

**Submission
No 35**

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

Organisation: Murrumbidgee Local Health District

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Health Services Amendment

Splitting of the Murrumbidgee Local Health District Bill to Parliament 2025

Submission by the Murrumbidgee Local Health District (November 2025)



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Introduction

The Health Services Amendment (Splitting of the Murrumbidgee Local Health District) Bill 2025 proposes to amend the *Health Services Act 1997* and divide the existing Murrumbidgee Local Health District into two separate entities: Murrumbidgee Local Health District (the district) and a new Western Riverina Local Health District.

Murrumbidgee Local Health District (MLHD) acknowledges the intention to improve local responsiveness to the health needs of western sector communities. However, this submission demonstrates that splitting the district, even with the best of intentions, would create significant and avoidable risks.

While the Bill aims to improve responsiveness for communities in the western sector, a structural separation of the existing boundaries would expose both the proposed Western Riverina LHD and the remaining Murrumbidgee LHD to significant system wide risks. These risks extend well beyond governance and financial sustainability; affecting clinical service capability, workforce stability and the capacity to progress reform needed to future proof healthcare in regional, rural and remote NSW.

Independent evidence supports the stability and effectiveness of the existing NSW local health district structure. In 2024, the Special Commission of Inquiry into Healthcare Funding conducted extensive consultation across NSW, including the MLHD. Its final report did not recommend changes to local health district boundaries. Instead, it emphasised the importance of strengthening governance, coordination and partnerships within existing frameworks to maintain equity, integration and sustainability across the health system.¹

The core challenge in the western sector is not the decision-making structure, but the rapidly changing landscape of healthcare. Demographic shifts, rising chronic disease, lifestyle-related pressures, and advances in contemporary medicine are reshaping how services must be delivered across rural communities. Rural settings are also shaped by housing availability, partner employment, schooling, community connectedness and perceptions of professional value, factors largely outside the control of the district.

More recent pressures, including a shrinking rural health workforce and reduced access to primary care, have intensified community concern about the sustainability of local services. Despite these pressures, MLHD has maintained a network of 31 hospital emergency departments (EDs) operating 24/7 to fill primary-care gaps, supported by virtual care that provides continuous medical coverage and mental-health assessment. These EDs now function as the default primary-care provider after hours and, increasingly, during business hours when no general practitioner is available.

MLHD operates as a coordinated network of hospitals and services, with Griffith Base Hospital acting as the specialist acute centre for the western sector. All regional base hospitals rely on strong clinical networks and established partnerships with referral and tertiary hospitals to ensure safe escalation for patients who require highly specialised, interdisciplinary clinical care.

Despite good intentions creating a new decision-making structure, with a duplicated board, executive and corporate and clinical systems, will not improve patient care or outcomes. Instead, it would increase costs, divert funding from frontline services, and weaken the clinical networks that safeguard patient safety.

Splitting the MLHD would destabilise services without addressing the real issues: workforce shortages, service gaps and increasing population complexity. The focus should remain on strengthening the existing integrated model and building on the systems, partnerships and workforce programs already in place.

MLHD is committed to working with clinicians and communities to deliver sustainable, high-quality, locally responsive care across the western sector.

¹ R. Beasley. *Special Commission of Inquiry into Healthcare Funding*. (2025, NSW Government).

1. About the region

Murrumbidgee Local Health District (MLHD) delivers public health services to a population of over 250,000 people living in regional, rural and remote communities across 126,000 square kilometres. The health service is the largest employer in the region, with over 5,500 employees.

MLHD works in close partnership with community organisations, primary care providers, specialist networks, and state and national health agencies to improve health outcomes and respond to the health needs of its communities.

Services are designed to be culturally safe, inclusive and responsive to the needs of all communities, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and people with complex health needs.

TMLHD's footprint covers the traditional lands of the Wiradjuri, Wamba Wamba/Wemba Wemba, Perrepa Perrepa, Yorta Yorta, Nari Nari and Muthi Muthi nations.

1.1. Facilities and services within Murrumbidgee Local Health District

MLHD's network of facilities and programs enables equitable access to health services across one of the largest rural and regional footprints in NSW. This includes:

- 2 base hospitals
- 8 district hospitals
- 2 community hospitals
- 19 Multipurpose services (MPS)
- 1 dedicated mental health inpatient facility
- 12 community health centres
- 2 Mercy Care public hospitals
- 1 brain injury rehabilitation service

A map of the MLHD and its facilities is provided at Appendix A.

1.2. The population in the western sector is aging and experiences a higher burden of chronic disease

Approximately 78,000 people live within the western sector, accounting for around 31% of the district's total population.² The region's demographic profile creates a distinctive set of challenges for health service planning, delivery and sustainability. These characteristics are amplified by rurality, socioeconomic disadvantage and an ageing population. Together, these demographic complexities require an integrated approach from acute, primary and social care providers.³

MLHD has developed coordinated prevention, early intervention and chronic disease programs delivered in collaboration with primary care, local government and community organisations. In many parts of the western sector, limited availability of primary care services has necessitated MLHD to deliver services that, in larger centres, sit within the primary care sector. These programs rely on district-wide clinical pathways that allow expertise and resources to be deployed across multiple sites. A single, integrated district structure provides the scale and coordination required to sustain these services and ensure communities receive timely and reliable care.

