Queensland Government

Queensland Health

Enquiries to: Associate Professor John Allan
Executive Director
Mental Health Alcohol and Other Drugs Branch
Telephone: [redacted]
Our ref: CAPS2223
Your ref:

Mr Joe Kelly MP
Member for Greenslopes
Chair
Mental Health Select Committee
Parliament House
George Street
BRISBANE QLD 4000

mhsc@parliament.qld.gov.au

Dear Mr Kelly

Please find attached the responses to the six additional questions from members of the Mental Health Select Committee received on Monday 24 January 2022.

Some of the questions do not relate directly to the roles and responsibilities of Queensland Health. Consequently, these responses are based on information provided by other jurisdictions (Question 2) or that which is available from publicly available sources (Questions 4 to 6).

Should you require further information, the Department of Health's contact is Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, on telephone [redacted].

Yours sincerely

Dr John Wakefield PSM
Director-General

7.2.22

Level 37
1 William St Brisbane
GPO Box 48 Brisbane
Queensland 4000 Australia

Website health.qld.gov.au
Email DG_Correspondence@health.qld.gov.au
ABN 66 329 169 412

Additional Questions

Mental Health Select Committee

24 January 2022

Question 1

With the implementation of QScript (the real time monitoring system for Schedule 8 and other prescription medications of dependants) there has been the abolition of the Medicines Regulation and Quality Unit (formerly known as the Monitored Medicines Unit or Drugs of Dependents Unit) leading to, as I understand it, a loss of advisory support to frontline clinical staff about complex alcohol and other drug advisory patient matters. Can I confirm that this is correct, and given clinician feedback, is Queensland Health reconsidering this decision, given the importance of this unit for both clinical advice and data capture and analysis, as it relates to the alcohol and other drugs sector in Queensland?

Answer 1

Under the previous Health (Drugs and Poisons) Regulation 1996 (HDPR) the Department of Health had established a telephone enquiry service for prescribers to obtain details of patients' dispensed Schedule 8 medicines. At that time, there was no other mechanism available to provide this information to prescribers. This information was provided by telephone counsellors employed by the Health Contact Centre (13HEALTH).

Under the HDPR it was also a regulatory requirement that prescribers had to obtain prior approval from the Chief Executive, Queensland Health before prescribing any Schedule 8 medicines or certain Schedule 4 medicines (restricted drugs of dependency – e.g., benzodiazepines) to a patient they reasonably believed was 'drug dependent'.

With the telephone enquiry service, prescribers were also able to obtain advice from Senior Clinical Advisers about their regulatory requirements, and where appropriate, to be granted approvals to treat patients with certain Schedule 8 and Schedule 4 medicines, to ensure their compliance with legislation. The Senior Clinical Advisers were delegates of the Chief Executive and able to grant approvals to prescribers in certain circumstances.

The *Medicines and Poisons Act 2019* (MPA) and subordinate regulations commenced on 27 September 2021. Relevant health practitioners, such as doctors and pharmacists were then able to directly access QScript, Queensland's real-time prescription monitoring program from this date.

From 28 October 2021, the requirement for certain practitioners to check QScript was mandated under the MPA. Mandatory checking of QScript is required before a relevant practitioner prescribes, dispenses, or gives a treatment dose of a monitored medicine for a patient.

Monitored medicines dispensing information is now available to all relevant Queensland health practitioners in QScript. QScript also now allows pharmacists, as dispensers, to access this information.

As such there is no longer a requirement to maintain a telephone enquiry service for medical practitioners. The dispensing history information is now available directly to relevant health practitioners via their access to QScript.

The list of monitored medicines also now includes a broader range of medicines than Schedule 8 medicines, that may present a high risk of physical, mental and social harms in the community. Monitored medicines include all Schedule 8 medicines and certain Schedule 4 medicines (all benzodiazepines, codeine, gabapentin, pregabalin, quetiapine, tramadol, zolpidem, and zopiclone).

Furthermore, under the MPA the regulatory requirements have significantly changed from those under the HDPR. The new MPA and Medicines and Poisons (Medicines) Regulation 2021 (MPMR) no longer requires a prescriber to obtain prior approval before treating a 'drug dependent person' with a monitored medicine.

