DR KAREN HOOPER:
Thank you. We're now ready to invite our first presenter, Michael Moodie, who is adjunct professor from the University of the Sunshine Coast. Michael, before you start your presentation, could I please ask you to identify yourself and your organisation for the purpose of the public record.

MICHAEL MOODIE:
I'm an adjunct professor at the University of the Sunshine Coast.

DR KAREN HOOPER:
Thank you, Michael, over to you.

MICHAEL MOODIE:
I am prepared a submission, which is what I consider to be shortcomings in the NDIS market within Queensland. I suspect it's an issue in other states as well. That issue relates to those people that enter hospital and for a variety of reasons become long... what's called long stay patients within hospital. In particular, these patients in hospitals are participants of the NDIS.

The nature of the NDIS is one of being a market based system, where funding is provided to the participants to then purchase services within a market.

That is an admirable goal. I think it's a good system. But it doesn't work particularly well for those populations of people that are in hospital, because it requires facilitation of a market response to enable those things to happen, for those people to exit hospital easily and in a planned way. Fundamental to the problem is that you have a group of people that have high complex needs, that for a variety of reasons ended up in hospital, normally they are a change of life circumstances, so they may have an injury, have behavioural issues etc. So their previous arrangements in terms of accommodation are often not satisfactory. So the process then starts to then try and find suitable alternatives for those people in the community.

The process today has largely been left to people when they arrive in hospital and then the circumstances about how does one get them out of hospital. And there are many examples where people have been hospital for extended periods, certainly over 100 days, and some people have been in there for periods a lot longer than that. The current arrangements within hospitals are that either social workers or discharge planners have responsibility to try and find suitable accommodation or suitable community options. And if the market hasn't been developed, i.e there isn't suitable accommodation or support mechanisms in the community, then it doesn't matter what you do in the hospital environment, those things don't exist.

So my view is just that the government needs to facilitate the market. And we're not speaking about mechanism when the Queensland state government would fund those services, but it should have a role in terms of facilitation of the market. And by that I mean an understanding of in particular, the numbers and the types of people that are in those facilities and typically the most difficult people to place are those with an intellectual disability, comorbidities and mental health and behavioural issues typically required to live by themselves and very high levels of support.

Most current NDIS providers because of the roll out are in demand either don't know about these populations in hospital or are too busy doing other work to do to take an interest. The processes within hospitals are complex around the ability of Queensland hospitals to refer to particular providers in a market environment.

There are a range of issues around appropriate tendering of those arrangements. Some, Queensland health services do refer directly to providers, and others don't. And they use the Queensland government tendering arrangements with a view that they are providing a benefit to a particular provider. That's all understandable. But I think it's an issue that needs to be resolved, particularly when it isn't state government money that's being used to provide the support and the accommodation arrangements.

So the complicating factor has been... with COVID has been certainly a tightening of the rental markets. It's very difficult to provide rental properties through public real estate agents, because they've mainly been at the bottom of the list. So when you have vacancy rates at 1%, or lower, these folks aren't going to get a look in. I'm of the view that it's probably too late once people get into hospital, I don't think it's a difficult thing to find out what that cohort of people is within a community. There really should be a planned approach around identifying those people before they enter the hospital, and making sure that they have adequate support, and that they have adequate accommodation. So that if they do end up in hospital, those arrangements are in place, it's a bit late once they are in the facility.

So from a public health perspective, it's really stratifying the population into those groupings. And taking those steps in a preventative sense, rather than waiting for them to be a response because they were in hospital. The provision of information from Queensland Health as you can appreciate, is a huge challenge because the existence of the person in the facility is confidential. Because the data is difficult to obtain and that's understandable, then the market response is very inadequate.

So if you talk to developers that want to develop property, for these folks, they're really saying, well, I want to know who the person is, I want to build something that met their requirements. And I want some indication that they would, if they come in terms of a rental arrangement, that they are going to stay because the investment is quite high. So, I think it's an issue that can be resolved with the current arrangement is it doesn't work in that way.