Features of the demographic profile include:

² Public Health Information Development Unit, *Social Health Atlas of Australia: Data by Primary Health Network* (Sydney, 2024).

³ Feltz-Cornelis et al, 'Integrated care pathways: a new approach for integrated care systems', *British Journal of General Practice*, (2023).

Rurality and remoteness

Much of the western sector is classified as Modified Monash Model (MMM) 4–7, reflecting significant geographic isolation and limited local service availability.⁴

Socioeconomic disadvantage

Many communities in the region experience lower socioeconomic status (SES), which is associated with poorer baseline health, higher prevalence of chronic conditions, and increased rates of preventable hospitalisations.⁵

Ageing population

Apart from Griffith, population growth across western sector remains static to low, with modest increases projected to 2041. The western sectors population is aging; with the proportion of residents aged 65 and over expected to be one in three residents by 2041 and the number of people aged 85 years and over is expected to more than double.⁶

High burden of disease

Communities in the western sector experience some of the highest rates of chronic and complex disease in rural NSW, including diabetes, cardiovascular disease, respiratory illness and renal disease.⁷ These conditions often co-occur, resulting in multi-morbidity that increases the frequency, length and complexity of hospital admissions.⁸

1.3. Redefining LHD boundaries will not address demographic challenges

Redefining local health district boundaries will not resolve the demographic and service pressures facing the western sector. The region's population distribution, high levels of socioeconomic disadvantage, elevated burden of chronic and complex disease and limited availability of primary health care create persistent and interconnected challenges that benefit from system-wide responses. These underlying drivers of demand remain unchanged by structural separation.

Evidence from decentralised and fragmented health systems demonstrates that smaller jurisdictions often face amplified inequities due to reduced coordination, variable resource allocation, and diminished economies of scale. A boundary split would not generate additional clinicians, expand primary care capacity or increase specialist availability. Instead, it risks diluting the integrated, cross-district responses required to meet high and compounding health needs.⁹

Sustained improvements in health outcomes depend on integrated planning, shared clinical governance, pooled specialist resources and coordinated outreach, capabilities that are strengthened through scale. A single, networked district is therefore better placed to direct resources where they are most needed, maintain continuity across care pathways and invest according to community need rather than administrative geography.

⁴ PHIDU, (2024).

⁵ J. Flavel, et al. 'Regional health inequalities in Australia and social determinants of health: analysis of trends and distribution by remoteness', *Rural and Remote Health*, 24(1) (2024).

⁶ PHIDU, *Social Health Atlas of Australia: Data by Primary Health Network* (2024)

⁷ Australian Institute of Health and Welfare. *Rural and Remote Health*. (Canberra, 2023).

⁸ Bureau of Health Information. *Healthcare in Rural, Regional and Remote NSW: Annual Report 2023*. (Sydney, 2023). AIHW. (2023).

⁹ J. Flavel, et al. (2024).

2. Care and safety: Patients are referred to services depending on the care they need

2.1. Existing models of care underpin safe quality care

MLHD operates as part of an integrated service network that ensures patients from regional hubs and local rural communities across a large geographical area can access safe, timely and coordinated healthcare. This current network strengthens safety and efficiency by helping patients access the service they need through established structured referral pathways. A networked model ensures local constraints do not limit access and provides clear pathways to higher-level care when it cannot be safely delivered locally.¹⁰

To support safe, timely and coordinated care, MLHD has established referral pathways and formal partnerships with neighbouring districts, NSW tertiary hospitals and cross-border Victorian services. These arrangements allow patients to access advanced trauma, surgical, medical and highly specialised services enabling escalation to higher acuity services when required.

Patients in the western sector also access higher-level care in Victoria, including Bendigo, Echuca, Melbourne, Shepparton and Swan Hill. These long-standing cross-jurisdictional pathways reflect geographic proximity, clinical partnerships and contractual arrangements that support timely access to appropriate care when specific services are not available locally.

To maintain safe care and timely referral pathways, MLHD has:

- formalised referral and escalation pathways with tertiary and quaternary hospitals to ensure timely access to clinical services unavailable locally,
- established district-wide patient flow and coordination functions, including 24/7 monitoring and clinical decision frameworks that enable safe, efficient transfers, and coordinated repatriation and follow-up care to support patients returning from other facilities, and
- implemented district-wide patient transport service, linked with retrieval services, aeromedical support and critical care pathways, with a centralised workforce, including clinical staff and dedicated patient transfer resources.

2.2. Equitable access to emergency care

MLHD operates a centralised Virtual Care Hub that ensures all facilities, regardless of size or location, have continuous access to emergency and critical care expertise. The virtual service is staffed by medical and nursing staff who specialise in emergency and critical care and provide real-time clinical assessment, stabilisation and shared decision-making. The district-wide service supports clinicians working in rural emergency departments (EDs) and maternity services.

The Hub provides remote medical consultation by general practitioners and critical care from specialist ED doctors; supporting frontline clinicians in rural hospitals 24 hours a day. The clinical teams oversee the management of ED and admitted patients, support time-critical interventions and coordinate escalation or transfer when required.

