



Review of the remoteness classification system for aged care

Final 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.

Acknowledgement of contributions to the review

We would like to express our sincere gratitude to all stakeholders and contributors to the review and the development of this report. Your insights, expertise, and collaboration have been invaluable throughout this process.

Special thanks go to the stakeholders who provided guidance and strategic direction, ensuring the report aligns with our shared objectives. We also extend our appreciation to the individuals and organisations we consulted, whose feedback and perspectives enriched the quality and depth of our analysis.

This report is the result of collective effort, and we are grateful for the time, knowledge, and commitment demonstrated by everyone involved.

About this report

This report presents the findings and recommendations from the review of the appropriateness of the remoteness classification system for aged care.

This report should read in conjunction with the [Consultation summary report](#).

Terms and definitions

Several terms are used in this report that may have different meanings in other contexts. For the purposes of this report, the following terms are defined as follows:

- Older people – people aged 65 years or older, or 50 years or older if they are an Aboriginal or Torres Strait Islander person, or homeless or at risk of becoming homeless.¹
- Regional, rural, and remote (RRR) – Modified Monash (MM) 2 to 7 areas
- Rural and remote – MM 3 to 7 areas
- Isolated towns – MM 3 to 5 areas surrounded by MM 6 or MM 7 areas.²
- Thin markets – this report uses the Aged Care Taskforce definition:^{3,4}
“Thin markets exist where there is a gap between the aged care needs of participants and the services available for them”.

¹ Department of Health, Disability and Ageing (2025). [Who is eligible for aged care services](#), DHDA website. Accessed 19 December 2025.

² This is a broad term used to describe areas that are categorised as rural under the Modified Monash Model (MMM) but are effectively 'isolated' within a more remote area of Australia.

³ Australian Government (2024). *Final report of the Aged Care Taskforce*, pg. 36.

⁴ Note: different definitions are used for thin markets across health, disability and aged care sectors.

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Executive summary

About the review

Ensuring older people can access quality and safe aged care services wherever they live is a key focus for Government. Under the *Aged Care Act 2024*, it is also the role of the Secretary of the Department of Health, Disability and Ageing (the department), as the System Governor, to facilitate access to funded aged care services, including in respect of the location where they are delivered. This includes ensuring that services are available to support older people to age in place.

In many places in Australia, particularly regional, rural, and remote (RRR) areas, there are often unique and complex challenges to deliver and access services. As a result, a range of approaches and policy settings are used to target funding and supports to improve access to services in these areas.

With 1 in 3 older people living in RRR areas and almost 3,600 providers delivering aged care services in these areas, it is critical the right policy settings and levers are in place to target additional funding and supports to providers in under-serviced markets.

The Modified Monash Model (MMM) is the main tool used to target these supports. The MMM classifies the remoteness of locations in Australia. These classifications then inform the allocation of available funding and supports.

Access to services in RRR areas is often limited and more expensive. As a result, ensuring this tool is fit-for-purpose is critical to support service continuity in these areas. It will also help ensure older people have sufficient access to services and a choice of providers. This is particularly important for older people with specialist needs. This includes those with high care needs, dementia or who require culturally safe or culturally appropriate care.

A review of how the MMM is used in aged care was completed by the Department of Health, Disability and Ageing (the department) in late 2025. The purpose of the review was to assess whether it remains an appropriate tool to target funding and support for service delivery in RRR areas.

The review was completed in response to Recommendation 17 of the Aged Care Taskforce Final Report. It is complemented by work underway to develop a new [RRR aged care policy framework](#) and workplan.

Key findings

The review provided important information about how the MMM is applied in aged care in practice. It also delivered valuable insights about the unique challenges of service delivery in RRR areas.

While originally developed to distribute primary health care workforce, the MMM is now used widely across health, aged care, and disability sectors. Overall, it is viewed as an appropriate tool for the aged care context, with broad support for its continued use.

Consultations for this review identified that the MMM is valued as an objective and nationally recognised tool to classify remoteness. It provides an important baseline to inform aged care policy settings and ensure remoteness is considered when allocating funding and supports. As a result, this review has found the MMM is a policy lever that should continue to be used in aged care (see Recommendation 1 below).

The MMM does, however, have several limitations. A key limitation is its simplicity. Applied on its own, it is seen to provide an incomplete picture about the local context, demographics, social and economic dynamics, and aged care needs of RRR communities.

Concerns also surround its inconsistent use in aged care, and across the care sector, potentially increasing the complexity of service delivery in RRR areas.

A need for improved currency, transparency and consistency has been a clear message from stakeholders during this review (see Recommendations 2 to 10 below).

The need to understand the local context and unique attributes of RRR communities has also emerged as an important finding from this review. This understanding should then inform Commonwealth aged care funding arrangements to ensure they fully reflect the costs of service delivery in RRR areas (see Recommendations 11 to 15 below).

Next steps

The review found that improving how the MMM is applied is a priority. Other adjustments, beyond changes to the MMM, are also required to overcome entrenched service delivery problems in RRR areas.

The recommendations also reflect that further work is required to explore the cost of service delivery in these areas. Much work is already underway in this space, which should continue. Together with the findings of this review, this will improve the evidence base available to Government to inform further adjustments to aged care policy settings.

The combined effort of this work will be critical to address service delivery challenges so older people can access quality and safe care in any location. The proposed new [RRR aged care policy framework](#) and workplan will provide a vehicle to prioritise and track this work, and be updated to reflect any new relevant Government decisions.

Recommendations

Continue to use the MMM with improved useability and transparency

Recommendation 1:

Continue to use the MMM in an aged care context subject to:

- adjustments recommended in this review report to ensure improved consistency and transparency of application, and
- further consideration of additional policy levers that could be applied in the future to ensure a more nuanced approach to targeting additional funding and supports in under-serviced markets.

Recommendation 2:

Develop and publish guidelines to explain how the MMM is used in aged care. Document processes and required timeframes to adjust remoteness categories following an update to the MMM.

Recommendation 3:

Maintain a publicly available list of where and how the MMM is used across aged care, as well as health and disability, to be informed by an annual department-wide MMM stocktake.

Ensure the MMM is a robust tool to classify and analyse remoteness

Recommendation 4:

Update the MMM in full after each Census to ensure it remains an objective, transparent and evidence-based classification tool. Timing and implementation of updates should consider transitional impacts, with alternative approaches adopted to manage outlier locations where necessary (see recommendations 8-9).

Recommendation 5:

Ensure the most up to date version of the MMM is used across aged care programs and policies.

Recommendation 6:

Ensure the MMM is used consistently where relevant across all aged care reporting, modelling, and analysis to support evidence-based policy adjustments for thin markets.

Recognise and address the impacts of location and remoteness

Recommendation 7:

Consider further adjustments to aged care program funding arrangements which do not accommodate service delivery cost variations based on remoteness. For example, subsidy components where the MMM is not currently applied, or only to a limited extent.

Recommendation 8:

Consider development of an aged care 'priority areas' list to be published and reviewed annually. This would complement (or use) the MMM. It would be used, where Government agrees, to provide additional funding or support for registered providers in specified areas. The list would be based on a set of objective factors.

Recommendation 9:

Consideration be given to using this priority areas list in the first instance to facilitate additional subsidy funding being provided to mainstream residential care providers in 'isolated towns'. This would provide certainty to impacted communities and remove the need for current separate grant arrangements under the AN-ACC Transition Fund.

Further consideration be given to using this priority areas list in the context of other aged care programs in future to help support viable service delivery in impacted isolated towns.

Recommendation 10:

Explore opportunities for improved alignment across aged care and disability. This could include using the priority list across aged care and disability, with adjustments for particular care settings where required.

Explore options to apply a more nuanced RRR policy lens

Recommendation 11:

Undertake detailed analysis to determine, and build an evidence base, about common factors other than remoteness (e.g. demographic factors, health services access, liveability factors), which may affect service delivery costs in regional, rural, and remote locations in one or more aged care settings. For example, as part of a future evaluation of AN-ACC, Support at Home pricing reviews, and the Multi-Purpose Service Program (MPSP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) funding model reviews already underway.

Recommendation 12:

Subject to the outcomes of recommendation 11, consider options for using the MMM, in combination with other indicators, to deliver more targeted access to grant funded viability supports. This would contribute to the evidence base about service delivery costs in RRR locations. For example, in the context of future grant rounds for the Aged Care Capital Assistance Program (ACCAP) or the Support at Home Thin Market grants.

Recommendation 13:

Subject to the outcomes of recommendation 11 and 12, consider expanding the priority list to include areas beyond 'isolated towns'. Selected locations would exhibit common factors identified as affecting aged care service delivery costs and which cannot be solved through business improvement and innovation.

Build the evidence base about costs in RRR areas to make adjustments where required**Recommendation 14:**

Consistent with Aged Care Taskforce recommendations, and in parallel with thin market and accommodation pricing review work underway:

- consider the appropriateness of policy settings, beyond the MMM, that impact funding available to deliver aged care services in thin markets
- consider further alignment of policy settings across the care sector to incentivise cross-sector diversification of home care service delivery and reduce compliance costs
- work with IHACPA to ensure pricing advice in rural and remote areas continues to accurately reflect the costs of service delivery in thin market areas.

Recommendation 15:

Following the completion of existing thin markets reviews and relevant inquiries into Support at Home implementation, consider whether further adjustments are required to ensure streamlined and evidence-based interventions in thin markets. Any such adjustments should consider options to support broader harmonisation efforts across the care and support sector where appropriate.

Introduction

About the review

This review was conducted to assess the appropriateness of the remoteness classification system, known as the Modified Monash Model (MMM), for aged care.

The review explored:

- how the MMM system is used in aged care
- any advantages and disadvantages of the system for aged care
- factors and conditions, including remoteness, which influence aged care service delivery in regional, rural, and remote (RRR) locations
- options for the ongoing use of the MMM for aged care.

The review is consistent with the Government’s aged care reform package and responds to Recommendation 17 of the Aged Care Taskforce (the Taskforce).⁵

It also follows on from current work under the [Working Better for Medicare Review](#).

Review process

The review was conducted in 2 phases, with a scoping phase completed in 2024 and formal public consultations completed in 2025.



Figure 1: Overview of review stages

During the initial scoping phase site visits were conducted in Broken Hill (New South Wales) and Kalgoorlie (Western Australia).

The second phase included formal public consultations held in April and May 2025.

⁵ Australian Government (2024). *Final report of the Aged Care Taskforce*.

Consultations were conducted through an online survey, key informant interviews and face-to-face discussions in the following locations ([Appendix 1: Profile of in-person consultation locations](#)):

- St Helens (Tasmania)
- Whyalla & Port Augusta (South Australia)
- Mildura (Victoria)
- Bowen (Queensland)
- Katherine (Northern Territory).

