PHARMACISTS BILL 2006

Second Reading

Resumed from 29 November 2006.

MR J.C. KOBELKE (Balcatta - Leader of the House) [10.26 am]: It is not normal for me to respond in this situation, but I think the fact that a couple of the reports presented to the house did not appear on the daily program has resulted in the absence of members who want to speak on this bill. I understand the member for Dawesville is the lead speaker on behalf of the opposition, and I know that as a medical practitioner he has a very keen interest in matters relating to pharmaceuticals.

The ACTING SPEAKER (Mr M. Cowper): I notice that a quorum is not present in the chamber, and as I am able to do so in the capacity of Acting Speaker, I call a quorum.

[Quorum formed.]

DR K.D. HAMES (Dawesville) [10.30 am]: That was excellent timing on my part. Now all we need is for the Minister for Health to be in the chamber to hear the debate on the Pharmacists Bill 2006, for which he has responsibility. The reason the Minister for Health should be in the chamber is that he has proposed amendments to this bill. I know those amendments are not yet ready and are still being drafted. However, I gave the copy of the proposed amendments given to me by the minister to my colleagues in the upper house for them to look at and determine whether to change their view on the way in which the opposition will vote on this bill. It has not, but those colleagues still have the copy of those amendments. I was hoping to get another copy of the proposed amendments that the minister intends to move. The opposition has agreed to support this bill.

The minister has arrived, and I welcome him.

Mr J.A. McGinty: I would not want to miss your speech.

Dr K.D. HAMES: Of course not. I would like the minister to provide me with a copy of the proposed amendments. As I said, I passed on the copy he gave me to opposition members in the upper house. The opposition will support the bill.

The Pharmacists Bill is one of a number of health-related bills that the minister has introduced into this Parliament to take into account competition policy. The bills include changes to the board structures of a number of health-related groups. The Osteopath's Bill 2005 was the first of these bills to be considered and we have dealt with nine or 10 similar bills. The bills provide for a restructure of the relevant board by increasing its membership to make it a more representative group; deal with issues related to competition policy, which is the main reason for these bills coming before the Parliament; and deal with alternative methods of disciplinary and complaints procedures, thus giving people the opportunity to make complaints about professional conduct. These bills vary; for example, the Medical Practitioners Bill 2006, which is yet to be debated, deals with complaints about medical practices and whether doctors are competent to practice. Each bill has its peculiarities, but they follow the same basic structure and theme. The peculiarity of this bill is that it deals differently with ownership; in this case the ownership of pharmacies.

Ownership of pharmacies and medical and dental practices has been a controversial issue. The medical and dental professions lost their argument. The competition policy guidelines state that a person does not have to be a doctor or dentist to own either a medical or dental practice. That was the beginning of what we now know as corporate practices. Large companies, often multinationals, bought out medical practices and started clinics. It has been to the detriment of medicine. Many of the clinics are now corporate practices with a high turnover of doctors and, as a result of the number of people attending the clinics, patients do not have a choice of doctor. The high turnover of doctors means that it is now difficult for somebody to develop a relationship with one doctor who will look after them and their children. Nevertheless, the corporate practices fill a need. If they were not popular, people would not use them.

Corporate practices provide people with the assurance that they can see a doctor. In my electorate, and I am sure it applies to all electorates, there are not enough doctors and people find it difficult to see a doctor. It has reached the stage where people have to anticipate that they will be sick two or three weeks in advance to be sure of seeing a doctor.

Traditionally, doctors vaccinated children. Although there have always been vaccination clinics, my preference has been for children to have a doctor administer the vaccination. I have nothing against vaccination clinics. However, if the doctor, who has an important role in assessing children's health, administers the vaccination, children tend to become frightened of him. In my practice, I always preferred the children who came to see me

to see another doctor for their vaccination so that they would not be frightened of me when they came to me when they were ill. I did not want them to think that I would jab them with a needle.