The new compliance obligations in the MPA and MPMR in relation to monitored medicines are focused on mandatory checking of QScript by relevant health practitioners and compliance with the Monitored Medicines Standard (a departmental standard outlining minimum requirements health practitioners must comply with when prescribing or dispensing monitored medicines for a patient).

Also, as the historical requirements to obtain an approval for the treatment of 'drug dependent' persons under the HDPR does not exist under the MPA, there is no longer a requirement for Senior Clinical Advisers to continue in their roles as decision making delegates or to provide advice in determining if a person might be 'drug dependent'. Information for prescribers on their regulatory requirements is available on the Queensland Health website (see https://www.health.qld.gov.au/system-governance/licences/medicines-poisons/medicines-poisons-act).

The new regulatory framework and ICT system has resulted in significant changes to the work that was previously undertaken by the Monitored Medicines Unit (MMU) and for the Department of Health's statutory obligation to administer the legislation and manage compliance requirements. The MMU structure and functions do not support the ongoing needs to both manage a complex ICT application and administer regulatory requirements in the same manner as it did to support the previous database and previous HDPR requirements.

The new QScript Management Unit (QMU) has been established to ostensibly administer and manage the ICT and policy and governance requirements in relation to QScript. Other units of the Chief Medical Officer and Healthcare Regulation Branch – Prevention Division manage other administrative and compliance aspects of the new legislative framework to support the Department of Health's statutory obligation to administer and manage compliance with the legislation.

Although not delivered by QMU, Queensland Health continues to offer clinical support to health professionals via the Alcohol and Drug Clinical Advisory Service (ADCAS) which is a specialist telephone support service for health professionals in Queensland, providing clinical advice regarding the management of patients with alcohol and other

drug concerns. This free statewide service is available from 8.00am-11.00pm, 7 days a week and is delivered by Metro North Hospital and Health Service.

Background

In response to numerous coronial recommendations, and recommendations of the Office of the Health Ombudsman, and with the support of peak medical and other health practitioner organisations and in line with all other Australian jurisdictions, the Department of Health has implemented a real-time prescription monitoring (RTPM) program, known as QScript.

In 2018 the Commonwealth Department of Health in collaboration with the states and territories proposed a new federated real-time prescription monitoring solution. Under this model, states and territories will aim to integrate with a national data exchange to enable a real-time prescription monitoring system in each state.

The Department of Health implemented a business case for change following the commencement of the *Medicines and Poisons Act 2019* and implementation of QScript.

Every eligible health practitioner (including medical practitioners and pharmacists) registered in Queensland was sent an invitation email to register for QScript access in April and September 2021. As at 31 December 2021, 56.79 per cent of eligible health practitioners had registered for QScript.

The Department has created a comprehensive e-learning portal (See: https://www.qscriptlearn.health.qld.gov.au/) to assist health practitioners who prescribe and dispense monitored medicines (including prescription opioids). This includes modules about the new legislative requirements, how to use QScript, and clinical best practice modules, containing the latest clinical information and advice about monitored medicines.

Information about the e-learning modules has been provided to all health practitioner stakeholder organisations (including medicine and pharmacy groups) for distribution to their memberships. Ongoing communication is being provided to health practitioners to direct them to the relevant e-learning modules and support materials.

The clinical best practice modules include electronic learning modules focussed on prescription opioids: 1) Understanding pain, opioid therapy and managing inherited patients; 2) opioid rotation; 3) opioid overdose and naloxone; and 4) opioid de-prescribing and withdrawal. There are also supporting factsheets on understanding pharmaceutical opioids (including codeine). The training materials have been accredited to meet the requirements for continuing professional development by relevant medical and pharmacy professional organisations.

The Queensland Health website (www.health.qld.gov.au/qscript) also provides direct access to information and resources for health practitioners and links to relevant training and the QScript Health Practitioner portal.

In conjunction with the commencement of the MPA and subordinate regulations, a series of resources was also published on the Queensland Health website to assist health practitioners to comply with their legislative obligations under the MPA in relation to the prescribing and dispensing of monitored medicines. These are available

at:https://www.health.qld.gov.au/system-governance/licences/medicines-poisons/medicines-poisons-act/supporting-documents.