Locations were selected to provide a representative sample of areas experiencing service delivery challenges, potential impacts related to the MMM (e.g. perceived misclassification), and geographic spread by MM category and jurisdiction.

A wide range of stakeholders were consulted in these areas, and for the scoping phase, to provide a broad and wholistic understanding about the context of aged care service delivery in RRR areas. Stakeholders included local aged care providers, hospitals and health services, Aboriginal Community Controlled Organisations, Primary Health Networks, local government, and community and business groups.

Overall, through these activities we:

- received a total of 270 responses, 8 separate submissions
- conducted over 50 consultations
- held 11 discussions with key stakeholders.

See the [Consultation summary report](#) for more detail.

Review activities also included a stocktake and analysis of MMM usage across aged care, a desktop scan of key documents and reports, and an internal review of costing data from across the aged care sector.

An internal working group was established to inform additional analysis and develop the recommendations. Targeted consultations were then held with key sector stakeholders to test and finalise the recommendations.

Supporting aged care service delivery in RRR areas

Almost 1.6 million, or 1 in 3, older people live in RRR areas ([Appendix 2: RRR aged care statistics](#)). The greatest proportion live in MM 5 (small rural towns), followed by MM 4 and MM 3 (medium and large rural towns) ([Figure 2](#))⁶.

As at June 2025, more than 480,000 older people access aged care services delivered by approximately 3,600 providers across these RRR areas. This includes through mainstream residential and home care, as well as specialist aged care programs.

Nevertheless, in many RRR locations, it remains more difficult for older people to access aged care services.⁷ Providers based in these areas can also experience additional and different challenges to deliver quality and safe aged care services. In addition, access to other health services is often more limited, with many communities experiencing lower health outcomes compared to metropolitan areas.⁸

The Government investment in aged care service delivery in these regions is substantial. More than \$2 billion a year is made available to help improve access to services.

There are a range of Commonwealth funded supports and initiatives in place including:⁹

- supporting providers with infrastructure grants, workforce programs, and professional and viability resources
- additional funding for providers who deliver mainstream aged care services in more remote locations

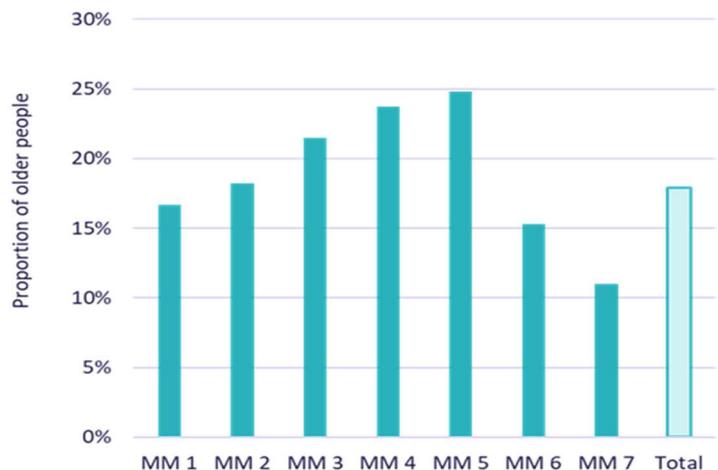


Figure 2: Proportion of older people as proportion of total population by MM category as at June 2025 (see [Appendix 2](#))

⁶ Obtained from departmental information systems and records for 2024-2025. Additional data, report and information can be accessed on the GEN Aged Care Data website.

⁷ Australian Government Department of Health, Disability and Ageing. (2025). *2024–25 Report on the Operation of the Aged Care Act 1997*, pg. 85.

⁸ Australian Institute of Health and Welfare. (2025). *Rural and remote health*. Retrieved from <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health>

⁹ Australian Government Department of Health, Disability and Ageing. (2025). *2024–25 Report on the Operation of the Aged Care Act 1997*, pg. 86.

- block funding through the Multi-Purpose Service Program (MPSP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) to support service delivery in rural, remote, and First Nations communities.

Access to these specialist programs and supports is determined by specific program approaches and policy settings, such as the MMM. These settings aim to ensure such supports are targeted and reflect the challenges and costs of delivering services in RRR locations.

Ensuring these approaches and settings are appropriate is critical so older people can access care and services wherever they live. The Aged Care Taskforce recognised it is also important that settings continue to evolve to accurately identify under-serviced areas.

The Modified Monash Model (MMM)

About the MMM

The MMM is a remoteness classification system using 7 categories to define areas as either metropolitan, regional, rural, remote or very remote ([Table 1](#)).¹⁰

Table 1: List of MM categories and example locations

MM rating	Type of location	Example location
MM 1	Metropolitan	Sydney, Newcastle, Perth
MM 2	Regional centre	Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury
MM 3	Large rural town	Dubbo, Lismore, Yeppoon, Busselton
MM 4	Medium rural town	Port Augusta, Charters Towers, Moree
MM 5	Small rural town	Mount Buller, Moruya, Renmark, Condamine
MM 6	Remote	Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland, Bruny Island
MM 7	Very remote	Longreach, Coober Pedy, Thursday Island

The MMM was originally designed to distribute and incentivise general practitioners (GPs) to work in RRR locations. The model assumes access to health services in these areas is often limited and more expensive.

It is intended to be updated every 5 years in line with Census data and is based on:

- the Australian Statistical Geography Standard-Remoteness Area (ASGS-RA) framework – this uses Census data and measures geographic remoteness based on road distances between towns and population size¹¹
- mapping 6 indicators from the Medicine in Australia: Balancing Employment and Life (MABEL) survey^{12,13} – the indicators influence how and where doctors choose to work, and include: total hours worked, public hospital work, on call after-hours, difficulty taking time off, partner employment and schooling opportunities.

¹⁰ Department of Health, Disability and Ageing (2025). [Modified Monash Model](#), DHDA website. Accessed 27 November 2025.

¹¹ Australian Bureau of Statistics. (Jul2021-Jun2026). *Remoteness Areas*. ABS. <https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas>.

¹² Humphreys, J. S., McGrail, M. R., Joyce, C. M., Scott, A., & Kalb, G. (2012). Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data. *Australian Journal of Rural Health*, 20(1), 3-10.

¹³ The MABEL survey collected information over 10 years from 2008-2018.

Currency of the MMM

The MMM was first used in 2015 and has been in use for 10 years.

3 updates have been applied to the model since it was first implemented:

- MMM2015 – based on 2011 Census data
- MMM2019 – based on 2016 Census data
- MMM2023 – based on 2021 Census data.

The MMM2023 is the latest version of the model, which was a partial ‘no losers’ update, and came into effect in April 2025. This resulted in 17 locations becoming more remote with no changes for other locations that may have become less remote. This partial update was an interim measure following the Working Better for Medicare review.¹⁴

The next update of the model is due after the 2026 Census.

Application of the MMM

The model has been widely adopted across at least 95 programs and policies in health, aged care, disability, and veterans care to target supports for RRR locations.

In aged care, as of 1 November 2025, the MMM 2023 is now used as the primary tool to allocate additional funding and supports for providers in RRR locations. Prior to this a combination of the MMM2015 and MMM2019 were used (see [Figure 3](#) below and section [Application of the MMM in aged care](#)).

The National Disability Insurance Agency (NDIA) also uses the MMM 2023 for National Disability Insurance Scheme (NDIS) planning and pricing arrangements. This facilitates higher price limits for RRR locations based on a participant’s location when support is delivered – including 40% higher prices in remote areas and 50% higher in very remote areas. Different pricing arrangements also apply for rural areas (MM 4 – 5) as set out in the NDIS Pricing Arrangements and Price Limits¹⁵, and the MMM is used to determine claimable time for provider travel costs.

¹⁴ Minister for Health and Ageing (10 March 2025). [Strengthening Medicare: more doctors and larger Medicare payments for dozens of communities](#) [Media release]. Accessed 27 November 2025.

¹⁵ NDIA (2025). [Pricing arrangements](#), NDIS website. Accessed 4 December 2025.

However, the NDIA uses the 'Isolated Towns Modification' list to apply higher MM categories for 133 suburbs and localities surrounded by remote or very remote areas.¹⁶ For example, Broken Hill and Kalgoorlie are re-classified as MM 6 rather than MM 3. An internal review of the Isolated Towns Modification is being undertaken by NDIA as part of the 3-year pricing work plan¹⁷.

The following is a timeline of how the MMM has been updated and applied across the care sector (Figure 3). Usage of the MMM is also broader than the care sector (for more information see [Appendix 3: All programs applying the MMM](#)).



Figure 3: Timeline of updates, reviews, and application of the MMM.

Recent reviews of the MMM

The MMM has been the focus of several health workforce distribution reviews:

- 2021 – Review of the DPA Classification System¹⁸
- 2022 – Senate Community Affairs References Committee¹⁹
- 2024 – Working Better for Medicare Review.²⁰

The Distribution Priority Area (DPA)²¹ relies on the MMM to apply automatic rules to classify areas with general practitioner (GP) shortages.

¹⁶ NDIA (2025). [Pricing arrangements](#), NDIS website. Accessed 4 December 2025.

¹⁷ NDIA (2025). [Pricing work plan](#), NDIA website. Accessed 17 December 2025.

¹⁸ Nous Group (2021). *Review of the DPA Classification System*.

¹⁹ Senate Community Affairs References Committee. (2022). *Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians: Interim report*. Parliament of Australia.

²⁰ Reid, M. and Knight, S. (2024). *Working Better for Medicare Review - Final Report*. Australian Government

²¹ Department of Health, Disability and Ageing (2025). [Distribution Priority Area](#), DHDA website. Accessed 4 December 2025.

In relation to determining the DPA status, a review of the DPA noted 3 challenges with using the MMM:

- the model relies on outdated data sets instead of real-time data²²
- an impact evaluation of the MMM is yet to be completed
- the model overlooks other issues such as road accessibility, which can be affected by extreme weather and climate conditions.

Based on these challenges, a review of how the MMM is used in relation to the DPA was recommended:

“It is timely to review the use of the MMM classification, and its methodology, in determining DPA status of a GP catchment given.”
(Review of the DPA Classification System, pg. 76)

The 2022 Senate inquiry also considered the MMM, alongside other policy levers, in relation to the delivery of primary health care services for RRR areas. The inquiry found the use of the MMM was broadly supported by stakeholders. However, it was also viewed as a ‘blunt’ tool that could be improved by considering the unique factors of towns such as health needs and social disadvantage. The committee recommended:

“Recommendation 2.102: The committee recommends that the Government’s review of the Modified Monash Model is open to public consultation, including from communities themselves, and is progressed as a matter of priority.”
(Interim Report for the Senate Community Affairs References Committee, pg. 44)

More recently, the Working Better for Medicare Review in 2024 was completed, which examined and recommended changes to:

- Sections 19AA and 19AB of the *Health Insurance Act 1973*
- Distribution Priority Area (DPA) classification
- District of Workforce Shortage (DWS) classification
- the MMM.