The Dental Bill has been passed by this house and is in the other place. That legislation deals with the ownership of dental practices. Dental practices will be subject to the same arrangements as those that apply to medical practices; that is, people other than dentists will be able to own dental practices. Obviously, a dentist has to undertake the work in the practice, but he does not need to be the owner of the practice. Under this legislation no-one other than a pharmacist is allowed to own a pharmacy. The number of pharmacies a pharmacist can own has been increased from two to four. However, the pharmacist must be the major shareholder in the practice. Other people can be part of the practice and this bill lists those people who can be owners or part owners. However, it creates an anomaly. Obviously, there is concern about that ownership. For example, if a doctor were to own a pharmacy that was across the road from his medical practice, there is an opportunity for misconduct. That doctor could make sure he writes lots of prescriptions and sends his patients to the pharmacy that he owned across the road so he could make more money. It opens the possibility to fraud and corruption. I think I am still allowed to use the word "corruption" in this place. It is correct for people to say that the legislation provides the potential for problems. As a result, they believe that doctors or other non-pharmacists should not own a pharmacy. By the same token, there is nothing to stop a pharmacist from owning a medical practice that is across the road from his pharmacy. Under this legislation a pharmacist can own only four pharmacies, but he can own the medical practice across the road. He could do what I explained a doctor could do - he could tell everybody who wants a flu tablet that they are really crook and should see the doctor across the road. That pharmacist may be a major shareholder in that medical practice. I do not see why pharmacists should be the only people who can own a pharmacy.

Mr J.A. McGinty: I agree with you but it is a tribute to the lobbying skills on the federal government by the Pharmacy Guild of Australia.

Dr K.D. HAMES: It is and I am coming to that. I am not blaming this government for this state of affairs. I do not see a difference between the pharmacist owning the doctor's surgery or the doctor owning the pharmacy and the potential for fraud to occur. Nevertheless, the rules that take into account competition policy have been applied by the federal body and that is the trigger for this legislation. A committee of review looked into pharmacists and said that only pharmacists can own a pharmacy. The reason that has been given is that a pharmacist should be the only person looking after and managing his patients. The same could apply to a doctor. If a doctor or a member of Parliament were to own a pharmacy, they would be required to have a pharmacist in the pharmacy looking after the patients. It is no different from a pharmacist owning a doctor's practice; a doctor would still be required to look after the patients. It seems a ludicrous outcome to me. As I said, it was something that was organised by the competition policy committee. As the minister has just said, the reason is that they must be much better lobbyists than we are to achieve that outcome.

I will address a couple of issues concerned with who can own what. I refer first to clause 58 of the bill, "Ownership of, and interests in, pharmacy business". It states -

> (1) A person must not own, or hold a proprietary interest in, a pharmacy business unless the person is -
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> (a) a pharmacist; or
>
> (b) a person who is a partner in a partnership that carries on the business and in which every partner is either -
>
> (i) a pharmacist; or
>
> (ii) a close family member of a partner who is a pharmacist;
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> . . .

That means that, when we look at outside interests and even though a pharmacist must be the controlling shareholder, he must be the controlling shareholder only with someone with whom he is closely associated. The pharmacist cannot be a shareholder with a doctor, for example, or anyone else. It must be a close family member. However, it can be a pharmacist-controlled company. That provides the opportunity for outside ownership. Even with that a pharmacist must be the leading shareholder in the company and must manage the company. There is also provision for a friendly society to own a pharmacy. I gather that that is, in effect, a grandfather clause because there is one friendly society-owned pharmacy in Perth. Does the minister know the name?

Mr J.A. McGinty: I believe it is in Victoria Park. I do not remember the name.

Dr K.D. HAMES: I do not remember either. However, there is only one. The provision allows that body to continue its ownership of the pharmacy. A pharmacy may also be owned by a preserved company. This is another grandfather clause that allows for an existing situation. The St John of God hospital in Subiaco has a pharmacy owned and managed by the hospital. This clause allows that arrangement to continue.

I do not have the list of amendments yet. Are they coming, minister? I know that one of the proposed amendments provides for other hospitals to establish a pharmacy on their premises as well. The minister explained to me earlier that Joondalup Private Hospital would look to do that. I do not think that is unreasonable.

Mr J.A. McGinty: Joondalup has a policy, which is that, to the extent it is possible, the services will be provided by the hospital. That is an "insourcing" approach to the way they wish to provide their services. I think they should be able to do that. The wording of the amendment will be important.

Dr K.D. HAMES: I agree. We will obviously debate that when we get to it.

I now turn to clause 59, "Limit on ownership of, and interests in, pharmacy businesses". It states -

> (1) A pharmacist must not own, or hold a proprietary interest in, more than 4 pharmacy businesses at any one time.