In addition to medical support, MLHD's Virtual Nurse Assist provides real time nursing advice and clinical support to

When local resident, Tony, brought his wife to Berrigan MPS having trouble breathing, he experienced first-hand how virtual care supports safe emergency treatment in small communities. Within minutes of arrival, the local nurse began assessment and connected them to MLHD's Remote Medical Consultation Service. A specialist reviewed his wife in real time, confirming that urgent transfer was not required. The rapid access to clinical expertise provided reassurance and timely care close to home.

¹⁰ NSW Health, *Guide to the Role Delineation of Clinical Services*, (Sydney, 2024)

nurses working in rural and remote facilities; assisting with triage, monitoring, escalation and early recognition of deterioration.

The Virtual Care Hub strengthens local capability, supports workforce sustainability and ensures that patients across MLHD receive safe, timely and clinically appropriate emergency care.

“Well done to MLHD for ensuring that smaller communities have such skilled and caring nurses, and the support of virtual care, linking us to specialist doctors in such a short amount of time.”

Tony, Berrigan resident

2.3. Care provided within the community

MLHD delivers a comprehensive range of community based and outreach services from regional hubs that support people to receive timely, coordinated care close to home. District-wide services including community nursing, chronic disease management, allied health, child and family health, mental health, drug and alcohol programs, and aged and palliative care services are delivered through local teams supported by district-wide specialist input.

Outreach services extend clinical reach across the region through visiting medical, nursing and allied health specialists, mobile and satellite clinics, community rehabilitation, school-based health programs and targeted chronic disease initiatives. Virtual care further strengthens access through telehealth-enabled assessments, remote monitoring and timely specialist advice. Together, these integrated models allow rural and remote communities access to coordinated, multidisciplinary care locally, easing the burden on communities where primary care services are limited.

2.4. Aboriginal health and wellbeing

MLHD’s district-wide approach to coordinating a comprehensive range of Aboriginal and Torres Strait Islander people’s health services promotes access, cultural safety and coordinated care across local hospital and community settings. Aboriginal health workers and practitioners provide services in EDs, inpatient and community-based care settings, maternity services, mental health and chronic disease clinics, ensuring patients and families feel safe, respected and connected to their care team.

‘Murundhu - I Live, I Breathe’ is a locally designed and led pulmonary and heart failure rehabilitation program for Aboriginal people in Griffith.

‘Murundhu - I Live, I Breathe’ is delivered in partnership with Griffith Aboriginal Medical Service.

Participants are equipped with the tools, resources and knowledge to empower them to manage their health at home.

Prevention, early-intervention and maternal and infant health programs are delivered in close partnership with Aboriginal communities and Aboriginal Community Controlled Health Organisations so that services reflect local priorities and cultural expectations. These integrated models strengthen early engagement, reduce barriers to care and support coordinated navigation across hospital, community and primary care services. Embedding culturally safe pathways across MLHD enhances patient experience, improves adherence to treatment and contributes to better long-term outcomes for Aboriginal people.

2.5. Risks of fragmentation to community and outreach services

Whole-of-district delivery of speciality, community-based and outreach services depend on economies of scale, enabling workforce flexibility and resource distribution based on need. Splitting the district would significantly reduce this flexibility, leading to inconsistent service access, longer delays and heightened clinical risk. Impacts that would be felt most acutely by patients in rural and remote communities.¹¹

¹¹ J. Flavel. et al., (2024).

Programs such as community nursing, allied health, child and family health, aged care, and oral health, are delivered through centralised intake and triage systems. Fragmenting these functions would weaken service reach and reduce efficiencies that support equitable access across the region.

The coordination of Aboriginal health and wellbeing services are similarly provided through a coordinated structure which supports shared workforce capacity and consistent support across geographically dispersed Aboriginal communities.

Fragmentation would place these functions at risk. Dividing governance, virtual care, triage and intake systems, outreach programs and specialist networks across two smaller LHDs would reduce continuity, weaken specialist coverage and require duplicated infrastructure and workforce. Smaller, services would face greater difficulty providing multidisciplinary outreach, particularly in communities already affected by workforce shortages and limited primary care availability. The result would be reduced access, less reliable service delivery and widening inequities across both Aboriginal and non-Aboriginal communities.¹²

2.6. Risks to clinical networks and pathways for safe patient care

In the current structure, Wagga Wagga Base Hospital (WWBH) serves as the primary referral and escalation point for high-acuity and complex patients. This arrangement is supported by established clinical protocols, decision making frameworks and centralised patient flow coordination, providing predictable and timely transfers. This service network ensures critically unwell patients are transferred without delay, while urgent and planned transfers can be coordinated efficiently, balancing capacity and clinical priority. Without a district virtual care hub, hospitals in the Western Riverina would need to individually coordinate transfers for critically unwell patients. This would increase the risk of transfer delays and pull clinical staff away from caring for the patient, to manage administrative tasks that are currently handled centrally and efficiently by clinicians in the district wide virtual care hub.