Similar to the Senate inquiry, the review examined how the MMM is applied in the primary care context. It confirmed the MMM is widely used in primary care and other sectors. It is also confirmed stakeholders were supportive of the MMM as a measure of remoteness, despite some limitations.

²² Note: the report refers to the MMM2019 version.

A key finding was in relation to the 'blanket application' of the MMM to identify DPA status. The review identified this approach was diminishing the effectiveness of the DPA. It recommended the MMM should no longer be used as the primary criterion to determine DPA status.²³

“The current method of determining DPA status via automatic application of MM 2-7 blankets means that of the 827 GP catchments across Australia, 700 (85%) now have DPA status. The almost universal view of submissions and consultations suggest DPA in its current format is no longer an effective distribution lever.”

(Working Better for Medicare Review – Final report, pg. 4)

²³ Reid, M. and Knight, S. (2024). *Working Better for Medicare Review - Final Report*. Australian Government, pg. 9.

Application of the MMM in aged care

The MMM has been used in aged care since 2017 as a key policy lever to support service delivery in RRR locations.

As at December 2025, the MMM is used by 21 programs and policies across aged care, with most programs catering for residential care settings only (n=8), or both residential and home care settings (n=6) ([Table 2](#)). For more detail on these programs see [Appendix 4: Aged care programs applying the MMM](#).

Table 2: Program and policies applying the MMM by aged care setting

Aged care setting	Program or policy applying the MMM in some way
Residential	<ol style="list-style-type: none"> 1. Australian National Aged Care Classification (AN-ACC) funding model 2. AN-ACC Transition Fund Grant (2023-24, 2024-25 and 2025-26) 3. 24/7 RN supplement 4. Aged care surge workforce support²⁴ 5. Exemption from the 24/7 RN requirement 6. General Practice in Aged Care Incentive (GPACI)²⁵ 7. Places to People (residential care place allocation prioritisation) 8. Care minutes supplement for residential aged care
Home or community ²⁶	<ol style="list-style-type: none"> 9. Assistive Technology and Home Modifications (AT-HM) Scheme 10. Commonwealth Home Support Program (CHSP) 11. Support at Home Thin Markets Grants 12. Regional, Rural and Remote Home Care Workforce Support Program
Flexible	<ol style="list-style-type: none"> 13. Multi-Purpose Service Program (MPSP) 14. Disability Support for Older Australians Program (DSOA) 15. National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) uplift funding
Multiple	<ol style="list-style-type: none"> 16. Aged Care Capital Assistance Program (ACCAP) 17. Market Adjustment Program (MAP) 18. Rural Locum Assistance Program for Aged Care (Rural LAP Aged Care) 19. Rural, Remote and First Nations Aged Care Service Development Assistance Panel (SDAP) 20. Rural Health Multidisciplinary Training Program (RHMT) – aged care stream 21. Specialist verification

²⁴ Ceased 31 December 2025.

²⁵ Primary care program for residential aged care settings.

²⁶ Up until 31 October, the MMM was also applied to the Viability Supplement under the Home Care Packages (HCP) program (see [Appendix 4: Aged care programs applying the MMM](#)).

Across the 21 programs, the MMM is used to determine ([Figure 4](#)):

- available funding (additional or flexible) – e.g. funding through the Base Care Tariff (BCT) of AN-ACC funding, and access to block funding under the MPSP
- eligibility for additional viability or capability supports – e.g. ACCAP grants, MAP and SDAP support
- eligible for workforce distribution or development supports – e.g. Rural LAP Aged Care or the Regional, Rural and Remote Home Care Workforce Support Program
- policy settings – e.g. exemption from the 24/7 RN requirement.

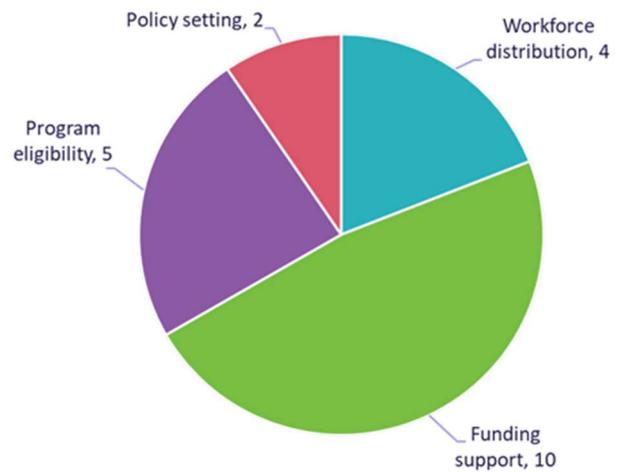


Figure 4: Policy intention for using MMM (n=21)

Until 1 October 2025, all aged care programs were applying the MMM2019 version with 2 exceptions: the MMM2015 version was applied to MPSP and the viability supplement under the Home Care Packages (HCP) program.²⁷

As of 1 November 2025, all programs apply the MMM2023 version.

Over half of the programs have either a rural and remote (MM 3 to 7) focus or a broader RRR focus (MM 2 to 7).

Most cater for MM 5 to 7 areas, and all 20 programs include support for MM 7 (very remote) areas ([Figure 5](#)).

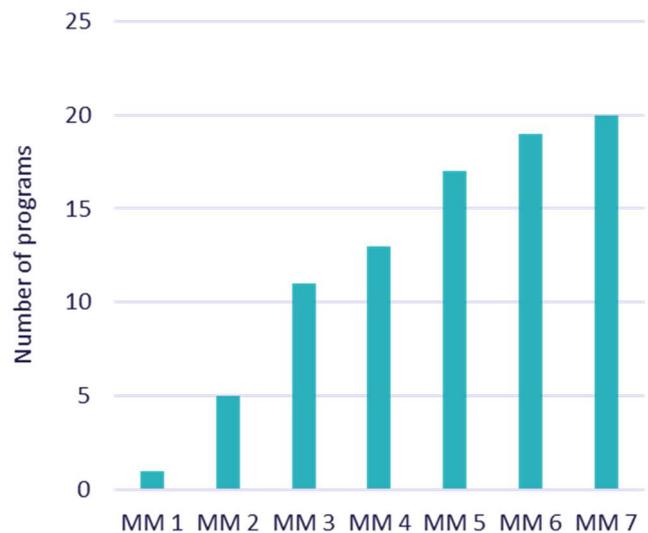


Figure 5: Number of programs by MM categories (n=21)

²⁷HCP ceased on 31 October 2025.

Feedback about the MMM and aged care

This section presents a summary of the consultation feedback collected for the review in relation to:

- the advantages and disadvantages of the MMM
- factors that influence aged care service delivery in RRR locations
- options for the ongoing use of the MMM in aged care.

A detailed report of the consultations findings is available [here](#).

Advantages and disadvantages of the MMM

Stakeholders reported the MMM was overall a useful tool to use in aged care providing a starting point to determine how to target support.

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

Aged care provider – MMM survey

The main reasons stakeholders indicated the MMM is a useful tool for aged care are because it is:

- simple and easy to apply
- 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.

However, a key concern for many stakeholders was the reliance on the MMM as the only tool to determine how and where to target funding and support.

This concern was related to several limitations raised about the MMM:

- it is too blunt and simplistic and lacks flexibility or sensitivity – the model relies on geographic remoteness and population size; as a result, it is not seen to accurately reflect true remoteness, with inherent anomalies for places like Kalgoorlie and Broken Hill.

- it does not provide enough information about the local context, demographics, and local dynamics – the model uses and provides an incomplete picture about the needs of communities and the factors that affect service delivery.

“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

- it is not fit-for-purpose for the aged care context – the model does not consider the aged care needs of a community, service delivery needs, workforce needs, or the costs for service delivery in RRR areas.

“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

Factors that influence aged care service delivery in RRR locations

A key message conveyed through the consultations was the need to consider other factors about RRR areas in addition to remoteness.

Stakeholders reported a key barrier for service delivery remains workforce recruitment and retention. This was due to challenges attracting and retaining aged care staff in both clinical and non-clinical roles, availability of other health professionals, and workforce competition across the care and other sectors.

“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

Recruiting and retaining Registered Nurses (RNs) was a key concern for residential care providers, particularly in the context of meeting care minutes and 24/7 RN requirements.

Availability of catering, cleaning, administrative and executive staff was also a concern and a challenge, particularly for remote and isolated areas. Access and availability of local General Practitioners (GPs) willing to visit Residential Age Care Homes (RACHs) was also highlighted as a key concern.

For home care providers, attracting support workers, as well as providers to deliver gardening and allied health services, was a critical concern. The nature of support work and travel distances in RRR areas were reported as barriers for recruiting and retaining workforce. But competition with NDIS providers, due to higher rates compared to aged care, was highlighted as a challenge by many stakeholders, particularly in the context of home care service delivery. This competition could be further amplified in places with different MM categories due to the NDIA application of the Isolated Towns Modification of the MMM.

Liveability was identified as a key factor driving workforce challenges, across all sectors, in many locations. Liveability encompassed factors including:

- 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.

“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 profile of the local population was also highlighted as a factor that could impact service demand and delivery. Communities with ageing populations and higher proportions of ageing residents reported higher demand for aged care and health services. The social and economic profile of a community was also reported to be linked to demand for social and health services in the community. Many RRR areas experience high social disadvantage, which is linked to higher rates of chronic health conditions and poor health outcomes for the local population.

Meeting the needs of culturally diverse communities, particularly older Aboriginal and Torres Strait Islander people, was highlighted as an issue for RRR and metro areas. Delivery and availability of culturally safe and appropriate care was reported to be an ongoing challenge resulting in unmet need for many older people.

Options for the ongoing use of the MMM in aged care

There was overall support for the continued use of the MMM, with minimal feedback suggesting it should be discontinued.

However, the consultations highlighted a need to improve **how** the MMM is applied in aged care to ensure it remains appropriate to support service delivery in RRR areas.

The need for additional information was identified as one of the main approaches to improve how the MMM is applied to provide a deeper understanding about the local context. This includes using key indicators about communities' aged care service(s), socio-economic conditions, health service access, and liveability.

Approaches to strengthen the application of the MMM also included:

- building knowledge and capability about its usage
- establishing processes and policy settings to enable flexibility
- providing transition support as part of successive updates
- consistent application across health, aged care, and disability sectors
- regular updates to ensure the model is current and reliable.

Recommendations

This review has highlighted that, overall, the MMM is an appropriate tool for the aged care context. However, it also highlighted that some adjustments are needed for how the MMM is applied in aged care to ensure it is used more consistently. This includes in relation to recognised outliers to the model.

In addition, the review confirmed there is strong support to consider using the MMM alongside other information to obtain a more nuanced and fulsome view of RRR areas. This includes overlaying the MMM with information such as social disadvantage, age, and the cultural diversity of communities. Further work will, however, be needed to consider how the MMM can be used more wholistically to target support where it is needed most. This includes consideration of how local factors identified in this review, beyond remoteness, can impact service delivery in RRR locations.