The same applies to a friendly society and a preserved company. As such, a hospital-based company must not own more than one pharmacy business in each hospital. I will require the minister to clarify that. Does that mean that each hospital can own only one pharmacy business? What happens in the case of St John of God, which has separate campuses? Will the pharmacy come under the ownership of the St John of God group altogether? I presume it will and will allow it to have pharmacies at different hospitals. I need to make sure that is clear in the legislation.

Mr J.A. McGinty: Again, it will be a question of getting the wording right.

Dr K.D. HAMES: A couple of issues were raised with me in the party room when this bill was discussed. Some concerns were expressed but I am reasonably sure they are addressed in the legislation.

My first concern is best shown through the example of my father's medical practice in Boddington. He ran a pharmacy attached to his practice because there were no other pharmacists for miles in any direction. A person would have had to travel 45 minutes to an hour in any direction to get to the nearest pharmacy. I assume there are other country areas that are the same. There are also places that provide for the distribution of medications. One example would be remote Aboriginal communities. The community nurse does not run a pharmacy as such but certainly has the ability to distribute medication. As I understand it from the minister's staff during the briefing, that capability is covered not under this legislation but under the Poisons Act. The Poisons Act provides licences that allow general practitioners to distribute medication. Having said that, I note that one of the clauses in the bill bears some resemblance to that issue of concern and refers to the Poisons Act. I cannot remember the exact wording. Perhaps it is further addressed in the amendments to make sure that doctors such as my father - he is no longer in practice so I do not need to declare an interest - are still allowed to carry on the practice.

Mr J.A. McGinty: There is particular application for Aboriginal communities. The ability to dispense where there is no pharmacy, which is the member's family circumstances in Boddington although on a more exaggerated scale, has traditionally been covered by the Poisons Act. We will need to make sure that the interaction between this legislation and the Poisons Act allows that to occur.

Dr K.D. HAMES: The difference is that those medications that are distributed in the Aboriginal communities are supplied by government and distributed but not sold. However, I am not absolutely sure of that. Whatever is done happens under government auspices and not under the auspices of the nurse, health sister, nurse practitioner or whoever is there.

Mr J.A. McGinty: It might be a step away from government in terms of an Aboriginal health corporation or something of that nature.

Dr K.D. HAMES: The difference is that, in my father's case, he ran that as a business. He sold that medication, although there were controls on what he was paid. He was able to sell medication and make a profit.

Mr T.K. Waldron: I will speak briefly later to that issue to make sure it is covered. A similar thing happened in Darkan.

Dr K.D. HAMES: That will be good because I do not fully understand; I have not asked my father what the process was. All I know is that it was part of his practice and that he derived income from it. We would not want to see that happen in too many cases because there is potential for conflict in a doctor writing prescriptions and then making a profit from selling drugs at the same time. Because of that potential conflict there are very

strict controls over what can be done. Obviously, we want to make sure that those controls stay in place because of the potential conflict. At the same time we want to make sure that people do not have to drive an hour when they have a prescription for an antibiotic that is in a cupboard. Those issues need to be resolved.

The other issue was raised by the Acting Speaker (Mr M.J. Cowper) regarding shopping centre-owned pharmaceutical practices. He was particularly concerned about companies like Woolworths and Coles. I know Mr Acting Speaker cannot speak on this right now. I hope I am not incorrectly putting words in his mouth. However, he will not be in the chair for all of this debate so it is worth expressing his concern. It is a concern for many that there is a conflict between pharmaceutical practices and the distribution of medications by large shopping centres. My explanation in our discussions was that this legislation does not cover the issue. It is an issue of what can be distributed by the major shopping centres. As a company, a shopping centre would not be able to own a pharmacy, because pharmacists must own pharmacies, and each can own a maximum of four. Unless the company can come to some arrangement with individual pharmacists owning chemist shops within the shopping centre, that would not be an issue. Once again, I notice that the minister's proposed amendments will deal specifically with this subject and will prevent companies like that having a pharmaceutical company within the shopping centre. That has been further clarified by the minister's proposed amendments, but we have not seen them yet.

Another particular concern was raised by Hon Anthony Fels. I cannot recall it at the moment, but I am sure it will come to me during consideration in detail. As I am coming to the end of my speech, I gather that I will not receive that list from the minister.

Mr J.A. McGinty: You've got the list, but not the text.

