

**Submission  
No 26**

**HEALTH SERVICES AMENDMENT (SPLITTING OF THE MURRUMBIDGEE  
LOCAL HEALTH DISTRICT) BILL 2025**

**Organisation:** Country Women's Association

**Date Received:** 15 December 2025



Monday 15 December 2025

Mr Clayton Barr (MP)  
Committee Chair  
Inquiry into Health Services Amendment (Splitting of the  
Murrumbidgee Local Health District) Bill 2025  
Legislative Committee on Community Services  
NSW Parliament House  
6 Macquarie Street  
Sydney NSW 2000

**RE: Inquiry into Health Services Amendment (Splitting of the Murrumbidgee Local Health District) Bill 2025**

The Country Women's Association (CWA) of New South Wales (NSW) is the state's largest women's rural issues advocacy group with well over 8000 members and close to 400 branches across NSW. There is no other rural, regional, remote member-based organisation that has the breadth and depth of membership on matters affecting country people.

The CWA of NSW aims to improve conditions for country women, children, and families by advocating for its members, helping local communities, creating a network of support and meeting together in towns and cities across NSW.

**CWA OF NSW POLICY PRIORITIES: HEALTH**

The CWA of NSW has a longstanding commitment to advocating for improved health outcomes in regional, rural, and remote NSW. The CWA of NSW health policy priorities focus on ensuring accessibility and affordability of healthcare for rural communities and addressing the growing disparity in health outcomes between rural and metropolitan areas in NSW. The CWA of NSW recognises the urgent need to enhance available health services, including mental health support and family services, particularly in times of emergency.

Families in regional, rural and remote NSW face challenges in accessing and affording healthcare, maintaining their health, and managing the costs of treatment. The ongoing erosion of healthcare services in these areas is a major concern, leaving people feeling marginalised and underserved. The CWA of NSW has consistently highlighted headline problems such as the shortage of General Practitioners (GPs), difficulties in recruiting and retaining specialists, nurses, and allied health professionals, and the downgrading or closure of local hospitals, including birthing and maternity units.

In addition, CWA of NSW continues to advocate for addressing shortages in crucial services such as palliative care, drug and alcohol support, mental health services (including psychological support for those with chronic or terminal illnesses and their families), access to blood products, dental care, and services for domestic and family violence. These gaps in healthcare services pose significant challenges to the well-being and resilience of rural communities and require urgent attention and action from policymakers at all levels of government.

In August 2025, the CWA of NSW formally endorsed the Rural Health Action Plan championed by Independent MP for Wagga Wagga, Dr Joe McGirr, recognising its clear alignment with the needs consistently raised by regional communities. The plan calls for a GP guarantee to ensure every town has access to a doctor supported by flexible, team-based primary care; the restoration of rural maternity services so women can give birth close to home in culturally safe settings; a shift away from costly fly-in locums toward permanent, well-supported local clinical teams; genuine consultation processes that give real power to diverse community voices; an integrated, multidisciplinary model connecting hospitals, GPs, councils and community health providers; and the creation of a dedicated rural health watchdog to drive accountability and uphold culturally safe care.

## **GUIDING PRINCIPLES FOR HEALTH SERVICE STRUCTURES**

The CWA of NSW welcomes the opportunity to respond to the *Inquiry into Health Services Amendment (Splitting of the Murrumbidgee Local Health District, MLHD) Bill 2025 (the Inquiry)*.

This follows our submission to the *Inquiry into Health Services Amendment (Splitting of the Hunter New England Health District) Bill 2025* earlier this year, and similarly does not take a position on the legislative proposal to divide the MLHD, instead, it suggests a set of guiding principles that the Committee should apply when considering structural reform of the MLHD and when making its recommendations. These principles are grounded in the experiences of members and reference past submissions to state and federal health reviews.

### **1. Patients and health workers must be central to change**

The health system exists to serve people—not structures. Any reform to Local Health Districts must prioritise the needs and experiences of both those receiving care and those delivering it.

- Patients must be engaged, informed, and empowered to make decisions about their care.
- Health professionals must be supported with safe working conditions, appropriate training, and incentives to remain in the regions.

Structural reform should not proceed unless it demonstrably improves health outcomes and service access for patients, and addresses workforce wellbeing, retention, and conditions.