This section discusses the key findings from the review in more detail and related recommendations under the 5 themes below:

- Continue to use the MMM with improved useability and transparency
- Ensure the MMM is a robust tool to classify and analyse remoteness
- Recognise and address the impacts of location and remoteness
- Explore options to apply a more nuanced RRR policy lens
- Build the evidence base about costs in RRR areas to inform any further adjustments.

Continue to use the MMM with improved useability and transparency

The MMM was designed to incentivise the distribution of GPs to RRR locations. It is now used widely across health, aged care, disability, and veterans care for a variety of purposes, programs, and policies. This broad usage means it is not being used as originally intended.

In aged care, it is predominantly used for funding allocation purposes, including for mainstream programs such as residential aged care. It only indirectly works to incentivise attraction and retention of aged care workers.

Of the 21 aged care programs using the MMM, only 4 apply the model in the context of determining access to additional workforce supports.

While the current application of the MMM is not wholly consistent with the original intent of the model, it is generally still accepted as a useful tool for aged care.

Feedback from stakeholders indicated there is broad support for the continued use of the MMM. Consistent with previous reviews, it is viewed generally as a useful, simple, and nationally recognisable tool to define remoteness.

There was very little, if any, support expressed during the consultation process for discontinuation of the use of MMM within aged care. As reflected in the Working Better for Medicare Review report, stakeholders also seemed to agree that an objective measure of remoteness is still needed to inform aged care policy and planning, particularly in thin markets.

A number of stakeholders acknowledged that no classification system would be able to perfectly reflect the situation in all locations in Australia. As a result, feedback did not focus on dismantling use of the MMM or adopting a new system.

Some stakeholders did suggest alternative approaches to the MMM such as developing an aged care specific index or scoring system, applying a horizontal equity analysis, or replicating the NDIS Isolated Towns Modification list. However, most feedback concentrated on how to better accommodate known outliers to the model and incorporate consideration of factors beyond remoteness that impact RRR costs.

This can be summarised as support for a 'MMM+ model,' with the MMM still seen as a useful starting point to determine how best to target supports.

This report therefore recommends the use of the MMM in aged care continues with improvements to its application (see Recommendations 2 to 7). Further work is also recommended to consider the appropriateness of applying additional policy overlays to achieve a more nuanced application of the MMM (see Recommendations 8 to 15).

Recommendation 1:

Continue to use the MMM in an aged care context subject to:

- adjustments recommended in this review report to ensure improved consistency and transparency of application, and
- further consideration of additional policy levers that could be applied in the future to ensure a more nuanced approach to targeting additional funding and supports in under-serviced markets.

As discussed above, as a remoteness classification tool, the MMM has broad utility for aged care and provides a good starting point to target support for RRR locations. However, as the MMM was designed for GP workforce distribution, its applicability may be limited for certain aged care programs or service delivery models.

Understanding and accepting the limitations of the model for aged care is critical. In this context, we consider it essential individual aged care programs fully consider why and how the MMM is applied in specific contexts, and whether adjustments are required to reflect the relevant service delivery context.

For transparency, more information should be made publicly available about the role and use of the MMM in aged care. This will improve care sector understanding of how the MMM is applied, and its important role as a policy lever for funding allocation and program eligibility.

Documenting MMM processes and applications will also streamline procedures where changes to MMM updates are required (see Recommendation 2 below). It will also ensure decisions regarding the MMM are made with consideration of the large and diverse programs that now utilise this system to facilitate more consistent application across the care sector (see Recommendation 3 below).

Recommendation 2:

Develop and publish guidelines to explain how the MMM is used in aged care. Document processes and required timeframes to adjust remoteness categories following an update to the MMM.

Recommendation 3:

Maintain a publicly available list of where and how the MMM is used across aged care, as well as health and disability, to be informed by an annual department-wide MMM stocktake.

Ensure the MMM is a robust tool to classify and analyse remoteness

The MMM was designed to be updated every 5 years in line with Census data to provide stability and consistency. In practice, this means the MM category, or remoteness, of locations will change according to population changes.

The most recent partial update of the model, the MMM2023, came into effect earlier this year. The ‘no losers’ approach to this update was a departure from the underpinning method of the MMM. However, this approach reflected the interim nature of this update as the Government continues to work through its response to the broader [Working Better for Medicare](#) review. It acknowledged a reduction in remoteness for a specific area would be disruptive if only in effect for a limited time.

The objectivity of the MMM has been highlighted by stakeholders as one of the main benefits and advantages of the model. If the MMM is not updated as intended, there is a risk the objectivity of the MMM – its most valued characteristic – will be diminished.

As the MMM relies on Census data, rather than real-time data, the model is also inherently 'dated'. Recent updates have also been delayed, resulting in the model becoming further outdated. This was highlighted as a concern by stakeholders and was also noted in other relevant reviews, such as the Nous review of the DPA²⁸.

With the continued, and likely expanded, use of the MMM, there is an increasing need to ensure the model remains objective and reliable. This can be achieved by ensuring successive updates of the MMM are applied in full and in line with current Census data. This will provide the aged care sector, and broader care sector, with stability and continuity. It will also provide confidence in the approaches used to support RRR locations.

The transitional impacts of MMM updates should be considered as part of government decision making or implementation approaches. However, where such impacts are identified and determined to be significant, it is suggested that targeted transitional arrangements be implemented. For example, when applying new MM categories in the context of a particular aged care program(s) rather than within the MMM itself.

This approach would ensure the MMM remains data driven and evidence-based with:

- departures from a consistent application of the MMM transitional only, and
- ongoing outlier locations, confirmed through other objective measures, managed separately (see Recommendation 4).

Recommendation 4:

Update the MMM in full after each Census to ensure it remains an objective, transparent and evidence-based classification tool. Timing and implementation of updates should consider transitional impacts, with alternative approaches adopted to manage outlier locations where necessary (see Recommendations 8-9).

In addition to delayed or partial updates to the MMM itself, until recently, different versions of the MMM have been used across aged care. Where older versions of the MMM continue to be utilised, this further undermines its role as an objective, reliable classification of remoteness.

The MMM is one of the main levers used in aged care to target funding and support for RRR locations. Therefore, there is a need to ensure the most current version is consistently used across aged care programs.

²⁸ Nous Group (2021). [Review of the DPA Classification System](#).

From 1 November 2025, with the start of the Act, the most recent version of the MMM (the MMM2023) came into effect in aged care. This ensures all new and existing aged care programs using the MMM apply the same version consistently, rather than using the MMM2015 or MMM2019.²⁹

Maintaining this consistent approach to using the MMM will help ensure its application is accurate, fair, and transparent.

Recommendation 5:

Ensure the most up to date version of the MMM is used across aged care programs and policies.

For aged care, the objectivity and utility of the MMM can be assured through consistent application in the context of reporting, modelling, and analysis.

If the MMM remains a key lever through which policy settings are adjusted to reflect the impacts of remoteness, it is critical aged care data and modelling also uses MM categories where possible and appropriate. Currently, many aged care reports and data models do not provide this granularity of data. This impacts the extent the department can confidently identify emerging trends for under-serviced markets. It can also impact the quality of pricing advice to inform the allocation of funding and support.

Utilising MM categories more consistently across aged care reporting and analysis will provide an evidence base about the outcomes of existing and new thin markets initiatives for RRR areas. It would also help deliver a better understanding about the impact of investment in these areas.

This is critical in terms of analysing future supply and demand for aged care services as the population ages. It will also help allay stakeholder concerns that statistics indicating sector level improvements in access and investability, while telling an important story, can mask emerging issues in particular locations.

This will be particularly important where the benefits of new initiatives vary across metropolitan areas and RRR areas. For example, Refundable Accommodation Deposit (RAD) retention reforms with RAD uptake and accommodation charges generally lower in RRR areas.³⁰ It will also be critical as Support at Home matures to track the extent this program assists older people in RRR areas, as well as metropolitan locations, to age at home, consistent with the objectives of the Act.

²⁹ While no longer referenced as such, ARIA (1999) data is still used in one component of the MPSP subsidy calculations (see ss 249-35 to 249-65 of the *Aged Care Rules 2025*). This is historical only and will be addressed as part of the MPSP funding model review already underway.

³⁰ Department of Health, Disability and Ageing (2025). *Financial Report on the Australian Aged Care Sector 2023-24*.

Existing performance measures regarding access to services in rural and remote areas are also under review by the department, alongside proposed new benefits realisation measures³¹. These will help identify ongoing access challenges in RRR areas, compared to metropolitan areas.

Ideally, reporting on all areas of the aged care journey for older people in Australia would compare outcomes in different MM locations to support evidence-based policy adjustments for thin markets. This may take some time to achieve. It will require a capability uplift, including system changes to ensure the right data is captured and reported.

Recommendation 6:

Ensure the MMM is used consistently where relevant across all aged care reporting, modelling, and analysis to support evidence-based policy adjustments for thin markets.

Recognise and address the impacts of location and remoteness

As noted above, stakeholders consulted in this review appeared to agree that an objective measure of remoteness is still needed to inform aged care policy and planning, particularly for under-serviced markets. They also emphasised service delivery location remains a relevant factor when considering aged care costs. Indeed, remoteness is seen to significantly increase the cost of aged care services, as well as other services required to live in the RRR areas more generally (see section below).

The MMM is currently the main tool through which the impacts of remoteness are factored into aged care funding and programs – with almost half of the 21 aged care programs using the MMM doing so to provide additional or flexible funding supports to providers located in more remote areas of the country.

It is acknowledged that as part of this review, stakeholders were supportive of other factors beyond remoteness to be considered in such policy settings. As discussed in the next section, this would require further data capture, analysis, and consideration. However, as a priority and in advance of any such adjustments, the department considers it important that:

- the impacts of remoteness are first considered across the aged care system
- a more consistent and transparent approach is taken to areas recognised as outliers in the context of the MMM (i.e. other geographic factors impacting service delivery in aged care).

³¹ Department of Health, Disability and Ageing (2025). *Corporate Plan 2025–26*. Australian Government, pg. 96.

The Government already recognises the impacts of remoteness to aged care service delivery through its significant additional funding and service delivery in RRR regions. A stocktake of this investment is being undertaken as part of the RRR aged care policy framework targeted for publication in 2026.³²

As noted above, block-funded specialist aged care programs, such as MPSP and NATSIFACP are available in rural and remote areas of Australia. These programs recognise the importance of funding stability in these areas to ensure the delivery of services. Many additional supports are also available for RRR providers, such as through programs like SDAP and Rural LAP Aged Care.

However, further consideration is required in terms of recognising remoteness across mainstream service delivery funding streams, across both residential and home care settings. This is consistent with the findings of the Aged Care Taskforce which acknowledged the importance of the need to recognise remoteness as part of mainstream funding mechanisms to ensure subsidies are accurately targeted.