Furthermore, over the last 12 months the Department has presented a range of webinars about monitored medicines including prescription opioids, all webinars have been recorded and are available online (see: https://www.qscriptlearn.health.qld.gov.au/training/webinars) for later review by health practitioners.

Question 2

With reference to the Mental Health Alcohol and Other Drugs Branch within Clinical Excellence Queensland, what is the allocated Full Time Equivalent of staff, what is the allocated staffing to mental health, as opposed to alcohol and other drugs responsibilities, and how does this staffing in the Mental Health and Other Drugs Branch within Queensland Health compare with similar branches in other Departments of Health in other State and Territory jurisdictions across Australia?

Answer 2

The Mental Health Alcohol and Other Drugs (MHAOD) Branch within Clinical Excellence Queensland currently has an allocation of 83 permanent Full Time Equivalent (FTE) positions. These positions sit across four sections:

- Office of the Executive Director
- Office of the Chief Psychiatrist
- Strategy, Planning and Partnerships Unit
- Clinical Systems, Collections and Performance.

A total of 6 FTE of the 83 FTE are dedicated to alcohol and other drug issues.

Other business areas across the Department of Health have associated system manager roles and functions that support the role of the MHAOD Branch and the purchasing and delivery of state-funded MHAOD services.

Queensland Health sought advice from other jurisdictions, but the information provided was incomplete and incomparable to the MHAOD Branch. It is recommended that the requesting Committee member contacts the relevant State/Territory Minister directly to seek this information.

The Royal Commission into Victoria's Mental Health System identified the key role of effective leadership of and accountability for the mental health and wellbeing system through the Victorian Department of Health and that this required a dedicated, well-resourced Division with high-level and legislated leadership.

Question 3

Can QH provide an overview of the planning process to identify needs and investment for mental health, alcohol and other drugs services in Queensland? Does this include consultation with stakeholders, inclusion of population data? What national or state planning frameworks exist and are applied? How is the decentralised nature of Queensland taken into account? Any areas for improvement?

Answer 3

A brief overview of the approach Queensland Health uses to identify and plan for needs and investment across state-funded mental health, alcohol and other drugs (MHAOD) services is provided in the previously submitted Written Briefing at Section 12 (pages 27 to 29).

Planning for state-funded mental health alcohol and other drugs (MHAOD) services in Queensland aims to identify current and projected needs and service gaps using a range of planning tools. These tools support workforce and infrastructure planning and include:

- National Mental Health Service Planning Framework (NMHSPF) – a national population based mental health service planning tool. More information can be found on the Australian Institute of Health and Welfare website here.
- Queensland Drug and Alcohol Services Planning Model (Q-DASPM) – the Queensland adaptation of the Drug and Alcohol Services Planning Model developed by the University of New South Wales.
- Mental Health and Addiction Portal (MHAP) – a data warehouse and business intelligence solution that enables reporting and analysis of Queensland Health MHAOD services.

To facilitate a comprehensive understanding of the MHAOD service system, a range of existing data sources are used. While the primary planning tools are the NMHSPF and the Q-DASPM, existing service use and population data are also used to develop the evidence base to assess need. For some Hospital and Health Services (HHSs), NMHSPF and Q-DASPM generated assessments of need may be adjusted to account to local knowledge and service utilisation patterns, including patient flows. Extensive consultation with HHSs and key stakeholders, including consumers and carers, is regularly undertaken, to support needs analysis efforts and identify priority actions and investment. This approach helps to account for the decentralised nature of Queensland.

The value of these planning tools cannot be underestimated. They have been critical in driving reform of MHAOD services, as they provide the blueprint for a joined up and integrated system. The NMHSPF and the Q-DASPM are genuine population-based health planning tools, as they account for population level health need and estimate the required level of services to meet these needs.

Consideration is also given to several other important factors that influence resource estimations, including regional contexts and population demographics, current service configurations, staffing and infrastructure requirements, and HHS bed flow arrangements. Comprehensive consultation with HHSs and key sector stakeholders

supports the application of planning tool outputs and needs analysis to identify priority actions and investments.