Dr K.D. HAMES: I wanted the list, so I could check.

Mr J.A. McGinty: My apologies. I'll give it to you now.

Dr K.D. HAMES: I wanted to check the list to make sure that there were no particular issues on it that I wanted to discuss. The list includes the definition of "pharmacy business" and "preserved company", which is what I have just been talking about. Again, it includes the issues of private hospitals, supermarkets and friendly societies. There are a couple of other items on the list that I need to see more detail on.

Mr J.A. McGinty: They were requested by the Pharmacy Guild and I regard them as being of a minor technical nature with no great policy considerations underpinning them.

Dr K.D. HAMES: That is okay, because those issues do not make a lot of sense on this list. I will need to see details of those.

In line with the opposition's support for the other health-related bills that have been introduced into this house, we support the concept of the reorganisation of boards to create a much more efficient board structure and more opportunities for public complaints and the resolution of disputes. It is a good structure, and the opposition continues to support it. We support it in this bill.

MR T.K. WALDRON (Wagin) [10.53 am]: The Nationals will also support the Pharmacists Bill 2006. We agree with the objective of the bill, which is to protect the public of Western Australia from potential harm by providing for effective regulation of pharmacies. To achieve this objective, the bill vests the Pharmacists Registration Board of Western Australia with two principal statutory functions. The first is registration, which has all been covered, and the second is professional regulation. The board will have the power to take appropriate action when a disciplinary or impairment matter, as set out by the bill, is established. Pharmacies are very important across our regional areas. They are scattered, and I will come to the point raised before by the member for Dawesville in a moment. However, pharmacies are important and it is important that the regulation side of these businesses be cleared up, because the public needs to have confidence in local pharmacies. I am always a bit cautious about applying regulation, and we should not over-regulate, which could stifle people in their everyday business. At times there needs to be some practicality and flexibility. Generally, however, the Nationals support the bill.

One of the issues the member for Dawesville touched on relates to the situation in my electorate. In Narrogin, where I live, there are two very good pharmacies and there are also pharmacies at Collie. However, Darkan has no pharmacies. Doctors from Narrogin are travelling to Darkan and conducting their practice there two days a week, and this will increase as time goes on. It is a great service for Darkan, because that town is in a bit of a vacuum. We had this silly situation in which mothers would come in with children to see the doctor. If they needed to get a prescription, they would have to drive to Collie or to Narrogin and back with a sick child to have the prescription filled by a pharmacist. The doctors applied for dispensing rights for prescription drugs. This was actually opposed by some of the pharmacists.

Dr G.G. Jacobs: Of course, they would do that, wouldn't they?

Mr T.K. WALDRON: It was not in Darkan, because there is no pharmacy there. However, we got around the problem because we brought the different parties together. The doctors were providing a service to the community, but the pharmacists did not want their businesses affected by having the doctors dispensing drugs in Darkan. They felt it would not be a large diminishment of their business. In the end, they came to an agreement on how this could be done, and this was approved by the Pharmaceutical Council. The pharmacists supply the drugs to the doctors on a continual basis, so they are still getting the business, and the doctors dispense them at Darkan. I hope that kind of arrangement will still be possible under the new professional rules contained in this legislation. It is a commonsense solution for mothers with sick children, who must drive 20 kilometres to Darkan to see a doctor. It is great for us to have those doctors there, but it was ridiculous that mothers had to drive a nearly 200-kilometre round trip with a sick child to get the medicine. It was costly, impractical and not good for the child. Commonsense prevailed, but it did take quite a bit of work with the Pharmaceutical Council to reach the agreement. As long as these things are handled with commonsense and practicality there will be no issues. That is pretty much all I wanted to highlight. Does the minister understand what I am talking about?

Mr J.A. McGinty: Yes, I do.

Mr T.K. WALDRON: That is good. To me, that was a commonsense result. The pharmacies are happy, the doctors are happy and the community is grateful that the service is available. My major concern was that regulation would mean that we would return to the previous situation, which to me was ridiculous. We will support the bill and I will listen with interest to the debate in consideration in detail.

MR J.B. D'ORAZIO (Ballajura) [10.57 am]: Being a practising pharmacist, I have a vested interest in this legislation.

Dr K.D. Hames: Are you still practising?

Mr J.B. D'ORAZIO: Not now, but I am still registered.

