Special Commission of Inquiry into Healthcare Funding

Statement of Peter Treseder AO

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Occupation:	Board Chair, Mid North Coast Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**) as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (MOH.0010.0542.0001), to the extent that such topics are relevant to my role. It also responds to matters raised in the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (MOH.0010.0541.0001).

A. INTRODUCTION

3. I am the Board Chair of the Mid North Coast Local Health District (**MNCLHD**), a role I have held since June 2023.

4. My previous professional experience is in banking and fundraising for health and medical research, and I have also held roles as the Chief Convenor of the Prime Minister's Community Business Partnership, the founding Chair of Mid North Coast Rural Health and Medical Research Foundation, and as Director of The Patricia Dukes Foundation. A copy of my curriculum vitae is exhibited (MOH.0010.0589.0001).

5. In my role as Board Chair, I take a holistic approach to the operations of MNCLHD understanding that MNCLHD operates in the context of NSW Government priorities and finances. My primary responsibility is to have an oversight role in respect of the Chief Executive, and I am responsible for managing the Chief Executive's performance and supporting the Chief Executive in the running of MNCLHD. My other main responsibility is to ensure the proper functioning of the Board.

B. BOARD GOVERNANCE

6. MNCLHD extends from the Port Macquarie Hastings Local Government Area in the south to Coffs Harbour Local Government Area in the north and provides healthcare services to a population of over 230,000 residents, of which 8.2% identify as Aboriginal or Torres Strait Islander, 13% were born overseas and 18% are aged 70+ (the highest

proportion of any NSW Local Health District (**LHD**)). Although MNCLHD is experiencing population growth, this population growth is focussed on the centres of Port Macquarie and Coffs Harbour.

7. The MNCLHD Board is constituted under the *Health Services Act 1997* and is structured in accordance with the NSW Health Model By-Laws. It operates in accordance with the MNCLHD Board Charter, exhibited (MOH.0010.0654.0001), and the functions set out in s. 28 of the *Health Services Act 1997*.

8. The MNCLHD Board has nine members from a range of backgrounds, including medical, nursing, business, compliance and local government experience.

9. The MNCLHD Board is responsible for various matters including:

    a. Approving systems to ensure MNCLHD delivers agreed services and performance standards within an agreed budget based on annual strategic and operating plans, and the Service Agreement between MNCLHD and the Secretary NSW Health (**Service Agreement**),

    b. Approving systems to ensure the accountable and efficient provision of services and producing annual reports, subject to State financial accountability and audit frameworks,

    c. Monitoring MNCLHD performance against the agreed performance monitoring measures in the Service Agreement,

    d. Improving local patient outcomes and responding to system-wide issues,

    e. Maintaining effective communication with State and relevant local stakeholders including clinicians and the community.

10. The Board provides governance oversight to MNCLHD but does not undertake the day-to-day management or operation of the District. The Board is focused on leading, directing and monitoring the activities of MNCLHD and driving overall performance.

Board and Committee Structure

11. The Chief Executive is accountable to both the Board and the Secretary, NSW Health and the Board is accountable to the NSW Government Minister for Health. The Board also exercises employer functions in respect of the Chief Executive.

12. The Chair and Chief Executive meet face to face on a weekly basis to discuss a variety of issues important to MNCLHD.

13. As part of his accountability to the Board, the Chief Executive regularly reports to the Board and attends Board meetings, along with various members of the Executive.

14. The Board meets monthly in locations across MNCLHD. The Chairs of the two Medical Staff Councils (**MSCs**) (from Coffs Harbour and Port Macquarie Hospitals) have access to the Board via regular catch ups with me as the Board Chair, and the Board also invites staff at each Board meeting location to present to the Board on patient stories or staff initiatives or issues.

15. The MNCLHD By-Laws reflect the Model By-Laws and provide for the MNCLHD to establish four committees:

    a. Audit and Risk Committee,

    b. Finance and Performance Committee,

    c. Health Care Quality Committee, and

    d. Medical and Dental Appointments Advisory Committee (**MDAAC**) including the Credentials (Clinical Privileges) Subcommittee.