The Mental Health Alcohol and Other Drugs Branch continue to work on improving overall planning processes and assessments of need. The evaluation of Connecting Care to Recovery supported the continued use the national planning tools, but with enhanced local considerations of MHAOD service needs. This included strengthening understandings of demand for MHAOD services and working in partnership with PHNs, HHSs and other stakeholders including consumers and carers to better estimate the impact of unmet need on different elements of the MHAOD service system.

Question 4

How does the MBS shape the development of the MHAOD workforce? Are there any barriers and improvements required (incl. recognition of scope of practice)?

Answer 4

The Medicare Benefits Schedule (MBS) is a part of Medicare – Australia's universal health scheme that enables all Australians (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost[1] – which lists health professional services subsidised by the Commonwealth Government.

As outlined in the Queensland Health submission to the Health and Environment Committee inquiry into the provision of primary, allied and private health care, aged care and National Disability Insurance Service (NDIS) care services and its impact on the Queensland public health system, Medicare:

- is a private practice model underwritten by the MBS and the Pharmaceutical Benefits Scheme (PBS)
- as a market-driven model it is subject to significant service gaps
- focuses on episodic care, which may be suitable for acute conditions but is less suited to chronic conditions
- focuses primarily on medical practitioners and provides only limited access to services provided by other health care professionals.

The Commonwealth Government can use incentive levers through the MBS to influence workforce distribution. Such an example is the Rural Bulk Billing Incentive which encourages more doctors to work in regional, rural and remote areas through incentives that increase with remoteness to bulk bill children under 16 year and individuals who have a Commonwealth concession card.

Through the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative[2] established in 2006, the Commonwealth Government provides rebates for selected mental health services provided by general practitioners, psychiatrists, psychologists and eligible social workers and occupation therapists.

While Better Access has improved access to these services it does not provide a full range of evidence-based intervention for people with mental health issues because it limits access to other health professionals (e.g., mental health nurses, Aboriginal and Torres Strait Islander Health Workers, other allied health practitioners). There are also a range of access issues caused by out-of-pocket costs for individuals even with MBS-rebates, limited and maldistributed workforce across the range of professions and across Queensland, increasing demand continually outstripping workforce supply, and the capping of services available to an individual annually.

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[1] Medicare, Australian Government Department of Health, Medicare | Australian Government Department of Health.

[2] For more information refer to Better Access initiative | Australian Government Department of Health

While other MBS items such as Chronic Disease Management (CDM) items may allow access to a broader range of allied health practitioners again issues like the capped number of services which can be accessed annually and out-of-pocket costs may impact on access. It also relies on medical practitioners use of CDM plans and making referrals for these workforces to be utilised.

MBS-initiatives can also have perverse impacts on other parts of the health system workforce. For example, additional sessions available under the Better Access initiative has seen a flow of psychologists from state-funded MHAOD services into private practice.

The MBS underwent a significant review between 2015 and 2020 and resulted in 1,400 recommendations that the Commonwealth Government has been considering and responding to incrementally. This has led to changes such as the inclusion of specific MBS items for responding to eating disorders (2019); new case conferencing items for allied health professionals who participate in case conferences organised by a patient's General Practitioner (GP) (2021), and further changes to mental health items including group therapy sessions and participation of family and carers in treatment (2023)[3]. While these changes may support and bolster some parts of the private health care sector workforce it is unlikely to be strategic or take into consideration a broader range of workforce issues that need to be addressed.

Other opportunities that have been put forward to influence the MBS-system on the MHAOD workforce include increasing the list of service providers that can receive MBS-rebates for mental health related services (e.g., services provided by mental health nurses) and enabling access to MBS-rebates for certain services (e.g., mental health nurses and allied health practitioners) without a need for a referral from a medical professional (i.e., direct access). Noting that this last option is a highly contested issue between the health care professions.

The Commonwealth Government also uses a range of strategies to address gaps caused by the existing Medicare model within and beyond MHAOD services. This often relies on programs delivered through the Primary Health Networks (PHNs) and Aboriginal and Torres Strait Islander Community Controlled Health Care Organisations. However, as stated in the Queensland Health submission to the Health and Environment Committee inquiry, these are not sufficient to overcome the market failures arising from the MBS-system.

[3] Refer to Medicare Benefits Schedule (MBS) Review | Australian Government Department of Health

Question 5

What are the roles and responsibilities of the federal and state governments in the development, attraction and retention of the MHAOD workforce? What strategies does QH have in place to address workforce need now and into the future? What would help improve workforce development, attraction and retention?

