



Australian Government

Department of Health, Disability and Ageing



# **Review of the remoteness classification system for aged care**

## **Consultation summary report**





# Acknowledgement of Country

The Department of Health, Disability and Ageing (the department) acknowledges the Traditional Owners of Country throughout Australia. We pay our respects to Elders past, present and emerging.

## Acknowledgment of contributions to the review

The department thanks everyone who took the time to contribute to consultations for the review. The experiences, thoughts and expert advice shared through the consultations are invaluable. They have provided us with a critical understanding about the views, concerns and expectations for aged care service delivery in regional, rural and remote (RRR) locations. These insights will help inform this review. They will also be taken into account as part of a broader review of RRR policy settings.

A special note of thanks to the local staff and service providers who were willing to share what they loved about the communities they serve, and their aspirations for support and services for older people in their areas.

Thank you for your time, wisdom and care.



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# Executive summary

This report provides information on key insights and themes from the consultation phase of the department's review of the remoteness classification system known as the Modified Monash Model (MMM).

A diversity of feedback was collected through:

- online survey and submissions
- site visit consultations in 6 locations
- key informant discussions with relevant peak bodies, non-government organisations and government agencies.

The key messages shared with us in connection with the MMM were:

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## 1. The MMM is a useful but limited tool for aged care

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- The MMM is viewed as a useful starting point to classify areas across Australia because it is simple, easy to use and a nationally recognised tool.
  - The simplicity of the MMM is, however, also seen as a key limitation of the tool to allocate funding and supports in aged care.
  - Used on its own, the MMM is viewed as not-fit-for purpose.
  - The MMM is perceived as too blunt, simplistic and inflexible to provide a complete picture of the people and local context in regional, rural and remote (RRR) locations.
  - It is considered insufficient to understand local care needs and the demand for aged care services in many areas.
  - Concerns were also raised about how the MMM is applied. These included that it can be applied inconsistently across the care sector, or without consideration of different models of care, programs and policies.
  - The application of the MMM is also viewed to be creating health and aged care access inequities in some metropolitan and RRR locations.
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## 2. Understanding the local context is everything in regional, rural and remote locations

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- Geographic remoteness is not the only factor that impacts delivery of quality and safe aged care in RRR Australia.
- It is critical that other factors and the broader local context be considered.
- Workforce recruitment and retention of aged care workers is rated as the most significant issue affecting providers and service delivery in RRR Australia.

- Workforce shortages of general practitioners and competition for allied health workers are also viewed as affecting access to quality services for older people.
- Liveability in RRR areas is reported as a key issue influencing workforce shortages across the care and support sector and the delivery of quality and safe care.
  - Housing availability, the cost of transport, the nature of the local industry, access to social infrastructure and services, and the local environment were identified as critical liveability factors.
- For locations with older populations, higher levels of health needs and/or higher levels of social and economic disadvantage, there are greater pressures on access to care services.
- Many factors that impact aged care service delivery on their own are not unique to RRR areas. However, feedback indicated some factors are more pronounced in some areas, and a combination of factors, such as housing, local industry and transport costs, can increase the impact on access to services in some communities.

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### 3. More information is needed to inform allocation of support and funding in aged care

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- There is strong support to use other factors, in addition to geographic remoteness and population size, to inform allocation of support and funding for aged care.
- Workforce, GP supply, cost of transport, demographics and housing were identified as crucial factors to inform targeted and needs-based allocation.
- There is support for combining the MMM with other criteria, such as population age and socio-economic indicators, to improve how the tool is applied across aged care.
- Assessing the compatibility of the MMM with different models of care, programs and policies is also suggested to improve how the tool is applied.

The above insights and themes will inform further investigations and recommendations for the review.

**Note:** A wide range of other issues and concerns were also raised about the aged care system, services and programs in RRR Australia through the consultations. Changes to the MMM or how the MMM is applied may not necessarily address these concerns. However, this feedback provides an important understanding of the broader context of aged care service delivery in RRR locations to inform policy and system change. As a result, it will also be explored in the context of broader RRR policy review work underway in the department.

# Introduction

## Purpose of this report

This report provides a summary of key insights and themes from the department's consultation on the Modified Monash Model (MMM) and its application in aged care.

## About the review

The department is conducting a review of the remoteness classification system for aged care, known as the MMM. The review will assess the appropriateness of the system as a tool to allocate aged care funding and supports in RRR locations.

The MMM defines whether a location is metropolitan, regional, rural, remote or very remote based on geographical remoteness and town size. The system was designed to better distribute health workforce in rural and remote areas. People in these areas can find it more difficult and more expensive to access health services and doctors.

In aged care, the MMM is used to allocate program funding and other supports for aged care providers based on where they deliver services. Eligibility for some programs or supports can also be based on where the service provider or the person accessing services is located, and their remoteness classification under the MMM. The relevant classification is known as the location's *Modified Monash (MM) category*. Categories range from MM 1 (metropolitan area) to MM 7 (very remote)<sup>1</sup>.

More information about the MMM is available [here](#).

## Why the review is important

The review is consistent with the Government's aged care reform package and responds to Recommendation 17 of the Aged Care Taskforce. It follows on from current work under the Working Better for Medicare Review.

## Consultation process

During the consultation phase of the review, the department met with a range of stakeholders and individuals from the aged care sector and communities across the country.

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<sup>1</sup> How the MMM is applied to a location depends on the type of aged care program and the relevant eligibility criteria. For example, funding for residential care services use the MM category of the street address of the provider, whereas for home care services the MM category of the suburb where the person accessing services lives is relevant.

This helped us understand what people think about:

- how the MMM is used to support aged care service delivery, and
- what we need to know about factors that impact service delivery in RRR locations.

As part of the consultation phase the department held an online public survey, completed face-to-face consultation in 6 locations, and carried out 11 key informant online discussions with a range of relevant organisations, agencies and departments.

## Online Survey

The online survey was conducted in May 2025. It was open to anyone within the aged care sector including providers, workers, families and individuals accessing aged care services.

We received a total of **270 responses** and **8 separate submissions**.

### *Appendix 1: Summary of survey findings*

## Site visits

The 6 site visits were in:

- St Helens, Tasmania
- Port Augusta and Whyalla, South Australia
- Bowen, Queensland
- Mildura, Victoria
- Katherine, Northern Territory.

During the site visits, **over 50 consultations** were held with local providers, hospitals and health services, Aboriginal Community Controlled Organisations (ACCOs), Primary Health Networks, local councils and community and business groups. These discussions provided invaluable insights about the context of service delivery in RRR areas and thoughts about how the MMM is applied in aged care.

### **Note:**

- Preliminary consultations in Kalgoorlie and Broken Hill also occurred in late 2024 as part of the scoping phase of the MMM review. These 2 areas are regularly raised with the department as impacted by current MMM arrangements.
- Feedback from these consultations is also included in this report. These visits provided important insights about the MMM and some of the specific aged care service challenges facing larger rural towns in Australia.
- The further 6 site visit locations that formed part of the formal consultation phase were selected in consultation with Local Networks based on:
  - identified aged care service delivery challenges
  - potential impacts related to the MMM (e.g. perceived misclassification)
  - geographic representation across states and territories.

### *Appendix 2: Summary of site visit consultations*



## **Key informant discussions**

The department held **11 key informant discussions** with relevant peak bodies, non-government organisations and government agencies to collect sector and system level perspectives about the how the MMM is used in aged care.

*Appendix 3: List of key informant stakeholders*

# Consultation findings

Feedback collected from the consultation activities are presented according to the following themes:

1. The MMM is a useful but limited tool for aged care
2. Understanding the local context is everything in RRR locations
3. More information is needed to inform allocation of support and funding in aged care.

## The MMM is a useful but limited tool for aged care

### ***Key findings:***

- The MMM is viewed as a useful starting point to classify areas across Australia because it is simple, easy to use and a nationally recognised tool.
- The simplicity of the MMM is, however, also seen as a key limitation of the tool to allocate funding and supports in aged care.
- Used on its own, the MMM is viewed as not-fit-for purpose.
- The MMM is perceived as too blunt, simplistic and inflexible to provide a complete picture of the people and local context in RRR locations.
- It is considered insufficient to understand local care needs and the demand for aged care services in many areas.
- Concerns were also raised about how the MMM is applied. These included that it can be applied inconsistently across the care sector, or without consideration of different models of care, programs and policies.
- The application of the MMM is also viewed to be creating health and aged care access inequities in some metropolitan and RRR locations.

## The MMM is a useful starting point

Feedback indicated the MMM was largely viewed as a useful tool to allocate funding and support in aged care.

Over 40% of survey respondents agreed the MMM was useful for *Table 4:*

- their local context or area – 42%<sup>2</sup>
- rural (MM 2-5) locations – 44%
- remote and very remote (MM 6 – 7) locations – 44%.

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<sup>2</sup> Note: most respondents selected MM 5 (31%) followed by MM 1 (18%) as their MM location or 'MM category of most concern for the purpose of this survey' (see Figure 2).

However, there was less agreement the MMM was useful for regional (MM 2) locations (34%).

The main benefits of the MMM were the simplicity and easy application of the tool to allocate funding and support in aged care. Other benefits included that the MMM is:

- a nationally recognisable tool
- consistent, objective and easy to interpret
- useful to clearly define and compare levels of remoteness across Australia
- useful as a proxy measure for challenges related to remoteness, such as higher costs.

For these reasons, feedback suggested the MMM generally made sense and was useful to target support and improve equity for regional, rural and remote locations.

*“The advantage of using the MMM model for aged care is that it’s a system that’s the same for everyone, across the board. It is very easy to understand and it’s simple to search for relevant zones.”*

*Aged care provider – MMM survey*

Some respondents and stakeholders also felt the application of the MMM could ensure appropriate funding and support was allocated to deliver services.

However, a stronger theme across the consultations was that the MMM, used on its own, was insufficient to reflect the characteristics of communities and service need. Instead, it was viewed as a useful starting point that could be combined with other information and relevant indicators to inform funding allocation.

*“The MMM is useful as an initial indicator of the many challenges involved in providing aged care funding and supports in thin markets. However, its use is limited as it doesn’t fully capture the costs of providing aged care supports in rural and remote areas due to the many other factors that impact costs. These other factors should be incorporated when finalising funding arrangements.”*

*Provider – MMM survey*

## **Limitations of the MMM for aged care**

While the MMM was considered a useful starting point, feedback highlighted several limitations about the MMM as a primary tool to allocate funding and support for aged care and the care sector more broadly.

The main limitations included that the MMM:

- is too blunt and simplistic as a tool to target support
- does not consider the local context and communities
- is not fit-for-purpose for the aged care context.



## **The MMM is too blunt and simplistic to target support**

The simplicity of the MMM, while a benefit, was also viewed as a key limitation due to the reliance on geographic remoteness and population size.

Feedback highlighted the MMM was not flexible or sensitive enough to consider differences or similarities between communities and locations.

There were concerns the MMM assumes areas with the same MM rating have the same needs and challenges, resulting in some anomalies or misrepresentations of true remoteness. For example, stakeholders in Kalgoorlie and Broken Hill felt the MM 3 rating did not properly reflect their remoteness and significant workforce and service delivery challenges.

*“Population size does not necessarily mean there are better resources available, especially for remote communities that are near state borders or remote communities that population growth has been boosted by mining, but the infrastructure has not followed.”*

*Provider – MMM survey*

However, the assumption that remoteness equals need was also reported to disadvantage many metropolitan communities due to similar challenges related to workforce, travel, and access to culturally safe care.

