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## RIVERINA

# Response to Senator Anadah-Rajah’s question on notice: Modified Monash Model - does it help or hamper attraction and retention of doctors regionally?

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## Summary

*“MMM is essential for targeting rural incentives and workforce programs, but when it’s used as a hard eligibility cutoff, it can misalign with real service demand and create ‘cliff-edge’ impacts for communities like the Riverina.”*

## Response

The Modified Monash Model (MMM) is a key national classification used to define the rurality of locations (MM1–MM7) based on remoteness and population size, and it underpins a wide range of Australian Government workforce policies, including financial incentives, workforce programs and eligibility requirements.

In the Riverina, MMM plays a direct role in shaping both the **financial viability of practices** and the **ability to recruit doctors**, particularly for locations outside major centres.

### 1. How MMM helps attraction and retention

#### (a) Targeting financial incentives to rural locations

MMM enables higher levels of support for more rural and remote areas. For example:

- **Medicare Rural Bulk Billing Incentives increase with remoteness based on MMM classification**, improving practice viability.
- Programs such as the **Workforce Incentive Program (WIP)** provide payments and rural loadings, including additional support in MM3–MM7 locations.

#### Examples in the Riverina:

- **Hay (MM5/6-type context)** and **Temora (MM4–MM5 context)** benefit from stronger financial incentives due to their higher MMM classification. This improves their ability to offer competitive packages and retain GPs.
- **Tumut** similarly benefits from access to rural loadings and incentives that support multidisciplinary team models under WIP.

This graduated approach is important in offsetting:

- smaller patient bases
- higher operating costs
- recruitment challenges

### (b) Enabling access to a broader workforce (IMGs and bonded doctors)

MMM is closely linked to the **Distribution Priority Area (DPA)** system, which determines where doctors with Medicare restrictions can work.

- The Department states that **MMM boundaries are used in DPA classification** and that **MM2–MM7 locations are generally eligible for DPA status**.
- DPA status is critical because **International Medical Graduates must work in these areas to access Medicare**, and it is also used for **bonded doctor return-of-service obligations**.

#### Examples in the Riverina:

- **Temora, Hay, and Tumut** benefit from this linkage, as their MMM classification supports DPA eligibility, allowing access to a wider recruitment pool.
- This can be the difference between a practice remaining open or closing, particularly in smaller communities.

## 2. How MMM can hamper attraction and retention

While MMM is essential, its application as a **binary eligibility threshold** can create challenges.

### (a) 'Cliff edge' impacts from classification

Small changes in classification can result in:

- loss of incentives

- loss of eligibility for workforce programs
- reduced ability to recruit restricted doctors

MMM is updated periodically using Census data, and these updates can change eligibility settings.

Stakeholder commentary following recent updates has highlighted that classification changes can significantly alter access to incentives and recruitment pathways.

#### Examples in the Riverina:

- **Wagga Wagga (MM2 regional centre)** can, in some cases, be treated similarly to larger regional centres despite servicing a wide hinterland and experiencing pressure on health services.
- A shift in classification or DPA status can materially affect the viability of practices and their ability to attract doctors.

### (b) MMM does not fully reflect service demand or catchment realities

MMM is based on geography and population size, not:

- patient flow across regions
- travel distances for specialist care
- actual GP-to-population ratios

The DPA system incorporates more detailed factors such as Medicare utilisation and demographics, but MMM still plays a significant gating role.

#### Examples in the Riverina:

- **Griffith**, while a relatively large regional centre, services a significant surrounding agricultural region and seasonal workforce. MMM classification alone may not fully reflect this demand.
- **Wagga Wagga** acts as a major service hub for smaller communities (e.g. Lockhart, Junee, Tumut), but this broader service load is not captured fully by MMM classification.

### (c) Potential misalignment of incentives

Because MMM determines access to incentives across broad geographic categories:

- multiple locations can receive similar incentives despite very different levels of workforce shortage
- more lifestyle-attractive regional centres may compete effectively with smaller or more remote towns

This can dilute the impact of incentives in the communities of highest need.

### (d) Challenges for specialist services covering regional catchments

A further limitation of the Modified Monash Model is its application to specialist services, particularly in regional hubs that deliver care across a much broader catchment than the local population used in classification.

MMM is based on the characteristics of a single geographic location (population size and remoteness), rather than the **functional service catchment** for specialist care. As a result, workforce planning metrics can underestimate actual demand.

#### Example in the Riverina:

- **Wagga Wagga** is classified as a regional centre, but it provides specialist services (such as ophthalmology) to a large surrounding region.
- Workforce assessments and position allocations (including Area of Need positions) are often based on the **resident population of Wagga Wagga alone**, rather than the **regional population it services**.
- This can lead to **under-allocation of specialist positions**, even where demand is clearly higher, effectively constraining recruitment and retention.

This issue highlights that while MMM is useful for defining rurality, it does not adequately capture:

- cross-regional patient flows
- specialist service hubs
- true doctor-to-population ratios at a service level

### 3. Overall assessment

The Modified Monash Model is a **necessary and valuable tool** for:

- consistently defining rurality
- targeting national workforce incentives
- supporting access to restricted workforce cohorts

However, in practice, its use as a **primary eligibility gate** means that:

- small classification differences can have disproportionately large impacts
- it does not always align with real-world service demand and workforce shortages
- it can create unintended competitive effects within regions

### 4. Suggested improvements

Based on the Riverina experience, improvements could include:

- **Retain MMM as the base rurality measure**, but avoid reliance on it as a sole determinant
- **Strengthen complementary measures** (e.g. functional service catchments, service demand, vacancy data, patient flows) in program eligibility
- **Improve transition arrangements** when MMM classifications change, to avoid sudden loss of support
- **Enhance flexibility mechanisms**, including DPA review processes, where classifications do not reflect local realities