As is well documented, in mainstream residential care, the impact of remoteness is addressed through the BCT subsidy component of AN-ACC funding. BCT weights are also adjusted based on annual pricing advice provided by IHACPA, with, for example, BCT funding for MM 4 to 5 RACHs increased by 6.5% from 1 October 2025.

Remoteness is also taken into account through the 24/7 RN supplement and related 24/7 RN policy settings. However, stakeholder feedback and recent internal policy analysis indicates other components of residential care funding, including everyday living are also impacted by remoteness. The Government has sought further advice on this matter from IHACPA with a review of the hotelling supplement underway to explore options for tiering. This review confirms the importance of such work proceeding and being prioritised to identify and address any gaps in current funding.

Ensuring data capture accurately identifies costs associated with different mainstream residential care funding streams (e.g. care, everyday living, and accommodation) will also be critical ahead of the further cost analysis recommended in this report (see next section). This will support further recommendations to Government on any other required adjustments to existing funding arrangements to address the costs and challenges of RRR service delivery.

In the context of aged care services delivered in a home or community setting, up until 31 October 2025, additional funding was available to RRR providers through the viability supplement under the HCP program.

³² Department of Health, Disability, and Ageing. (2025). [Regional, rural and remote aged care policy framework and workplan](#). DHDA website. Accessed 8 December 2025.

Since 1 November 2025, support for RRR areas is provided through Thin Market grants. Additional funding is also available where AT-HM services are provided in more remote areas. IHACPA also provides aged care pricing advice to Government on Support at Home to ensure available funding is informed by the cost of delivering in-home aged care services.

It is anticipated further analysis of the impacts of remoteness on service delivery costs in RRR areas should, and will, continue to be undertaken as Support at Home matures. This will be particularly important in the lead up to the transition for remaining CHSP arrangements to Support at Home no earlier than 2027.

This review acknowledges the Senate Community Affairs References Committee is also considering some of these matters currently, including the impact of the transition on providers in thin markets.³³

Recommendation 7:

Consider further adjustments to aged care program funding arrangements which do not accommodate service delivery cost variations based on remoteness. For example, subsidy components where the MMM is not currently applied, or only to a limited extent.

Recommendation 7 is intended to improve consistency in terms of the application of the MMM. A key issue raised by stakeholders in this review was anomalies with the MMM for certain areas, such as Broken Hill and Kalgoorlie. That is, where the MMM is viewed as failing to identify the actual levels of remoteness experienced by these larger yet remote towns.

It has been recognised the MMM does not properly accommodate townships surrounded by an area of higher classification. For example, Kalgoorlie is classified as MM 3 (RA3 with population of between 15,000 and 50,000) but is surrounded by an area classified as MM 7. For this reason, these towns are often described as 'isolated towns'.

Such towns are currently treated inconsistently across aged care programs. For example, AN-ACC transition grant funding is available for a small number of RACHs in these locations. However, such funding is currently only available until 30 September 2026, and a separate grant application is required to access this funding.

³³ See [The Transition of the Commonwealth Home Support Program to the Support at Home Program – Parliament of Australia](#).

Providers in these locations can also access Support at Home thin markets grants, but at rates lower than providers in MM 6 – 7 regions. Other thin markets supports may also be unavailable – for example, for programs or grant rounds where eligibility is limited to providers in MM 5 – 7 locations.

The most substantial concerns raised by stakeholders in the context of the review was the inconsistent treatment of these towns across aged care and disability.

New approaches could be adopted in future to ensure the situation of isolated towns is addressed in a more transparent and consistent manner. This would provide improved stability for providers in these areas, while ensuring any departure from standard remoteness settings are based on a set of objective factors(s).

In the first instance, this could be achieved by standardising situations where additional supports are already provided.

A new ‘priority areas’ list is suggested as an approach to achieve this, with a list of areas where additional supports are provided to be legislated and/or published. The approach, rationale, and criteria for determining the list would be outlined in a published policy document.

Recommendation 8:

Consider development of an aged care ‘priority areas’ list to be published and reviewed annually. This would complement (or use) the MMM. It would be used, where Government agrees, to provide additional funding or support for registered providers in specified areas. The list would be based on a set of objective factors.

In the first instance, it is proposed that such a list should be used in the context of mainstream RACHs in ‘isolated towns’, which currently receive support through the AN-ACC Transition Fund. These homes receive additional funding because they do not fit the profile of current BCT categories due to certain characteristics. This includes RACHs in isolated MM 3 areas surrounded by remote and very remote areas (e.g. Kalgoorlie and Broken Hill), and larger RACHs in remote and very remote areas with high occupancy.

As per Recommendation 9 below, this priority areas list would then also be available in the medium term for other aged care programs to use as relevant and appropriate to reflect a varied approach where providers are located in isolated towns.

These changes would be subject to Government agreement, including through budget processes where this could not be accommodated within existing funding allocations.

In the longer term, as discussed below, this new priority list could then potentially be extended for use by disability (see Recommendation 9 below). Additional locations could also be included in the list based on other factors or combinations of factors if there is an evidence-base to do so in future (see next section [Explore options to apply a more nuanced RRR policy lens](#)).

Recommendation 9:

Consideration be given to utilising this priority areas list in the first instance to facilitate additional subsidy funding being provided to mainstream residential care providers in 'isolated towns'. This would provide certainty to impacted communities and remove the need for current separate grant arrangements under the AN-ACC Transition Fund.

Further consideration be given to utilising this priority areas list in the context of other aged care programs in future to help support viable service delivery in impacted isolated towns.

The review has also confirmed the MMM is used widely, but inconsistently, across the care sector.

The latest version of the MMM has now been adopted across health, aged care, and disability. In a disability context, the 'modified' version of the MMM (the Isolated Towns Modification List) is, however, used for NDIS RRR pricing purposes.

This approach is used to address anomalies with the MMM by allocating a higher MM category to isolated towns. For example, Geraldton in WA is rated MM 3 under health and aged care, but MM 6 for NDIS purposes.

Given the known limitations of the MMM, this is a practical policy solution to improve the usability of the model and combat pricing misalignment across the care and support sector.

Initial analysis suggests the current misaligned approach is, however, creating competition across aged care and disability for allied health, gardening services, and access to support workers. This is because NDIS providers in these 'isolated towns' receive additional supports despite their rural MM categories, unlike in aged care, which stakeholders advise enables them to offer higher wages³⁴. This is on top of existing pricing differences for aged care, disability and veterans care which further add to sector complexity and can lead to confusion or service gaps.

This review acknowledges the Productivity Commission has recently called for greater alignment across aged care, NDIS, and veterans' care sectors.³⁵ This is considered important given the significant overlap across the care and support sector with many providers operating across these sectors. Improving how the MMM is applied to support RRR providers operating in these sectors would be a positive preliminary step to achieving better alignment across the care sector.

³⁴ Further analysis of comparative funding supports and prices in these isolated towns should be undertaken, alongside implementation of Recommendations 9 and 10, noting consultation for this report was undertaken before the commencement of the Support at Home program and NDIS pricing changes in July and November 2025.

³⁵ Productivity Commission. (2025). *Delivering quality care more efficiently: Interim report*. Australian Government, Canberra.

As a result, consideration should be given to whether the proposed new priority list could be used across aged care and disability (and potentially the broader health and care sector in future). As noted above, this would be a key first step towards pricing alignment across the care sector for Commonwealth funded services delivered in the home or community. It would also facilitate broader care and support sector alignment, replacing the existing isolated towns arrangements maintained by the NDIA.

Importantly, should the scope of the priority list be expanded in future (see discussion in the [next section](#)), this approach would also ensure that a consistent care sector approach is taken where appropriate, avoiding further market distortions or negative impacts on the work force in particular sectors.

Recommendation 10:

Explore opportunities for improved alignment across aged care and disability. This should include consideration of using the priority list across aged care and disability, with adjustments for particular care settings where required.

Explore options to apply a more nuanced RRR policy lens

This review has provided an important understanding about the context and landscape of service delivery in RRR locations.

Stakeholders reported there are many challenges for providers to deliver safe and quality aged care in RRR locations. These are typically related to remoteness and travel distances which are considered in determining the MM category.

However, providers and communities also indicated that service delivery challenges are shaped not only by distance, but by unique local conditions and liveability factors.

- Such factors can include housing availability, childcare and education options, social and economic conditions, extreme weather conditions, demographics, and health and aged care needs of the local population or community.
- Stakeholders advise that such factors can impact workforce recruitment and retention. They are also perceived to result in higher service delivery and compliance costs for RRR areas, particularly in combination with existing geographic challenges.

This is why the practice of applying the MMM in an aged care context in isolation is viewed by stakeholders as problematic, especially where it directly impacts eligibility for funding and access to supports.

Stakeholders emphasised more nuanced eligibility settings were vital to ensure providers can meet service costs and deliver sustainable services that older people can access wherever they live. As a result, there is strong support for the Government to consider using the MMM **alongside other information** to obtain a more nuanced and fulsome view of RRR areas.

There may be other opportunities to ensure the RRR context is fully embedded in aged care policy. This could include exploring different approaches to target or identify other priority areas that need supports or innovative service solutions via a ‘MMM+’ model. For example, overlaying the MMM with additional information such as the social disadvantage, age, and the cultural diversity of communities – with similar approaches already used by the department in other areas.

- This includes the DPA classification which determines locations with a shortage of GP services. The system uses information about Medicare billing and the demographics of the community, including age, gender, and Socio-Economic Indexes for Areas (SEIFA)³⁶. The MMM is used to overlay automatic rules for geographic remoteness. While changes have recently been recommended to improve the DPA (see [Recent reviews of the MMM](#)), the underpinning method still provides a template that could be replicated for aged care.

There are also other examples of more nuanced approaches in other portfolios, including employment, education, and infrastructure. Areas of need are identified based on several factors, including local socio-economic status and limited service availability, to prioritise funding and support.

- For example, the Department of Education established a priority areas list³⁷ for different grant programs and initiatives under the Community Child Care Fund³⁸, such as the Limited Supply Grant³⁹. Priority areas are identified by weighting the ratio of children to approved services, the 2021 Australian Early Development Census (AEDC) results, and the SEIFA index.
- Primary care funding for Aboriginal Community Controlled Health Organisations similarly uses a multifactor approach to distribute grant funding under the Indigenous Australians’ Health Programme. The Funding Distribution Model measures client numbers and episodes of care and uses the ASGS and the Indigenous Relative Socioeconomic Outcomes index to adjust for remoteness and health needs of a community.⁴⁰

³⁶ Australian Bureau of Statistics. (2021). *Socio-Economic Indexes for Areas (SEIFA)*, Australia. ABS. <https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release>.