### **2. Equity, access and outcomes should be the core metrics of success**

Reform should address the deep and persistent disparities in health outcomes between metropolitan and regional NSW. Data from the CWA of NSW and multiple inquiries consistently show that people in rural and remote areas:

- Have shorter life expectancies.
- Experience higher burdens of disease.
- Face excessive wait times or lack access altogether to essential services like maternity care, oncology, mental health, and dental care.

The CWA of NSW cautions that reshuffling bureaucratic boundaries will not solve these systemic inequities unless accompanied by real, on-the-ground investment in staffing, infrastructure, and culturally appropriate services.

### 3. Reform must be evidence-based, locally informed, and avoid bureaucratic fragmentation

Any changes to the MLHD must:

- Be based on independent evidence that a split will improve service delivery, not just efficiency metrics or political convenience.
- Involve extensive consultation with regional communities, local health workers, and patient advocates.
- Avoid creating new administrative silos or duplicated governance structures that divert funding away from frontline care.

As evidenced at Griffith Base Hospital (details in section 5. following) and other regional health centres, inadequate staffing and reliance on locums are core problems, not merely district size or structure.

### 4. Workforce reform must be central

CWA of NSW members repeatedly report that a shortage of GPs, nurses, specialists, and allied health professionals remain the greatest barrier to accessing timely, quality care. Midwifery-led continuity of care, for example, cannot work without adequate midwife numbers and real investment, not just policy statements. No structural reform can succeed without addressing workforce issues:

- Attraction and retention, including through regional loadings and secure employment conditions.
- Career pathways for rural generalist doctors, nurse practitioners, and midwives.
- Appropriate and competitive remuneration.
- Professional development and support (housing, childcare, schooling) for rural health workers and their families.

### 5. Structural change must be monitored for impact

Despite NSW Health's assurances of progress, the outcomes expected from the 2022 Parliamentary Inquiry into Regional, Rural and Remote Health are not materialising on the ground. For example: Recommendation 26 called for the statewide rollout of gold-standard midwifery continuity-of-care models to improve safety, quality and maternal outcomes for women outside metropolitan areas. NSW Health reports this recommendation as "completed" in its June 2024 Progress Update. Yet across regional NSW, women continue to face the same barriers the Inquiry highlighted three years ago unsafe travel distances, inconsistent care, and thinning clinical capacity. Far from demonstrating continuity of care, many women are instead navigating fragmented services or being displaced entirely from their communities to access basic maternity support.

Members in the Griffith region report a sustained and worsening shortage of qualified midwives within the Griffith Base Hospital maternity unit, a unit responsible for antenatal, birthing, postnatal and special-care services across an enormous footprint including Griffith, Hay, Leeton, Narrandera, Hillston, Lake Cargelligo, Cobar and several smaller communities. For years the service has been chronically understaffed and allegedly, there have been multiple occasions where just one midwife has been rostered to cover the full spectrum of maternity care, raising serious concerns about safety, workload, fatigue, and the ability to respond to emergencies across such a broad catchment.

In response, the Murrumbidgee Local Health District has acknowledged "staffing challenges" and noted its reliance on agency and casual midwives to keep the service operational. While this stop-gap approach may keep doors open, it falls well short of what Recommendation 26 envisioned. A high-turnover mix of temporary staff does not—and cannot, provide the relational continuity, stability, and trust that continuity-of-care models require. The lived reality for women in Griffith and surrounding towns bears no resemblance

to a “completed” recommendation. Instead, it reflects a system still dependent on patchwork solutions rather than the sustained, reliable maternity care regional communities were promised.

CWA of NSW has witnessed multiple government commitments on rural health that have amounted to promises without delivery. It is critical that any reform to the MLHD is tied to:

- Clear performance indicators focused on health outcomes, not just service throughput.
- Public reporting and accountability mechanisms.
- Regular review cycles involving local communities.

## CONCLUSION

The CWA of NSW urges the NSW Legislative Committee on Social Services to use this Inquiry as an opportunity to ensure that structural reform in the health system must be about people, not just boundaries. Splitting a Local Health District must not become a distraction from addressing the real crises in regional, rural and remote healthcare: critical workforce shortages, lack of maternity and specialist services, poor infrastructure, and deeply inequitable health outcomes.



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