

**Submission  
No 36**

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

**Organisation:** Murrumbidgee Local Health District Board

**Date Received:** 17 December 2025

The Chair  
Legislative Assembly Committee on Community Services  
NSW Parliament  
Macquarie Street  
SYDNEY NSW 2000

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## Splitting of the Murrumbidgee Local Health District Bill to Parliament 2025

Dear Sir

I write in response to the Committee's Inquiry entitled Health Services Amendment (Splitting of the Murrumbidgee Local Health District) Bill 2025.

The Murrumbidgee Local Health District (MLHD) is making a submission to the Inquiry, and this letter is provided to the Committee in support of that submission. The MLHD Board strongly supports the District's submission.

### Introduction

The MLHD Board comprises eight (8) members, appointed by the NSW Minister for Health for their skills. All Board members reside within the District, with a spread across the northern, southern, eastern and western regions. The Board members skills include a mix of clinical, Aboriginal health, finance, business and health management. This letter is provided by the MLHD Board to support the District's submission.

### We have been here before

The Murrumbidgee region has spent three decades navigating repeated restructures as governments searched for the "right size" for rural health administration. That history matters when considering the proposed Health Services Amendment.

- **Pre-1993:** Every hospital ran its own Board, 137 in total, overseen by six country regions.
- **1993:** NSW created **23 District Health Services**, replacing those 137 Boards. NSW Health's 1998–99 Annual Report notes that *the administrative savings were redirected to patient care*. The area now known as MLHD was split across **three districts**: Riverina, Murrumbidgee and Murray.
- **1996:** 23 districts were deemed inefficient and consolidated into **eight**. NSW Health's 1995–96 Annual Report stated the change *improved population health planning and lifted rural administration to metro standards*. The **Greater Murray Health Service** then covered almost the same footprint MLHD has today.
- **2005:** Rural services were merged again into **four large Health Services**, including the **Greater Southern Health Service**, spanning 166,000 km<sup>2</sup>, 468,000 people and 45 facilities.
- **2011:** NSW settled on the current structure of **seven rural LHDs**, including MLHD.

This history shows one thing clearly: size and structure matter, and constant change carries real impact for rural communities.

The government has already tested smaller health services. In 1993, three separate districts, Murray, Riverina and Murrumbidgee, were created. Within just three years, they were merged into the Greater Murray Health Service, roughly the size of today's MLHD. Across the decades, governments have tried small districts, then large ones, and ultimately settled on the current model in 2011.

Our Board members, many with firsthand experience of the pre-1990s structures, see no evidence that reverting to smaller, or larger, districts would improve efficiency or productivity. In fact, they believe splitting MLHD would deliver the opposite.

### **Listening and acting on rural community needs**

Our Board is made up of members who live across both the eastern and western parts of the District, people who understand rural issues because they experience them. Unlike some regional districts with metropolitan-based Boards, our governance is genuinely local.

The Board Chair, along with other members and the District's Chief Executive, visits every facility at least annually, including meeting with local staff, patients, Local Health Advisory Committee (LHAC) members, Shire Council Mayors and Council General managers. This highlights the importance the Board places on listening to and acting on the needs of our communities.

Through our six-monthly LHAC forums, Board and Executive members receive direct presentations from every town on their achievements, challenges and priorities. Across all centres, our focus is constant: building local capacity and strengthening rural health services. It is core to our mission.

### **Special Commission of Inquiry into Healthcare Funding**

The Commissioner and legal counsels visited our District from 13 to 22 March 2024, interviewing MLHD Board members, District leaders, clinicians, medical advocates, consumers and local government representatives. Facility visits included small facilities in the east (Batlow-Adelong and Tumut) and the west (Berrigan and Finley). The Commissioner found no evidence of disadvantage in any part of the District and raised no concerns regarding MLHD's governance or management of health services, including in our western communities.

### **Recent and current capital projects support the Western region**

MLHD undertook community consultation and data analysis to develop health service plans for the recently completed Griffith Base Hospital and for the redevelopment currently underway at Finley Hospital. This reinforces our commitment to improve health services in our western region. We see the new Griffith Base Hospital as a catalyst for progressing improved health services in Griffith and surrounds. Likewise, a redeveloped Finley Hospital will create further opportunities for improvements in that locale. Far from neglecting the west, we understand their health needs and have been responding with commitment to improve services.