*“Aboriginal and Torres Strait Islander communities in MM 1 or MM 2 areas like Toowoomba still face systemic racism and barriers to aged care, but receive less support because they are not considered rural or remote.”*

*Aged care advocacy organisation – MMM survey*

Feedback also suggested the MMM does not recognise similarities between MM areas, or natural connections and resource sharing between communities, regions, catchments or local government areas.

*“Many communities classified as MM 4 face challenges similar to MM 5 areas, including workforce shortages, high demand and limited local services. The model focuses heavily on population size and distance, but overlooks factors such as catchment area, hospital overflow, and the role of providers as regional hubs.”*

*Provider – MMM survey*

In effect, the MMM creates hard, and often arbitrary, boundaries between locations that typically functioned as one region. This includes border towns such as Mildura, which is viewed as a ‘natural’ service hub for communities living near the NSW/Victoria border. Port Augusta was similarly a service hub for surrounding remote communities.

*“The main reason MMM is not suitable is it creates geographical boundaries on a map and puts a fence with different categories on either side. The boundary is the problem especially when it comes to funding.”*

*Key informant participant*

## The MMM does not consider the local context

Most feedback suggested the tool was not sophisticated enough to consider information about the local context, local dynamics and local population of metropolitan and RRR areas.

*“MMM isn’t providing the unique details of each community, MMM doesn’t tell us what the need is in the community, MMM doesn’t tell us if there are workforce shortages.”*

*Provider – Site visit*

Feedback highlighted the MMM does not provide an understanding of local factors that affect demand for aged care services. This included information about:

- the proportion of older people in a community which will impact demand for aged care services
- cultural diversity and the need for culturally safe and appropriate care
- local health outcomes, including the prevalence of dementia and chronic diseases
- socioeconomic conditions and their impact on the local demand for services.

*“The MMM methodology is too restrictive and rigid. A more nuanced method is required which has a range of quantity and quality indicators. It also should be underpinned by social justice goals.”*

*Provider – MMM survey*

Feedback also highlighted the MMM overlooks information about local factors that can affect capacity to attract workforce and deliver aged care services. This included factors such as access to:

- access to affordable housing and accommodation
- access to health services and specialists
- local amenities, services and recreation
- cost of transport and travel distances.

*“Take MM 5 - there's so much variability amongst MM 5 - from towns of 350 with very little infrastructure/ support (1 pub, 1 general store, no health or aged care, no GP, no hairdressers, no supermarkets, no petrol/service station, no social groups) to towns of 3,500 with much infrastructure by comparison...”*

*Family member/carer of an older person – MMM survey*

## The MMM is not fit-for-purpose for aged care

Feedback indicated the MMM, used on its own, overlooked aged care specific information and was not fit-for-purpose for the aged care context. This included overlooking information about aged care needs, the size of residential care homes, and service delivery costs.

Several commentators noted the original design of the MMM as a workforce distribution tool for primary care meant it was likely incompatible for aged care services. That is, the underpinning assumptions to distribute GPs may not be relevant to allocate funding and support for aged care service delivery.

*“The MMM was designed primarily as a health workforce planning tool, e.g. incentives for GPs, accessing medical help. Its use as a tool for aged care resourcing is secondary. Therefore, it is unclear whether the MMM considers the actual drivers of costs for aged care providers, namely the sparsity of the RNs and personal care worker workforce, let alone the allied health and lifestyle type workers.”*

*Key informant participant*

In line with this, concerns were also raised that the MMM was applied too simplistically across aged care without consideration for differences between models of care or program goals. For example, differences in service delivery, workforce recruitment and transport costs in residential care settings compared to home care settings.

*“MMM a GP workforce allocation tool to get GPs from 1 area – versus applying the tool to get services out - completely different way of thinking about what need is or what remoteness is. More about distance to a service.”*

*Key informant participant*

Concerns were also raised that the MMM was applied too narrowly as an eligibility criterion for various aged care program and policies. For example, eligibility to apply for grant funding or exemptions to the 24/7 registered nursing obligation. Feedback indicated many areas felt disadvantaged and discriminated against where eligibility was based only on MM ratings.

*“Generalising funding across MMM for aged care makes too many assumptions and it does not take into account the lack of competition for goods and services in regional Victoria.”*

*Provider – MMM survey*

Combined with the perceived bluntness of the MMM, its application across aged care was viewed to be reinforcing funding and service access inequities.

*“The rigid application of distance-based criteria fails to consider actual service access, local resource availability, and the realities of rural aged care delivery. This misclassification results in inequitable outcomes and undermines the sustainability of essential services in small regional towns like ours.”*

*Provider – MMM survey*



## Understanding the local context is everything in regional, rural and remote locations

### *Key findings:*

- Geographic remoteness is not the only factor that impacts delivery of quality and safe aged care in RRR Australia.
- It is critical that the other factors and the broader local context be considered.
- Workforce recruitment and retention of aged care workers is rated as the most significant issue affecting providers and service delivery in RRR Australia.
- Workforce shortages of general practitioners and competition for allied health workers are also viewed as affecting access to quality services for older people.
- Liveability in RRR areas is reported as a key issue influencing workforce shortages across the care and support sector and the delivery of quality and safe care.
  - Housing availability, the cost of transport, the nature of the local industry, access to social infrastructure and services, and the local environment were identified as critical liveability factors.
- For locations with older populations, higher levels of health needs and/or higher levels of social and economic disadvantage, there are greater pressures on access to care services.
- Many factors that impact aged care service delivery on their own are not unique to RRR areas. But feedback indicated some factors are more pronounced in some areas, and a combination of factors, such as housing, local industry and transport costs, can increase the impact on access to services in some communities.

### Remoteness is not the only challenge to service delivery

The ‘tyranny of distance’ was a consistent theme across the site visits, and other consultation activities. Issues of remoteness were considered inextricably linked to higher living costs, which affected liveability and service delivery in RRR locations.

Feedback from consultations, however, highlighted that while remoteness was a factor impacting the scope and cost of service delivery of quality, safe and culturally safe aged care in RRR Australia, this was **not** the only factor.

We discussed with stakeholders and communities what other factors they considered to have a critical impact on service delivery. We also heard that it was important to understand how a combination of factors operating in RRR locations can impact access to care services.

These factors and how they can interact are discussed in detail below.

## Workforce recruitment and retention is a key challenge affecting aged care in RRR areas

A consistent and almost unanimous concern raised across the consultation activities was the challenge to attract and retain workforce in RRR areas. This issue was ranked as the main barrier for providers to deliver aged care services in RRR locations (*Figure 5*).

*“Workforce shortages are the single greatest barrier to delivering high-quality aged care outside of major cities. Without a consistent and well-supported workforce, including nurses, personal care workers, allied health professionals and GPs, aged care providers struggle to meet basic standards, let alone deliver culturally appropriate, personalised and coordinated care.”*

*Survey respondent – MMM Survey*

Workforce challenges were reported in terms of:

- retention and attraction of aged care workers (both direct care and non-care staff)
- availability and access of other health professionals
- competition for staff in RRR areas.

These challenges are outlined broadly in the following sections. The underlying reasons for these challenges are also discussed in the section *Liveability is a key enabler*.

### Aged care workforce

Over 50% of survey respondents identified attracting and retaining clinical staff as the greatest impact for providers to deliver sustainable, quality and safe aged care services in RRR locations (*Figure 6*). This was closely followed by attracting and retaining non-clinical staff (48%).

These survey findings reflect the feedback heard during sites visits. At each site, workforce attraction and retention, of both clinical and non-clinical staff, was nominated as the leading concern for providers. Recruiting staff from the local area was noted as a distinct challenge for RRR areas. Both health and aged care services reported the need to explore recruitment strategies to bring in external workforce.

For residential care providers, attracting and retaining Registered Nurses (RNs) was identified as the leading challenge. All providers across sites were concerned about meeting compliance requirements such as care minutes and 24/7 RN requirements. Providers use various recruitment strategies such as seeking overseas staff or using agency staff. But these strategies incurred significant costs and resulted in a lack of continuity of care for residents. Several providers also reported taking beds ‘offline’ to minimise quality, safety and compliance risks due to staff shortage.

Attracting and retaining non-care staff such as catering, cleaning, administrative and executive staff was also reported to directly affect service delivery. While not involved in direct care, these staff were seen as critical to the day-to-day operations and quality of services.

Home care providers also reported significant challenges to recruit staff, particularly for support worker roles. Several providers noted it was often difficult to attract people from the local area because of the nature of support work. This could include long travel distances between clients, personal car use, unpredictable work schedules, unstable income, and personal safety all which were unsuitable for many people.

Limited local training options also acted as a barrier to upskill local people. High demand services, like gardening, are also difficult to source in some areas directly impacting service delivery and use of packages.

*“There are no training organisations in town, so you have to organise and support new workers to gain skills. It can be very challenging.”*

*Provider – Site visit*

### **Availability and access to other health professionals**

Supply of GPs and allied health professionals was also identified as a critical issue resulting in unmet care needs. This was a key concern raised across the site visits and confirmed by survey feedback and submissions.

Limited access and availability of GPs was a common concern for residential services across the sites. The reasons for limited availability of GPs were reported to be two-fold:

- fewer GPs in the local area, with many at retirement age and low numbers moving to RRR areas
- GPs often reluctant to visit residential services.

Feedback indicated GP willingness to visit residential services could be influenced by several factors:

- visits are conducted in addition to private practice, often after regular business hours, increasing GP workloads
- care needs of residents are often complex and time consuming and GPs must navigate different systems and processes
- financial incentives, such as the GP Aged Care Incentive (GPACI), are not enough to encourage some GPs to visit services regularly.

*“Financial incentives are not enough to get GPs here. GPACI is not improving access to GPs in residential aged care services currently.”*

*Non-government organisation – Site visit*

GP workloads and unwillingness to visit services was also highlighted by one survey respondent:

*“Rural GPs workload is excessive, and they have very limited time to effectively service residential aged care facilities (RACFs). GP's often find the required processes/procedures of RACF's tedious and unnecessary, therefore avoid servicing RACFs.”*

*Care professional – MMM survey*



High demand and low supply of allied health professionals was also a concern for residential and home care providers. This included podiatrists, occupational therapists (OTs), speech pathologists, physiotherapists and dentists.

Demand for podiatry services was a common concern especially in locations with high rates of chronic health conditions such as diabetes. This included remote places like Katherine, where it was reported that many older Aboriginal and Torres Strait Islander people needed, but were not always able to get, diabetes foot care from podiatrists.

Similar to managing RN shortages, providers were often reliant on fly-in-fly-out (FIFO) allied health professionals, which increased the cost of care in RRR areas compared to metro areas.

*“Cost of allied health is about 40% higher in Port Augusta – if you can get it, we’re often unable to get podiatry.”*

*Provider – Site visit*

Other options included telehealth or transporting residents to the local hospital to access allied health care. But hospitals also experienced allied health shortages and transporting residents could be disruptive to routines and increase costs for providers. Some providers, such as in Kalgoorlie, established their own dental clinic to ensure residents could access dental care on-site.

Home care providers also reported low availability of local allied health services was resulting in unmet care needs for older people in RRR areas. Older people often needed to travel to access allied health services or assessment. But the cost of travel, in addition to service costs, was often prohibitive and many people went without services. Or conversely, the cost of allied health services and travel may be prioritised over other home care services.

### **Competition for staff between aged care, health and disability sectors**

A contributing factor for workforce shortages in RRR areas was reported to be competition for staff between aged care, health and disability services in RRR areas. This insight was identified through the site visit consultations and noted in several survey responses. Liveability and local population were also identified as contributing factors and are discussed in more detail in *Liveability is a key enabler* and *Profile of the local population*.

