMA7	24	6	20.0	30
<b>Total</b>	<b>830</b>	<b>355</b>	<b>30.0</b>	<b>1185</b>

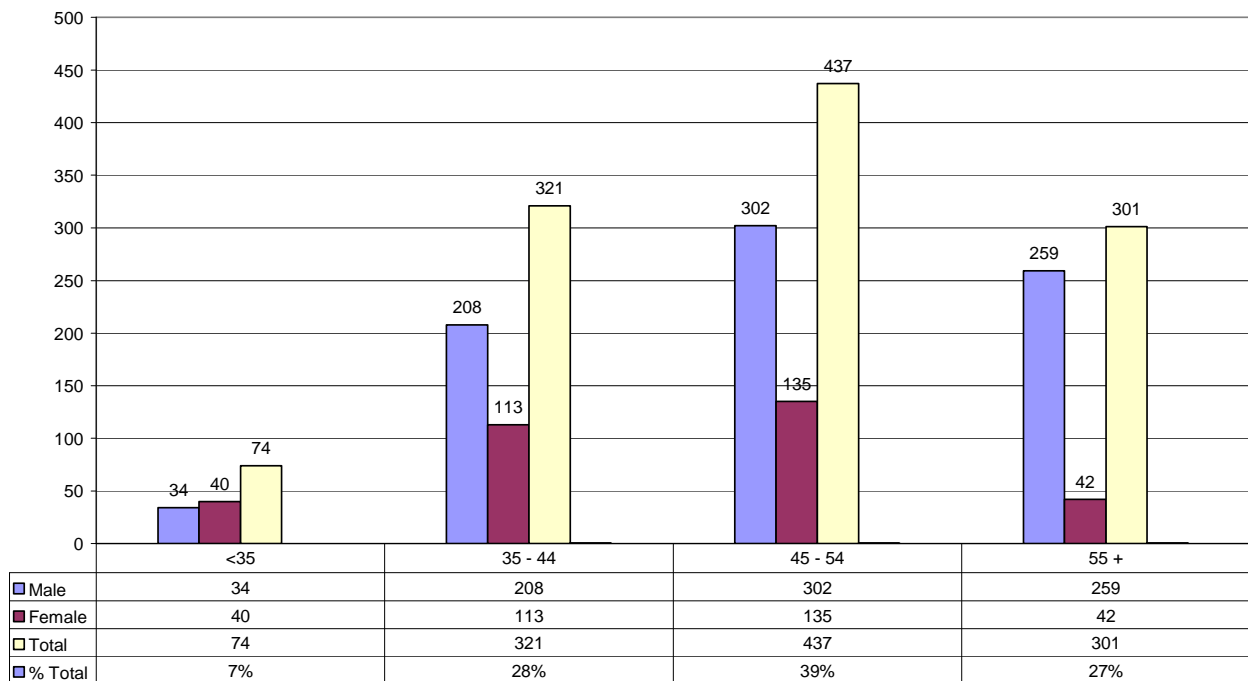
Table 2 indicates that the proportion of female practitioners in RRMA 4 areas is comparatively higher than any other RRMA. Figure 1 displays the percentage of female practitioners by RRMA compared with the state average for rural and remote female practitioners. Figure 2 provides a breakdown of the number of rural and remote medical practitioners by gender and age categories. Figure 3 displays the proportion of male and female practitioners in age categories.

