

**Submission
No 40**

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

Organisation: National Rural Health Alliance

Date Received: 17 December 2025

17 December 2025

Clayton Barr MP
Committee Chair
Legislative Assembly Committee on Community Services
Parliament of New South Wales, Parliament House
Macquarie Street, Sydney NSW 2000
Email: communityservices@parliament.nsw.gov.au

Dear Chair

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

The National Rural Health Alliance (the Alliance) is pleased to provide feedback to the Inquiry into the Health Services Amendment (Splitting of the Murrumbidgee Local Health District) Bill 2025 (the Inquiry). I note the Bill proposes to split the Murrumbidgee Local Health District into the Murrumbidgee Local Health District and the Western Riverina Local Health District.

Introduction

The Alliance is the peak body for regional, rural and remote (hereafter rural) health in Australia, comprising [55 member organisations](#) which include healthcare professionals, service providers, health and medical educators, researchers, medical and health practitioner students and the Aboriginal and Torres Strait Islander health sector.

Our vision is for healthy and sustainable rural communities, which make up the over 7.4 million people residing outside our major cities, or more than 30% of the Australian population. We are focused on advancing rural health reform to achieve equitable health funding to that of urban per capita spending and equitable health outcomes for rural communities.

As the national peak body for rural health, it should be noted that the Alliance's response does not focus specifically on the risks and benefits of the proposed split of the Murrumbidgee Local Health District into two separated health districts.

Rather, we seek to highlight solutions to issues that affect health care access and equity for people living in rural Australia and the additional administrative cost burdens – some of which the Inquiry may wish to take into account when making a decision on the proposed split.

Notwithstanding the national context provided in this submission, the Alliance notes that the delivery of health care in the Murrumbidgee Local Health District was considered during the Special Commission of Inquiry into Healthcare Funding. A range of issues were explored during the public hearings in March 2024, such as challenges in recruiting and retaining both primary healthcare and specialist workforce in rural, regional, and remote New South Wales (NSW), and the effect of fragmented funding structures (State of NSW 2025).

Indeed, the Alliance provided a submission to this inquiry and some of the key points are discussed further below. Our view has always been that the regional, rural and remote contexts along with the complexities of the service delivery environment require consideration of the varying disparities across the different geographic classifications.

A shift is needed towards geographic justice i.e. equity and parity, that is, where people live should not determine their access to essential resources and opportunities. This is especially pertinent when Australia relies so heavily on these populations for our export income, the food we eat and tourism income for example.

I note that the NSW Government has released its response to this Inquiry on 4 December 2025, highlighting the challenges in accessing primary care and the lack of Commonwealth Government aged care and NDIS placements which are “both placing tremendous pressure on state hospitals”.¹

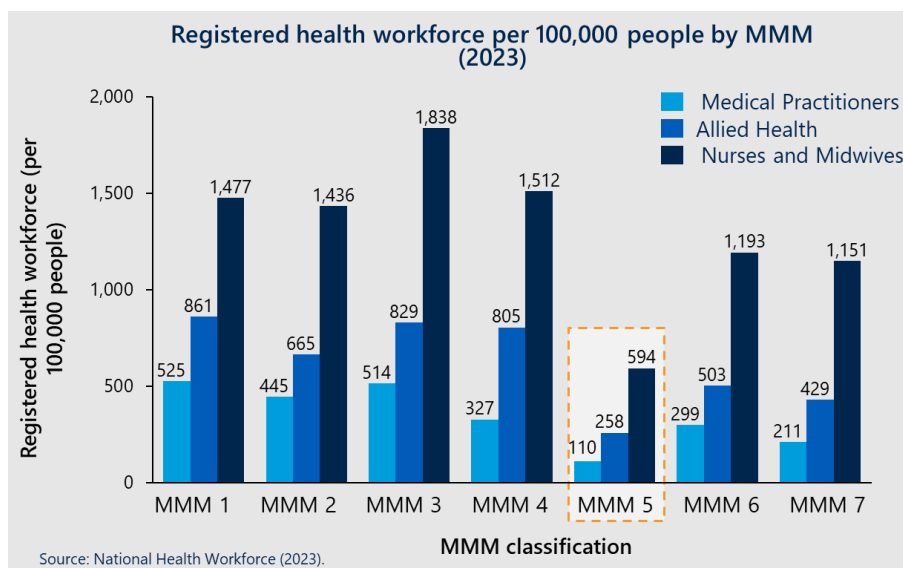
The ongoing health expenditure deficit between rural and urban areas

As part of its advocacy to improve health access and equity in rural Australia, the Alliance recently published [The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia](#) (The Forgotten Health Spend Report) undertaken by NOUS Group. The Forgotten Health Spend Report provides an updated analysis of government health expenditure and access across rural Australia for 2023-24, covering, but not limited to, public and private hospitals, ambulance, Aboriginal and Torres Strait Islander primary care, Medicare Benefits Schedule (MBS), pharmaceuticals, aged care, and the NDIS.