³⁷ Department of Education. (2025). [Priority areas for limited supply grant](#), Department of Education website. Accessed 11 March 2026.

³⁸ Department of Education. (2026). [Child Care Community Fund](#), Department of Education website. Accessed 11 March 2026.

³⁹ Department of Education (2025). [Limited Supply Grant](#), Department of Education website. Accessed 11 March 2026.

⁴⁰ Department of Health, Disability and Ageing. (2025). [Indigenous Australians’ Health Programme primary health care funding model – overview and calculation steps](#), DHDA website. Accessed 8 December 2025.

In terms of other information relevant in an aged care sector, this could include using the SEIFA, in combination with the MMM, to consider the impact of social disadvantage in communities. This has already been highlighted in several reviews, and, given social disadvantage is often associated with poorer health outcomes, this could help inform where to target supports.

A comparison of other social and economic factors of locations visited for this review also illustrates other factors that could provide a deeper understanding about RRR areas and their aged care needs, alongside their MM category. For example, this could include the proportion of older people and/or the median age of the local population, and the number of older people needing assistance.

Broader factors such as housing availability or the main type of industry or economic activity of the local area could also be relevant in terms of cost drivers given their potential impact on workforce recruitment and retention.

As recommended below, further analysis is required to determine which factors have a determinative and common impact on costs drivers for providers in a particular area.

This analysis should consider that the impacts of specific factors, or combinations of factors, may be different in particular care settings. Importantly, it should also progress alongside broader program reforms, as well as further aged care cost and pricing analysis by IHACPA (see also Recommendations 14 and 15), and not in isolation.

Recommendation 11:

Undertake detailed analysis to determine, and build an evidence base, about common factors (e.g. demographic factors, health services access, liveability factors), other than remoteness, which may affect service delivery costs in regional, rural, and remote locations in one or more aged care settings. For example, as part of a future evaluation of AN-ACC, Support at Home pricing reviews, and the MPSP and NATSIFACP funding model reviews already underway.

The analysis recommended above is critical before any more detailed recommendations are put to Government regarding adjustments to aged care service delivery funding. This is because further analysis and determination of clear and objective factors of causation is required so further policy adjustments contribute to targeted Commonwealth investment in aged care and deliver value for money.

This staged and informed approach is also important to fully address the important feedback provided by stakeholders as part of this review. This is because it will help maximise the opportunity to develop more nuanced and flexible solutions that reflect the complexity of challenges in the RRR areas and ensure funding stability.

As discussed in the final section of this report, such analysis must also be informed by improved information about the unit costs for service delivery in RRR areas.

In the interim, addressing recommendations 8 to 11 above as a priority would also address key concerns raised by stakeholders. As recommended below, in parallel to detailed analysis, more expansive arrangements could also be piloted for certain capped grant programs to contribute to the evidence base regarding alternative cost drivers in RRR.

Where warranted and practicable, further adjustments could then be sought to the priority list where relevant, and ideally, with application across both aged care and disability as discussed above at Recommendation 10. That is, additional locations could be included in the list based on other factors or combinations of factors if there is an evidence-base to do so in future.

- For example, this could include additional rural and remote locations where data analysis identifies common cost drivers as reported by stakeholders in this review, such as Whyalla (MM 3), Port Augusta (MM 4), and St Helens (MM 5). For example, costs associated with long travel distances, freight and delivery of goods and services.
- It could also include some MM 1 and MM 2 locations reported by stakeholders, such as Pottsville or Toowoomba, where they are identified as sharing similar characteristics and cost drivers to MM 3 – 7 locations.

While preliminary analysis of the mainstream RACHs in the locations visited did not provide sufficient evidence about common factors impacting costs or resulting in funding pressures, this does not suggest concerns of relevant providers and communities are not valid. Rather, as noted above, further analysis is required to inform recommendations to Government on any such expansion. As discussed in the [last section of this report](#), improved reporting and further policy adjustments may also be required for certain programs to identify any remaining funding shortfalls or anomalies.

Recommendation 12:

Subject to the outcomes of recommendation 11, consider options for using the MMM, in combination with other indicators, to deliver more targeted access to grant funded viability supports. This would contribute to the evidence base about service delivery costs in RRR locations. For example, in the context of future grant rounds for the Aged Care Capital Assistance Program (ACCAP) or the Support at Home Thin Market grants.

Recommendation 13:

Subject to the outcomes of recommendation 11 and 12, consider expanding the priority list to include areas beyond 'isolated towns'. Selected locations would exhibit common factors identified as affecting aged care service delivery costs and which cannot be solved through business improvement and innovation.

Build the evidence base about costs in RRR areas to make adjustments where required

This review has highlighted a range of issues in relation to how the MMM is applied in aged care and the care sector more broadly.

It has also brought forward many issues about the delivery of aged care services in RRR areas which are beyond the scope of the review but remain relevant to ensuring funding and supports for RRR aged care are targeted and effective.

While not always directly related to the MMM itself, the central concern, underscored by stakeholders' feedback, was that current funding is not considered sufficient to cover the costs of service delivery in many RRR locations.

The perception is that costs of 'doing business' in these areas is higher – not only due to the remoteness of the location, but also due to other factors that impact service delivery in the local community (see previous section).

- Costs related to service delivery were reported to include incentives for workforce recruitment, travel and transport, freight and delivery, trades and services and maintenance of infrastructure and equipment, all of which can be higher in RRR areas.
- But stakeholders also emphasised costs can include items and factors that are more difficult to measure and are not necessarily reported. This can include the impact of road quality and extreme weather on staff travel, and additional costs to maintain emergency supplies to ensure service continuity.

As recommended in this report, short-term measures could be implemented to improve how the MMM is applied in aged care and address known anomalies with MM categories for certain locations. However, these changes are not expected to fully address broader stakeholders concerns about whether current funding adequately matches the costs for RRR areas.

In addition, as discussed in the last section of this report, other approaches beyond the MMM in isolation could be considered to determine whether a more nuanced approach to targeting intervention in under-service markets can be adopted.

Approaches to address entrenched service delivery challenges in RRR communities cannot be considered in isolation. They must also be informed by improved information about the unit costs for service delivery in RRR areas and consider options for broader care sector harmonisation as is reflected in Recommendation 14 below.

Several mainstream funding and thin market reviews are already underway to explore the cost of service delivery and determine whether further adjustments to aged care policy settings are required – both at a sector level, and to accommodate specific challenges in under-serviced markets. This includes funding model reviews of the MPSP⁴¹ and NATSIFACP, the Accommodation pricing review⁴² for residential care and the residential care thin markets review; alongside regular annual pricing reviews of AN-ACC and the new Support at Home program – with the Aged Care Taskforce recognising that:

"IHACPA should continue to review the appropriateness of its pricing in rural and remote areas so the cost of providing services in these areas is accurately reflected in its pricing recommendations."

(Final report of the Aged Care Taskforce, pg. 37)

Moving forward, it is critical these reviews, alongside other new and ongoing initiatives to support innovative and integrated service delivery in underserved markets, continue in close coordination and take a system wide approach.

Relevant findings must also then be brought together to inform further adjustments to policy settings to improve support for all older people in RRR areas, recognising those with specialist needs can face challenges accessing services outside metropolitan areas.

The proposed new [RRR aged care policy framework](#) is anticipated to be the vehicle to do this, ensuring a more coordinated and transparent approach to intervention in under-serviced markets. This new framework also recognises that, as with the MMM itself, aged care policy settings cannot remain static. They need to be regularly reviewed and adjusted overtime. This is important to ensure they effectively, efficiently, and equitably address both existing and emerging challenges impacting RRR service delivery.

Public consultation on a draft policy framework, informed by the consultations of this review and other engagement to date, will be undertaken in the first half of 2026. A revised framework and work plan will then be finalised for publication later in 2026. This is expected to include projects recommended to progress following this review.

⁴¹ Department of Health, Disability and Ageing (2025). [Multi-Purpose Service Program Funding Model Review](#), DHDA website. Accessed 5 December 2025.

⁴² Department of Health, Disability and Ageing (2025). [Residential Aged Care Accommodation Pricing Review](#), DHDA website. Accessed 5 December 2025.

Recommendation 14:

Consistent with the recommendations of the Aged Care Taskforce, and in parallel with thin markets and accommodation pricing review work underway, continue to:

- consider the appropriateness of policy settings, beyond the MMM, that impact funding available to deliver aged care services in thin markets
- consider further alignment of policy settings across the care sector to incentivise cross-sector diversification of home care service delivery and reduce compliance costs
- work with IHACPA to ensure pricing advice in rural and remote areas continues to accurately reflect the costs of service delivery in thin market areas.

Recommendation 15:

Following the completion of existing thin markets reviews and relevant inquiries into Support at Home implementation, consider whether further adjustments are required to ensure streamlined and evidence-based interventions in thin markets. Any such adjustments should consider options to support broader harmonisation efforts across the care and support sector where appropriate.

Appendix 1: Profile of in-person consultation locations

Demographic data (2021 Census) ⁴³	St Helens, Tas	Whyalla, SA	Port Augusta, SA	Mildura, Vic	Bowen, Qld	Katherine, NT	Kalgoorlie, WA	Broken Hill, NSW
LGA	Break O'Day	City of Whyalla	City of Port Augusta	Rural City of Mildura	Whitsunday Regional Council	Katherine Town Council	City of Kalgoorlie-Boulder	The City of Broken Hill
MMM category	MM 5	MM 3	MM 4	MM 3	MM 4	MM 6	MM 3	MM 3
Population								
<i>Total</i>	6,770	21, 244	13,829	56,972	37,152	9,643	29,306	17,588
<i>All people 65+</i>	2,138 (31%)	4,013 (18%)	2,452 (17%)	11,168 (19%)	6,257 (16%)	855 (8%)	2,660 (9%)	4,079 (23%)
<i>Aboriginal & Torres Strait Islander persons 50+</i>	88 (1%)	206 (0.9%)	593 (4%)	397 (0.6%)	438 (1%)	481 (4%)	404 (1%)	296 (1%)
<i>All people 65+ with need for assistance with core activities</i>	343 (16%)	802 (20%)	450 (18%)	2,311 (21%)	984 (16%)	122 (14%)	395 (15%)	787 (19%)
Median age	56	41	38	40	40	33	34	44
SEIFA quintile ⁴⁴	1	1	1	2	3	2	4	1
Next major service centre (road distance + travel time) ⁴⁵	Launceston ⁴⁶ (165km, 2.5hrs)	Adelaide (385km,4hrs)	Adelaide (308km, 3.5hrs)	Melbourne (542km, 6hrs)	Townsville/ Mackay ⁴⁷ (200km, 2.5hrs)	Darwin (316km, 3 hrs)	Perth (593km, 6.6hrs)	Adelaide (517km, 5.5hrs)
# of residential aged care homes	1	2	2	4	2	2	2	3
Main industry	Accommodation & Food Services	Manufacturing	Health care & Social Assistance	Health care & Agriculture	Accommodation & Mining	Defence	Mining	Mining & Health care

⁴³ All data by LGA unless otherwise stated; ABS (n.d.). [2021 Census All persons](#) QuickStats webpage, accessed 2 December 2025.