**Figure 1 Percentage of female practitioners by RRMA**



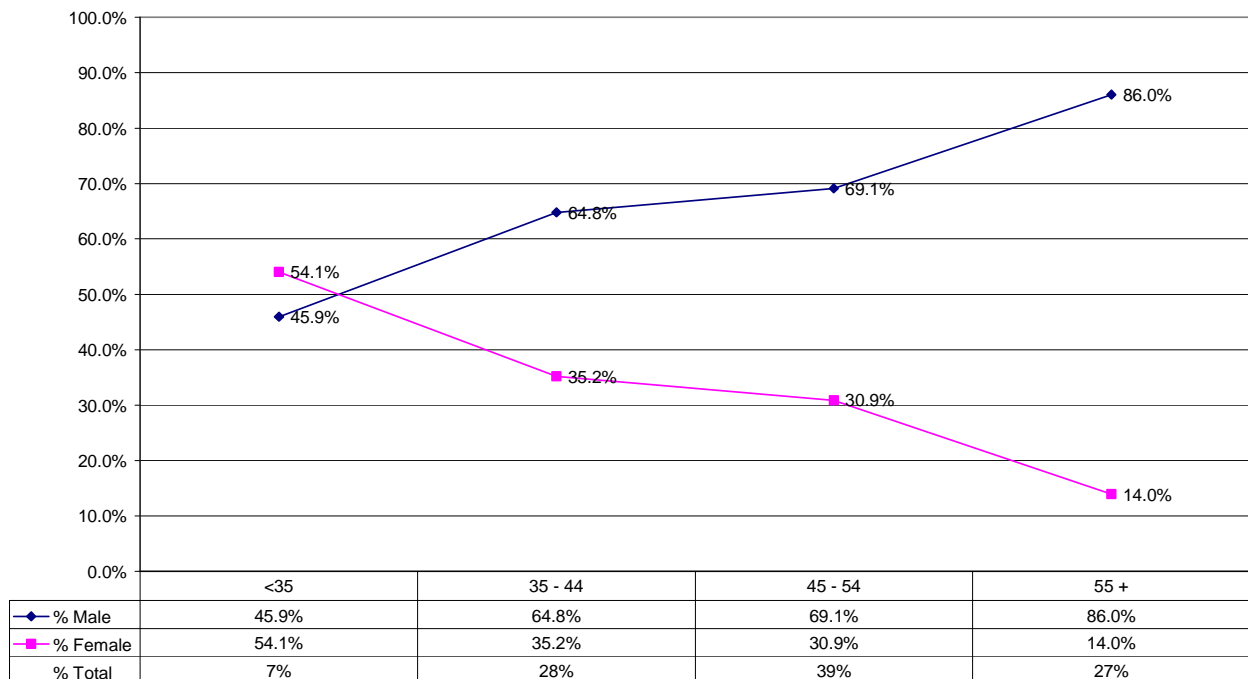
**Figure 2 Number of rural and remote medical practitioners by age categories (N=1133)**

**Number of rural and remote medical practitioners by age categories**



**Figure 3 Proportion of male and female practitioners in five year age categories (N=1133)**

**Proportion of male and female practitioners in age categories (N=1133)**



The average age for male GPs was 51.9 (N803) years and 47.0 years for females (N330). The overall average age for all practitioners (N1133) was 50.5 years. Table 3 displays gender distribution by broad age categories by RRMA.

**Table 3 Practitioner ages by gender and RRMA - broad age categories (N=1133)**

Age Category	Gender	RRMA4	RRMA5	RRMA7	Total
< 35	Male	11	22	1	34
	Female	23	16	1	40
	Total	34	38	2	74
35-44	Male	86	112	10	208
	Female	55	56	2	113
	Total	141	168	12	321
45-54	Male	120	177	5	302
	Female	72	61	2	135
	Total	192	238	7	437
55 +	Male	112	140	7	259
	Female	20	22	0	42
	Total	132	162	7	301

### 3. Workloads

Estimates of Full Time Equivalent (FTEs) and Full Time Workload Equivalent (FWEs) as used by Medicare Australia (formerly HIC) in calculating GP medical service provision are based solely on the number and the dollar value of claims made by a provider over a given reference period (usually 12 months). While these can be useful measures of overall service provision under Medicare, they do not reflect the number of hours worked in providing medical services or services provided that are not claimed or are not claimable through Medicare Australia. For example, a medical practitioner is classified as full-time by Medicare Australia if the Schedule fee value of services processed over a 12 month period is \$86,727<sup>1</sup> (2003-2004) or more for that practitioner. Similarly, a Full Time Workload Equivalent (FWE) value is calculated for each doctor by dividing the doctor's Medicare billing (Schedule fee value of claims processed by Medicare Australia during the reference period) by the mean billing of full-time doctors for reference period. For the 2002-2003 reference period, this value for vocationally registered doctors was \$221,864.<sup>2</sup>

An alternative measure of service provision is number of hours worked. The Australian Bureau of Statistics (ABS) defines full-time work as being 35 hours per week or more and part-time work as less than 35 hours. It is this measure that has been chosen by ARRWAG to differentiate between full-time and part-time service provision.

<sup>1</sup> Australian Government Department of Health and Ageing. (2005). *RFT 127/0405 - Request for tender for a medical workforce profile project*. Canberra: ADoHA

<sup>2</sup> Ibid

An estimate of full-time or part-time medical service provision utilising ABS benchmark was undertaken based on self reported GP clinical hours worked. Data was available for 69.5% of the total number of GPs. Data as displayed in Table 4 indicates that 59.0% of respondents worked 35 hours a week or more in the provision of routine clinical GP services.

**Table 4 Self-reported GP clinical hours**

Hours	Frequency	Percent
Less than 20 hours	110	13.4%
20 to 35 hours	227	27.6%
35 hours plus	486	59.0%
Total	<b>823</b>	<b>100.0%</b>

It should be noted that hours reported are for those worked in GP practice only and should not be interpreted as total hours since hospital hours, travel, teaching, supervision time etc. are not included. The average number of GP clinical hours reported was 34.6 hours per week (N823).