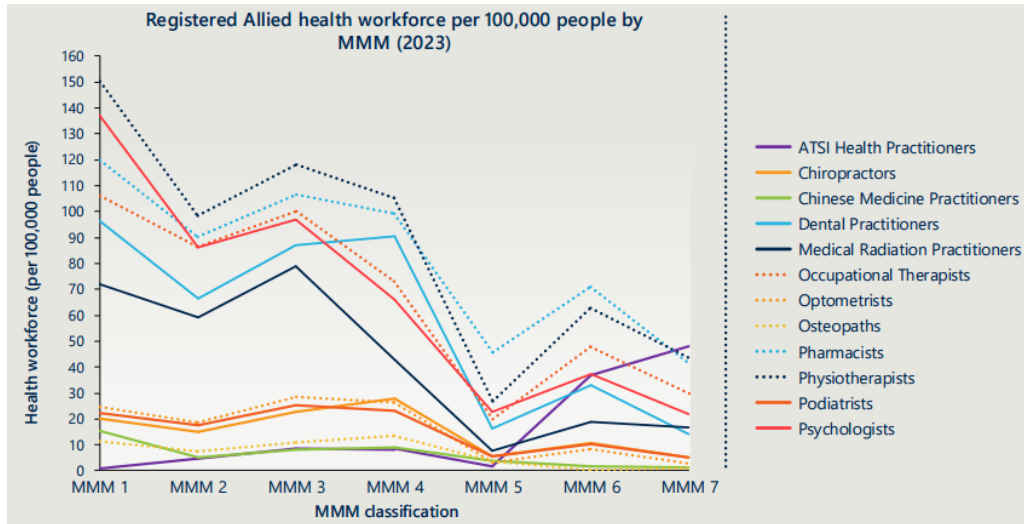
The Report found that the expenditure gap between urban and non-urban populations was **\$8.35 billion** in 2023-24, equating to an average of **\$1,090.47 per person per year** – an increase from the \$848.02 gap per person per year reported for 2020-21.

Concerningly, the Report highlights that the underspend is most pronounced in rural to remote areas (MMM 5–7), where the annual per capita expenditure is now **\$4,701 lower than in metropolitan areas**. This is a growing shortfall that is deepening health, economic and social inequalities and reflects lower health practitioner availability, and inflexibility of policy and funding to meet the circumstances of rural communities.

MMM 5 areas, in particular, have the smallest per capita workforce across all almost health professions (refer to the diagrams below sourced from The Forgotten Health Spend Report).



¹ Joint media release - Chris Minns, Premier of New South Wales, and Ryan Park, Minister for Health, Minister for Regional Health, and Minister for the Illawarra & the South Coast, *Government's health inquiry response sets out reform agenda* 4 December 2025



It is of note that the Murrumbidgee Local Government Area is **classified as MMM 5**.

In addition, The Forgotten Health Report found that expenditure trends vary across states and territories. The NSW breakdown is provided in the table below:

State / Territory	Amount	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7
New South Wales	Funding per capita	\$10,774	\$5,589	\$15,452	\$10,793	\$5,605	\$7,573	\$10,341
	Population	5,890,766	32,9304	72,5749	341,937	724,929	38,433	9349
	Difference to metro	\$-	\$(5,185)	\$4,678	\$19	\$(5,170)	\$(3,201)	\$(433)
	Total gap (\$M)		\$(1,707.51)	\$3,394.84	\$6.51	\$(3,747.60)	\$(123.03)	\$(4.05)

NSW expenditure by MMM area, FY 2023-24²

In relation to NSW expenditure, the Report found that:

- Many of the large regional hospitals in NSW fall within MMM 3 areas, contributing to higher per capita spending in these regions
- The small per capita expenditure surplus seen across MMM 4 areas is driven less by public hospitals, and more by higher per capita expenditure on MBS, PBS, NDIS and aged care.
- With a significant population in MMM 5 areas, notable per capita expenditure deficits are evident, and consistent with the challenges in supporting dispersed rural populations in NSW.
- MMM 6 regions show per capita expenditure shortfalls, highlighting the ongoing difficulties in delivering services to remote communities.

A multi-faceted approach to supporting the health system

Potential solutions recommended by stakeholders during the development of The Forgotten Health Spend Report placed priority on a multi-faceted approach to supporting the health system:

² The above table is an extract from Table 6 *Total state and territory expenditure by MMM area, FY2023-24*, page 19-20 of The Forgotten Health Spend Report which provides a breakdown for all states and territories.