The stability of the local health and care network was viewed by many stakeholders as an important enabler for quality and safe aged care service delivery in their local area. Yet, across all the sites, it was reported there was direct competition for clinical and non-clinical staff between aged care providers and the local health and care network.

A dominant driver of competition was reported to be differences in wages and incentives for different sectors. Similarly, differences in scope of practice and/or work conditions between sectors could also drive competition.

For residential services, there was often direct competition with the local health networks for RNs. State funded hospitals and local health services were sometimes able to offer higher wages and rural loading incentives as part of enterprise agreements. The nature of

clinical work in the hospital setting could also be more appealing compared to aged care settings, particularly for RNs trained in acute care settings. Several residential providers reported investing time and money recruiting RNs only to lose them to the local hospital.

Competition between aged care providers and NDIS providers was also identified as a significant factor affecting workforce supply. This was reported to be particularly pronounced for home care providers and often specific to RRR areas.

*“With NDIS the space is highly competitive, we’re more competitors than colleagues.”*

*Provider – Site visit*

Many providers reported being in direct competition for staff, such as support workers, but also for services like gardening and allied health. This was noted to be directly related to more competitive rates available under the NDIS.

*“Competition with workforce in aged care is also related to the NDIS – they throw the money around and workers are able to earn more delivering NDIS services compared to home care.”*

*Provider – Site visit*

Competition was also reported to be amplified in places like Kalgoorlie and Broken Hill where aged care and health providers reported being in direct competition with the NDIS sector and the local mining industry.

Competition with NDIS providers was related to 2 elements of NDIS pricing arrangements:

- higher pricing limits for services compared to aged care services
  - This includes 40% higher price limits for remote areas (MM 6) and 50% higher prices for very remote areas (MM 7).
- the NDIS use of the ‘Isolated Towns Modification’, a modified version of the MMM that applies higher MM ratings for certain areas.
  - For example, Kalgoorlie and Broken Hill are rated MM 3 (regional) under aged care and health application of the MMM, while for NDIS they are rated as MM 6 or remote.<sup>3</sup>

In relation to the Isolated Towns Modification, many stakeholders in Kalgoorlie and Broken Hill raised concerns about the real-world consequences of the different applications of the MMM. This included feedback from aged care providers, health services and hospitals, local councils and community groups.

Combined with limited and stretched resources, and with all sectors drawing from the same smaller pools of available workforce, feedback indicated that competition was often amplified in some RRR areas. As articulated by one survey respondent, the ultimate impact of this competition was unmet care needs for older people in many RRR areas.

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<sup>3</sup> Note: Providers in these areas also receive additional targeted funding through the [AN-ACC Transition Fund](#) in recognition of geographic isolation.

*“Very limited aged care resources up against a flourishing NDIS market in remote central Australia. NDIS pays workers more and...Even when clients are allocated a home care package, there is often no service provider to resource this.”*

*Provider – MMM survey*

## **Liveability is a key enabler**

The site visit consultations provided an important understanding of how liveability, or suitability, of an area directly influences the delivery of quality and safe aged care.

Across the sites, the factors raised about liveability included:

- housing and accommodation availability and affordability
- travel and transport costs
- the nature of the local economy and industry
- access to social infrastructure and services
- personal safety
- environmental and climate factors.

The presence, or absence, of these factors was noted to enable or limit attraction and retention of people to live and work in RRR areas across all sectors and industries.

In some areas, some factors are more pronounced, and the combination and interplay between certain factors could exacerbate their impact and influence on liveability.

These factors are discussed in terms of their impact on workforce attraction and aged care service delivery. In-depth insights about these factors were identified through the site visits consultations and confirmed by feedback from the survey, submissions and key informant interviews.

## **Housing and accommodation**

Availability and affordability of housing and accommodation was one of the most common issues raised in relation to liveability. Across all locations visited it was reported as a key barrier to attract and retain workforces for all sectors.

In aged care, especially for residential care providers, housing was identified as a critical barrier to recruit clinical and non-clinical care staff. In some locations, housing was also a barrier to recruit executive, cleaning and catering staff. Without such staff, there was a direct impact on service delivery and access to aged care services for older people in the community.

*“Housing is an issue affecting recruitment, there is nil [housing] available in town...”*

*Aged care provider – Site visit*

To overcome this barrier, residential care providers reported offering incentives for accommodation and housing were ‘part of the deal’ to attract workforce. This included covering the cost, subsidising rent, or investing in staff accommodation on site or in the community. Providers also offered higher salaries which contributed to higher operating

costs. Housing shortages in some locations meant providers were reliant on expensive FIFO models using agency staff.

As reported by one provider, overcoming these costs required working closely with staff to ensure they felt supported and properly remunerated.

*“We previously had 95% agency rate for FIFO RNs. This was costing \$1200 a shift per RN. But this is now turned around, and we rarely use agency staff. This was enabled by having conversations about work and pay conditions to attract staff.”*

*Aged care provider – Site visit*

Local health services and hospitals also reported providing accommodation and incentives in the form of ‘rural loadings’ as part of state health awards to attract and support clinical staff to work in RRR areas.

In some locations visited, the local industry and economy was a significant contributor to increased demand and competition for housing. This included heavy industry in Whyalla and Port Augusta and the surrounds, agriculture and horticulture in Mildura, and tourism and retirement destination in St Helens in Tasmania (see [Appendix 2: Summary of site visit consultations](#)).

### **Travel and transport costs**

As discussed above, the ‘tyranny of distance’ was a consistent theme across the site visits, and other consultation activities. The delivery of goods and services, including food, building materials, services and trades, were linked with higher prices due to the cost of fuel and time, and viewed as the cost of ‘doing business’ in RRR Australia.

Higher costs and challenges were associated with travel to, and from, an area directly affecting access to aged care and health services.

*“In a remote area, accessibility should be taken as a factor for funding. Distance can be manageable in some conditions, however changeable weather and potentially unsafe driving conditions slow down delivery of services and products. This increases risk of higher freight charges making some services inaccessible as far as cost, or a delay that places residents at a disadvantage.”*

*Age care worker – MMM survey*

The distance from the closest capital city was noted to affect perceptions of liveability to attract and retain staff to an area. Residential care and health services reported the ability to easily travel to, and from, an area could support recruitment, so staff did not feel isolated working in some RRR areas. But in many areas, transport was often limited and expensive, which could be a barrier to keep staff in an area.

For residential care providers reliant on FIFO agency staff, the cost of travel was reported to be a large component of operational costs. Staff development and training was also associated with high costs due to travel and accommodation for staff to attend offsite courses.

For home care providers, travel costs were reported as the biggest concern across the sites. Costs were associated with long distances and travel time between clients, across service catchment areas, and were typically absorbed by providers. There were also costs related to managing road safety or travelling to isolated areas (for example allocating 2 staff to travel together to deliver home care services in line with work, health and safety requirements). Survey feedback and submission also confirmed this finding, including for MM 1 areas.

*“Actual time taken to transition from an office space to a client’s home in the ‘real world’ and in ‘real time’ is the only useful indicator for how travel should be billed. Even in MM1 zones, due to Australian geographical and urban spread – travel within MM1 zones to a client can extend up to 1 hour in one direction.”*

*Care professional – MMM survey*

And while travel was a key component of delivering home care services, it was a significant barrier to recruit and retain staff. This was due to the challenging nature of service delivery, primarily long distances between clients (including across different MM locations), quality of rural roads, and limited mobile phone coverage, all of which could be a disincentive for staff.

Providers also reported travel costs and limited public transport meant many older people prioritised their services. This included going without essential care services or specialist assessments due to the travel cost that would consume a large amount of their packages.

### **Local economy and industry**

Competition with certain types of industries such as mining, manufacturing and tourism was reported to be a driver or barrier of liveability across sites. They were reported to impact aged care services in 2 ways:

- housing availability and affordability for staff
- direct competition for staff with higher wages available in other industries.

Both issues were reported to be particularly pronounced in Kalgoorlie and impacting aged care and health providers, as well as other sectors such as hospitality ([Appendix 2: Summary of site visit consultations](#)). For example, stakeholders reported hotels were often ‘block-booked’ and rentals were taken up for the mining workforce, pushing up prices and demand for locals and visitors. Higher wages offered by mining companies also meant aged care providers competed for cleaning and catering staff and services and trades.

The presence of these industries was reported to bring many economic benefits and opportunities for individuals and communities in RRR areas. But over-reliance on, and dominance of, these industries meant communities were vulnerable and at the whim of ‘boom and bust’ cycles. At the time of consultations, a good example of this was the



uncertainty around the future of the local steelworks in Whyalla and how it was affecting the 'psyche' of the community.<sup>4</sup>

*"Looming closure of the steelworks has a huge impact on the community – financial, psychological – this affects local economy and business, ability to spend, puts pressure on services on with people needing support... has an impact on the fabric of the community."*

*Provider – Site visit*

Where tourism was the dominant industry, such as for St Helens in Tasmania, seasonal influx of people also had a dramatic impact on housing availability and affordability. Retirees moving to the area also placed pressure on housing and access to health and aged care services. This created downstream impacts such as less housing for older people to downsize and therefore less housing available for families and working aged people to move and establish in the area.

Tourism was also noted as an impact for less remote MM 2 areas:

*"Our home is located in an MM 2 area where the main industry is tourism, wineries and restaurants. In peak season these industries offer high rates of pay and overtime. We often lose some of our kitchen team and food service assistants during this period."*

*Provider – MMM survey*

Similar pressures were also reported for Mildura. With agriculture and horticulture the main industry, there was a heavy reliance on external workforce, such as through the Pacific Australia Labour Mobility (PALM) scheme. But combined with retirees moving to the area, and regional migration during the COVID-19 pandemic, there was increasing pressure on housing.

### **Social infrastructure, services and safety**

Availability and access to social infrastructure and services like childcare, schools and recreational services were also noted as important factors for liveability.

Lack of childcare was identified as a common limiting factor in terms of being able to attract workforce in aged care and other sectors in RRR areas. All sites reported long waiting lists, or limited to no availability of childcare, which affected workforce participation. This was also noted as an issue by several survey respondents.

*"...there is a 5 year wait on childcare places in our community, so we are constantly having families who are nurses, carers etc relocate to cities where services are available."*

*Provider – MMM survey*

In Port Augusta, the local council provided childcare services for the local community in recognition of the need and to attract people to the area. Yet, incentives of \$30,000 over

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<sup>4</sup> Note: Since the consultations, the status of the steelworks has been updated following [an announcement by the Government and the Premier of South Australia](#).

the award were also needed to attract childcare workers. Demand was also significant and often needed to be prioritised.

Some residential providers reported exploring establishing childcare services to attract staff. One residential care provider near Mildura had established a co-located childcare centre, which was reported to also provide an important intergenerational connection for residents and children. Availability of quality high schools could also influence whether families moved to, and stayed in, an area.

Access to spaces for leisure and recreation, or opportunities for social connection, were also factors for liveability. Some residential providers talked about staff often feeling isolated, especially staff from overseas, and helping them to make connections in the community was important to encourage them to stay.

In several locations, personal safety, crime and social cohesion in the local community were reported as factors affecting liveability of the area. Several aged care and health providers reported this directly affected the perception of certain remote locations and the ability to attract and retain staff.

### **Environment and climate factors**

The environment and harsh climate conditions of an area were also highlighted as a factor for liveability. Extreme temperatures and weather events such as flooding and cyclones affected access and isolation of some areas. This affected workforce attraction and could also directly impact the capacity to deliver services.