While the intent of the Bill is to deliver more responsive services in the western sector, the proposed change introduces several risks:

Continued need to transfer patients

Griffith Base Hospital does not have the activity levels or workforce required to provide highly specialised care. Patients needing services not available within the western sector would therefore be managed as inter-district transfers. While critically unwell patients would continue to be transferred immediately to an appropriate facility, other transfers, such as non-urgent, non-critical, or planned procedures, would depend on the accepting facility's capacity and operational priorities. Transferring patients within an integrated district is significantly more streamlined and timelier than managing inter-district transfers and would introduce avoidable delays and added administrative burden.¹³

Patients from southern towns in the western sector do not flow to Griffith Base Hospital

One-third of communities in the western sector do not access services in Griffith, their usual service links are with Albury and Victoria. Over 99% of patients treated in Griffith Base Hospital come from its immediate catchment of five hospitals, with less than 1% from the southern communities, which flow to Albury and Victorian health services. These patterns are unlikely to shift with a boundary redistribution, as referrals are driven by established clinician networks and longstanding care pathways rather than administrative lines. The District has established flow pathways with these interjurisdictional services.

Challenges for timely repatriation

¹² J. Walters., et al. 'Supporting efficiency improvement in public health systems: a rapid evidence synthesis'. *BMC Health Services Research* 16(3), (2019).

¹³ NSW Health. *Adult Critical and Specialist Care Inter-Hospital Transfer*. (Sydney, 2025)

The western sector does not have the economy of scale to provide some specialist services which support repatriation of patients from tertiary centres. Patients could be required to remain in metropolitan centres for longer periods, with greater separation time from their families.

Increased administrative burden on clinicians

Transfers triaged across multiple networks, require local teams or a duplicated centralised hub to coordinate inter-hospital transfers. This process requires engagement with multiple facilities to arrange transfers, monitor bed availability and provide updated patient status information while maintaining safe care locally.

3. Workforce: the heart of the health system

3.1. Workforce recruitment and retention challenges

MLHD faces persistent challenges in attracting and retaining a skilled workforce, particularly in rural and remote communities. These pressures reflect national shortages across nursing, medical and allied health professions. These shortages are further compounded by strong competition for healthcare clinicians in metropolitan areas that offer larger specialist teams and broader professional development pathways, increasing preferences for flexible work arrangements, personal and family considerations and perceived professional isolation in rural areas.¹⁴

MLHD's integrated structure remains a critical enabler for recruitment. Recruitment is locally managed by individual facilities and services, with support from the MLHD's People and Culture team. District-wide workforce planning, shared education and training programs and cross-site clinical networks support services and individual staff in ongoing development. These arrangements support career progression, enhance retention and ensure that clinicians working in rural sites are connected to broader professional and clinical systems.

In addition, the Rural Health Workforce Incentive Scheme plays an essential role in maintaining MLHD's service continuity, particularly in communities where recruitment remains challenging. Incentives support the stabilisation of hard-to-fill and critical positions across nursing, medical, allied health and mental health, enabling MLHD to sustain essential services. As of November 2025, MLHD had a total of:

- 657.94 hard-to-fill positions (FTE)
- 374.78 critical positions (FTE)

Although the western sector accounts for 31% of MLHD's population, it represents 36.3% of all roles classified as hard to fill or critical to service continuity.

3.2. District wide workforce development and pipelines

A stable and well supported workforce is essential to delivering safe, high-quality and sustainable healthcare. Like many rural and regional areas, the western sector faces persistent workforce shortages, constrained recruitment pipelines and increasing pressure on existing staff.¹⁵

MLHD has established a comprehensive, interconnected suite of workforce initiatives to address the workforce challenges, including:

Rural Generalist Single Employer Model

- In 2023 the Murrumbidgee Rural Generalist Training Program (MRGTP) was scaled to a state-wide model, the Rural Generalist Single Employer Model, to strengthen the rural generalist workforce. The training pathway attracts and supports junior doctors to train, practise and remain in the region under a single employer model. GP training is coupled with

¹⁴ C. Cortie, et al. 'The Australian health workforce: disproportionate shortfalls in small rural towns'. *Australian Journal of Rural Health*, 32(2) (2024).

¹⁵ C. Cosgrave, et al. 'Social Determinants of Rural Health Workforce Retention: A Scoping Review'. *International Journal of Environmental Research and Public Health*, 16(3). (2019).

advanced skills training to provide a skilled rural generalist workforce needed for rural hospitals.

Rural Generalist Nursing Pathways

- In partnership with Charles Sturt University, the district has established a career pathway that supports nursing students complete their tertiary placement requirements within the district. On graduation, nurses transition directly into a guaranteed position, strengthening local retention.

University and TAFE partnerships:

- Long-standing partnerships with rural clinical schools including the University of New South Wales, Charles Sturt University, Notre Dame and University of Wollongong to support student placements. These partnerships foster early interest in rural practice and a pipeline of graduates with ties to the region.

School-based traineeships and cadetships:

- Early entry points for local students into nursing, allied health and support careers, creating a sustainable, locally embedded workforce pipeline. Many participants transition from traineeships to permanent roles within the District, strengthening workforce stability.

Scholarship and mentoring programs:

- Targeted supports assisting nursing, allied health and medical graduates to transition into rural practice and advance into specialised or leadership roles, ensuring career progression.