A further breakdown of self-reported GP clinical hours by gender is displayed in Table 5 below.

**Table 5 Self-reported GP clinical hours by gender**

Clinical Hours	Male		Female	
	Number	Percent	Number	Percent
Less than 20 hours	48	8.4%	62	24.7%
20 to 35 hours	132	23.1%	95	37.8%
35 hours plus	392	68.5%	94	37.5%
Total	572	100.0%	251	100.0%

Self reported total hours were also explored. In addition to clinical hours, these hours may include hospital hours, time spent in travel between practices, population health, teaching, administrative or representative work. Data were available for 40.6% of practitioners. Table 6 displays self-reported total weekly hours while Table 7 displays total hours by gender. The average reported total hours were 47.1 hours per week (N=481).

**Table 6 Self-reported total hours**

Hours	Number	Percent
Less than 20 hours	22	4.6%
20 to 35 hours	73	15.2%
35 hours plus	386	80.2%
Total	481	100.0%

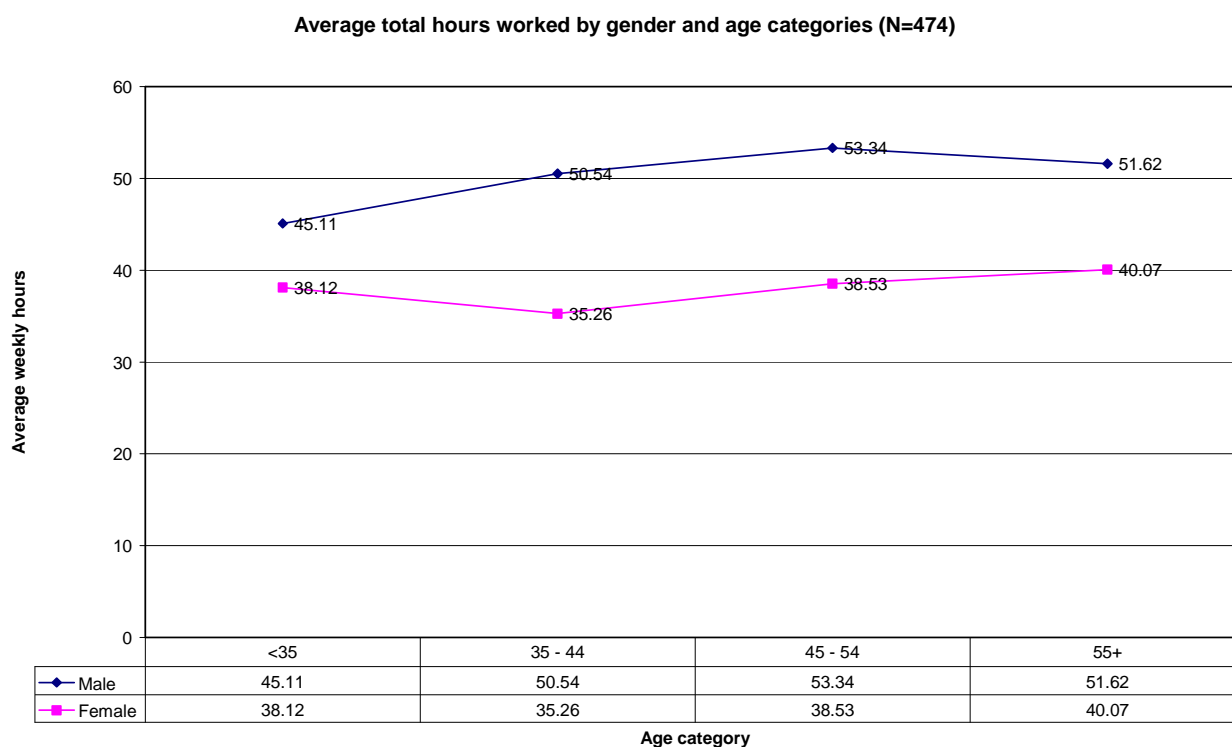
Data indicates that 19.8% of practitioners are currently working part time as defined by the ABS (i.e. less than 35 hours per week).

**Table 7 Self-reported total hours by gender**

Total Hours	Male		Female	
	Number	Percent	Number	Percent
Less than 20 hours	5	1.5%	17	11.3%
20 to 35 hours	20	6.1%	53	35.1%
35 hours plus	305	92.4%	81	53.6%
Total	330	100.0%	151	100.0%

Data for both self reported GP and self reported total hours, appears to be in line with national trends that suggest that female practitioners tend to work less hours compared with their male counterparts (AMWAC, 2005; CDHAC, 2001). A more refined breakdown of average total hours by gender and age categories is presented in Figure 4. Additional, detailed data in relation to hours worked is presented in Appendix 1.