    As well as these, the Board has established the following subcommittees:

    a. Close the Gap,

    b. Local Health Advisory Council,

    c. People and Culture.

16. Other than the Audit and Risk Committee, each Board committee is chaired by a Board member and is usually comprised of at least one member of the MNCLHD Executive or delegate.

17. The Chair of each Board Committee or Management Committee presents the minutes of their Committee and provides updates to the Board on the work being done and also feeds back information and direction from the Board to their respective committees. The Committees provide focused governance for the main strategic imperatives of the Board.

18. The Model By-Laws provide for the establishment of a number of structures for clinician consultation and input into the LHD including MSCs. In MNCLHD there are MSCs at Coffs Harbour and Port Macquarie Hospitals. The Chair of the MSC is a direct point of contact between the Board (via the Board Chair) and clinicians.

Board consultation with staff

19. I facilitate the Board hearing from and communicating with staff of MNCLHD in a variety of ways, both through formal processes and informal opportunities.

20. I provide a report to all of the MNCLHD staff outlining what is discussed in our Board meetings. I also use this as an opportunity to remind staff of issues occurring in the District. Following each Board meeting I provide an update on Board activities to all staff. This is in the form of a Note from the Chair which is uploaded to a site available to all staff to read. I also appear regularly on a live broadcast to the staff where I am able to discuss a variety of matters of interest to them.

21. I have attended a number of MSC meetings, especially when there are particular issues of concern to clinicians. For example, where there was recent concern about understaffing at Coffs Harbour's Emergency Department, I met with the Chairs of both MSCs (Coffs Harbour and Port Macquarie) and listened to concerns. I discussed the strategy for resolution with the MSC Chairs and spoke to the staff member raising the concerns.

22. The Board receives the People Matter Employee Survey (**PMES**) results and uses these results to understand staff concerns and inform strategies to improve staff experience. For example, one of the disappointing results we received from our PMES results was the unacceptable amount of racism and sexual harassment occurring in MNCLHD, from staff to staff and patient to staff. This has informed the "Racism. It stops with me" campaign that was launched by MNCLHD in March 2024. The Board continues to monitor PMES results for improvement in this and other areas.

23. More informally, I spend a lot of time facilitating one on one meetings with Board members and senior executives of MNCLHD. We are in the people business and the more I interact with the senior executives the more I can promote respectful conversations throughout the organisation. It is also a way that I can check in on them to ensure that they are okay and that they are coping with the pressures of their roles. I also spend time walking around the hospitals and speaking to staff where I am able to receive a lot of information on what is happening on the ground.

24. The Board also holds a morning tea with staff at each monthly Board meeting. This promotes interaction between the Board and a variety of staff on a regular basis.

Board consultation with community and consumers

25. The Board has established a Local Health Advisory Council which consults regularly with communities and consumers. It is chaired by a member of the Board and includes members drawn widely across our community. We advertise on our website for interested consumers to join the committee. We also approach consumers with lived experience to join the committee. Committee membership rotates on a sensible basis. As well as this, the Board Chair and Chief Executive regularly meet with local politicians of the three tiers of government and other local influencers updating them and garnering their opinion on certain aspects of our business.

C. INTEGRATED HEALTHCARE

26. When I became Chair of the Board, I regarded as a priority the development of a Memorandum of Understanding (**MOU**) between MNCLHD, the Healthy North Coast Primary Health Network (**PHN**) and Northern NSW Local Health District (**NNSWLHD**).. After discussions with other Board members, we began work on a MOU which was executed in February 2024 and is exhibited (MOH.0010.0585.0001). This was discussed and agreed at joint board meetings involving the three boards.

27. The MOU provides for activities to be undertaken, some by MNCLHD with the PHN, some by NNSWLHD with the PHN, and the balance jointly. There has been a noticeable improvement since executing the MOU, including greater cooperation in locations such as Coffs Harbour. For example, there is now a much stronger integration of mental health service delivery between General Practitioners and Coffs Harbour Hospital and a more streamlined process for patients moving through the system.