3.3. Education and training opportunities supports career development

MLHD provides comprehensive education and training pathways and supports end to end rural training for doctors, nurses and allied health. Partnerships are established with the University of NSW (Biomedical Training School), Charles Sturt University and Three Rivers Department of Rural Health. Medical Education and Training networks are established for:

- **Postgraduate junior medical officers:** a commended two-year program which includes rural preferential positions, a dedicated council and extensive wellbeing and development support. The program includes a diverse range of term rotations, including primary care.
- **International medical graduates (IMG):** MLHD supports IMG integration through orientation, cultural induction and tailored education programs such as emergency medicine. A split would limit access to assessment and supervision opportunities for IMGs in rural areas, undermining workforce sustainability.
- **Specialist training and accreditation:** MLHD provides structured training pathways through Wagga Wagga Base Hospital in areas including anaesthetics, emergency medicine and physician training. If separated, clinicians may have to travel to Sydney for accredited rotations, affecting lifestyle, retention and workforce supply.

3.4. Risks of fragmentation of workforce and loss of flexibility

Workforce pressures in the western sector mirror broader national trends and are not unique to the district. They reflect a well-documented national pattern in which small rural towns record the lowest numbers of health professionals per capita across all disciplines, despite sustained recruitment initiatives and training investment.

Retention in rural settings is shaped by housing availability, partner employment, schooling, community connectedness and perceptions of professional value; factors largely outside the control of local health districts.¹⁶ Consequently, workforce pressures in the western sector cannot be resolved through structural separation or localised administrative reform. Sustainable improvement

¹⁶ C. Cortie., et al. (2024).

demands cross-sector collaboration between government, industry and communities to ensure that rural areas remain viable places for health professionals to live, work and build lasting careers.¹⁷

Dividing MLHD would fragment workforce planning, training and deployment systems, creating duplication across human resources, credentialing and workforce functions. More critically, it would prevent the ability to mobilise staff, share expertise and provide peer support throughout the region.

For a region already challenged by workforce scarcity, such disruption would significantly increase recruitment costs, reduce continuity of care and weaken the clinical networks that underpin patient safety and staff wellbeing. A structural change of this magnitude would trigger a complex and prolonged transition. Redefining district boundaries would require affected clinical and corporate staff to reapply for positions, with others facing redeployment, or relocation. For teams already under strain, this uncertainty risks reducing morale and prompting valued staff to leave.¹⁸

4. Supporting strong, connected communities

4.1. Community perception and public confidence

Communities across throughout the region have a long memory of restructures and shifting local health district boundaries. Against this backdrop, public confidence in the health system depends on stability, predictability and clear evidence that local hospitals remain supported and connected to the wider system of care. MLHD has rebuilt and sustained this confidence through engagement and sustained community partnerships for the past 13 years.

Local hospitals are central to community identity and resilience. In many towns they are one of the few remaining government services, and their presence signals that the community remains supported. MLHD's integrated networks ensure rural facilities are not isolated but connected to district-wide clinical support, specialist advice and reliable escalation pathways. Communities have confidence that their care is backed by a larger, stable system rather than dependent on the limited capacity of a small jurisdiction.

MLHD has strengthened its connection with communities through a well-structured and inclusive community engagement strategy supported by active Local Health Advisory Committees (LHACs). Local volunteers who understand the needs, priorities and cultural contexts of their towns, form the MLHD's 27 LHAC's. They are integral in connecting the community, its residents and health services. Through close collaboration with local health leaders, LHACs help identify gaps in care, promote local health initiatives and support ongoing improvement in service delivery. Their work ensures that planning is guided by genuine community insight, enhances trust in the health system and enables MLHD to deliver more responsive, culturally safe and patient-centred care across the region.

Biannual LHAC Forums further strengthen this collaboration by bringing committee members together to share experiences, highlight emerging issues and learn from one another. These forums also provide a structured space for MLHD's executive and health leaders to engage directly with community representatives and discuss priorities at a district-wide level. MLHD has been commended for the maturity of these partnerships; which support clear communication, grounded decision-making and a shared understanding of the challenges facing rural health.

The District acknowledges that community engagement can always be improved by continuously refining feedback channels to ensure every voice, especially those hardest to reach, is heard. Ongoing evaluation, innovation and co-design with community members help ensure engagement remains relevant, transparent, and meaningful.

¹⁷ C. Cosgrave., et al. (2019)

¹⁸ Duffield, C., et al, 'The Impact of Hospital Structure and Restructuring on the Nursing Workforce'. *Australian Journal of Advanced Nursing*, 24(3), 2007.

4.2. Health equity and cultural connection

MLHD has built strong and enduring partnerships with Aboriginal communities across the region, including in the western sector where Aboriginal people represent 6.5% of the population.¹⁹ These relationships are grounded in long-term, respectful engagement with Elders, community leaders and local decision-making structures, supported through collaboration with ACCHO's, Aboriginal Land Councils, inter-agency groups and community-based organisations.

This sustained engagement has strengthened trust and accountability, while building cultural safety. Although there is significant work remaining to address the longstanding disparities in health outcomes experienced by Aboriginal people, MLHD is committed to supporting local decision making and co-designing models of care, placing culture and community at the centre of services. Through this approach, MLHD aligns cultural leadership, clinical services and community priorities; ensuring that care remains culturally grounded, community-led and responsive to local needs.

4.3. Risks to community confidence, cultural continuity and partnership

A boundary change will create uncertainty across regional communities. Lack of stability risks undermining trust that has been rebuilt gradually through sustained engagement, consistent communication and the work of the District's LHACs.