⁴⁴ Based on Index of Relative Socio-economic Disadvantage (IRSD) (2021); quintile 1 = most disadvantaged up to quintile 5= least disadvantaged.

⁴⁵ Based on information collected from stakeholder consultations.

⁴⁶ Note: Stakeholders reported specialist or complex care needed to be sought from Hobart and Melbourne.

⁴⁷ Approximate – both locations are services centres and equidistant from Bowen.

Appendix 2: RRR aged care statistics

The following statistics have been obtained from departmental information systems and records for 2024-2025.

Additional data, report, and information can be accessed on the GEN Aged Care Data website.⁴⁸

Table 3: Total population by MM category

	MM 1	MM 2	MM 3	MM4	MM 5	MM 6	MM7	Total
Total population	19,759,047	2,532,073	1,712,559	1,032,480	1,848,755	296,487	205,951	27,387,352
Total population 65+	3,308,833	460,863	368,758	244,188	458,276	45,257	22,004	4,908,179
Proportion of people 65+ of total population	16.70%	18.20%	21.50%	23.70%	24.80%	15.30%	10.70%	17.9%
ABS remoteness classifications - 2021 ASGS	Major Cities	Inner Regional & Outer Regional				Remote & Very Remote		
Total First Nations population	439,977	465,342			153,866			1,059,185
Total First Nations people over 50	72,757	92,627			31,980			192,198
Total First Nations people aged 50 to 64	49,037	59,439			22,409			129,243
Total aged 65+ plus First Nations people aged 50-64	3,357,870	1,591,524			89,670			5,039,189
Proportion of First Nations people aged 50+ of Total population aged 65+ plus First Nations people aged 50-64	2.2%	5.8%			35.7%			3.8%

⁴⁸ <https://www.gen-agedcaredata.gov.au/>

Table 4: Total population over 65 years by state, territory, and MM category

State	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6	MM 7	Total
NSW	1,077,001	42,756	183,906	106,925	152,996	5,834	1,015	1,570,858
VIC	874,376	92,704	68,851	74,856	107,126	979	-	1,218,904
QLD	609,169	203,746	30,541	42,041	93,822	11,750	7,897	999,018
WA	409,097	20,452	24,721	4,878	28,462	8,889	5,153	501,675
SA	270,791	8,365	38,951	14,598	47,684	9,426	4,034	393,888
TAS	-	75,859	21,787	889	27,657	2,793	717	129,810
ACT	68,398	86	-	-	4	-	-	68,488
NT	-	16,895	-	-	526	5,587	3,188	26,211
Total	3,308,832	460,863	368,757	244,187	458,277	5,587	22,004	4,908,852

Table 5: Number of providers delivering services by MM category

MM category	Residential care	Home care	CHSP	MPSP	NATSIFACP	Total
MM 1	498	701	773	-	6	1,978
MM 2	106	123	116	-	3	348
MM 3	128	126	111	-	1	366
MM 4	115	82	102	-	1	300
MM 5	177	107	149	22	2	457
MM 6	20	32	36	8	6	102
MM 7	6	31	39	10	19	105

*Note: Providers are reported against each MM category for which they had one or more operational service as at 30 June 2025, based on the physical location of the service. Some providers may be counted more than once. CHSP providers are reported based on the physical location of the Provider.

Table 6: Service locations by aged care program and MM category

Program	MM 1	MM 2	MM 3	MM 4	MM 5	MM6	MM 7	Total
Residential	1,660	204	229	178	286	25	8	2,590
Home Care	1,559	213	279	108	125	40	39	2,363
CHSP	2,099	344	353	260	362	105	115	3,638
MPSP	0	0	0	0	113	40	30	183
NATSIFACP	7	3	1	1	2	7	26	47
Total	5,325	764	862	547	888	217	218	8,821

Note: This table reflects the physical locations where services are delivered and can include a residential care home, a service delivery branch, or an 'outlet' where CHSP or NATISFAC home care is delivered.

Table 7: Number of older people accessing services by aged care program and MM category

Service type	MM 1	MM 2	MM 3	MM 4	MM 5	MM 6	MM 7	Total
Residential - permanent	139,345	17,040	17,103	11,154	10,646	814	211	196,313
Residential – respite	57,892	6,100	8,127	5,406	5,650	381	90	82,388
Home Care	217,529	25,534	28,930	11,268	8,277	1,370	2,003	292,911
CHSP	521,374	89,451	73,103	49,741	85,373	9,932	5,304	838,694
MPSP – residential	-	-	-	-	2,859	710	596	4,165
MPSP – home care	-	-	-	-	640	17	123	780
NATSIFACP	720	0	40	27	12	153	1,035	1,987

Note: Total includes 168 clients from Other Territories and 4,330 recipients with unknown location. Based on the physical location of the recipients. 4,416 CHSP clients did not have a geo-coded address. These have been included in the grand total (816,132) but are not shown.

For residential respite care recipients – recipients may be counted more than once if a person changes MM or state/territory throughout the financial year. Clients may move from one state/territory to another, or move MM, during the year. They are counted once against each state/territory and/or MMM, leading to some duplication.

The national total is a distinct count and will better account for instances where there are duplicate recipients who changed location during the financial year.

Appendix 3: All programs applying the MMM

Agency/sector	Program/Policy	MM range
DHDA Aged care	1. 24/7 RN supplement	MM 1 – 7
	2. Aged Care Capital Assistance Program (ACCAP)	MM 2 – 7
	3. Aged care surge workforce support	MM 3 – 7
	4. AN-ACC funding – residential aged care	MM 1 – 7
	5. AN-ACC Transition Fund Grant	MM 3, 6, & 7
	6. Assistive Technology and Home Modifications Scheme (AT-HM)	MM 6 – 7
	7. Commonwealth Home Support Program (CHSP)	MM 5 – 7
	8. Disability Support for Older Australians Program (DSOA)	MM 6 – 7
	9. Exemption from the 24/7 RN requirement	MM 5 – 7
	10. General Practice in Aged Care Incentive (GPACI)	MM 3 – 7
	11. Market Adjustment Program (MAP)	MM 2 – 7
	12. Multi-Purpose Service Program (MPSP)	MM 5 – 7
	13. Places to people	MM 5 – 7
	14. Regional, Rural and Remote Home Care Workforce Support Program	MM 3 – 7
	15. Rural Health Multidisciplinary Training Program (RHMT) – Aged Care	MM 2 – 7
	16. Rural Locum Assistance Program for Aged Care (Rural LAP Aged Care)	MM 4 – 7
	17. Rural, Remote and First Nations Aged Care Service Development Assistance Panel (SDAP)	MM 4 – 7
	18. Specialist verification	MM 3 – 7
	19. Support at Home Thin Markets Grants	MM 3 – 7
	20. Care minutes supplement for residential aged care	MM 1
	21. Uplift funding for NATSIFAC residential services in MM 7	MM 7

Agency/sector	Program/Policy	MM range
DHDA Health / primary care	22. Advanced Skills Training (AST) Posts Rural Generalists (RGs) and General Practitioners (GPs) Program (AST Program)	MM 2 – 7
	23. Australian General Practice Training Aboriginal and Torres Strait Islander Salary Support Program	MM 1 – 7
	24. Australian General Practice Training Program (AGPT)	MM 1 – 7
	25. Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) initiative (Better Access)	MM 1 – 7
	26. Bonded Medical Places Scheme	MM 2 – 7
	27. Bonded Medical Program	MM 2 – 7
	28. Council of Australian Governments (COAG) Section 19(2) Exemption Initiative - Improving Access to Primary Care in Rural and Remote Areas	MM 5 – 7
	29. Election Commitment 2022 (to reinstate a 50% MBS loading for rural and regional telehealth psychiatry consultations)	MM 2 – 7
	30. Emergency Locum Service (ELS) Program	MM 3 – 7
	31. Exemption to subsection 19(2) of the Health Insurance Act 1973 for GPs at regional and remote headspace services (headspace s19(2) Initiative)	MM 2 – 7
	32. Eye and Ear Surgical Support Program (EESS)	MM 3 – 7
	33. Federation Funding Agreement (FFA) on Public Dental Services for Adults	MM 5 – 7
	34. First Nations Health Worker Traineeship Program	MM 1 – 7
	35. Flexible Approach to Training in Extended Settings	MM 2 – 7
	36. GP Procedural Training Support Program (GPPTSP)	MM 3 – 7
	37. Health Workforce Scholarship Program (HWSP)	MM 1 – 7
	38. HealthDirect After Hours GP Helpline Services	MM 2 – 7
	39. Healthy Ears – Better Hearing Better Listening (Healthy Ears) Program	MM 2 – 7
	40. Hearing Services Program Community Service Obligations	MM 6 – 7
	41. HELP for Rural Doctors and Nurse Practitioners	MM 3 – 7
42. Home Medicines Review – Rural Loading Allowance (HMR-RLA)	MM 3 – 7	

Agency/sector	Program/Policy	MM range
	43. Indigenous Health Scholarship Program (IHSP)	MM 1 – 7
	44. Indigenous Health Workforce Traineeship (IHWT) Program	MM 1 – 7
	45. Innovative Models of Collaborative Care (IMoC) Program	MM 3 – 7
	46. Intern Incentive Allowance for Rural Pharmacies – Extension Program (IIARP-EP)	MM 5 – 7
	47. Intern Incentive Allowance for Rural Pharmacies (IIARP) Program	MM 3 – 7
	48. John Flynn Prevocational Doctor Program	MM 2 – 7
	49. Lowitja Foundation Nursing Scholarships	MM 1 – 7
	50. Medical Outreach Indigenous Chronic Disease Program (MOICDP)	MM 1 – 7
	51. Medicare Benefits Schedule	MM 1 – 7
	52. Medicare Equipment Eligibility Requirements for Magnetic Resonance Imaging (MRI)	MM 1 – 7
	53. Murray-Darling Medical School Network (MDMSN)	MM 2 – 7
	54. National Bowel Cancer Screening Program	MM 1 – 7
	55. National Nurse Clinical Placement Program (NNCPP)	MM 1 – 7
	56. Nursing in Primary Health Care (NiPHC) program	MM 1 – 7
	57. Outcome 2, Program 2.4 Private Health Insurance, administered expenses	MM 1 – 7
	58. Pre-Fellowship Program (PFP)	MM 1 – 7
	59. Premium Support Scheme	MM 3 – 7
	60. Primary Care Nursing and Midwifery Scholarship Program (PCNMWSP)	MM 3 – 7
	61. Primary Care Workforce Support Program (PCWSP)	MM 1 – 7
	62. Primary Health Network Program: Primary Mental Health Care flexible funding pool	MM 1 – 7
	63. Primary Health Networks	MM 1 – 7
	64. Private Hospital Stream (PHS)	MM 2 – 7
	65. Psychiatry Workforce Program	MM 2 – 7
	66. Puggy Hunter Memorial Scholarship Scheme (PHMSS)	MM 1 – 7
	67. Regional Pharmacy Maintenance Allowance (RPMA)	MM 3 – 7