I had some discussions with QIC and some of the banks around and in particular, with the Office of Public Guardian, removing complexity from the accommodation provision, if there was some scheme where the person, or and or their family could be assisted to purchase the property themselves. Because of the complexity of need, the SDA payments are quite considerable. Some arrangement for those people can be facilitated to own the properties themselves would be a major advance, and that takes , so you're not dealing with an investor that's looking for a return, you're dealing with a family member or the person themselves, in terms of the design process, whatever.

The other complication is the identification of the particular need, or the complexity of the need of the person. I've taken interest in the NDIS since it started and have worked in Queensland Health and in intellectual disability facilities. Showing my age, but when Challinor centre was an operation in Ipswich, I don't think there's a consciousness of the nature of the need of these folks and the

numbers of these people. I think, NDIS is great for people that don't have any intellectual disability that can manage the purchase of services themselves, whatever it is, this is a different category of person, that requires specialist support. And I don't think there's enough research done on those particular needs, and what the responses need to be within the community. And therefore, the response that needs to be in terms of facilitation of the market.

They are often in the whole sector called frequent fliers. The disability group are a major component of the estimated 4% that use about 40% of public resources in terms of healthcare, and it's because they cycle in and out of the community of public health, if you get the basics like housing and support right, then there's often not a need for those folks to come into hospital. Or if they do come in, there's an exit path out. So the... and in terms of the provider community, unless they can be assured of some level of scale or volume, it's very hard for them if they have a particular and the scheme encourages you to specialise in particular groupings of people. So you get good at that, and you scale around that and you get your efficiencies.

So if you've got a group of people that don't have an intellectual disability, and you're providing support, someone with in a wheelchair, as opposed to someone that has severely intellectual disability and chronic health issues, whatever. That mix is very difficult for you to manage. We find that the provision of those service providers is limited, because they don't get certainty around the scale because of the investment required. So they don't do it. I've said in my paper that the Queensland Government should seriously reconsider the closure of AS and RS, the accommodation services, respite services, I still think it should be an NDIS funded service.

But staffed by public offices that specialise in these categories of people, in particular transition from hospital, it will be a lot cheaper for the state to provide those services rather than keeping people in acute medical facilities. In some facilities in the state, a third of the current beds, mental health beds are occupied by people from the NDIS, they can't exit. And I think that problem will grow over time. Because what you'll find is that providers that have clients at the moment that become problematic, because of the issues within the NDIS they will take them to hospital and they will withdraw service, they can't get out of the hospital, those numbers will naturally grow over time. And the state government will be picking up the costs, not the NDIS.

There is a significant human rights issue that sits around all of this, because I think it will be very difficult for a executive running a hospital to argue that given the NDIS, they can't exit people. So it raises the question then around why is the person retained in hospital when on the surface, ignoring the complexity, that there is sufficient government support- significant government support for the person to live in a meaningful arrangement in the community. I think that's a test that will come at some stage unless these issues are resolved. So, there are issues around the provision of facilitation in the market. There is issues around the nature of the person in understanding those particular needs. And there's issues around the supervision in terms of expertise to provide those services.

The other areas that I think are important are in terms of support coordination, generally, and want to stress as a generalisation. Queensland public hospitals have sought to undertake the support coordination role internally by either social work staff or allied health staff. I think that has caused a range of issues, that do not facilitate the long term placement of people in the community. The major one being is that folks that work in, in Queensland public hospitals in those roles, see the

world from a sense from a deficit perspective, where it's an analysis of what you can't do. Whereas the NDIS is very focused on what supports do you need to do the things you need to do. Those folks are not in a position to actually facilitate the market. Because of the issues around tendering and dealing with the market, I think it needs to be done at a more macro level, because it does involve a multi agency response. So they do the best they can.