For Aboriginal people and communities, the risks are even more pronounced. MLHD has built strong relationships with Aboriginal organisations, Elders and communities over many years. These relationships underpin the provision of culturally safe care and ensure our health services continue to improve health outcomes for Aboriginal people. Structural separation will require new governance, engagement and partnership structures to be established, duplicating processes and fragmenting relationships that currently operate as part of a single system.

A boundary change would also further divide the cultural geography of the Wiradjuri Nation. Families and communities across Griffith, Leeton, Narrandera and Wagga Wagga are connected through deep kinship ties and shared histories, including those linked to the Warangesda Mission at Darlington Point. Creating an additional administrative boundary within this cultural region risks severing established service pathways, weakening cultural continuity and undermining the coordinated delivery of culturally safe, community-led care.

For the broader community, uncertainty about the purpose and impact of structural change will lead to disengagement and reduced trust. In smaller towns, hospitals represent more than a point of care, they are anchors of community identity, security and resilience. Any perception that a local hospital may lose connection to the wider network of clinical support and expertise will further erode community confidence.

5. Corporate functions and system enablers

5.1. Effective and efficient governance systems support front line services

MLHD is governed by a Board with members who reside in towns across both the eastern and western sectors of the region, including Albury, Coolamon, Finley, Griffith, Wagga Wagga and Young. The Executive Leadership Team are similarly regionally based, with members located in Albury, Corowa, Gundagai, Griffith, Tumut and Wagga Wagga.

MLHD's governance and operational model balances local autonomy with the benefits of district-wide systems and expertise. Facilities operate with delegated authority for recruitment, workforce planning, operational management and service delivery. This empowers general and facility managers to tailor services to local needs and manage day-to-day operations efficiently.

Corporate functions are strategically located throughout MLHD, with hubs in Albury and Wagga Wagga. These locations are historical and based on previous health district structures. Many corporate staff are not based in these locations and work effectively from locations across the

¹⁹ PHIDU. (2024).

region. Corporate services provide supportive functions that allow facilities to focus on patient care, the include:

Robust clinical governance and quality systems

District wide governance and leadership frameworks support accountability for the delivery of safe quality care.

Coordinated people and culture services

District level support for recruitment, credentialing and professional development systems streamline processes and provide specialist support across facilities.

Shared financial services, asset management and digital infrastructure

District wide financial services and asset management support local hospitals and services. Integrated digital platforms enable real-time information sharing, timely clinical decision-making and continuity of care across all sites.

Specialised district support functions

District-wide public health, emergency response coordination and biomedical functions provide expertise for local services.

Strategic planning and data analytics

District planning and data analytics teams guide better value care, capital investment, and clinical improvement.

In addition to these key enablers, MLHD shares some corporate and clinical services with Southern NSW Local Health District, expanding the scale to support a flexible workforce and recruitment of a specialist workforce. These services include Governance, Risk and Audit, Public Health, Oral Health, BreastScreen, and Information, Communications and Technology.

Centralised corporate functions support consistent governance, streamlined processes and the uniform application of policies and standards across all services. They also improve efficiency by reducing duplication, strengthen procurement and workforce planning capabilities and enable coordinated decision-making at a system level. Dividing the MLHD could introduce inconsistencies in compliance, oversight and risk management; impacting the ability to detect and address safety issues promptly and weakening the overall system.

5.2. Redirecting funding from frontline care

Establishing a new health district would require significant upfront and ongoing investment to duplicate governance, corporate and digital systems that are currently delivered centrally. This would require investment in new infrastructure to support corporate teams, finance and asset management services, human resources and clinical governance functions.

Dividing the MLHD would require reconfiguration or duplication of digital systems, including electronic medical records, imaging repositories and reporting infrastructure, along with the people managing these services; introducing additional costs and raising risks related to data fragmentation.

Indicative modelling on corporate expenditure benchmarks suggests that replicating these functions would require an additional \$26 million in recurrent annual expenditure. Funding would not be supplementary but redistributed between two smaller LHDs, increasing financial pressure on both organisations.

Additionally, MLHD's funding model, which combines Activity Based Funding (ABF) with block-funded allocation for small and rural facilities, does not reflect actual service costs. Many facilities within the western sector, including Leeton and Griffith hospitals, face greater staffing and logistical challenges, leading to an additional \$13 million in costs which are subsidised by other facilities throughout the MLHD. Redefining MLHD's boundaries would disrupt this balance and increase financial pressure on rural and remote facilities and services.

Establishing a separate Western Riverina LHD would redirect limited resources and draw essential funds away from clinical care and patient-facing services toward duplicating corporate and

infrastructure requirements. A split will erode system flexibility, reduce efficiency and dismantle the shared asset model that currently enables MLHD to respond to patient and operational demand. Without comprehensive financial modelling and cost-benefit analysis a proposed structural duplication presents a material risk to the long-term financial sustainability of both the Murrumbidgee and the Western Riverina LHDs.

6. Research, innovation and partnerships

6.1. MLHD's strength lies in its partnerships

MLHD's extensive geographic footprint, combined with its long-standing relationships with regional, state and national industry, education and research partners creates a strong foundation for innovation and evidence-based practice. These partnerships collectively support locally driven health transformation initiatives that are closely aligned with the regions priorities.