Answer 5

The Commonwealth and state and territory governments have distinct roles and responsibilities. However, they are not mutually exclusive and fostering a sustainable, sufficient, and skilled MHAOD workforce is a joint effort.

This joint effort is supported by the *National Mental Health Workforce Strategy* (NMHW Strategy) and the *National Alcohol and other Drug Workforce Development Strategy 2015-2018* (NAODWD Strategy).

The NMHW Strategy released in 2011 aimed to develop and support a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health service. It focused on:

- developing, supporting and securing the current workforce
- building capacity for workforce innovation and reform
- building the capacity of the general health and wellbeing workforce
- data monitoring and evaluation.

In 2020, a National Mental Health Workforce Strategy Taskforce was announced to support development of the next 10-year National Mental Health Workforce Strategy. This strategy will consider the quality, supply, distribution, and structure of the mental health workforce. This work is being supported by the Commonwealth Department of Health and is expected to be released in 2022.

The NAODWD Strategy was developed to:

- enhance the capacity of the Australian AOD workforce to prevent and minimize alcohol and other drug-related harm across the domains of supply, demand and harm reduction activities
- create a sustainable Australian AOD workforce that is capable of meeting future challenges, innovation and reform.

The National Centre for Education and Training on Addiction has been commissioned by the Commonwealth Department of Health to update this strategy to continue to build the capacity of the AOD workforce to respond effectively to contemporary AOD issues and be prepared for future emerging needs.

Commonwealth Government responsibilities:

The Commonwealth Government supports a range of strategies and programs to educate, support, develop and understand the broad health workforce (including MHAOD) to support access to health care across Australia. These include supports for:

- undergraduate and post-graduate training
- addressing workforce issues in rural and remote areas
- increasing Aboriginal and Torres Strait Islander participation in the health workforce.

Detailed information on Commonwealth Government initiatives can be obtained from Health workforce | Australian Government Department of Health.

Through its 2021 Federal Budget announcement the Commonwealth Government made specific announcements to grow and upskill the mental health and suicide prevention workforce including:

- increasing the number of nurses, psychologists and allied health practitioners working in mental health settings through scholarships and clinical placements
- increasing the psychiatrist workforce by making additional training places available by 2023, supporting regional and remote training pathways, and promoting psychiatry as a career pathway
- increasing Aboriginal and Torres Strait Islander peoples' representation in the mental health workforce through additional mental health-specific scholarships, and providing training to support healthcare workers to deliver culturally safe care
- increasing the mental health peer workforce through scholarships and opportunities for professional collaboration
- providing support to continue mental health training for practitioners working in aged care and collaboration through the Mental Health Professionals' Network
- developing initiatives to reduce the stigma associated with mental health among health practitioners and promote mental health as a preferred career option
- identifying opportunities to boost the skills of mental health professionals who work with children and families.

The exact impact of these commitments in Queensland is yet to be established.

Queensland Government responsibilities:

The Queensland Government supports efforts to build the future health work force of Queensland through a range of approaches outlined in *Advancing health service delivery through workforce: A strategy for Queensland, 2017-2026.* This strategy guides effort in workforce design, clinical education and training, leadership, culture, employment regulation and administration of the clinical and clinical support workforce. Queensland Health works collaboratively with stakeholders across the health sector to respond to emerging priorities and challenges and to support contemporary approaches to workforce policy and program development.

Queensland Health supports a range of recruitment and incentive processes to attract medical practitioners, nurses, allied health practitioners, and other clinical staff to Queensland both nationally and internationally. Queensland Health supports clinical training through student placements and pre- and post-graduate training in public hospitals and services in Hospital and Health Services.

The development of the MHAOD workforce in Queensland is underpinned by these broader approaches.

The development of the MHAOD workforce within state-funded MHAOD services is a key priority of *Connecting Care to Recovery: A plan for Queensland's State-funded mental health, alcohol and other drug services 2016-2021.* This resulted in the development of the Mental Health Alcohol and Other Drugs Workforce Development Framework 2016-2021 which focused on the key workforce issues of:

- designing the workforce
- enabling the workforce
- strengthening the workforce
- keeping connected.