And I think at the end of the day, the focus, the pressure is to discharge- to get them out. So they get them out often into substandard accommodation- substandard provider. So, I do think there is a need as part of the mix that they be some to get around the tendering things they should be, particularly for health services that there be a select tender process or support coordinators that they'd be a select tender process for the providers.

Where the public hospital system enters a process with the provider about mutual obligations is one of the criticisms of support coordinators for hospitals is either the support coordinator doesn't know what how the hospital system works, which is understandable. But also support coordinators don't work 24/7, well, they go on leave so, they have got a person they're dealing with, there's no obligation for them to act as in a sense as an emergency service, so hence the notion around the AS and RS being revitalised where those requirements would be placed, because social workers within hospitals need to be able to call somebody 24/7 and get some service. But the cost of the public health system of the supporting of those people into operating internally is picked up all this state. Whereas this is a significant funding from the NDIS to do that work.

And it's not necessarily an easy process, where people are working across a mix of clients with a hospital environment to do that work. A select tender process, in a sense as a pre qualification exercise, because I think the state, public hospitals have a responsibility to make sure that they discharging a person to an appropriate environment, a safe environment. And that, you know, there's a variety of providers, because it's a market. So, I think pre-qualification will go a long way to ensure that people stay in the marketplace, you know, for these particular populations.

So the OPG has a lot of these folks. OPG is responsible for the administration. So the OPG needs to be part of that discussions as well. So the support coordination is certainly a big area of deficit in terms of the mix. And that's part of the design of the scheme that those things work with. The other area and in the NDIS, the disability folks don't like the term case management. Because its health, but I'll deliberately use, one of the issues as being case management is that certainly a major complaint of people from public hospitals is that the person comes in, they're discharged and they come back, there's no notes, there's no records kept about what the issues were or whatever. And an area that's often neglected is the health of the person. Given the nature of the population, they have health issues as well as disability.

So you have a scheme around disability and you have a scheme that sits around health, there needs to be some efforts around bringing those two factors together, they can use a goal of the NDIS but for these folks to stay in the community that needs to be resolved. So a case management environment and support coordination in the scheme is designed around a short term, so facilitation, to training thing where people once they get on their feet, and they know what to do they don't need the support coordination, I get that. But in terms of these populations, they're going to require that support their life because of the complexity of the issues that they may come from.

There might be some reduction in some reallocation of resources internally from the NDIS. But normally, as they age their need grows, it doesn't fall away.

And I think that those design features within the scheme are because in the design of the scheme, these populations weren't necessarily understood and considered because, you know, because they were away. They're normally in hospital facility. And not known about, but they are certainly eligible for that. And the case management environment should be owned by the person. So there should be a scheme where the case management environment rather than being controlled by a provider, because the reality is that multiple providers, so the case management environment should be and so the person or their family can say, OK, who is responsible for them.

If you're providing services, you're going to use this particular platform and those things, so they do come back In the hospital, and I have had healthy input from whoever, then all of those things are in place that will go a long way to making sure that those people stay in the community. So putting all those things together, it is a considerable cost of the state government. There was a big push to get people out with COVID. I don't think that's worked very well. I think there is significant risk to the Queensland Government in terms of substandard arrangements in terms of discharge out, particularly the providers that just don't have a skill set. Because the market can just develop. This is very high needs high complicated people.

This general dissatisfaction about how it works, particularly in the health community, within public hospitals, but it's not an emergency department issues, that's not a showstopper, it's a secret and hidden issue, that is probably not top of mind for hospital administrators. Because the end of the day, they get paid for that activity, which is a disincentive at one level. But it's certainly I think, an issue for the state government. So you're talking about markets. This is probably out there and lots in terms of an issue that needs to be addressed.