**Figure 4 Average total hours worked by gender and age categories (N=474)**



#### 4. Length of stay in current principal practice

The average length of stay in current principal practice was 11.03 years. A more refined breakdown by duration and RRMA is provided in Table 8.



**Table 8 Length of stay in current practice by RRMA**

	Duration							Total
	< 6mths	6-12 mths	1-3 yrs	3-5 yrs	5-10 yrs	10-20 yrs	20 yrs +	
RRMA 4	59	40	82	48	94	101	99	523
RRMA 5	63	66	100	61	104	118	120	632
RRMA 7	5	5	4	5	3	7	1	30
Total	127	111	186	114	201	226	220	1185

Data indicates that while 79.9 % (N=947) of respondents have practiced in their current rural and remote locations for more than a year, 20.1% (N=238) are relatively new to their current practice and have been practising in these locations for less than 12 months.

## 5. Known number of proceduralists

The MDS survey further seeks to enumerate the number of rural and remote non-specialist practitioners providing procedural services in RRMA 4 to 7 locations. However, data in relation to the provision of procedural services in rural and remote Australia may be incomplete due to non-respondents. The known number and proportions of practitioners providing specified procedural services as at 30 November 2007 is detailed in Table 9 and Table 10 (below). In many cases it is possible for a practitioner to perform a number of procedures e.g., Anaesthetics and Obstetrics or Obstetrics and Surgery. The number of known procedural practitioners as detailed in Table 9 and Table 10 (N=185) is therefore less than the total number of procedures documented (N=253). Of the 185 procedural practitioners, 117 (63.2%) perform multiple procedures. A Venn diagram illustrating practitioners undertaking single or multiple procedures is displayed in Figure 5. Gender composition of proceduralists compared to the general rural and remote medical workforce is displayed in Figure 6.

**Table 9 Number of practitioners undertaking procedural work by type**

Procedure	Number
Anaesthetics General	84
Obstetrics Normal delivery	113
Surgery Operative	56
Known Proceduralists**	185
Total Practitioners	1185

**Table 10 Number of practitioners undertaking procedural work by type and RRMA**

	RRMA4	RRMA5	RRMA7	Total*
Anaesthetics General	18	63	3	84
Obstetrics Normal Delivery	34	77	2	113
Surgery Operative	22	32	2	56
Known Proceduralists**	52	128	5	185
Total Practitioners	523	635	30	1185