Structural separation would risk fragmenting these relationships and weakening the collaboration that underpins service innovation, equity and workforce sustainability. Retaining a single, integrated district protects the shared governance, scale and capability required to drive long-term population health improvements and regional development.

Dividing the MLHD would also disrupt years of collaborative investment, diminish efficiency and compromise the integrated approach essential for research advancement and cultural partnership across the Riverina-Murray region. Maintaining a unified district ensures these established relationships continue to strengthen rural health outcomes, build workforce capability and uphold community confidence in a sustainable, evidence-informed health system.

6.2. The District shares geographical boundaries with the Murrumbidgee Primary Health Network

MLHD and the Murrumbidgee Primary Health Network (MPHN) share the same geographical boundary, creating a unique and highly effective partnership for the coordinated planning, commissioning, and delivery of integrated health services. This shared boundary facilitates clearer care pathways, smoother service coordination, and better-aligned planning between primary and acute care. The alignment supports joint population health strategies, reduces service duplication, and enhances the collective capacity to address local health needs efficiently and consistently.

This highly regarded partnership is formalised through the Murrumbidgee Collaborative Agreement, which operationalises joint priorities, shared accountability, and cross-sector system improvements. A joint Board Sub-Committee oversees the implementation of an evidence-based roadmap. The partnership has delivered tangible benefits through:

- collaborative commissioning, aligning funding and service design to support prevention, early intervention and community-based care, in areas of chronic disease, diabetes, paediatrics and mental health
- shared data and analytics, enabling a collaborative approach to population health needs assessments and outcome monitoring,
- integrated service planning, and
- joint workforce and capability initiatives, strengthening local recruitment and professional development pathways.

Living Well, Your Way aims to improve care for people living with chronic illness.

The program tackles the challenges of distance, cost and fragmented care by connecting hospitals GPs, pharmacists and allied health providers through coordinated, community-based models.

It includes outreach diagnostic clinics, education for primary-care clinicians, after-hours services and culturally safe rehabilitation.

Living Well, Your Way shows how collaborative commissioning, and local partnerships can reduce preventable hospitalisations and deliver care closer to home.

The shared boundary between the district and MPHN is a significant structural advantage that supports efficiency, consistency and shared investment. It enables unified health system planning and service delivery, avoiding duplication and fragmentation between primary and secondary care sectors.

“Patients have expressed gratitude to the specialists and staff for bringing the clinic to their rural communities in the western sector. The patients speak of convenience, cost savings including travel and accommodation, time off work and the reduced burden on carers.”

Clinic Organiser, Senior Lead, Living Well, Your Way

6.3. Murrumbidgee Health and Knowledge Precinct

The MLHD-wide Murrumbidgee Health and Knowledge Precinct provides a strategically coordinated platform for integrating clinical services, research, education and industry collaboration across the region. By bringing together health providers, universities, training organisations, and innovation partners, the precinct strengthens the pipeline of rural health professionals, accelerates research translation, and supports the development of new models of care tailored to the needs of regional communities.

Operating at a district scale enables the precinct to leverage shared infrastructure, broaden research participation, and create consistent pathways for workforce development from entry-level training through to advanced clinical practice. This unified approach also ensures that innovations developed within the precinct can be implemented system-wide, improving service quality, strengthening digital and clinical capability, and maintaining a coherent strategy for rural health advancement.

A structural split would dilute the precinct’s reach, reduce critical mass for research and training initiatives, and undermine the partnerships that depend on a single, integrated operating environment. Maintaining a unified district preserves the precinct’s scale, influence and capacity to drive long-term health, education and economic benefits for the entire Murrumbidgee region.

6.4. The Riverina Murray Regional Alliance Local Decision-Making Accord

The Local Decision-Making Accord, between the Riverina Murray Regional Alliance (RMRA) and NSW Government clusters, provides a formal framework for shared governance and decision-making on initiatives that directly impact Aboriginal communities across the region. This Accord ensures that Aboriginal voices are central to planning, service design and policy development; fostering culturally safe and responsive health, education and community programs.

Maintaining a single, unified district strengthens the implementation of the Accord by providing a consistent and coordinated point of engagement, supporting long-term relationships with Aboriginal communities, and enabling the delivery of integrated, locally-led initiatives. Structural separation would risk fragmenting these partnerships, diminishing the ability to respond to community needs effectively, and weakening the collective capacity to advance equity, cultural safety, and sustainable outcomes for Aboriginal peoples in the Riverina–Murray region.

6.5. Research and innovation

The district research and innovation system embeds evidence generation, evaluation and translation into clinical and operational practice. This capability directly supports NSW Health's strategic priorities for rural health improvement and ensures that local service design is guided by data, inquiry and measurable outcomes.

The Clinical Trial Enabling Unit strengthens MLHD's capacity to deliver world-class research locally, ensuring rural and regional communities have equitable access to clinical trials. The Unit coordinates trial governance, ethics, and delivery across key areas including paediatrics, cardiology, oncology, rehabilitation, and infectious disease.

Through collaboration with regional and metropolitan partners, the Unit supports clinicians and patients to participate in studies that improve care quality, safety, and access to emerging treatments.