Mr T. Buswell: I thought you had sold up.

Mr J.B. D'ORAZIO: I have, but I am still registered.

The Pharmacists Bill 2006 is a very important piece of legislation, and it has been a long time coming. There has been a lot of discussion over many years about bringing the Pharmacy Act into line with today's circumstances. I congratulate the minister for doing that. I have had a number of discussions with both the Pharmacy Guild and the Pharmaceutical Council. The minister has given a commitment to the guild that a number of the amendments he has proposed to the bill will help protect the community pharmacy. The bill actually clears up a number of the issues that have been hanging around pharmacies for a long time. It is the intention of both the federal and state governments to protect the interests of the industry. I refer to both sides of politics, because protecting the integrity of pharmacists and pharmacies in this state has been a unanimous position.

As members can see, pharmacists are the most supported group of professionals in the community. Polls about satisfaction with the various professions show pharmacists at either number one or number two. Their rating is better than that of doctors and far better than politicians. I think I might go back to becoming a pharmacist; I will become a lot more popular.

It is important that some of the things that have been happening in the pharmacy profession be addressed, particularly matters relating to ownership. This bill does that. All sorts of methods have been employed to get around the rules applying to pharmacy ownership, not a few of which have been to enable pharmacists to get more than the two pharmacies that they are allowed under the present legislation. Increasing the number to four liberalises that aspect to some degree. The important provision as far as I am concerned is that which stops the major supermarkets from trying to get a foot in the door. The bill does that by making sure that the pharmacy is owned by a natural person who is a pharmacist registered under the act.

I have a couple of concerns, and I have spoken to the minister about them. The first concerns having a pharmacy in a private hospital. I understand there is currently only one, at St John of God Hospital, Subiaco. That has been grandfathered, which means it is protected. The intention of this legislation is to allow pharmacies in private hospitals. On the surface that might seem an innocuous decision in that they could be supplying drugs only to people who are in the hospital. It is not that simple. Once the hospital owns the pharmacy, it will be owned by a corporate body. It will then get a national health system licence from the commonwealth. Under the commonwealth legislation pharmacies must dispense drugs to whoever has a national health prescription. I know the intent of this legislation is that pharmacists at the hospital will dispense only to patients in the hospital. However, under the national health system a pharmacist who has an NHS licence will have to dispense to anyone

presenting an NHS script. That raises the question of how we can restrict the operation of the clause solely to people who are in hospital and needing the services of the pharmacy. That is the first step. What is to stop a pharmacy in a private hospital becoming a full-blown pharmacy that stocks everything and is owned by a corporate body? As we saw in the liquor industry, Coles Myer and Woolworths went to all sorts of lengths to get bottle shops by buying the whole -

Dr K.D. Hames: Do you think they will buy the hospital?

Mr J.B. D'ORAZIO: A hospital at Joondalup is one thing but a day surgery in South Perth that might qualify as a hospital might be a different ballgame. The definition of a hospital is paramount. I have had discussions with the minister and he assures me that somehow the wording will be very tight to make sure that the definitions are restricted. It is a very important matter and the Pharmacy Guild highlighted to me as recently as Friday last week that this was an area of concern. We will have to wait to see the wording that is used. I am sure the minister will have that covered because I have had discussions with him and he understands the ramifications of a corporate body going through the back door and using the national health legislation. Federal legislation overrules state legislation and it may provide a wedge to open the door and break the nexus of ownership, which presently requires a pharmacy owner to be a pharmacist registered under the Pharmacy Act. That is an area we need to look at very carefully. The original bill that was brought before the Parliament also raised questions about the breaking down of ownership requirements. I know the minister has agreed to all the amendments put forward by the guild.

Dr K.D. Hames: Oh!

Mr J.B. D'ORAZIO: It is very important for community pharmacies to provide -

Dr K.D. Hames: I didn't see you defending doctors when we were being taken over.

Mr J.B. D'ORAZIO: I always defend doctors. They are absolutely fantastic except that they are not sure what they prescribe -

Dr K.D. Hames: Or they don't write enough prescriptions!

Mr J.B. D'ORAZIO: It would nice if they prescribed - I will not follow that line or I will have a blue with the Australian Medical Association, and I do not want that.

Mr T.K. Waldron: Professional punch-up!