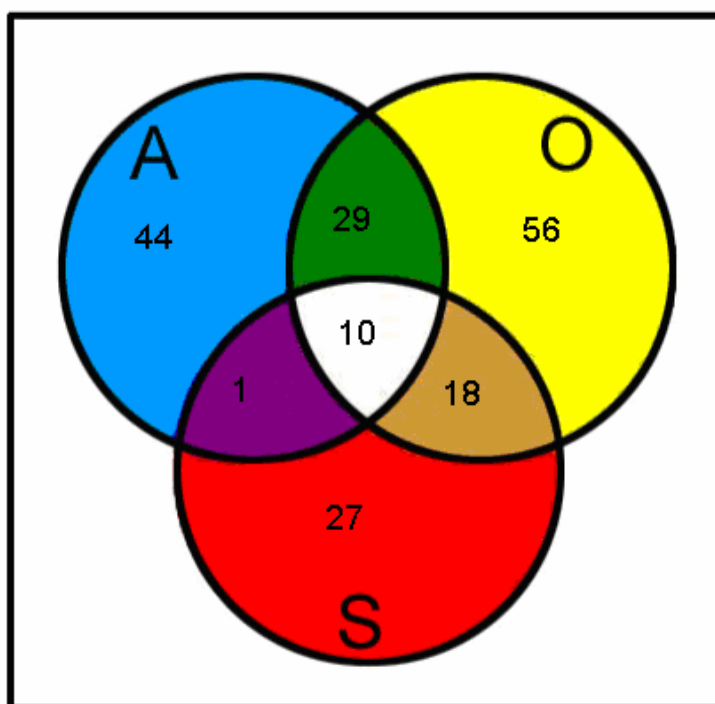
\* GPs practicing in RRMA 4 - 7

\*\* GPs practicing in at least one procedural field

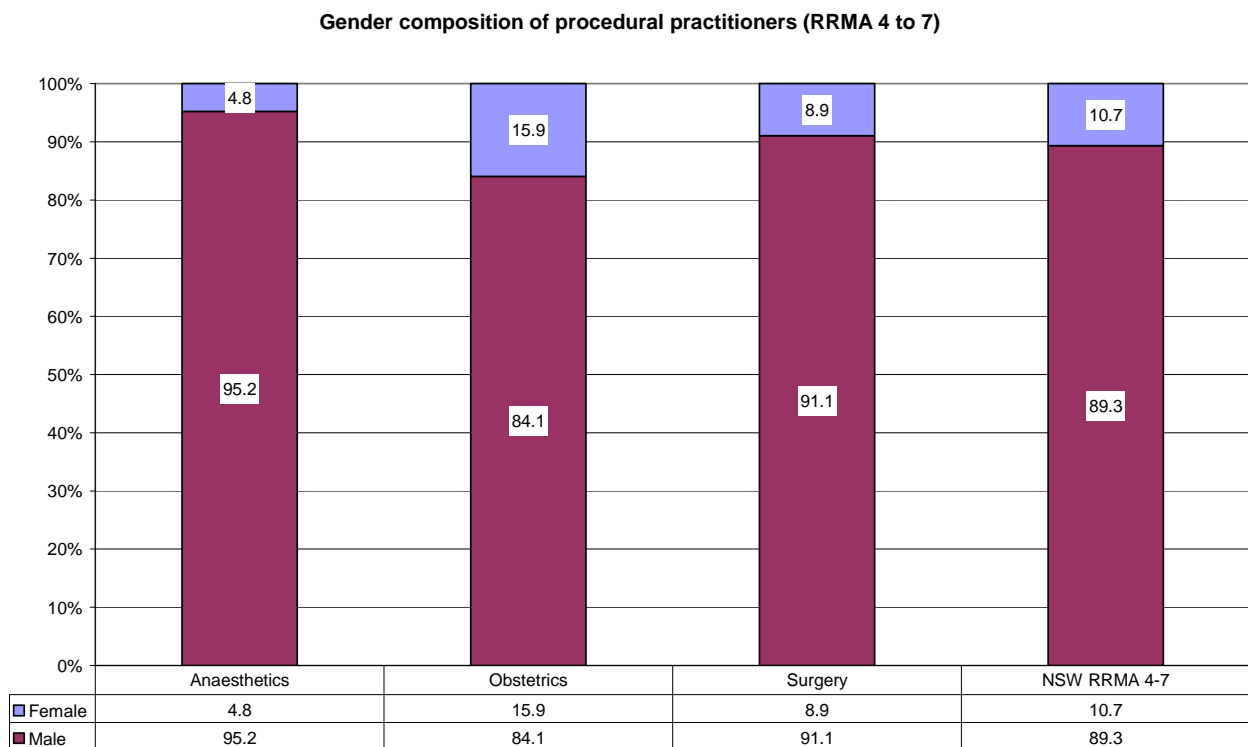
**Figure 5 Venn diagram illustrating numbers undertaking single or multiple procedures (N=185)**



Total: 185



**Figure 6 Gender composition of procedural practitioners (RRMA 4 to 7)**



## 6. Emergency care and Aboriginal health

The survey further sought to enumerate the number of rural and remote practitioners who provide regular emergency care or Aboriginal health services. Table 11 and Table 12 display these figures by RRMA.

**Table 11 Number and proportions of practitioners providing emergency care services by RRMA**

RRMA	Number	Percent
RRMA4	90	27.2%
RRMA5	230	69.5%
RRMA7	11	3.3%
Total	331	100.0%

**Table 12 Number and proportions of practitioners providing Aboriginal health services by RRMA**

RRMA	Number	Percent
RRMA4	65	35.7%
RRMA5	110	60.5%
RRMA7	7	3.8%
Total	182	100.0%

## 7. Types of practice

The number of GPs working in each practice type by RRMA was also explored. Table 13 displays the number of doctors working in each practice type by RRMA. Data was missing or inadequately described for 28 practitioners.

**Table 13 Practice type by RRMA**

RRMA	Solo		Group	
	Number	Percent	Number	Percent
4	79	6.8%	440	38.0%
5	151	13.1%	458	39.6%
7	17	1.5%	12	1.0%
<b>Total</b>	247	21.4%	910	78.6%

## 8. Primary Income Source

Table 14 below displays self-reported data on primary income source. Data was available for 891 (75%) respondents. Caution should be exercised in interpreting these data as a significant number of practitioners had more than one income source and in some cases the option selected was not always consistent with known data.