So I agree with the thrust of the report, but I think it needs to focus on as an example, the impact on that particular group, or the young, younger people in residential aged care is a priority issue for the, NDIS and it's been addressed by the Commonwealth, but this is clearly a state issue. (INAUDIBLE) That's the questions or comments.

DR KAREN HOOPER:
Great. Thanks so much. You've obviously touched on many issues that we've identified in the report from the importance of accommodation, the role of support coordination, and issues around interaction of Queensland Government Services with the NDIS.

MICHAEL MOODIE:
And other Queensland Government Services.

DR KAREN HOOPER:
Michael, could I ask you to cast your mind back to pre-NDIS? So has there been any improvement in accommodation outcomes for people with a disability at risk of long term hospital stays since the introduction of the NDIS?

MICHAEL MOODIE:
What I have certainly come across instances where it has worked, they are rare, but certainly when

it comes together, and this is a general observation as well, not just necessarily this population, but in particular where the families have taken responsibility for the outcomes. Generally, families don't believe it. And that's, I think, an issue within the health system where you're often in or not. When you talk to people in the public health system, and you explain what NDIS participants are eligible for in terms of funding, and also in rental assistance under SNA. I think it's fair to say that most people don't believe you. Because of the nature of the clients they deal with.

And the difficulty in terms of trying to organise these things, between centres that there's a huge gap between most people that you deal with and are trying to get them out of hospital, into social housing, whatever that is family support, there's really not a lot. But then you come along and say, yeah, but for NDIS people, this is what's on the table. This is the (UNKNOWN) and people don't... And it's also a particular issue within prisons. So they have their existing systems. But if you come along and say, yeah, but these things are available, like they just don't believe me.

So when it does work, it works wonderfully. It is a fantastic scheme. There are obviously issues with it. And really, the issue here is that how do we in the state, make it work so people access those things? And it essentially goes to collaboration. And it's essentially goes to an understanding of dealing with that. What are the needs of this cohort? What do we need to do to then provide the services in a systemic way and to get them out of hospitals?

DR KAREN HOOPER:
You mentioned the importance of support coordination. And our draft report talks about support coordination, the value that support coordinators bring to coordinating services. So for those that are in hospital waiting for discharge, do they have access to support coordinators through their plan? Has that been your experience?

MICHAEL MOODIE:
No.

DR KAREN HOOPER:
No.

MICHAEL MOODIE:
And there are a number of reasons and probably the most important one goes to culture is that there was talk in the NDIS is that they'd be labels to support coordination where people are qualified allied health professionals that stripped away, it's very difficult to engage with the public health system about a discharge of a client if you're not qualified. And it's similar to talking to a doctor. And it's the same applies to somebody that's a Support Coordinator, or with the best intent, that doesn't have those qualifications and doesn't understand the operations of the public health system becomes very challenging.

So what the hospitals have done is to build that capacity internally. And that's understandable to then try and exit people but so the hospitals are doing for these folks generally they're doing the applications for the clients, they've done in a particular way that focused on discharged and focused on the longer-term arrangement, they have hotlines to the NDIS because it's government priority.

But I think it's the nature of, tendering for support coordinators, really is to put market signals that there's a need for this type of service. And that we want to engage with you, but we want some satisfaction, that you know what you're doing. And there's some mutual obligation, ie that you'll be available. Without those mechanisms, it's very difficult for support coordinators to get into the swing, it's very difficult generally.

I've worked in health for 30 years, it's very difficult even to get in the door to discuss the issue, because of workload pressure, whatever, let alone have a conversation about, you know, the needs of particular people. And particularly if it's from a systemic perspective, when someone wants to build a system, or waiting, one entry point to come out as the social worker is the breakdown, or whatever, because there's just a plethora of people that are in this in the public hospital system that's eligible for the NDIS. But resolving that support coordination issue is really important.