MLHD's Research Unit provides district-wide governance and coordination for clinical trials, ethics and translational research, enabling clinicians, students and academic partners to lead projects that strengthen quality, safety and efficiency in care delivery. Research activity spans clinical safety, workforce wellbeing, population health and service design, with recognised expertise in community-based and Aboriginal and Torres Strait Islander health research.

Formal partnerships with Charles Sturt University, the University of New South Wales, the University of Notre Dame and the University of Wollongong further expand regional research capability, support academic supervision and strengthen student placement pathways. Collaboration with the Three Rivers Department of Rural Health has also enhanced local research capacity, providing structured support for workforce development, interdisciplinary training and the retention of skilled professionals in rural practice.

6.6. Risks to ongoing research and innovation

Structural separation would disrupt the partnerships that underpin research, innovation and system integration across the region. These arrangements function as a single system and rely on aligned boundaries, unified decision-making and consistent accountability.

A structural split would require new governance structures, duplicated committees and re-negotiated agreements, fragmenting relationships that have taken years to build. The interdependence that currently allows partners to plan jointly, commission services collectively, share analytics, coordinate research and deliver region-wide workforce initiatives would be weakened. Fragmentation would reduce efficiency, dilute collaborative capability and slow progress on regional priorities.

Maintaining a single, integrated district preserves the continuity, scale and shared accountability necessary to sustain research growth, workforce development and long-term innovation throughout the region

Conclusion

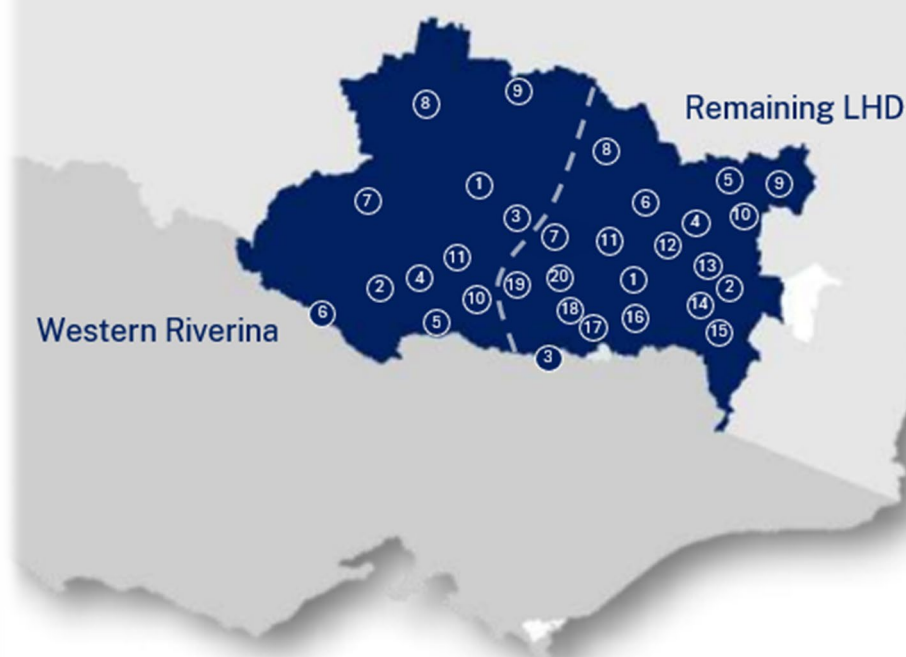
A single, unified Murrumbidgee Local Health District enables coordinated, accessible and responsive care for all communities. MLHD's mature clinical networks provide reliable pathways to higher acuity and specialist services, ensuring timely, safe and efficient care. Its workforce strategies sustain a skilled and supported workforce and reinforce community trust in local health services.

Centralised corporate functions and systems deliver consistency, efficiency and strong governance, reducing duplication and directing resources to areas of greatest need. Combined with MLHD's established research, innovation and partnership capability, this integrated model strengthens service delivery, supports evidence-informed improvement and enhances long-term system sustainability.

Maintaining one cohesive district is essential to safeguarding high-quality, patient-centred care and securing enduring health outcomes across the Riverina – Murray region.

Appendix A: Murrumbidgee and Western Riverina LHD boundaries

Murrumbidgee Local Health District



Proposed Western Riverina LHD

1. Griffith Base Hospital
2. Deniliquin District Hospital
3. Leeton District Hospital
4. Finley Community Hospital
5. Tocumwal MPS
6. Barham MPS
7. Hay MPS
8. Hillston MPS
9. Lake Cargelligo MPS
10. Berrigan MPS
11. Jerilderie MPS

Murrumbidgee LHD

1. Wagga Wagga Base Hospital
2. Tumut District Hospital
3. Corowa District Hospital
4. Cootamundra District Hospital
5. Young District Hospital
6. Temora District Hospital
7. Narrandera District Hospital
8. West Wyalong Community Hospital
9. Boorowa MPS
10. Murrumburrah-Harden MPS
11. Coolamon MPS
12. Junee MPS
13. Gundagai MPS
14. Adelong-Batlow MPS
15. Tumbarumba MPS
16. Holbrook MPS
17. Culcairn MPS
18. Henty MPS
19. Urana MPS
20. Lockhart MPS

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