**Table 14 Self-reported primary income source**

Primary Income Source	Number	Percent
Fee for service	680	76.4%
Private practice wage or salary	150	16.8%
Non government wage or salary	12	1.3%
Aboriginal community controlled health service salary	18	2.0%
VMO Hospital	10	1.1%
Other	21	2.4%
<b>Total</b>	891	100.0%

## 9. Primary Model of Service Provision

Table 15 below displays self-reported data on primary models of service provision. Data was available for 1146 (97%) respondents. Again, caution needs to be exercised in the interpretation of these data as many practitioners have several models of service provision and in some instances, the option chosen was not always consistent with known data. For example, the number of Registrars is understated as many described their primary model as 'Resident GP' or 'Hospital Based GP'.

**Table 15 Primary model of service provision**

Primary Model of service provision	Number	Percent
Resident GP	1011	88.22%
"Fly in Fly Out"	4	0.35%
Member of a Primary Health Care Team	4	0.35%
Hospital based GP	1	0.08%
Registrar	122	10.65%
Other	4	0.35%
<b>Total</b>	<b>1146</b>	<b>100.00%</b>

## 10. Registrars

The number of registrars currently working in RRMA 4 to 7 locations was 129. These data differ slightly from self-reported data as shown in Table 15. This is largely due to the tendency of some respondents to describe their primary model of service provision differently to known data maintained by NSW Rural Doctors Network and Regional Training Providers. Data indicates that registrars comprise approximately 10.9% of the rural and remote medical workforce.

## 11. On-call hours available and worked

Respondents were also asked the number of hours they were available on call each week at their practice or hospital and the number of on-call hours actually worked. As many practitioners in small communities and solo doctor towns consider that they are on call 24 hours per day, 7 days a week, the number of on-call hours available was allowed a maximum of 168 hours. Due to a number of erratic responses in relation to on-call hours actually worked, the maximum number of hours allowed was restricted to 40 hours. Table 16 displays the responses that satisfied both these conditions and shows the average number of hours reported as being worked and the average number of hours reported as being available on call.

**Table 16 Average hours available on call and average hours on call worked**

	Number	Minimum	Maximum	Average	Std. Deviation
<b>Hours per week on call worked</b>	312	0.5	40	10.8	9.6
<b>Hours per week available on call</b>	397	1.0	168	67.7	54.6

## 12. Leave wanted versus leave taken

Respondents were asked to indicate the number of weeks leave desired each year and the number of weeks actually taken. As a significant number indicated 26 to 52 weeks leave desired, it was decided to set a more realistic maximum of 10 weeks for both leave wanted and desired. All other responses have been filtered out. Data for the valid responses indicate that there is an average 1.63 week deficit between annual leave wanted and annual leave taken.

**Table 17 Average leave wanted and average leave taken (weeks)**

	<b>Number</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std. Deviation</b>
<b>Annual leave taken</b>	470	1.0	10.0	4.9	2.2
<b>Annual leave wanted</b>	397	1.0	10.0	6.3	1.9

### 13. Summary

The data provided in this report has been based on agreed elements for a national Minimum Data Set for Rural Workforce Agencies. While the data may differ to that produced by the Medicare Australia, we believe that it is probably as valid since numbers reported reflect ‘on ground’ realities and are based on local knowledge of medical provision in communities. Measures such as FTE and FWE are based on the number and dollar value of claims processed by the Medicare Australia and often do not capture the full complexity of medical service provision in rural and remote communities.

While the data do have some limitations particularly in relation to self-reported hours worked, on-call hours and missing data, NSW Rural Doctors Network is satisfied that the data provides a relatively accurate portrayal of medical service provision in rural and remote areas of the state as at the 30<sup>th</sup> November 2007 reporting date.

As indicated in the introduction, many aspects of the data contained in this report are not solely dependent on survey response but are derived from known working data maintained by NSW Rural Doctors Network. Survey responses are largely used to validate and update known data. The response rates for the current data collection period was 45.6.

#### **Trends evident in this report include:**

- A very slight increase of 1.0% (N=12) in rural practitioner numbers between 30<sup>th</sup> November 2006 and 30<sup>th</sup> November 2007.
- A small change in the percentage of female practitioners working in RRMA 4 to 7 locations.
- A reduction in the number of rural and remote practitioners working in sole practice situations (21.4% as opposed to 23.1% in 2006).
- A continuation of the increasing number of female practitioners in lower age groups.
- A continuation of trends that suggest that female practitioners tend to work less hours compared with their male counterparts.
- A reduction in the average number of clinical hours worked per week. Average clinical hours reported in November 2006 were 35.2. For 2007, the average clinical hours reported was 34.6 hours.
- A decline in the proportion of rural and remote practitioners providing procedural services.