The other complexities is is that generally most providers look to capture the client. So they come along with a deal. And they say, come with me, I'll provide the SIL, I will provide the house and I'll provide everything else. And generally, the public health system is uncomfortable with that, because that's not the principles of this game. So and the providers are doing that. So there needs to be control over that, so that there market signals from the state that says you engage with us, is a fundamental rule of the system, that these things need to be separated out, so there are separate providers for all within the NDIS, in particular.

DR KAREN HOOPER:
In terms of the challenge that you identified around rights in hospital and discharge process interactions with the NDIS, are there any good examples interstate where these challenges are being addressed? Any good models that you can pinpoint, or is this an issue for hospital systems across the country?

MICHAEL MOODIE:
Look, there have been different initiatives. South Australia ran programs to get people out. Well, I think those specific...I can't talk authoritatively about. But I think there are pushes at particular times around getting people out because they need the beds, probably that's the wrong place to start. I think it's better to look at it from a population health perspective, when you look at the particular cohort, and it's not something you do as a one-off, it's got to be a longer term arrangement. Because the reality is that if you've got a group within that popular group within the hospital, now, they are only a subset of a much larger group that in the community that cycle in and out.

So to think it’s will do something for 12 months and it will go away, is not correct, I think you're looking at the longer term and a systemic issue. And that leads to the notion that there needs to be some government agency service that takes on that if you can't get the market to step up, then you need to have the things like and AS and RS that still receives its funding from the NDIS. But there are specific people that you have absolutely no problem getting SDA providers to do this combination work. I don't think you'd have trouble with getting sole providers to step up if they had that support.

So there was a there may be a process of suggestion, person comes out of hospital, they enter an AS and RS type environment, where there is medium term accommodation arrangements put in place. So there's a transition and then the because the behaviours of the person typically settled down

once they come out of hospitals almost stable environment, particularly you know where the houses, it's far easier to then do a handoff to a market based provider, because they've got this, they've been trained to have the skill set.

It's not that there's a shortage of money, I think they've adequate money there, and then there's some mechanism to keep an eye on, because you just don't hand off and let it go. But there's some, you know, mechanism. So those folks don't end up in hospital for long periods, or if they do require health assistance, it's provided another way. So it's a facilitation of the market model. And it's not a replacement of the market. But you've got to facilitate and step the market up.

DR KAREN HOOPER:
And you mentioned in your earlier comments about the importance of case management notes or information sharing on the participant's health records and disability needs. Are there existing systems in place that could be utilised better, like My Health Record? Or do we need new systems to be able to create that opportunity for information capture and sharing?

MICHAEL MOODIE:
Look, there's certainly within the health, it's not specific to disability. No, because what the IT platforms in disability have really been, essentially administration systems. And people may say, Well, that's not right. But essentially, they're there to record basic information, so the provider can be paid.

But certainly, if you look at other areas, in the health sector, if you look at the operations of people at Medibank Health Solutions that provide call centre technology that are heavily based case management systems, where somebody like me that's getting on overweight, has risk of cardiac issues, whatever, if you've got private health insurance, they will assign a case manager to you, that will give you access to GPs, they'll recommend it, it's not a difficult thing to do. It's just not being applied to the disability sector. But it needs to operate at that level of sophistication, because disabilities has said over here, it's about bringing them into the fold. So it's not it's not something with government has to invest lots of money in these things can be purchased in the marketplace, but they just need to be applied to, you know, to the to the disability sector, with a focus to provide a better level of care and support.

And I use the word 'care' deliberately, because these folks do need care. And that, you know, the objective is that they don't come back to hospital, you know, $2,500 and $3,000 a day, per bed day, over 100 days, over a year. Really mounts up, particularly if you can get the funding from the NDIS in the first place.

DR KAREN HOOPER:
In your earlier comments, you commented on the rehousing efforts that were motivated by COVID. And you expressed a view that you don't think that worked well, what didn't work well in that process? Obviously, people exited hospital. But what was the key challenge there? Or what didn't work?