Mr J.B. D'ORAZIO: It is all right. The member for Dawesville and I have had many discussions about these things. Ultimately, pharmacists have a role and doctors have a role. It is important that we protect the ownership of pharmacies and also make sure there are enough powers in the legislation for the Pharmaceutical Council to keep the profession in line, protect the industry and the community, and provide people with the best possible care. I support the bill and I am informed that the council and the guild support it too, subject to agreement on some minor amendments. It is important that the wording of the amendments relating to private hospitals be very carefully drafted. Some consideration needs to be given to pharmacists who already have pharmacies inside private hospitals. A number of them exist; for example, there is one at St Anne's and another at Joondalup. These people have been operating for a long time. This legislation will take away their livelihoods, because when their leases are up the hospitals will have a right to open their own pharmacies. That will be a problem. It would be nice if we could give those pharmacists a period of grace so that they can get their house in order and deal with the change that will hit them. I am not sure that many of them know that this change will affect them so soon. Once their leases are up they could be out of business, and some of them have quite a few hundred thousand dollars tied up in their businesses. I would not like to see some people out on their ears a day after this legislation comes into effect.

Dr K.D. Hames: Why would you support it? That does not sound reasonable to me.

Mr J.B. D'ORAZIO: Most of those people have leases. If a pharmacist operates in a shopping centre, when his lease expires he will be subject to the vagaries of lease negotiations.

Dr K.D. Hames: They still retain their licence for that area. They can move across the road.

Mr J.B. D'ORAZIO: They will have an NHS licence and then they will have to shift that licence. That licence is worth a few hundred thousand dollars on its own without premises because it can be located somewhere else. The problem for those people is that it will mean they have to shift their businesses. If a pharmacist is in the hospital, he is guaranteed script trade because people get sick and go into hospital every day. If a pharmacist has to shift premises and is thrown out into the street with no business from doctors supplying people with prescriptions, it will be difficult for him. There will be direct competition from the new pharmacy inside the hospital that will be owned by the hospital. Perhaps we should consider having a period of grace so that these

pharmacists can adjust to the change. It may not have to be implemented straightaway. I understand that some of these people have leases that may run for five or 10 years, depending on how good their negotiations were. They will have some protection as a result of that. I do not know how many pharmacists are involved or their lease structures because most people like to keep those matters confidential. Those with very short leases will be very worried when they hear that this legislation has gone through the house, which will be in the next few weeks. Something needs to be done; the matter should at least be discussed with some of these people to find out what the extent of the problem is and how we can protect them. It may require a clause that says this provision will not take effect for two years. That will give them time to adjust to the changed circumstances. In some cases the hospitals will not want to go to the expense of setting up their own structure and will probably carry on with the existing pharmacy in the hospital. It is a point that has been raised with me and it will create a problem for some people.

There are some minor amendments relating to the wording. I will address them one by one when the amendments are moved. It is important that we see the wording of the amendments because the devil is in the detail. In the eastern states the challenge to the law has always been based on the interpretation of words. Therefore it is important before we pass these amendments that we scrutinise them closely and understand their ramifications. We need to consider whether there are any loopholes. I look forward to the guild and the council providing us with more feedback once we have seen the wording of the amendments. We want to make sure that the system of community pharmacies continues as it is and is not taken over by corporations or multinationals, and that the level of services being provided to the community by pharmacies is second to none, as it is now. It is recognized as such by the community in all the surveys that have been done from time to time.

I congratulate the Minister for Health for bringing the bill forward. This has been a long time coming. When I graduated in 1976 there was already talk about the rules having to be changed. That has never occurred.

Dr K.D. Hames: Page 21 refers to registration of non-practising pharmacists. This will obviously affect the member. The question was raised with me as to why non-practising pharmacists need to be registered. In a medical practice one is either registered or one is not. If a doctor is not practising, as I am, he still retains registration as a medical practitioner. Why do we need a separate registration and listing in the act for non-practising pharmacists?

Mr J.B. D'ORAZIO: Under this legislation, a pharmacist who has not practised for five years is deleted from the register of practising pharmacists. To get back on the list, a pharmacist has to sit a test to determine whether he or she is still suitably qualified.

Dr K.D. Hames: Doctors don't have that; that's very good.