A table outlining these trends or changes is provided in Appendix 1.

## 14. Terminology

ABS	Australian Bureau of Statistics
ACCCHS	Aboriginal Community Controlled Health Service
AMWAC	Australian Medical Workforce Advisory Committee
ARRWAG	Australian Rural and Remote Workforce Agencies Group (now Rural Health Workforce Australia)
CDHAC	Commonwealth Department of Health and Aged Care (now Australian Government Department of Health and Ageing)
AGDoHA	Australian Government Department of Health and Ageing
FTE's	Full-time equivalents (calculated on HIC billings of \$82,414 or more)
FWE's	Full-time workload equivalents (calculated on average HIC billings for full-time doctors - (\$221,864 for 2002-2003 reference period)
HIC	Health Insurance Commission (now Medicare Australia)
RFDS	Royal Flying Doctor Service
RRMA	Rural Remote and Metropolitan Area Classification
RWA	Rural Workforce Agency

## 15. References

Australian Government Department of Health and Ageing. (2005). *RFT 127/0405 - Request for tender for a medical workforce profile project*. Canberra: ADoHA

Australian Medical Workforce Advisory Committee. (2005). *The General Practice Workforce in Australia: Supply and Requirements to 2013, AMWAC Report 2005.2*. Sydney.

Australian Bureau of Statistics (2001). Outcomes of ABS views on remoteness consultation, Australia. ABS Cat No 1244.0.00.001. Canberra, ABS.

Australian Institute of Health and Welfare (2002). *Australia's health 2002*. Canberra: AIHW.

Commonwealth Department of Health and Aged Care. (2001). *The Australian Medical Workforce. Occasional Papers New Series No.12, August 2001*. Canberra: CDHAC.

Commonwealth Department of Health and Aged Care. (2001). *Measuring remoteness: accessibility/remoteness index of Australia (ARIA). Occasional Papers: New Series Number 14, October 2001*. Canberra: CDHAC.

## Appendix 1

### Trends or changes November 2003 to November 2007

	2003	2004	2005	2006	2007
Total practitioners	1126	1164	1198	1173	1185
Percent female	26.9	28.4	28.3	29.1	30.0
Percent male	73.1	71.6	71.7	70.9	70.0
Average age female	44.5	45.2	45.9	45.8	47.0
Average age male	49.7	50.1	50.7	50.4	51.9
Average age (all)	48.4	48.8	49.4	49.1	50.5
Average GP clinical hours	33.9	33.0	33.6	35.2	34.6
Average total hours	45.9	44.9	46.2	44.8	47.1
Average length of stay in current practice (years)	9.9	9.9	10.1	10.2	11.03
*Proceduralists General Anaesthetics	103	99	100	88	84
*Proceduralists Obstetrics (Normal delivery)	154	152	149	122	113
*Proceduralists Operative surgery	61	67	62	61	56
*Known Proceduralists (practising in at least one procedural field)	239	233	230	201	185
* Proportion of rural practitioners providing procedural services	21.2	20.0	19.2	17.1	15.6
Proportion of practitioners providing emergency care services	38.0	27.8	20.9	26.7	27.9
Proportion of practitioners providing Aboriginal health services	18.8	4.2	12.0	14.9	15.4
Proportion of GPs working in solo practices	21.8	25.7	24.6	23.1	21.4
Proportion of GPs working in group practices	78.2	74.3	75.4	76.9	78.6



## Appendix 2

### **Rural, Remote and Metropolitan Area Classification (RRMA) and Accessibility/Remoteness Index of Australia (ARIA)<sup>3</sup>**

Many regional programs are targeted at areas of geographic disadvantage and the convenient label of being 'rural' areas often refers to these areas. However, there is not a generally accepted or generally applicable definition for the Australian context that can be used to identify rural areas. As a result, the RRMA classification has been widely used to determine eligibility of an area for program funding. The RRMA classification was used to assign each SLA (based on 1991 boundaries) to one of 7 categories that were further aggregated into three basic zones (Metropolitan, Rural, and Remote).

The seven RRMA categories are:

1. Capital Cities (Metropolitan Zone)
2. Other Metropolitan Centres (Metropolitan Zone)
3. Large Rural Centres (Rural Zone)
4. Small Rural Centres (Rural Zone)
5. Other Rural Areas (Rural Zone)
6. Remote Centres (Remote Zone)
7. Other Remote Areas (Remote Zone)

The use of the word 'rural' in several of the category names of the RRMA classification was not originally intended to be a definition of rurality. However, over time, RRMA category names have evolved into a simple and convenient way of interpreting rurality. Many programs that have to make decisions on eligibility for assistance are constrained by legislation and policy to using RRMA categories that 'define' rural areas. Within the Commonwealth Department of Health and Ageing administration of regional assistance will move from the use of the RRMA classification to use of ARIA over time.