Safety and accessibility of rural roads was a common concern raised across the sites. For example, the long and winding road between Launceston and St Helens was reported as often closed in winter due to black ice on the road. Despite being a popular tourist destination, limited access to the town in the off-season also impacts recruitment of staff, the delivery of goods and service. This has impacted the delivery of residential and home care services and could impact a provider's compliance with their obligations.

Similar concerns were noted in survey feedback and submissions for 'peri-urban' MM 1 areas, such as Pottsville in NSW and Tamborine Mountain in Queensland. As noted in a survey response:

*"...Mount Tamborine...is currently rated MM 1 ("metropolitan"), despite its accessibility issues, rural setting and effective remoteness by winding mountain – during weather events, access to the Mountain is often blocked or unsafe and staff stay away."*

*Provider – MMM survey*

In places like Bowen and Katherine, road closures due to flooding were reported as a common occurrence, blocking access for staff and the local community. Hot weather and wildlife in many places also affected road safety, and increased the complexity of travel and service delivery in RRR areas. Extreme temperatures in some areas, such as in South Australia and the Northern Territory, can also increase demand for services where some communities and transient populations move to other towns to escape the heat.

## Profile of the local population

The characteristics of the local population were highlighted as an important factor in site visits and other consultation feedback, affecting service delivery in RRR areas. The most critical factors identified were age, socio-economic factors and the cultural diversity of communities.

### Ageing communities

The age profile, or median age, of communities in RRR was reported to impact the demand and delivery of aged care services in several ways:

- **High demand for services:** communities with ageing populations, or a higher proportion of older residents, experienced increased demand for aged care and health services. Some areas, such as Mildura and Bowen, were seeing more retirees move into their communities, increasing pressure on services. Some communities with ageing populations also include limited people of working age. This, combined with a typically older workforce, can impact workforce supply, including volunteers.

*“The ageing population is a factor that should be considered. Once a certain age [older people] don’t want to drive out of the area.”*

*Provider – Site visit*

- **Social isolation and limited access:** in remote areas, older people may be socially isolated, especially if family members have moved away from the area. This can result in low or nil access to health services, leading to increased complexity in care needs.

*“Care packages and accessing assessment long wait times and limited services - acute social isolation of some people may mean they access services to late.”*

*Provider – MMM survey*

- **Limited capacity to support complex needs:** residential aged care services in RRR areas may have limited capacity, due to workforce shortages and/or the design and age of infrastructure, to meet acute care needs, particularly for residents with dementia-related behaviours.
- **Pressure on local system and services:** When older people are unable to access home-based or residential care, this can result in delayed discharge of older people, placing pressure on local services and systems overall.

### Socioeconomic factors

Across all sites, the social and economic profile of a community was also highlighted as a key factor that could impact demand for services in RRR areas.

Several locations were described by stakeholders as highly disadvantaged with entrenched welfare dependence. Lower levels of education, digital literacy and health

literacy were also reported to be common, which was attributed to limited access to social infrastructure and services (e.g. education and training facilities) in RRR areas.

While some locations visited experience economic prosperity, there could also be a stark disparity between high- and low-income earners in the community, depending on the nature of the main industry or economy:

*“...have people with a lot of wealth, self-funded retirees, but a lot of disadvantaged people...these people have very little access to services in their area and need to travel to [city] for services.”*

*Provider – Site visit*

Overall, this could result in higher care needs and demand for services, with social disadvantage associated with higher rates of smoking, chronic health conditions and poor health outcomes. It could also result in lower workforce participation and availability of potential aged care workforce in communities limited the capacity to deliver services.

*“...lower income earners are more likely to be smokers, poor health habits, need higher care in a residential care service.”*

*Health service – Site visit*

### **Cultural diversity and cultural safety**

Cultural diversity was viewed as an important characteristic of communities that can greatly impact demand for services, in terms of care needs for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse (CALD) communities.

Across the sites, the care needs of older Aboriginal and Torres Strait Islander people, which can be more complex, was highlighted as a concern by several providers and services. They reported limited availability of culturally safe services often resulted in unmet care needs for people across both metropolitan and rural and remote communities.

*“There are many Aboriginal people [in the community] therefore there is a high need for culturally appropriate services – but they tend to come to aged care sicker because they’re not accessing services until they need to.”*

*Health service – Site visit*

In locations like Mildura, understanding and responding to the care needs of the highly diverse community was also reported as a concern and priority for services,

The impact of ‘culturally thin markets’ and limited access to culturally safe services was also highlighted as a concern for Aboriginal and Torres Strait Islander communities in the survey and submissions. This included being able to cater for different food needs, paying attention to cultural nuances such as eye contact, and importantly, consideration of historical trauma of Aboriginal and Torres Strait Islander people.

*“Needs of Aboriginal people in urban settings can be very complex, and many mainstream services are not culturally safe.”*

*Provider – MMM survey*

Providers reported a commitment to providing culturally appropriate care, yet indicated it was often a challenge without skilled workforce or due to limited infrastructure capacity. For example, availability of Aboriginal and Torres Strait Islander staff could be insufficient to meet cultural needs including regarding the gender of staff. Residential care homes are also not always able to provide segregated living spaces for men and women.

In places like Katherine, local providers supported residents to return to country, but this was often expensive and increased demand on staff.

*“Currently approximately one in three adult Aboriginal and Torres Strait Islanders are Stolen Generation survivors or descendants. All Stolen Generation survivors are now aged over 50 and so are eligible for aged care.”*

*Submission response*



## More information is needed to inform allocation of support and funding in aged care

### ***Key findings:***

- There is strong support to use other factors, in addition to geographic remoteness and population size, to inform allocation of support and funding for aged care.
- Workforce, GP supply, cost of transport, demographics and housing were identified as crucial factors to inform targeted and needs-based allocation.
- There is support for combining the MMM with other criteria, such as population age and socio-economic indicators, to improve how the tool is applied across aged care.
- Assessing the compatibility of the MMM with different models of care, programs and policies is also suggested to improve how the tool is applied.

### **Using more information to allocate support and funding**

As discussed above, the strong message from our consultation activities was that remoteness is not the only factor that increases challenges to aged care service delivery across Australia.

Feedback also strongly indicated other factors, in addition to remoteness and population size, were required to identify aged care needs and allocate funding and supports in thin markets.

Almost 80% of survey respondents agreed to strongly agreed other information was needed in addition to remoteness ([Table 4](#)). The main additional factors identified were ([Figure 3](#)):

1. recruitment and retention of clinical and non-clinical staff – 59%
2. supply of GPs – 51%
3. access and cost of transport – 41%
4. characteristics of the local population (e.g. age, gender, income, etc.) – 35%
5. availability of housing/accommodation – 34%.

Across the consultation activities a range of other factors were also suggested. These factors reflected concerns raised about the key issues affecting quality and safe service delivery in RRR areas discussed in this report. They have been summarised into ‘local context’ and ‘aged care service context’ factors in [Table 1](#).

**Table 1: Summary of additional local and aged care service context factors to inform allocation of funding and support for thin markets**

<b>Local context</b>	<ul style="list-style-type: none"> <li>• housing and accommodation</li> <li>• travel distances, transport options and freight costs</li> <li>• population/client demographics – e.g. age, socio-economic status, care needs</li> <li>• cultural diversity – e.g. Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse (CALD) communities</li> <li>• access to local services, supports and social infrastructure – e.g. childcare, education</li> <li>• health service access – including to culturally appropriate and trauma-informed care</li> <li>• community safety and security</li> </ul>
<b>Aged care service context</b>	<ul style="list-style-type: none"> <li>• service setting – e.g. home or residential</li> <li>• residential care home size/number of clients</li> <li>• workforce – supply and recruitment costs (e.g. visas applications, incentives for staff)</li> <li>• service and supply costs</li> <li>• capacity of carers, and the level of volunteers and community engagement</li> </ul>

## Improving the application of the MMM in aged care

There was strong support to improve how the MMM is used in aged care to allocate funding and support. While several limitations and concerns about the MMM were raised, it is worth noting there was, however, only limited feedback that the MMM be discontinued as a tool for aged care.

Various suggestions were made across the consultations to improve how the MMM is used. The most common was for the MMM to be used in combination. This suggestion underscores feedback for more information to be used to inform allocation of funding and support.

The types of indicators or eligibility criteria that could be combined with the MMM included:

- population age (i.e. to understand aged care needs)
- the Socio-Economic Indexes for Areas (SEIFA), which measures socio-economic conditions by geographic area
- proximity to the closest capital city
- health service access indicator
- Aboriginal and Torres Strait Islander specific indicators
- health outcome indicators
- liveability index.

Feedback suggested combining these factors with the MMM could reduce the ‘bluntness’ of the MMM and provide a more sensitive understanding about communities. This could address current inequities and anomalies by providing a clearer understanding of need, so aged care funding and support is targeted and needs-based.

A selective application across aged care was also suggested by some survey respondents and stakeholders. It was identified that the MMM did not allow for distinction between different models of care, and suggested greater consideration was needed before applying the MMM to certain programs.

Other suggestions to improve the application of the MMM included consideration of:

- developing guiding principles for policy makers on the use, and application of MMM, that supports nuanced application for inclusion or exclusion of certain settings
- a pathway for providers to apply for special consideration for additional support due to local conditions and challenges
- transition support for providers when new updates are made to MM categories
- the intersection between MMM boundaries with other classification and planning systems – e.g. Aged Care Planning Regions, Primary Health Networks and Local Government Areas
- strategic alignment with other priorities such as the National Agreement on Closing the Gap.

Suggestions were also provided to improve the design and broader application of the MMM including:

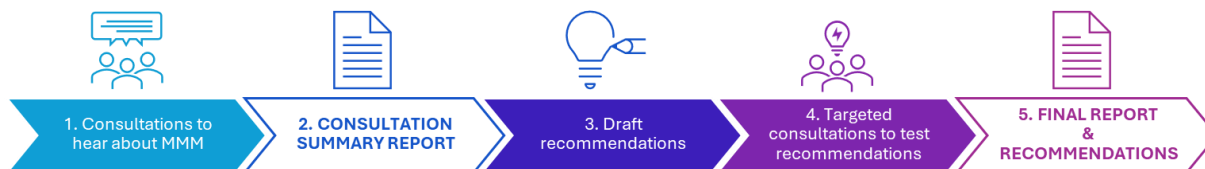
- streamlining application across health, aged care and disability sectors
- using current census data to ensure the currency of the model
- using other variables to inform MM categories.

Several alternative approaches to using the MMM to allocate support and funding in aged care were also suggested by several submissions and key informant participants.

These included:

- developing a new system or index such as:
  - an aged care specific index or scoring system based on different indicators, similar to the SEIFA system
  - applying a horizontal equity analysis to determine aged care service gaps
- replicating the NDIS Isolated Towns Modification list to identify locations that are always unlikely to fit criteria of classification systems.

# Next steps for the review



The findings presented in this report will be used to inform further work to develop draft recommendations about the use of the MMM in an aged care context.

These recommendations will be developed in collaboration with relevant policy teams in the department and tested through targeted external consultations.

**A final report, including recommendations, is targeted for publication by early 2026.**

Further updates about the review will continue to be provided on the project webpage:

[Review of the remoteness classification system for aged care](#)

## Note:

It is important to recognise that valuable insights and concerns about the broader aged care systems, programs and services and other sectors and industries were raised through the consultation activities.

Many of these issues are beyond the scope of this review and may not be fully addressed through the final recommendations for how the MMM is applied in aged care. However, the feedback provides the department with an important evidence base and understanding about the context of service delivery in RRR areas. As a result, the feedback will also be explored in the context of broader RRR policy review work underway in the department. This feedback will also be shared with relevant policy areas and other Australian Government agencies to inform broader policy and systems impacting the care and support economy sector.