### **Workforce: building and retaining staff across the district**

The Board considers recruitment and retention of skilled staff a critical challenge for MLHD, a challenge shared across regional Australia. In response, the MLHD has focused on District-wide workforce strategies including international recruitment and grow-our-own initiatives for school-based trainees. Such strategies are targeted across areas of need and specifically in the western region, such as securing midwives for Griffith. We also recognise and applaud excellence in our workforce and have consistently identified staff from our western services as excellent role models for our District.

### **Collaboration with the Murrumbidgee Primary Health Network (MPHN), a one system approach**

The MLHD submission identifies the current geographic footprint shared by both the MPHN and the MLHD. This facilitates effective and coordinated collaboration between primary and secondary care. This productive partnership, cultivated by both Boards and Executive teams, is highly regarded across NSW Health. Together, we are leaders in NSW in delivering integrated services spanning both Federal and State-funded healthcare, a synergy that would be undermined if MLHD were split, forcing the MPHN to navigate two separate LHDs.

## Patient care pathways and networks are established

The submission identifies the current strong and effective clinical referral pathways and patient flow management that MLHD has successfully established right across our District. A split in MLHD would disrupt these existing, effective patient pathways and partnerships, potentially delaying access to care for patients who need to be transferred between facilities. This would compromise or delay health outcomes for those in our western areas, particularly for vulnerable populations who already face health inequities.

## Subsidising the western region

The two larger hospitals in the western region are Activity-Based Funded (ABF), a NSW Health wide funding mechanism where funding is allocated based on the volume and type of healthcare services delivered, rather than a fixed budget. Due to lower activity and higher costs in parts of the western region, the MLHD is currently subsidising the western region by approximately \$13M.

## Extra funding for western areas

Splitting MLHD and creating an extra District would have a cost to the NSW Health system with an additional District to manage and govern. Instead of spending resources on administrative and governance functions for a new District, we would advocate that funding should be spent on front-line clinical services for the western region.

## Potential governance risks associated with splitting MLHD

To encapsulate the risks of splitting MLHD, the Board has identified the following critical risks.

Risk	Potential Implications
Continuity of Services	Disruption of care pathways and referral processes. Unnecessary duplication and increased system complexity. Threat to integrated care systems. Operational risks during transition.
Financial Implications	Loss of economies of scale related to procurement, administration, compliance and governance arrangements. High transition and ongoing operational costs of the additional District.
Workforce Impacts	Exacerbation of recruitment and retention challenges. Impact on staff morale due to uncertainty and change.
Compliance and Regulatory Implications	Disruption of systems and processes supporting accreditation and compliance with standards and regulations.
Community and Partnership Implications	Disruption of long-standing relationships with LHACs, Aboriginal Community Controlled Health Services, communities, and partners such as the MPH. Loss of well-established points of contact and entry points to services. Erosion of community trust.
Equity and Access Implications	Remote and small communities are at risk of loss of services without the support of a larger integrated system.

## Summary

In conclusion, the MLHD Board strongly opposes the proposed splitting of the District, based on decades of experience navigating rural health restructures, first-hand knowledge of local communities, and evidence of effective governance and service delivery. The District has repeatedly demonstrated that smaller or fragmented structures do not improve efficiency or outcomes; in fact, splitting MLHD would disrupt established patient care pathways, referral networks, workforce strategies, and community partnerships, particularly in western areas. The Board and Executive are deeply embedded in the District, visiting every facility, engaging with staff, patients, LHACs, and local councils, and working closely with the MPHN to deliver integrated, high-quality health services across a shared geographic footprint. Recent investments, including the new Griffith Base Hospital and Finley Hospital redevelopment, reinforce the District's ongoing commitment to improving services for western communities.

MLHD acknowledges that the current system is not perfect, but the proposed split may not be the best way to improve it. Instead, MLHD will continue to focus on solution-centric alternatives that should strengthen the existing LHD and improve services within the current structure, rather than breaking it up.

Sincerely,

Adrian Lindner  
**Board Chair**  
Murrumbidgee Local Health District