ARIA stands for Accessibility/Remoteness Index of Australia. During 1998, the Commonwealth Department of Health and Aged Care commissioned a project to measure and classify the remoteness of populated localities in relation to 'service centres' of various sizes (based on the 1996 Census). The result was the ARIA index developed by the National Key Centre for Social Applications of Geographical Information Systems (GISCA) at the University of Adelaide. ARIA uses Geographic Information System (GIS) technology to provide a measure of remoteness (from service centres) for all places and points in Australia.

The development of the ARIA index deliberately avoided defining 'rural' areas. In many cases the term 'rural' is used when people are really referring to regional or non-metropolitan Australia. In these situations regional or non-metropolitan areas can be interpreted based on the degree of remoteness of an area (as measured in ARIA by accessibility to service centres). However in other situations a pure remoteness measure may not be the preferred approach. It may be more appropriate to take into account the population size of nearby urban centres and the use of RRMA categories is an accepted way of doing this. Thus it is acknowledged that some program areas rely on RRMA categories to determine eligibility for funding and there is a need to overlay the RRMA categories to current geographic boundaries and use this approach in conjunction with ARIA. To

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<sup>3</sup> Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA). Occasional Papers: New Series No. 14. Commonwealth Department of Health and Aged Care. Further information is available from the department website <http://www.health.gov.au/ari/aria.htm>

meet the need for programs being able to identify the RRMA-like categories, each of the 1996 SLAs have been allocated a RRMA category code, with categories 6 and 7 being collapsed into a single group for the remote zone.

ARIA defines **five categories** of remoteness based on road distance to service centres, and is available for a variety of geographical units including localities, Census Collection districts (CCDs), Statistical Local Areas (SLAs) and postcodes. The five categories are:

1. **Highly Accessible** (ARIA score 0 - 1.84) - relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction
2. **Accessible** (ARIA score >1.84 - 3.51) - some restrictions to accessibility of some goods, services and opportunities for social interaction
3. **Moderately Accessible** (ARIA score >3.51 -5.80) - significantly restricted accessibility of goods, services and opportunities for social interaction
4. **Remote** (ARIA score >5.80 - 9.08) - very restricted accessibility of goods, services and opportunities for social interaction
5. **Very Remote** (ARIA score >9.08 - 12) - very little accessibility of goods, services and opportunities for social interaction

Until recently, rurality has been described almost exclusively by the seven level Rural, Remote and Metropolitan Areas (RRMA) classification. This classification is based on the size of the local population centre as well as a measure of remoteness<sup>4</sup>.

Work by the National Key Centre for the Social Applications of Geographical Information Systems (GISCA) from 1996 saw the development of improved measures of remoteness: the Accessibility/Remoteness Index of Australia (ARIA), a continuous variable with a remoteness score of 0-12; and its successor, ARIA+ (similar to ARIA, but with a remoteness score of 0-15).

From ARIA, the department of Health and Ageing developed its five-level classification (also called ARIA), and from ARIA+, the Australian Bureau of Statistics developed its six-level classification, the Australian Standard Geographic Classification (ASGC) Remoteness Structure<sup>5</sup>.

### Remoteness classifications

Broad Category	RRMA		DoHA ARIA			ASGC Remoteness			
	Fine Category	Population (000,000)	%	Category	Population (000,000)	%	Category	Population (000,000)	%
Metropolitan	Capital Cities	11.6	64	Highly Accessible	14.9	81	Major Cities	12.1	66
	Other Metropolitan centres	1.4	8						
Rural	Large Rural centres	1.1	6	Accessible	2.2	12	Inner Regional Outer Regional	3.8	21
	Small Rural centres	1.2	7						
	Other Rural centres	2.4	13	Moderately Accessible	0.8	4		2.0	11
Remote	Remote centres	0.2	1	Remote	0.2	1	Remote	0.3	0.3
	Other Remote areas	0.3	2	Very Remote	0.2	1	Very Remote	0.2	0.2
				Remote			Remote Migatory	<0.1	

Note: This table is a rough guide only; the various classes in each classification are not equivalent.  
Sources: AIHW Population Estimates; AIHW Australia's Health 2002.

<sup>4</sup> Australian Institute of Health and Welfare (2002). Australia's health 2002. Canberra: AIHW

<sup>5</sup> Australian Bureau of Statistics (2001). Outcomes of ABS views on remoteness consultation, Australia. ABS Cat No 1244.0.00.001. Canberra, ABS.