Mr J.B. D'ORAZIO: Pharmacists who have not practised for five years can be reregistered, but first they must sit a practical test to ensure that they are up to scratch. Drugs change fairly dramatically in five years, so pharmacists must maintain their professional capabilities. When I first read the legislation I thought that a 10-year period would be more suitable. The word in the industry is that five years is acceptable.

Dr K.D. Hames: It probably should be the case for doctors too. We can be out for any time and just start practising again.

Mr J.B. D'ORAZIO: The member for Dawesville would be aware that medicine changes dramatically in five years.

Dr K.D. Hames: I was out of medicine for that long and when I started again I was worried about that.

Mr T. Buswell: So were your patients!

Dr K.D. Hames: Yes, they might have been. However, once the first patient walks in the door you know what to do and what to ask and you know what is required. You have to update yourself on the latest medication, but the practice of medicine, as opposed to the practice of pharmacy, is not only about medication; it is also about medical management and people management.

Mr J.B. D'ORAZIO: When I walked back into the pharmacy after an absence of 15 months, the hardest part was getting used to the new computer system. Basically, the processes are the same. Drugs change, but one becomes au fait with them within a short period. Five years is a reasonable period. If a pharmacist has not practised for five years, he or she must do some work to get back into it. Pharmacists who practise a few days a week are still qualified, because they are maintaining their skills. Is that correct, minister?

Mr J.A. McGinty: Yes.

Mr J.B. D'ORAZIO: The five-year period relates to ongoing management, because even when pharmacists are practising, they continue to undertake ongoing refresher courses. The member for Dawesville knows as well as I

do that the best practice is on the ground with the chemist dealing with the various queries that have to be resolved. That happens every day and pharmacists never stop learning. One is always confronted with a new set of circumstances or learns about a new use for a drug. I am intrigued by the way some drugs are used in such minute doses, but they work. No-one seems to know why. Some specialists are using extremely low doses of certain drugs to treat all sorts of conditions, including fatigue syndrome. That has surprised me, because I would have thought that given that the dosage is so low, it would not have an effect. However, it does. We never stop learning. The medical profession will keep coming up with new ideas and pharmacists will continue doing what we are told by the medical profession and they will continue to say yes sir, no sir, how many bags full sir?

Dr K.D. Hames: And learning how to read prescriptions.

Mr J.B. D'ORAZIO: Legislation should stipulate that medical practitioners do a course to learn how to write!

Mr T.K. Waldron: Don't they use computers.

Mr J.B. D'ORAZIO: Some do; however some old-school doctors still handwrite their prescriptions.

The legislation and its provisos should be supported and they should be watertight. Both state and federal Liberal and Labor Party members have indicated that they want to protect the base of community pharmacies in Western Australia and Australia. We must ensure that the amendments do not create any loopholes. I am sure that the Pharmaceutical Council of Western Australia will advise us accordingly. I look forward to receiving its advice. I congratulate the Minister for Health on the legislation.

DR G.G. JACOBS (Roe) [11.25 am]: After those few barbs from the pharmacist, I cannot resist the opportunity to say that although it all sounds good, all is not necessarily well. The emperor does not have a full set of lovely clothes. Legislation governing ownership of medical practices has allowed the medical practice at which I worked to be owned by a person who was not a doctor. However, when it comes to owning a pharmacy, pharmacists must have a significant ownership interest. It was okay to give away my medical practice to corporatisation under the guise that it would not affect clinical practice and that the practice would not be driven by commercial considerations. However, the situation for pharmacies is different. As a doctor, I have no desire to own a pharmacy. Indeed, I do not think that that would be correct. One must look more closely at the key objectives of this bill, which are to protect the public from harm by ensuring that only suitable, qualified and trained pharmacists are permitted to practise pharmacy and to ensure that pharmacy premises meet appropriate standards. If that rule applies to pharmacists, why does it not apply to doctors? The member for Yokine is holding back from talking about a conflict of interest. I have no conflict of interest. All I am suggesting is that what is good for the goose is good for the gander. It could be that medical practices should be owned and operated only by doctors who are suitable medical practitioners to protect the public from harm. The legislation has nothing to do with protecting the public. It is more about a turf war and about looking after one's own patch. Under this legislation, a pharmacist would need to be on site at a pharmacy. A medical practice owned by Joe Blow, at which I could work, needs a medical practitioner to practise clinical medicine. All the clinical standards issues in that practice would be determined by the practitioners on the premises. They are regulated by the Medical Board of Western Australia, codes of practice, the Royal Australian College of General Practitioners or, as in my case, the Australian College of Remote and Rural Medicine. They are the watchdogs of the standards of clinical practice. The suggestion that I need to own a practice to maintain my clinical standards does not hold up. Commercial considerations are taken into account in practices that are owned by someone else. The owner of a medical practice at which I may work could tap me on the shoulder and say, "Look Jacobs, you're not seeing enough patients. You only see 30 a day; I want you to see 50 because this operation is not paying." I suggest that the determinant of that is good medical practice overviewed by colleges and that it is up to the professional standards of the practitioner, which can still be maintained. That was not an issue for medical practices. The standards of medical practices are determined essentially by the clinical practitioner.