# Appendix 1: Summary of survey findings

Figure 1: Type of respondent (person completing the survey) (n=270)

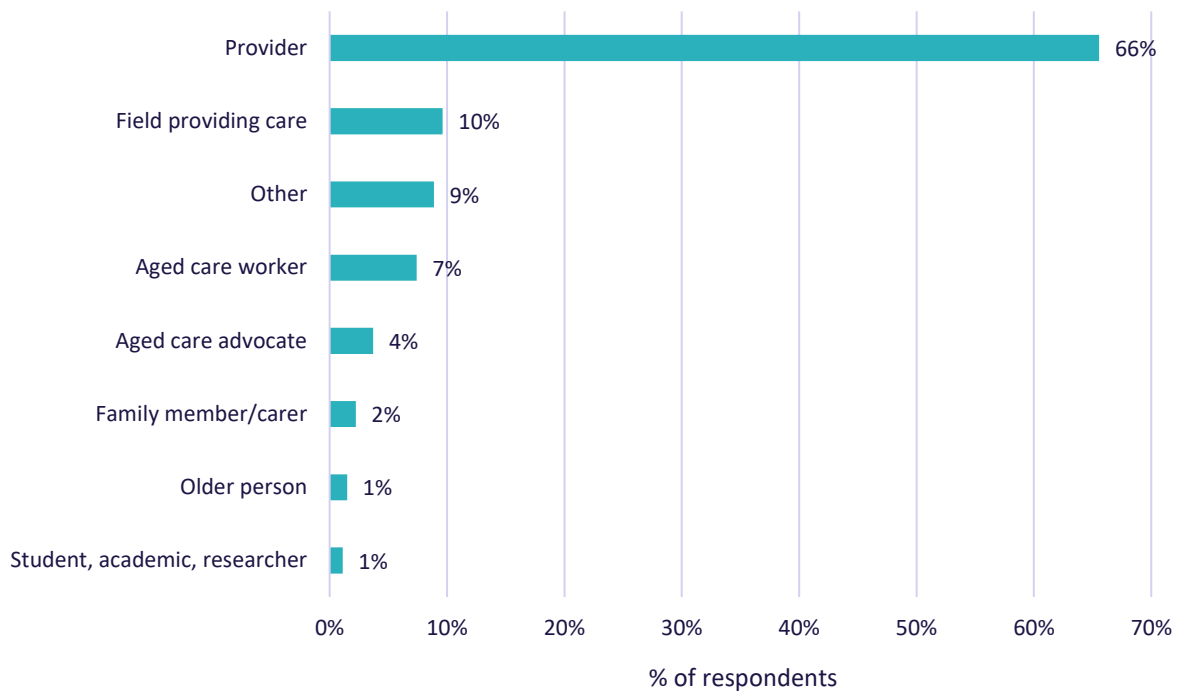
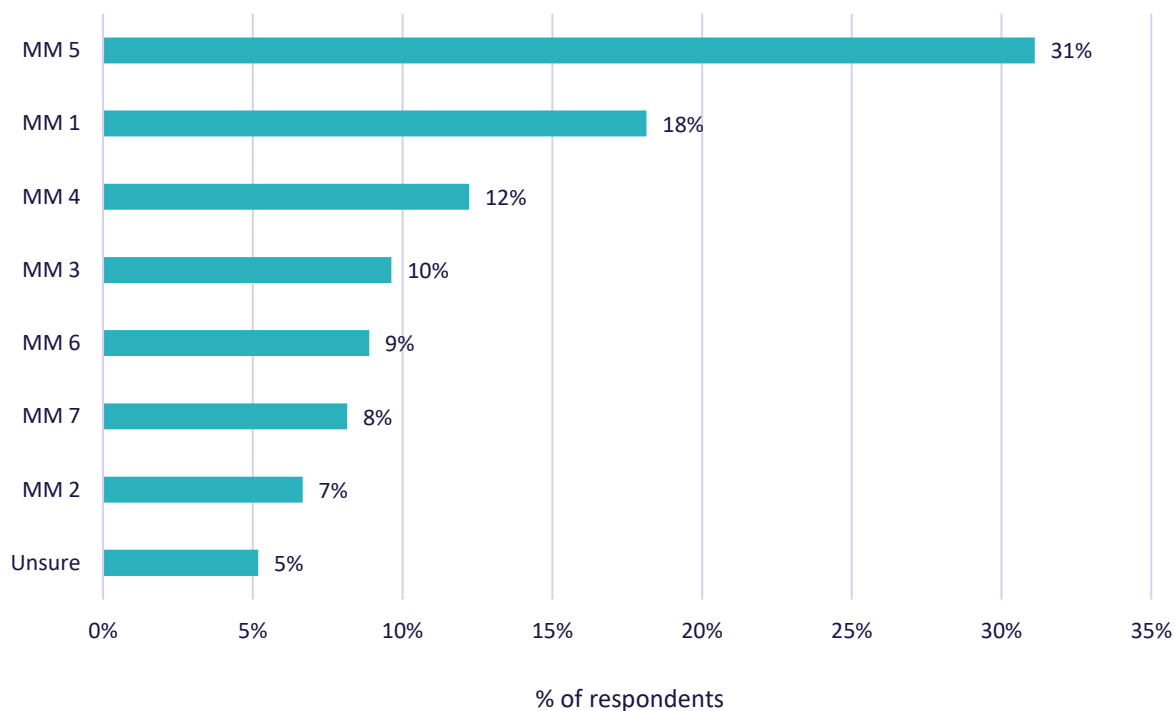


Table 2: Responses provided for 'Other' (person completing the survey; n=23)

Respondent type	Total
Local Government	10
Role/position title provided	6
Professional body	1
Peak body	3
Aboriginal body	1
Neighbourhood centre	1
No response	1
<b>Total</b>	<b>23</b>



**Figure 2: Please indicate the MM category of your location or the MM category of most concern for the purpose of this survey (n=270).**



**Table 3: Additional information provided about MMM selection (n=100).**

Main themes	Total	%
Transport/Freight/Travel	13	13%
Looking to operate in another location	1	1%
Rural/Remote/Very Remote	22	22%
Multiple MMM locations relevant	42	42%
MMM tool not representative	22	22%
<b>Total</b>	<b>100</b>	<b>100%</b>

**Table 4: Level of agreement with statements about the usefulness of the MMM (n=270).**

Statement		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A	Totals
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in my context or local area	N	33	59	53	75	39	11	270
	%	12%	22%	20%	28%	14%	4%	100%
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in regional locations (MM2)	N	20	41	62	70	23	54	270
	%	7%	15%	23%	26%	9%	20%	100%
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in rural locations (MM3 - MM5)	N	39	45	41	79	39	27	270
	%	14%	17%	15%	29%	14%	10%	100%
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in remote locations (MM6 - MM7)	N	19	38	41	69	51	52	270
	%	7%	14%	15%	26%	19%	19%	100%
Remoteness and population size are useful criteria to allocate funding and supports in thin markets	N	17	19	34	95	95	10	270
	%	6%	7%	13%	35%	35%	4%	100%
Other information, in addition to remoteness and population size, should be used to allocate aged care funding and supports in thin markets.	N	7	9	22	59	155	18	270
	%	3%	3%	8%	22%	57%	7%	100%

**Table 5: Please provide a brief comment about your responses (n=178).**

Main themes	Total	%
Other information and indicators should be used for allocation	89	50%
MMM is not appropriate / a blunt instrument	69	39%
MMM is a useful tool	11	6%
Limited knowledge about the MMM and funding for aged care	7	4%
Other systems criteria	2	1%
Referred to separate submission	2	1%
<b>Total</b>	<b>180</b>	<b>100%</b>

**Table 66: Perspectives about advantages for using the MMM for aged care (n=199).**

Main theme	Total
Useful tool to target support and improve equity for regional, rural and remote areas	83
Useful proxy for challenges in regional, rural and remote areas	50
Useful to define geographic	41
Consistent and recognisable	33
Easy to use and understand	29

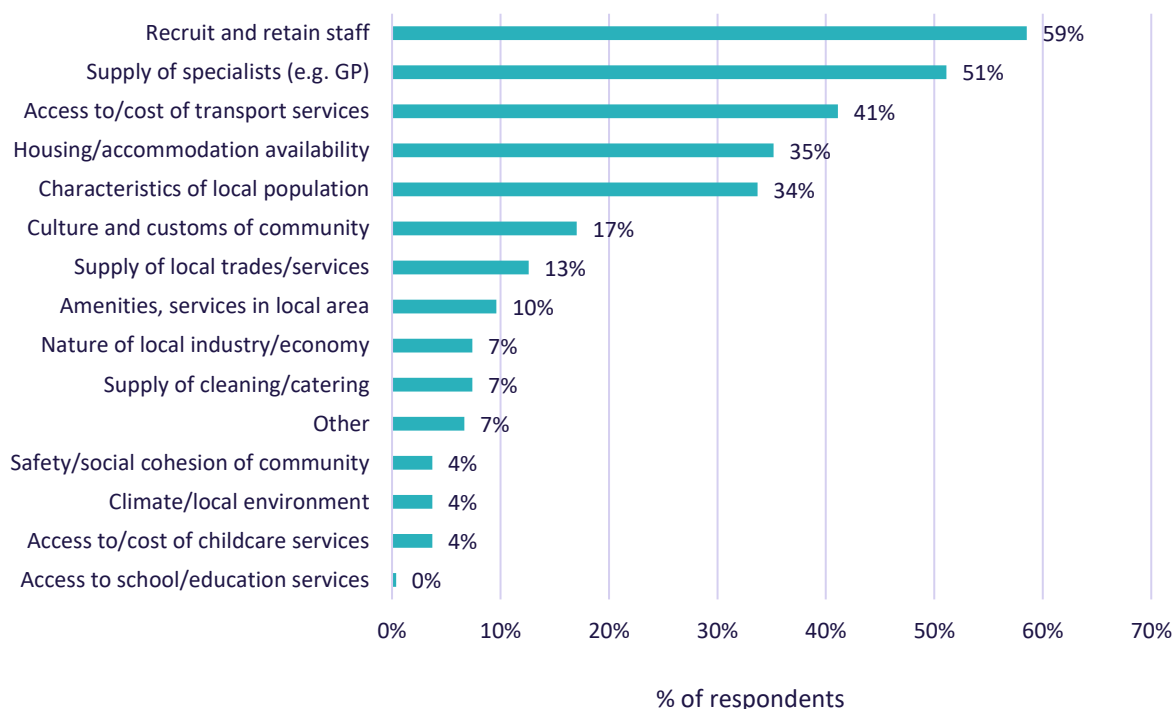
**Note:** Responses covered 1 or more of the themes listed.