MICHAEL MOODIE:
Well, they started in the wrong place, the objective was to get people out of hospital.

DR KAREN HOOPER:
Right?

MICHAEL MOODIE:
What I'm advocating, I look at, and it's not a criticism of the people that are involved in those processes. But it's, it's really about saying, it's like many people I speak to about SDA, you know, they come out and from an investment perspective, that's the wrong place to start, what you need to start with is the client and their family and talk about what's the most appropriate accommodation solution for them, location, design, whatever. If you do that well and you do that properly, the money will flow, the investment will be a good one. It's where you start from the wrong place, and you don't understand those fundamentals.

So if your objective is to get people out of hospital, then that's your objective. It's not about a long term solution in the community, ideally, with a person who owns the property themselves, which is quite feasible. Because what you're trying to do is get them out of your net, get them out of that cycle, where they come and go in and out of hospital. And that requires a different skill set different approach altogether. And because what will happen is you get them out, something will happen, they just come back and around again. And so you just get this big cycle of people moving in. And that's where the 4% uses the 40% of resources.

And the studies that people like Medibank have done in terms of those case management arrangements, you know, there's significant returns in ensuring that people stay healthy and well and out of the very expensive acute ends of the of the market. And this is a population that does that but the difference here is that you have a scheme that's well designed, that can be utilised to ensure that they have a better life. And we're not doing that. We're definitely not doing that. And there's no silver bullet. And yeah, one of the things I've suggested in the proposal is there be a, you know, a pilot project, let's give it a go, let's work it out, get better at it.

And there's been some discussions with OPG about, you know, because at the end of the day for those people that they respond to, they're the decision maker. They have people calling them about what to do but don't have the options, then those options are not presented and it's, we got to get Michael out of the hospital, we've got a rental accommodation down the road, and we'll put him in there. And that when you speak to social workers within the major services, they'll tell you, they'll be back within two or three months. They know, who they are, they know when they'll be back. And that's just how it works.

DR KAREN HOOPER:
And so, that knowledge that they'll be back is that informed by the fact that they have a view that perhaps the accommodation that they're going to is not appropriate for their disability?

MICHAEL MOODIE:
They know it's sub-standard.

DR KAREN HOOPER:
(INAUDIBLE)

MICHAEL MOODIE:
And not just accommodation, but in terms of the SIL provision, but in particular the behaviours of the person. So it's not, it's not a criticism of the SIL provider or whatever, it's the work that's required to match the needs of the person to specific arrangement. And that's a feature of this particular layout. This is not the same with somebody that's coming to hospital that's had so motor vehicle accident, and they need a wheelchair, and they go out that's a different environment. These are people with very complex needs that are in our systems. But we don't have the technologies in terms of we have the technology and understanding and diagnosing the issue.

We don't have the technologies in the provision of the service mix in terms of response that's best for them, you only get there through the case management environments, where you trial, a particular thing, this is what you need to do. And you then learn that there needs to be some group that then embodies that knowledge over time. And market responses don't normally do that. That's because the market has different sets of agendas. But for these groups, if you want to keep them in hospital, well, the alternative is you say we're going to keep these people, and we'll build facilities.

They used to be called institutions to house them. And that will be the solution. And we all know what happened, with institutions, but you know, there's certainly there's certainly been discussion about that. It's not dead and gone, despite the NDIS, that's still alive, because you know, what do you do? They can't stay in because the opportunity cost for the whole system is significant, those people sitting in those beds, there's only so many bed then you can't treat other people who have probably have a good chance of rehabilitation and getting on with their lives. So it's a serious issue.

DR KAREN HOOPER:
Michael, thank you very much for your written submission that we received yesterday and your oral submission this morning. Clearly the issues that you raised are within the terms of reference to the inquiry, and we're particularly interested in the accommodation connection, both within the NDIS and the issues that you raised around the importance of appropriate accommodation.

So, thank you for your participation today. We might close your session there.