28. If we are to improve the wellbeing of our patients there needs to better coordination between primary, acute and aged care health care providers. It would be my suggestion that one Board representing the three aspects of our business could achieve this better than say the two LHD boards and PHN that currently administer the MOU and the system it supports.

29. The Board sees the next priority focus for integrated healthcare as being required in the aged care space. There is both a clinical and cost imperative in ensuring that aged care patients can be transferred to residential aged care facilities when they are suitable for

discharge. I have asked the Board and Executive to look at this issue over the next six months and liaise with NNSWLHD and aged care facilities with a view to a joint agreement, similar to the MOU with NNSWLHD and the PHN. These discussions commenced some time ago and stalled but will be picked up again as part of MNCLHD's future preparation of its Aged Care Plan.

D. HEALTHCARE FUNDING & BUDGET

30. The Activity Based Funding (**ABF**) model is complex and causes the health system to be heavily focussed on funding and delivery of acute care. I chair the Healthcare Service Plan Steering Committee and we regularly discuss what we can do to deliver the best quality of health care over the next ten years, looking at the numbers of consumers rather than allocated budgets based on acute care activity. I regularly report this Committee's activities to the Board, and at appropriate times, the Board will be consulted as to proposed plans of the Health Service Plan Steering Committee.

31. On this basis, we are developing a model which reflects four pillars of health care delivery as follows:

    a. Preventative Healthcare,

    b. Primary Care and Partnering,

    c. Care in the Community and Virtual Care,

    d. Care in our Hospitals.

32. These pillars all need to integrate to deliver care across the system. Without proper funding of preventative and community care, and the resolution of market challenges in aged and primary care, the acute care system is going to fail. For example, if there is bed block in a facility due to inability to discharge to residential aged care, no matter how many staff there are in the Emergency Department, the blocked patients will not move through the system and it will stagnate.

33. The budget is difficult to understand and needs to be simplified. For example, I have never seen a budget presented to a Board for approval which has a negative starting position. Further complicating this with reference to MNCLHD's 24/25 budget which has a negative starting position of $25 million, which a reasonable person would assume to be an unfavourable Net Cost of Service (**NCOS**) position. Our finance professionals tell me that this is not the case and indeed the NCOS position is much worse. They come to

this conclusion by calculating various aspects of the appendices. This does not make sense and it needs to be clear.

34. On a more basic level, the budget includes a statement of the state efficient price and the targeted volume applied to various aspects of our business. Again, a reasonable person would multiply the state efficient price by the targeted volume to arrive at the total dollars available to fund a particular service. When I run a calculator over those, it never works, and it should.

35. Although I do not have expertise in funding models sufficient to recommend an alternative model, it is apparent to me that the current budgeting needs to be simplified to encourage full transparency and accountability.

36. There is also community and political pressure that affects funding allocation. For example, the Chief Executive Officer and I, with the Board's knowledge, initially declined requests for further funding by Coffs Harbour Emergency Department staff on the understanding that there was no room to extend MNCLHD's funding and the greater need was in our Port Macquarie Emergency Department. However, when the issue gained media attention some of the requested positions were granted by the Ministry of Health which we needed to absorb in our already extended budgets. The difficulty with funding on the basis of political pressure is that it encourages the idea of causing a stir to gain a desired outcome.

E. WORKFORCE CHALLENGES

Regional recruitment and locum reliance

37. The workforce challenges MNCLHD faces are twofold. Firstly, there are difficulties in attraction and retention of staff, both directly and indirectly related to MNCLHD. Secondly, the consequential reliance on locum and agency staff has impacts on both culture and budget.

38. MNCLHD has difficulty attracting staff, particularly nurses, to the region. Students from metropolitan areas tend to want to commence their careers in big tertiary facilities. MNCLHD is making good progress in facilitating students to train here and remain here and has recruited nurses from overseas.