**Table 7: Perspectives about disadvantages of using the MMM for aged care (n=199).**

Main theme	Total
Not a good representation of local context	110
Oversimplified, inflexible, lacks nuance	51
Does not account for service delivery costs	51
Creates inequities/gaps in funding and support	48
Not fit for purpose for aged care needs/demand	43

**Note:** Responses covered 1 or more of the themes listed.

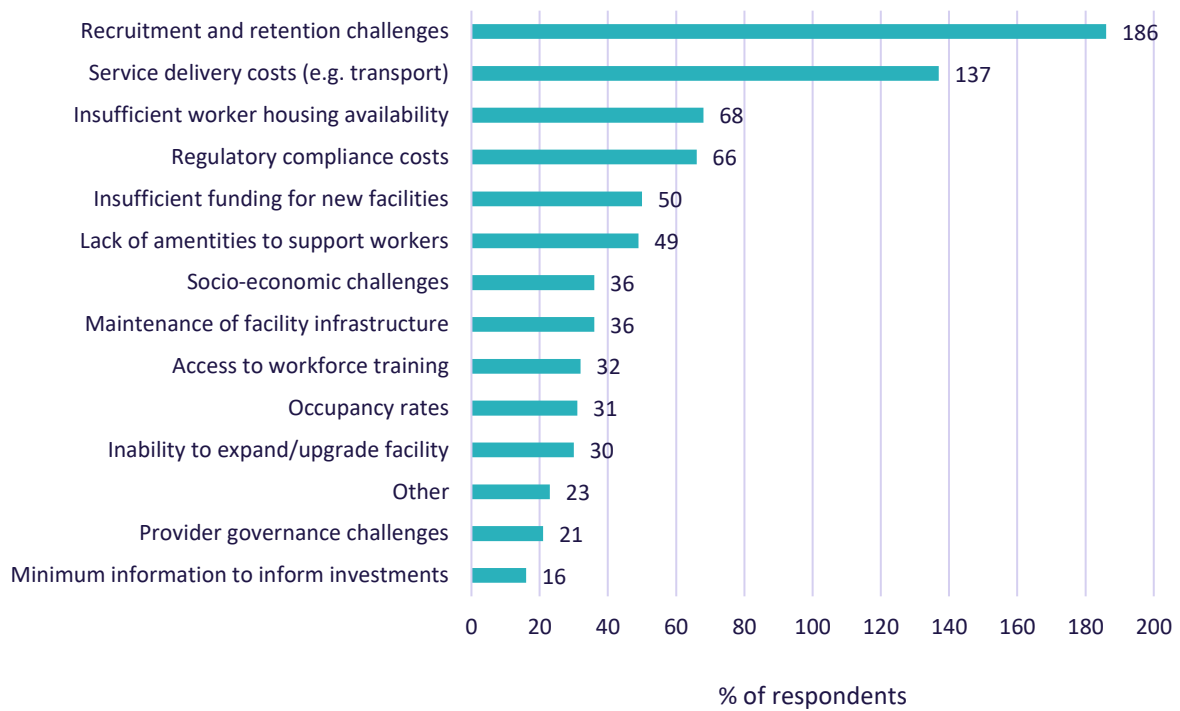
**Figure 3: Other factors, in addition to geographic remoteness and population size, useful to allocate funding and supports for aged care in RRR locations (up to 3 items selected; N=270)**



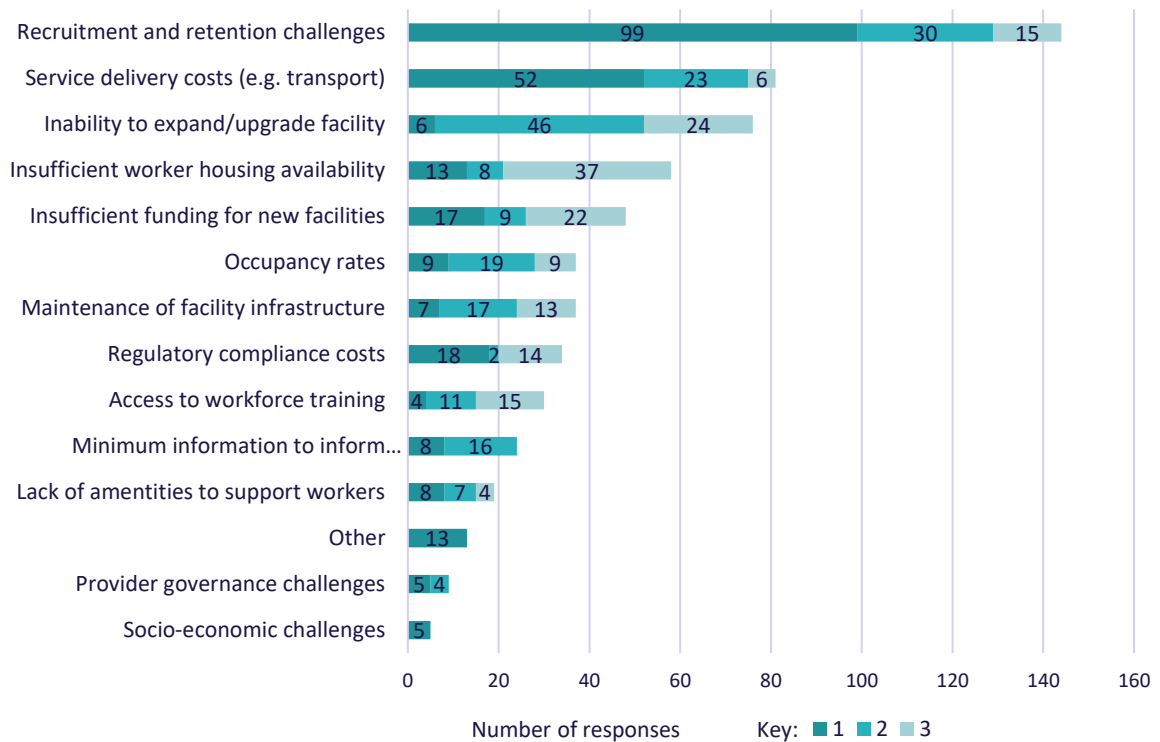
**Table 8: Final comments about how the MMM is applied in aged care (n=84)**

Main theme	Total
Variety of factors need to be considered for RRR areas – e.g. demographics, housing, local services and amenities, local economy, access and cost of transport, childcare	31
Travel distances, cost and access to transport is a critical issue for RRR	13
Current policy settings/funding do not match need	11
Workforce recruitment and retention is a critical issue for RRR – e.g. aged care workforce, GPs, allied health, skilled workforce	10
MMM unfairly classifies/disadvantages communities	7
MMM is useful tool to allocate funding and support	4
Housing/accommodation is a critical issue for RRR areas	3
Support and funding allocation should be case by case	3
Digital literacy is a barrier for older people to access services	2
<b>Total</b>	<b>84</b>

**Figure 4: Main barriers for providers to deliver aged care service in RRR locations (up to 3 items selected)**

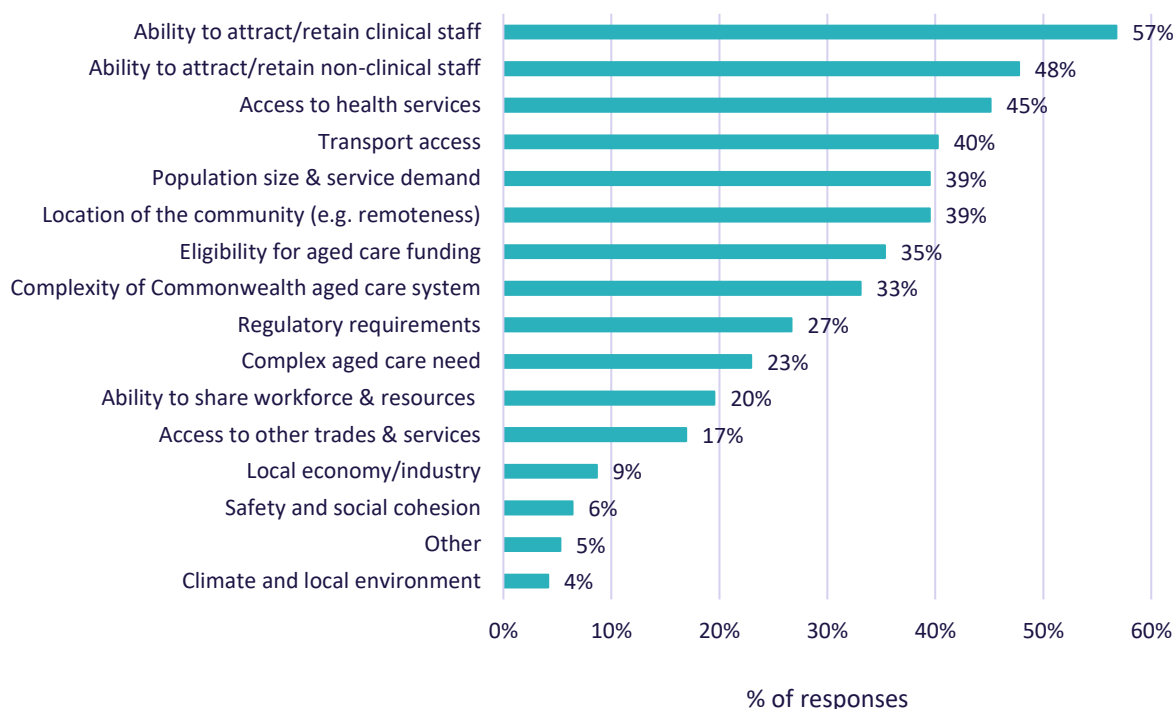


**Figure 5: Main barriers ranked 1 to 3 (with 1 being the biggest barrier and 3 being the least) (n=265)**





**Figure 6: Main factors that impact delivery of sustainable, quality and safe aged care services in RRR locations (up to 5 selected (n=266))**



**Table 9: Responses provided for 'Other' main factors (n=14).**

Main theme	Total
Financial and service delivery models	3
Education/knowledge of staff (clinical and management)	2
Attraction and retention of staff	2
Funding available	2
Infrastructure (cost and capacity)	2
Impacts are variable region to region	2
Referred to separate submission	1
<b>Total</b>	<b>14</b>

**Table 10: Additional comments about main factors that impact delivery of sustainable, quality and safe aged care services in RRR locations (up to 5 selected; n=147).**

Main theme	Total
Workforce attraction and retention is an ongoing issue	70
Lack of funding, access to grants and funding models	40
The complexity and impact of regulatory/compliance changes, standards and requirements	24
Transport costs	18
Geographical isolation/remoteness of the service and region	10
Geographical spread of clients	9
Not having an economy of scale	5
Navigating a complex aged care system	5
Shared governance	3
An ageing rural population	3

**Note:** Responses covered 1 or more of the themes listed.

**Table 11: One thing that could be changed to make it easier for providers to deliver quality and safe aged care services in RRR areas (n=183).**

Themes	Total	%
Increased funding – such as for travel costs, infrastructure, staff incentives, to support RRR providers and to facilitate the expansion of specialist aged care services for Aboriginal and Torres Strait Islander people	89	49%
System flexibility and simplicity – system harmonisation, reduced regulatory and compliance burden, funding models, pricing for Support at Home, access for older people	32	17%
Increased skilled workforce – including requirement for RRR aged care placements, better education and training opportunities, support for volunteers, telehealth services	29	16%
More housing for staff	9	5%
Better collaboration and integration between services/sectors	7	4%
Aged care system delivered by government	4	2%
System improvements – such as reduced wait times for services, better access to My Aged Care, better understanding by assessors of RRR areas	4	2%
Consultation with individuals and communities about aged care needs	3	2%
Improved use of MMM	3	2%
Comments about broader system concerns (e.g. NDIS)	3	2%
<b>Total</b>	<b>183</b>	<b>100%</b>

# Appendix 2: Summary of site visit consultations

The following is a summary of the key issues we heard from stakeholders across the site visits for the consultation phase (April to May 2025) and the scoping phase (October to November 2024) of the review. They include:

- St Helens, Tasmania
- Port Augusta and Whyalla, South Australia
- Bowen, Queensland
- Mildura, Victoria.
- Katherine, Northern Territory
- Kalgoorlie, Western Australia
- Broken Hill, New South Wales

Consultations were held with the following types of stakeholders:

- local aged providers – residential and home care
- local hospitals and health services (state/territory funded)
- Aboriginal Community Controlled Organisations (ACCOs)
- Primary Health Networks
- local councils and local government councillors
- community and business groups.