Specific projects such as the Statewide Mental Health Allied Health Scope of Project was undertaken to identify the current scope of practice of allied health practitioners working in adult community health services and to identify opportunities to expand of scope of practice to improve client outcomes.

Question 6

Is there any data available on the amount of primary health care: psychologists, psychiatrists, MH counsellors across Queensland? Is there a disparity between regions across Queensland?

Answer 6

The information provided by Queensland Health in this answer is limited because primary health care, particularly primary mental health care, is the responsibility of Commonwealth Government and generally subsidised through the MBS or other programs delivered through PHNs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations. It also does not include primary health care services that Queenslanders can purchase directly or which are subsidised by private health insurance, provided through workplace mental health and wellbeing programs, through other sectors, or through charitable/philanthropic organisations or programs.

The following information, including tables, have been derived from data publicly available from the Australian Institute of Health and Welfare reporting on mental health services in Australia[4]. This information is limited to the types of service providers who provide mental health-specific services that are eligible for MBS rebates (i.e., general practitioners, psychiatrists, clinical and registered psychologists, and other allied health (eligible social workers and occupational therapists)). This data also includes service types that would generally not be included within a definition of primary mental health care (e.g., specialist services, electroconvulsive therapy).

In 2019-20 in Queensland the number of service providers delivering Medicare-subsidised mental health-specific services was:

- 7,673 GPs
- 4,008 psychologists
- 662 psychiatrists
- 596 other allied health professionals.

Table 1 below provides further information on these service providers and the numbers and rates of service provision to Queenslanders.

Table 1 Medicare subsidised mental health-specific services by service provider in Queensland, 2019-20

Provider Type	# of service providers	Rate providers/ 1,000	# services	Rate /1,000 Qlders	# Qlders receiving services	% Qlders receiving services
General practitioners	7,673	149.6	803,086	156.5	474,697	9.3
Other psychologists	2,839	55.3	688,460	134.2	168,223	3.3
Clinical psychologists	1,169	22.8	489,799	95.5	111,045	2.2
Psychiatrists	662	12.9	598,122	116.6	96,428	1.9
Other allied health	596	11.6	93,596	18.2	23,275	0.5

[4] Refer to Mental health services in Australia, Overview of mental health services in Australia - Australian Institute of Health and Welfare (aihw.gov.au)

Although Queensland specific data is not publicly available, Australian-wide per capita expenditure on Medicare subisidised mental health-specific services for people whose usual place of residence is in outer regional, remote or very remote areas is much lower when compared to people who live in major cities or inner regional areas (see Table 2).

Table 2 Australia Medicare expenditure on mental health-specific services $ per capita by provider types 2019-20

Service provider	Usual place of residence				
	Major cities	Inner Regional	Outer regional	Remote	Very remote
Psychiatrist	16.76	12.56	8.69	5.86	3.07
General practitioner	12.75	12.47	9.86	6.53	3.22
Clinical psychologist	14.43	11.21	6.47	3.72	1.79
Other psychologist	11.53	9.99	6.52	3.66	1.69
Other allied health	1.40	2.02	1.43	0.61	0.16
All providers	**56.87**	**48.25**	**32.97**	**20.38**	**9.92**

Across Australia in 2019-20, the rate (per 1,000 population) of Medicare-subsidised mental health-specific services, by provider type, rapidly declined as the level of remoteness increased from major cities to very remote regions (see Table 3).

While GP services are the most accessed services in rural and remote areas, access is reduced to a half and a quarter respectively of the rate in major cities. Psychiatry and psychology services are even less available when compared with major cities.

Table 3: Australia Medicare MH specific services per 1,000 population by provider types 2019-20

Service provider	MBS services per 1,000 population		
	Major cities	Remote	Very remote
General Practitioner	155	78	38
Psychiatrist	112	35	20
Clinical psychologist	112	30	14
Other allied health provider	17	8	2

There are well documented workforce shortages in regional, rural and remote Queensland resulting in wide variations in access to primary and specialist mental health mental health services. This is due to a range of social, environmental, and geographical factors which contribute to poorer access to services and increasing disadvantage demonstrated in more remote areas.

Queensland Health recommends to the Mental Health Select Committee its submission to the Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system which is available here.