- **Defining the levels of access to care** that should be expected in rural and remote areas
- **Undertaking integrated planning at a regional level** to define the best service approaches to meeting local needs
- **Ensure rural hospitals are funded equitably and have parity** to meet additional costs, tyranny of distance and workforce development
- **Establishing coordinated and flexible (blended or block) funding for regions with thin or failed markets and limited infrastructure** to support implementation of regional plans e.g accommodation for the development of future or visiting workforce, health/medical education facilities and rural hospital expenditure
- **Supporting localised, multidisciplinary collaborative service delivery models** rather than assuming an urban based model is better and deliver the outcomes needed
- **Improving workforce pipelines, recruitment and retention** in rural and remote areas as picking rural to rural medical and health school to rural post grad training to rural career.

The Alliance is aware that defining the levels of access to care in rural and remote areas, in particular, must consider the economic and social conditions of people and households in the community, distance to the closest healthcare service or healthcare provider, access to transport, workforce distribution and capacity, infrastructure and technology availability, amongst others.

Benchmarking reasonable levels of access to care (for any Australian) would help to analyse how these drivers and barriers interact to impact on a person's health access and equity, and importantly, enable a rural loading to be applied to funding formulae to account for economic, social, demographic and geographic factors. In this way, rural health care at the community level will be viewed from a whole-of-system perspective, given the limited resources available³.

In terms of defining the best service approaches to meeting local needs, the Alliance's submission to the Special Commission of Inquiry into Healthcare Funding stressed the importance of place-based models that are determined according to the health needs of the local population through community engagement.

Indeed, the complexity of the conditions that people face in rural and remote areas and the limited access to multidisciplinary services to refer patients, leads to long waitlists and delays in receiving diagnoses and management. These delays place pressure on state-based health services, often the provider of last resort for vulnerable communities, and is particularly the case where there are thin or failed markets (AHURI 2022).

To truly make a difference, place-based solutions must be supported by integrated regional level planning, underpinned by coordinated, flexible, equitable and parity in funding mechanisms. The solutions must support innovative approaches to recruiting and retaining the workforce and facilitate models of care and services that can be delivered at economy of scale.

Workforce recruitment and retention, in particular, have inherent challenges driven by factors such as demographic shifts, geographical isolation, and often a mismatch between the skills required and who is on the ground to provide the service – all of which require long-term planning (National Skills Commission 2022).

³ National Rural Health Alliance, 2023. [Submission to the NSW Special Commission of Inquiry into Healthcare Funding, 20 December 2023.](#)

The Alliance has long advocated for a **National Rural Health Strategy (the Strategy)** as a vehicle to coordinate Commonwealth, state and territory investment, supported by an agreed program of work, priority actions and milestones. National datasets, benchmarking of levels of access to care, socioeconomic considerations and appropriate rurality weighting in funding formulae would provide a blueprint for a targeted funding plan to address the inequity between rural and urban Australia.

The Strategy would incorporate several other components that address barriers to access to care, such as support for rural education and training, housing and infrastructure (including childcare), indexed patient transport and accommodation, telecommunications to support digital connectivity, and much more.⁴

Conclusion

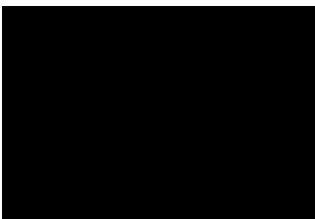
Whether or not the Murrumbidgee Local Health District is split into the Murrumbidgee Local Health District and the Western Riverina Local Health District Rural, rural and remote areas must be supported to receive the funding they need. Indeed, the evidence is clear - the gap in expenditure is widening between rural and urban areas, and across states and territories including NSW and covering the Murrumbidgee Local Health District. Accordingly, more funding must be invested, not less, and allocated based on local population health need, supported by community-designed solutions reflecting the diversity of these areas.

The Alliance is continuing to update and report on health expenditure deficit data between rural and urban areas into future years so that we can track Commonwealth and state and territory spending on health, disability and aged care services on rural communities.

Further action to address the inequitable health spend, lack of access to care in many rural communities and poorer health outcomes would ensure both social justice and economic productivity for Australia.

I would be pleased to provide further information on any of the information contained in this submission if required.

Yours sincerely,



Susi Tegen
Chief Executive

⁴ National Rural Health Alliance, 2024. 2025-26 Commonwealth Government Pre-Budget Submission December 2024
<https://www.ruralhealth.org.au/policy/submission/2025-26-pre-budget-submission/>

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