## Site 1: St Helens – Tasmania – MM 5

### Local context and demographics

- *'hyper-ageing' population* – residents have an average age of 55+ and are from a wide range of socio-economic backgrounds, with self-funded retirees moving in and younger people leaving
- *housing challenges* – status of town as a key tourism and retirement destination leads to expensive rentals and seasonal population peaks, with limited affordable options for aged care workers and older people looking to downsize
- *geographic isolation* – limited access to the area via a single narrow road and very limited transport options, affecting recruitment and access to (and the cost of) services
- *limited infrastructure* – limited infrastructure impacts liveability and affects recruitment (e.g. no large supermarkets, limited freight deliveries, low internet coverage, limited education and childcare options, limited employment options)

### Aged care service delivery challenges

- *growing demand* for aged care services, especially for complex needs – key issues include social isolation resulting in cognitive decline for many older people and high rates of chronic conditions in the community
- *limited services* available despite growing demand, impacting continuity of care – there is only 1 standalone residential care home, limited access to GPs, allied health and support workers, and reported long wait times for home care services
- *significant workforce shortages* – recruitment impacted by travel distances, competition for workforce with the health, disability and tourism sectors, limited local training options and limited ability to recruit international workers

### Key concerns about MMM

- *funding disparities* – MM 5 area but experiences same issues as surrounding areas rated MM 6 (e.g. Swansea)
  - *scope of the MMM* – MMM seen as a “blunt instrument” with a more refined approach needed to reflect local conditions
- 

## Site 2a: Whyalla – South Australia – MM 3

### Local context and demographics

- *ageing population* – population ageing, but also decreasing in size overall
- *economic uncertainty* – local steelworks has been a longstanding industry for the town, but, at the time of the consultations, uncertainty about its future was identified as an impact for the community
- *socio-economic disparities* – vast disparity in wealth/income across the population
- *liveability barrier to population growth* – key factors include limited housing supply, local services, schooling options and employment opportunities, as well as harsh environmental conditions

### Aged care service delivery challenges

- *high demand for services* – only 1 residential care home and long waiting lists for home care (e.g. gardening in great demand but expensive due to limited suppliers)
  - *workforce challenges* – recruitment impacted by long travel distances from Adelaide, safety of roads, remoteness, housing shortages, high rents, social isolation, lack of community connections and workforce competition with the NDIS
-

- 
- *culturally appropriate services* – available services for older Aboriginal and Torres Strait Islander people are already limited, with often a seasonal influx of people from remote communities up to 5 hours away to escape the heat and extreme weather also impacting the community

#### **Key concerns about MMM**

- *funding disparities* – not a typical MM3 area because it experiences similar, if not greater challenges, than areas rated MM5 or higher (e.g. Clare and Jamestown), with Adelaide, the main centre for specialist health services 4 hours by car
- 

### **Site 2b: Port Augusta – South Australia – MM4**

#### **Local context and demographics**

- *ageing population* – older generations staying in the area, but younger people leaving results in a mostly “Drive-In Drive-Out workforce”
- *service hub* – town caters for communities and industries in the broader region
- *liveability* – impacts the ability to attract new people and workforce across, due to limited options for recreation, affordable housing and childcare, combined with a harsh climate and perceived safety issues
- *socio-economic challenges* – highly disadvantaged population, with high welfare dependence in parts of the community

#### **Aged care service delivery challenges**

- *workforce shortages* – incentives are needed to attract health and aged care workers (e.g. paying for housing, offering higher salaries to compete with other industries such as mining).
- *increasing care needs* – many older people are isolated as families move away, and increased rates of dementia and poor health outcomes place pressure on the local hospital
- *limited access to health services* – access to GPs and allied health services for aged care residents is limited, as are culturally safe services for Aboriginal and Torres Strait Islander people
- *high service delivery costs* – increased costs for freight, food delivery and laundry services (allied health services were also reported to be 40% higher)

#### **Key concerns about MMM**

- *funding disparities* – MM4 rating not seen to cover costs of service delivery
  - *scope of the MMM* – MMM insufficiently nuanced and does not take into account liveability of the area
-



## Site 3: Bowen – Queensland – MM 4<sup>5</sup>

### Local context and demographics

- *ageing population* – popular retirement destination with a steadily ageing population, including older people with limited financial resources
- *transient population* – driven by tourism, mining, and fly-in fly-out workers, this adds complexity to service planning, and actual population can be misrepresented
- *liveability* – the region is impacted by housing and rental shortages, alongside a high cost of living
- *geographic challenges* – cyclones and floods frequently disrupt service delivery, and there are challenges due to scarce public transport and taxi services, and hazardous conditions (e.g. due to flooding and wildlife such as kangaroos)
- *limited infrastructure* – limited infrastructure impacts liveability and affects recruitment (e.g. access to supermarkets, banks and reliable internet can be restricted, as well as options for schooling and childcare)

### Aged care service delivery challenges

- *workforce shortages* – attracting and retaining staff remains a significant challenge, compounded by reported GP and allied health shortages, including due to high staff turnover, strong competition from hospitals and the NDIS, and the high cost of recruiting overseas workers (\$15,000 - \$30,000 per worker)
- *professional development* – there are limited opportunities to support new staff to acquire essential skills due to the absence of local training providers
- *high demand for services* – there is significant pressure on existing services, with limited bed availability partly driven by overflow from neighbouring regions
- *transport costs and challenges* – can be a significant delay in accessing specialists and critical medications (e.g. two-week wait for palliative care prescriptions), and maintenance costs are high, with service callouts reaching up to \$1,600

### Key concerns about MMM

- *scope of the MMM* – MMM classifications do not reflect true remoteness and service needs, or take into account the cost of service delivery, socio-economic inequities, and Aboriginal and Torres Strait Islander communities
- *funding disparities* – MM 4 areas many hours from major cities are treated the same as others that are much closer, with raising base care tariffs to MM5 levels not considered sufficient

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<sup>5</sup> **Note:** The town of Bowen is rated MM 4 (ABS Statistical Area Level 1), while the Bowen-Basin North area (ABS Statistical Area Level 3) is rated MM 5.

## Site 4: Mildura – Victoria – MM 3

### Local context and demographics

- *population & industry* – population of approximately 60,000, with horticulture as the main industry, healthcare and aged care second-largest employers
- *demographic trends* – many retirees moving into the area, transient workforces (e.g. PALM scheme workers and other working visas) are also common, impacting census accuracy and workforce stability
- *geographic challenges* – geographically isolated area, about 5 hours from Adelaide and Bendigo, but transport infrastructure is limited, with poor road conditions and no direct flights to Adelaide
- *culturally diverse population* – area has a high population of cultural and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples, though some do not identify officially, increasing the need for culturally safe and appropriate services and skilled staff
- *housing & cost of living* – area is experiencing a housing crisis and high cost of living, affecting residents and workforce recruitment

### Aged care service delivery challenges

- *workforce shortages* – difficulty recruiting and retaining qualified staff, especially GPs, nurses, and allied health professionals, aged care wages are seen as often insufficient to support families, and visa-related workforce instability is identified as a common issue
- *access to services* – reported limited access to GPs, geriatricians, and allied health, long wait times for services like Short Term Restorative Care, lack of dementia support and specialist care
- *infrastructure & transport* – poor infrastructure, lack of public transport, and unsafe rural roads hinder service delivery and affects recruitment with staff often travelling long distances without mobile coverage or safety support

### Key concerns about MMM

- *inaccurate classification* – MM 3 rating is not viewed as properly reflecting the remoteness of Mildura and surrounding areas (e.g. Merbein), which is viewed as facing similar challenges to MM 5 areas, or the costs of service delivery
  - *impact on workforce & services* – MMM based funding models disadvantage providers in Mildura and surrounding areas, affecting workforce incentives, training opportunities, and service viability
-

## Site 5: Katherine – Northern Territory – MM 6

### Local context and demographics

- *population & industry* – mining and agriculture are the main industries in the area, but the town also supports a RAAF base with many people living in the area temporarily
- *housing & cost of living* – overcrowded housing, safety and social instability is an issue for some communities, as well as the high cost of living, limited housing and food scarcity due to remoteness and isolation of the area
- *demographics* – high proportion of Aboriginal and Torres Strait Islander people, typically younger and with distinct cultural needs (e.g. gender segregation, eye contact norms), English is often not the first language and there are many challenges with literacy

### Aged care service delivery challenges

- *workforce challenges* – service providers rely heavily on agency staff, especially in remote areas, as it remains difficult to recruit and retain clinical and allied health staff, staff also often experience burnout and isolation; international workforce has been critical for several providers, but access to allied health professionals remains a challenge (OT, physio, speech, dental, optometry)
- *complex care needs* – chronic disease more prevalent than acute illness with dementia and Fetal Alcohol Spectrum Disorder emerging as major aged care concerns; some Elders also experience financial abuse and elder abuse which needs to be managed by providers
- *culturally safe care* – provision of gender-specific care or supporting Elders to return to Country is a priority, but can be a challenge in terms of cost and staffing availability
- *geographic challenges* – poor internet connectivity with some areas relying on satellite; high maintenance; transport costs are high due to safety and quality of roads, with 4WD vehicles required and ongoing maintenance costs due to damage cars and drive-up service costs (e.g. \$5000 for a plumber or charter plane)
- *limited capacity to expand services* – difficult for new providers to establish services due to building requirements (e.g. cyclone shelter requirements and high insurance premiums), as well as planning and development legislation.

### Key concerns about MMM

- *inconsistent application* – concerns the MMM is not consistently applied across aged care, health, and disability sectors
  - *not reflective of local context* – MMM seen to have limited nuance, and is not considered to reflect workforce shortages, unique community needs or the Aboriginal and Torres Strait Islander population size
-

## Scoping site 6: Kalgoorlie – Western Australia – MM 3

### Local context and demographics

- *isolated and landlocked town* – the town is the main service hub in the region, wholly surrounded by remote areas, and 6.5 hours away from Perth; travel to and from the area involves long distances and high travel costs, and there is limited capacity to expand development due to planning boundaries
- *fluctuating population* – there is a high turnover of people in the area coming from remote communities or moving temporarily for employment in the mining sector, but many older people are ageing in place while their families move away leaving them isolated
- *local industry* – mining is the dominant industry and the main driver of the local economy, but this creates differential wages between sectors and influences the cost of living
- *housing shortage* – significant demand and competition for housing in the area, resulting in limited availability (with stock mostly taken up for mining workforce) and higher costs, which impacts workforce recruitment and retention
- *liveability affects workforce recruitment and retention* – due to limited availability of services, especially health, education, childcare, public transport, and unstable power and internet connectivity, there is perceived lower liveability with incentives needed to attract workforce

### Aged care service delivery challenges

- *high demand for aged care* – long waiting lists for residential care and limited home care availability identified as placing pressure on health services
- *high cost of service delivery* – there are higher service delivery costs in terms of workforce, food and laundry and infrastructure upgrades, as the costs of housing, labour, trades and services is much higher due to cost of freight and transport associated with remoteness
- *workforce challenges* – difficult to recruit and retain workforce due to remoteness, travel and transport costs, and also significant competition with mining industry and NDIS providers who offer more competitive wages; this results in reliance on a FIFO model for RNs and also low availability of GPs and allied health services for aged care
- *culturally appropriate services* – the town supports a wide service catchment area for Aboriginal and Torres Strait Islander people living in remote communities, but limited services are available in Kalgoorlie