Agency/sector	Program/Policy	MM range
	68. Remote Northern Territory Locum Program (RNTLP) (Formerly the Remote Area Health Corps (RAHC))	MM 2 – 7
	69. Remote Vocational Training Scheme (RVTS)	MM 2 – 7
	70. Rural Bulk Billing Incentive	MM 2 – 7
	71. Rural Continuing Professional Education (CPE) Allowance	MM 3 – 7
	72. Rural Health Multidisciplinary Training (RHMT) Program	MM 2 – 7
	73. Rural Health Outreach Fund (RHOF)	MM 3 – 7
	74. Rural Intern Training Allowance (RITA)	MM 3 – 7
	75. Rural Locum Assistance Program (RLAP)	MM 2 – 7
	76. Rural Pharmacy Scholarship Mentor Scheme (RPSMS)	MM 3 – 7
	77. Rural Pharmacy Scholarship Scheme (RPSS)	MM 3 – 7
	78. Rural Pharmacy Student Placement Allowance (RPSPA)	MM 3 – 7
	79. Rural Procedural Grants Program (RPGP)	MM 3 – 7
	80. Single Employer Model (SEM) Trials	MM 2 – 7
	81. Specialist Training Program	MM 2 – 7
82. Support for Rural Specialists in Australia	MM 2 – 7	
83. Supporting Provisional Psychologists to Practice	MM 3 – 7	
84. Visiting Optometrists Scheme (VOS)	MM 1 – 7	
	85. Workforce Incentive Program - Practice stream	MM 1 – 7
	86. Workforce Incentive Program (WIP) – Doctor Stream	MM 3 – 7
	87. Workforce Incentive Program (WIP) – Rural Advanced Skills	MM 3 – 7
Pharmacy Programs Administrator	88. Rural Pharmacy Maintenance allowance	MM 3 – 7
Department of Veteran Affairs	89. Incentive payments for General Practitioners	MM 1 – 7
	90. Community Nursing Providers	MM 4 – 7

Agency/sector	Program/Policy	MM range
Aged Care Quality and Safety Commission (ACQSC)	91. Reduced fees for new providers	MM 6 – 7
Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts	92. Regional Arts Fund	MM 2 – 7

Appendix 4: Aged care programs applying the MMM

The following is a list of aged programs currently applying the MMM as at 10 December 2025.

Program name	Program/policy description	Aged care setting	Target group	Application ⁴⁹	MMM locations
24/7 RN supplement	Provides financial support to RACHs with 50 or fewer residents, that report at least 87.5% RN coverage (current threshold), to cover the gap in the costs of RN labour for the MM location of the RACH. Supplements funding not met through AN-ACC funding, to enable the service to provide 24/7 RN coverage. This helps providers to meet the regulatory requirement to ensure at least one RN is onsite and on duty at all times. The amount received by each RACH is based on the MM location and is paid on a sliding scale, with the supplement decreasing as the number of occupied bed days claimed in the reporting month increases. Smaller RACHs with 30 or fewer residents that report at least 50%, but less than 87.5% RN coverage, receives half of the standard supplement rate.	Residential	Providers	A	MM 1 – 7
Aged Care Capital Assistance Program (ACCAP)	Ongoing infrastructure grants program which aims to increase access to quality aged care services in thin market settings. Eligibility for funding opportunities is determined on a round-by-round basis which, in some cases, will be based on MMM geographies.	Various	Providers	B	MM 2 – 7
Aged care surge workforce support	Provided temporary surge workforce support to eligible RACHs in MM 3 – MM 7 that are impacted by COVID-19. The program ceased on 31 December 2025.	Residential	Providers	D	MM 3 – 7
AN-ACC funding – residential aged care	RACHs automatically receive a BCT category based on their MM category. BCT funding for standard and specialised Indigenous services in MM 6 - MM 7 locations are also paid per operational bed rather than per occupied bed (i.e., paid regardless of whether a bed is occupied).	Residential	Providers	A	MM 1 – 7

⁴⁹ Categories: A – funding support, B – eligibility for additional support, C – workforce distribution or development, D – policy setting only (no additional funding)

Program name	Program/policy description	Aged care setting	Target group	Application ⁴⁹	MMM locations
AN-ACC Transition Fund Grant (2023-24, 2024-25 & 2025-26)	The purpose of the grant is to provide targeted temporary support for a small number of RACHs with specific characteristics that do not align with existing BCT settings under the current AN-ACC funding model.	Residential	Providers	A	MM 3 – 7
Assistive Technology and Home Modifications Scheme	The national AT-HM Scheme provides upfront funding for Support at Home recipients to access needed Assistive Technology and/or Home Modifications to live safely in their home. A remote supplement is available to participants who reside in MM 6 - 7. The amount of the remote supplement is 50% of the assigned assistive technology and/or home modifications funding tier.	Home care	Older people	A	MM 6 – 7
Commonwealth Home Support Program (CHSP)	If a CHSP provider can substantiate more than 50% delivery in MM 5 - 7 they are eligible to request a 'loading' of up to 40%. This loading manifests in a reduction of target outputs - i.e. their funding is for comparatively less services, in recognition of higher costs in regional and remote.	Home care	Providers	A	MM 5 – 7
Disability Support for Older Australians Program (DSOA)	Supports older people who cannot be supported by the in-home aged care system and were not eligible for the NDIS when it was rolled out. The program does not accept new clients. The program replaced the Commonwealth Continuity of Support Programme. There is a higher rate for DSOA services that are delivered in remote and very remote areas. DSOA's regional loading adopts the equivalent NDIS 'very remote' rate. DSOA service coordinators can claim 30 minutes in MM 1 – 3 and 60 minutes in MM 4 – 5 for travel to each client.	Various	Older people	A	MM 6 – 7
Exemption from the 24/7 RN requirement	The program helps RACHs affected by high staff turnover, sudden departures of staff, or when staff take leave or undertake continuing professional development. It allows eligible RACHs in MM 5-7 to be exempt from the 24/7 RN requirement. The RACH must also have no more than 30 operational places on the day the decision about the exemption is made and have taken reasonable steps to ensure the care needs of the residents will be met during the exemption period.	Residential	Providers	C	MM 5 – 7

Program name	Program/policy description	Aged care setting	Target group	Application ⁴⁹	MMM locations
General Practice in Aged Care Incentive ⁵⁰	Rural loadings will apply to the responsible GP and practice incentive payments for MM 3 – 7. Primary care providers and practices registered in MyMedicare can receive incentive payments for providing their MyMedicare registered patients who permanently live in RACHs with care planning services and regular visits.	Residential	Providers	B	MM 3 – 7
Home Care viability supplement ⁵¹	The supplement for home care providers delivering services in rural and remote locations (MM 4 – 7). Eligibility was determined by the location the person received their home care services based on the MMM 2015.	Home care	Older people	B	MM 4 – 7
Market Adjustment Program	Funding for RACHs and Support at Home providers facing viability risk, designed to reduce the risk of disorderly closure or financial failure and ensure continuity of care for care recipients. Applications are by invitation only, with prioritisation given to providers located in MM 2 - 7, as these regions face higher risks. Providers in MM 1 are generally not prioritised unless exceptional circumstances exist.	Various	Providers	B	MM 2 – 7
Multi-Purpose Service Program	Provides integrated health and aged care services for older people living in small communities in RRR areas.	Various	Providers	A	MM 5 – 7
Places to people	Place allocation is prioritised for older people living in MM 5 - 7 areas who are approved for residential care from 1 November 2025. Note these categories have no practical impact unless the new prioritisation mechanism for residential care is switched on. Not applicable to MPSP or NATSIFACP as places are allocated to providers for these programs.	Residential	Older people	B	MM 5 – 7
Regional, Rural and Remote Home Care Workforce Support Program	Building the home care workforce in RRR areas where workforce shortages are the most acute and will allow for an additional 4,000 PCWs to be engaged in these regions. Eligible regions must be in an SA3 region/s in MM 3 – 7 where there is a market for home care services and workforce shortages in the home care sector.	Home care	Workforce	D	MM 3 – 7

⁵⁰ Primary care program directly relevant to aged care settings.

⁵¹ Home care ceased on 1 November with the introduction of the Act but has been included as it was a key program applying the MMM.

Program name	Program/policy description	Aged care setting	Target group	Application ⁴⁹	MMM locations
Rural Health Multidisciplinary Training Program (RHMT) – aged care stream	Offers health students the opportunity to train in rural and remote communities via a network of training facilities to Improve geographic distribution of the health workforce through the delivery of positive and immersive rural training experiences. The expansion of the RHMT in Aged Care Services grant opportunity offers clinical training for allied health and nursing students in aged care settings MM 2-7 locations in the NT, VIC, NSW, SA, WA, TAS, and QLD. Commonwealth funding is provided to universities to deliver the program.	Various	Workforce	D	MM 2 – 7
Rural Locum Assistance Program for Aged Care (Rural LAP Aged Care)	Provides access to a temporary locum workforce, incentives for permanent relocation payments and annual retention bonuses, for aged care providers. Support is available for home care, RACHs, MPSP and NATSIFAC services located in MM 4 –7 and CHSP services located in MM 6-7.	Various	Providers	D	MM 4 – 7
Rural, Remote and First Nations Aged Care Service Development Assistance Panel (SDAP)	SDAP provides free professional support to aged care service providers located in MM 4 –7 areas or who provide care to First Nations peoples. It aims to help providers in 3 main areas – provider capacity and support, sector development and infrastructure project management.	Various	Providers	A	MM 4 – 7
Specialist verification	Aims to help older people to find aged care providers who are verified as providing specialised services. Tier 1: Outlet is located in, or provides services, to older people in a rural (MM 3 - 5) or remote (MM 6 - 7) area Tier 2: There are established connections and regular engagement between the outlet and local government, local health service(s) or other local organisation(s) which assists people who live in rural and remote areas, and at least half of outlet staff live in these areas (MM 3 - 7).	Various	Older people	C	MM 3 – 7
Support at Home Thin Markets Grants	The grants provide flexible funding to eligible Support at Home providers in thin markets, to support service delivery and help set reasonable prices for services.	Home care	Providers	A	MM 3 – 7
Uplift funding for NATSIFAC residential services in MM 7	Additional funding for NATSIFACP residential services in MM 7 locations to meet the higher costs of delivering culturally safe aged care in remote locations.	Various	Providers	A	MM 7



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