39. There are, however, other factors beyond MNCLHD that also impact staff attraction and retention, principally the unavailability of affordable housing in the Port Macquarie and

Coffs Harbour areas. The Board has worked with the Executive to address this issue in relation to overseas recruited nurses, who are provided with rental accommodation for an initial settlement period. This comes at an initial budget expenditure, but it is considered that over time the initial costs will be recouped by not having to pay exorbitant agency costs.

40. Difficulties in attraction and retention of staff to the geographic region has caused a need to rely on agency and locum staff. This in turn can have a negative impact on permanent staff, given that locums are paid much more than permanent staff who are doing a consistently good job. This has an even greater impact than the knowledge of higher interstate wages, as it occurs immediately alongside existing staff who may have worked at MNCLHD for decades, including through COVID. This creates poor morale and a feeling of ill will to MNCLHD as the employer.

41. Exorbitant locum and agency wages impact not only morale. They have a significant impact on MNCLHD's ability to deliver services within its allocated budget. Knowing these impacts, the Board focuses discussions on how to reduce this reliance and hence cost. The overseas engagement of nursing staff is an example.

42. Recognising potential issues arising from the application of competition legislation, I consider the solution to this problem to be centrally fixing a maximum locum rate (Australia wide) and the setting up of a centralised agency network by the MOH to manage the system's locum and agency requirements. LHDs could then register their needs through a central MOH agency which could then position staff anywhere in the State where needed.

43. I have reviewed the statement of Dr Shehnarz Salindera dated 8 August 2024 and consider, during my time on the Board, there has always been a clear understanding among the Board of the roles of VMOs and Staff Specialists. In relation to her comments regarding full time equivalent (**FTE**) staffing reductions, an FTE reduction program can be achieved with rostering improvements and reducing overtime, amongst other initiatives and while taking into account patient safety.

Aboriginal and Torres Strait Islander employment

44. The other challenge facing MNCLHD is the implementation of strategies for employment of Aboriginal and Torres Strait Islander staff to achieve equity in Closing the Gap. The Board takes a very serious approach to the need to achieve this in MNCLHD, given that we have one of the largest populations of Aboriginal and Torres Strait Islander people in

the State. The Board regularly monitors MNCLHD's compliance with the MNCLHD Aboriginal Strategic Plan, which sets out operational strategies not only in relation to employment but also engagement with and service delivery to Aboriginal and Torres Strait Islander consumers.

Innovation

45. The continued development of virtual care, the expansion of research, adoption of innovation and the introduction of new technologies in facilities across the system, along with new ways of working sustainably, environmentally, and digitally, will create new opportunities. However, underpinning this innovation, is the challenge of workforce and how we attract and engage sufficient staff going forward.

F. CONCLUSION

46. As a former banker, I bring a commercial lens to the Board of MNCLHD and some innovative ideas on overcoming healthcare fundings problems. If we spend the entire annual NSW budget on NSW Health it could still not be enough. The healthcare system must operate within set financial parameters and efficiencies and although I do not yet consider that we have reached the limit of available efficiencies, there will be a time when they are reached.

Sovereign Wealth Fund

47. I have raised the idea of a sovereign wealth fund (**SWF**) with a number of former Prime Ministers and past Federal Governments as a means of creating a savings fund for the Nation. In discussions over time, I have suggested that our nation should have a SWF of a trillion dollars. This is a funding approach taken by other international governments, such as Norway and the United Arab Emirates.

48. As a compromise to my SWF suggestion, the Medical Research Future Fund was established in 2015, which is now worth approximately $22 billion, and supports investment in Australia's health and medical research. The fund uses net interest to support research requests and there is opportunity to use a Future Fund in a similar manner to support the delivery of health care in NSW.

My suggestion is the NSW Government set up Health Future Fund which could be grown to say $60 billion over a decade. The earnings of this fund could then be used to support the funding of the health system as needed. Most people would say I am dreaming, but

my experience is someone needs to take the first step and if someone doesn't our state health finances will continue to be crippled by the State's inability to fund them.

Peter Treseder AO	Witness: Laney Lawrence
13 September 2024	13 September 2024
Date	Date