### Key concerns about MMM

- *MM3 rating not reflective of geographic remoteness and isolation* – as a landlocked town in a remote region, current rating is seen to misrepresent service delivery challenges in Kalgoorlie and the remote communities supported by the town across a wide catchment area
  - *inconsistent application* – different NDIS rating for Kalgoorlie (MM 6) under Isolated Towns Modification is directly impacting aged care and health services and creating market distortions and inflating growth of NDIS services
-

## Scoping site 7: Broken Hill – New South Wales – MM 3

### Local context and demographics

- *highly isolated and remote town* – town is located in geographically remote area, 4 to 5 hours from Mildura and Adelaide
- *ageing population* – many older people are staying in the area while younger people tend to leave the area for education and employment opportunities
- *housing and accommodation challenges* – high demand, but low availability of, quality and affordable housing affects tourism and the health and aged care workforce
- *limited services and amenities* – the town is a central service centre for communities across a wide catchment area service, but it can be difficult to attract businesses to town due to high freight and delivery costs; there are also limited services such as education and childcare affecting workforce participation.
- *local economy and industry* – mining remains the main industry in town, but changes are occurring with some mine closures and new sectors opening up (e.g. renewables industry); and construction projects are often still constrained due to workforce availability
- *unstable infrastructure* – the town can experience power outages for several days at a time which affects liveability and service delivery; also internet connectivity in the town can be unstable

### Aged care service delivery challenges

- *increasing demand for aged care* – there is only 1 residential care provider in the area and home care providers support a large catchment area, requiring them to travel long distances on remote roads
- *workforce shortages* – there are ongoing challenges to attract and retain workforce with the isolation of the town a significant barrier, as well as competition with NDIS providers who can provide more competitive wages
- *challenges to access services and trades* – it can be difficult to obtain trades and services for infrastructure upgrades and maintenance due to higher rates offered by the mining and resources sector
- *GP and allied health access* – there are ongoing challenges to attract health professionals to the area due to isolation and limited capacity to offer incentives due to MM 3 rating; there also fewer GPs willing to visit residential care homes and difficulties accessing allied health services due to competition with NDIS sector (e.g. OTs, speech pathology, dentists)

### Key concerns about MMM

- *MM3 rating not reflective of geographic remoteness and isolation* – the community feels the current rating misrepresents the town's isolation and remote catchment area
  - *funding disparities* – aged care and health services are ineligible for additional funding and support where they experience the same challenges as rural and remote areas
  - *inconsistent application* – different NDIS rating for Broken Hill (MM 6) under Isolated Towns Modification is directly impacting aged care and health workforce availability due to higher incentives and loadings available for disability services
-

# Appendix 3: List of key informant stakeholders

Targeted online discussions were held in May 2025 with the following peak organisations, non-government and government agencies:

- Aged Care Commission
- Aged Care Workforce Remote Accord
- Ageing Australia
- Catholic Health Australia
- Department of Social Services
- Federation of Ethnic Communities Council of Australia (FECCA)
- Independent Health and Aged Care Pricing Authority (IHACPA)
- National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIACC)
- National Disability Insurance Agency (NDIA)
- National Rural Health Alliance
- UTS Ageing Research Collaborative (UARC).



# Appendix 4: Survey for the review of the Modified Monash Model for aged care

## About this survey

This survey is being conducted by the Thin Markets Branch in the Department of Health and Aged Care (the department) for the Review of the remoteness classification system for aged care.

## What is the MMM?

The MMM is used to define locations by metropolitan, rural, remote or very remote based on geographical remoteness and town size. The system was designed to improve distribution of health workforce in rural and remote areas where it can be more difficult and more expensive to access health services and doctors.

In aged care, the MMM is used to allocate program funding and other supports for aged care providers in regional, rural and remote locations. Eligibility for some programs or supports can also be based on a provider's MMM location.

## Why is there a review of the MMM for aged care?

The review is being completed to assess the appropriateness of the MMM and how it is applied in aged care to support service delivery in regional, rural and remote locations.

The review is consistent with the Government's aged care reform package and responds to Recommendation 17 of the Aged Care Taskforce Final Report. It also follows on from current work under the Working Better for Medicare Review.

## Who should complete the survey?

This survey is most relevant for aged care providers and other organisations and agencies contributing to aged care in Australia.

However, the survey has been designed to be completed by anyone who would like to contribute to the review.

## How will the information be used?

Information collected through this survey will help us understand:

- the advantages and disadvantages of the MMM for aged care
- what's important about delivering aged care services in regional, rural and remote locations.

This information, combined with other review activities, will contribute to the review and inform other regional, rural and remote policies and initiatives.

A summary of the results will be published in a Consultation paper later in the year.

## Completing this survey

The survey will be open until Friday 30 May 2025.

The survey has 9 multiple choice and free text questions and will take approximately 20 minutes to complete.

You can also prepare a longer submission and upload a separate file at the end of the survey.

## More information about this survey

If you have any questions about this survey, please contact the Thin Markets Branch at [ACRuralAndRemote@health.gov.au](mailto:ACRuralAndRemote@health.gov.au).

### Section 1: About you

The following section will ask basic questions about you. This will help us understand who has completed the survey and which MM areas are most relevant to the survey responses.

1. Which of the following options best describes you (as the person completing the survey)?

- ☐ An older person accessing aged care or concerned about aged care services
- ☐ A family member or carer of an older person
- ☐ A provider of aged care services
- ☐ An aged care worker (i.e. I work for a provider of funded aged care services)
- ☐ Another person who works in a field providing care for older people (e.g. nurse, social worker, allied health professional etc.)
- ☐ An aged care advocate or I am representing an aged care advocacy organisation
- ☐ A student, academic or researcher
- ☐ Other – please specify

2. Please indicate the MM category of your location or the MM category of most concern for the purpose of this survey. Please select 1 option. Use the [Health Workforce Locator](#) if you are unsure of the MM category for your location.

☐ MM 1   ☐ MM 2   ☐ MM 3   ☐ MM 4   ☐ MM 5   ☐ MM 6   ☐ MM 7   ☐ Unsure

If relevant, please provide more information about your selection.

## Section 2: Your views about using the Modified Monash Model for aged care

The following section will ask questions to understand your views of the MMM for aged care.

3. Please indicate your level of agreement for the following 6 statements using the below scale.  
Please select 'N/A' if the statement is not relevant to your context.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services <u>in my context or local area</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in <u>regional</u> locations (MM2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in <u>rural</u> locations (MM3 – 5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The MMM is a useful tool to allocate funding and supports for the delivery of aged care services in <u>remote</u> locations (MM6 – 7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remoteness and population size are useful criteria to allocate funding and supports in thin markets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other information, in addition to remoteness and population size, should be used to allocate aged care funding and supports in thin markets.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide a brief comment about your responses (max 400 character limit).

4. What do you think are some advantages for using the MMM for aged care?  
Where possible please provide specific examples (max 1000 character limit).

5. What are some disadvantages of using the MMM for aged care?  
Where possible please provide specific examples (max 1000 character limit).

6. MM ratings are based on geographical remoteness and population size. What other factors do you think would be useful to consider when allocating funding and supports for the delivery of aged care services in regional, rural and remote locations? Please select up to 3 items from the following list.

Note: MM ratings and the design of the MMM is not in scope for this review.

## Section 2: Your views about using the Modified Monash Model for aged care

- Ability to recruit and retain clinical and non-clinical care staff
- Supply of GPs, specialist health professionals and allied health
- Supply of cleaning, catering and other staff
- Supply of local trades and services
- Availability of housing/accommodation
- Nature of local industry/economy (e.g. mining, tourism, agriculture, etc)
- Amenities, services and recreation in local area
- Characteristics of local population (e.g. age, gender, income, etc.)
- Access to/cost of transport services
- Access to/cost of childcare services
- Access to school/education services
- Climate and local environmental conditions
- Cultural needs and customs of local community
- Safety and social cohesion in local area
- Other – please describe

7. Please provide any other comments about how the MMM is applied in aged care (max 1000 character limit).

## Section 3: Your views about aged care service delivery in regional, rural and remote locations

The questions in this section will explore your views about the factors that impact aged care service delivery in regional, rural and remote locations.

8. Which of the following do you think are currently the main barriers to providers delivering aged care services in your regional, rural and remote location? Please select the top 3 barriers from the following list

- Workforce recruitment and retention challenges
- Access to required workforce training and cultural competency
- Insufficient worker housing availability
- Maintenance of existing aged care infrastructure
- Inability to expand or upgrade aged care infrastructure
- Insufficient incentives or funding to build new aged care infrastructure
- Additional service delivery costs, including transport costs
- Occupancy rates and inability to leverage economies of scale Regulatory complexity and compliance costs
- Lack of local amenities, services and infrastructure to support workforce
- Insufficient information available about supply gaps and demand at a local level to inform investment decisions
- Provider governance challenges
- Broader socio-economic challenges in my local community
- Other – please specify

9. Please rank the barriers you selected by numbering them from 1 to 3 (with 1 being the biggest barrier and 3 being the least)

10. Which of the following factors do you think have the greatest impact on the ability of aged care service deliver sustainable, quality and safe aged care services in regional, rural and remote locations?

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i.e. what things do you think overall have the biggest impact, positive or negative, on the ability of providers in your location to deliver sufficient services to meet the needs of the community

Please select up to **5 factors** from the following list.

- 
- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• The location of the community (e.g. remoteness, geographic spread)</li><li>• The size of the population and demand for aged care services (e.g. number of older people who need services)</li><li>• The climate and local environmental conditions</li><li>• The nature of the local economy/key industries (e.g. mining, tourism, agriculture, etc)</li><li>• Safety and social cohesion in local area</li><li>• Complex community aged care needs</li><li>• Ensuring providers can attract and retain clinical staff (e.g. with housing, other social services, childcare services and infrastructure are available for workers and their families)</li><li>• Ensuring providers can attract and retain non-clinical staff (e.g. with sufficient housing, other social services, childcare services and infrastructure are available for workers and their families)</li></ul> | <ul style="list-style-type: none"><li>• Ability to share workforce and resources to deliver health and care services for the local community</li><li>• Availability of transport services and/or subsidised transport services for older people/ aged care workers</li><li>• Availability of broader health care services in the region for older people (e.g. access to GPs and hospital care)</li><li>• Availability of other services in your region (e.g. local trades and services, cleaning services, catering services)</li><li>• Eligibility for additional aged care funding via grants or other funding supplements</li><li>• Complexity of the Commonwealth aged care system and need to amend processes where changes are made</li><li>• Regulatory requirements for aged care and extent of regulatory harmonisation across health and care sectors</li><li>• Other – please specify</li></ul> |
|--|---|
- 

Please provide a brief comment about your response (max 500 character limit).

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11. If you could change one thing to make it easier for providers to deliver quality and safe aged care services in regional, rural and remote Australia, what would it be? (max 1000 character limit)

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Thank you for completing this survey.

You can also submit a longer response in a separate file here (e.g. word or pdf).

For information and updates about the review please visit this webpage [Review of the remoteness classification system for aged care | Australian Government Department of Health and Aged Care](#)

Please click *Submit* to finalise your response.

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**End of survey**



Phone **1800 200 422**  
(My Aged Care's free call phone line)



Visit **[health.gov.au/aged-care-reforms](https://health.gov.au/aged-care-reforms)**

For translating and interpreting services, call **131 450** and ask for My Aged Care on **1800 200 422**.

To use the National Relay Service, visit **[nrschat.nrscall.gov.au/nrs](https://nrschat.nrscall.gov.au/nrs)** or call **1800 555 660**.