Another little inconsistency that is worth mentioning is the issue of a large-scale monopoly. In the minister's second reading speech, he referred to the intention to deter large-scale monopoly ownership. The number of pharmacies that a pharmacist can own will be increased from two to four. Unless I am missing something, increasing the number of pharmacies that a pharmacist can own from two to four is intended to deter large-scale monopoly ownership. I will refer to a situation in my town. A pharmacist came to town and bought two practices. He then duly closed one pharmacy and concentrated the other one in the major shopping centre. Yes, we need to protect the public from harm by ensuring that the pharmacist is a suitable, qualified practitioner. However, I am talking about the issue of a commercial monopoly. A monopoly is never healthy in one sense, because it does not give people a choice. In fact, the normal driver in a commercial enterprise is that the public gets the best deal and the best value when there is competition between businesses. In the situation in my town, the pharmacist bought two pharmacies and then closed one and made everyone in the country town go to that pharmacy. Now that pharmacist will be able to buy four pharmacies. I cannot see how that will deter a large-scale monopoly. I am a little sceptical of these changes. They are not necessarily driven by the very honourable

ideal of protecting the public from harm and ensuring that only suitable, qualified pharmacists are permitted to practise pharmacy. This may be a little closed shop. It has been said that situations could arise in which doctors could be deemed to be being anticompetitive because they were wrapping up the market. To counter that, national competition policy has been foisted on doctors.

Mr R.C. Kucera: Didn't the ACCC actually find that?

Dr G.G. JACOBS: I was very involved with that issue, because there was a lot of angst within the community. Is the member talking about my country town?

Mr R.C. Kucera: No; I'm talking about colleges in general. In fact, it was this state that raised the issue with the ACCC. The colleges were preventing proper competition taking place in that they were blocking the entry of people to particular sections of the medical profession. The ACCC raised that issue with all state ministers, and this state was the first to raise it in that context. I understand that the ACCC is examining the way in which colleges dictate the number of people who will practise various forms of surgery and medicine. That is a totally different issue from that which you are referring to now. I do not think that the AMA and doctors generally can hold their heads up high when it comes to issues of competition policy.

Dr G.G. JACOBS: In response to the member for Yokine, it was the issue of surgical training. The Australian Competition and Consumer Commission asked the Royal Australian College of Surgeons why it had only 30 places for training surgeons. The tenor of the argument was that the college was not training more surgeons because it was creating a closed shop. If it trained too many surgeons, it would have decreased the demand for those surgeons in the marketplace - if members will excuse the expression. That issue was seriously looked at by the ACCC, and I believe that changes were made. As a country member who has struggled to attract a surgeon to my region, I encourage those changes.

Returning to the bill, this matter probably relates more to commercial considerations than it does to protecting the public from harm by pharmacists. Even if a pharmacy were owned by an outside interest who was not a pharmacist, at least one pharmacist would be working on the floor of the pharmacy. That pharmacist must practise within the guidelines of good pharmaceutical practice, be suitably trained and have the appropriate college -

Mr J.B. D'Orazio: The Pharmaceutical Council.

Dr G.G. JACOBS: I note that that will be changed slightly. Pharmacists have a professional body that provides guidelines for their professional standards. I cannot see how a pharmacy which is owned by an outside interest who is not a pharmacist, but which has a pharmacist on the floor, could be harmful to the public, unless the outside commercial interest put undue pressure on the pharmacist because he was not selling enough drugs.

Mr J.B. D'Orazio: It is bit like a doctor who gets his fishing trip to Exmouth and then comes back and prescribes that particular brand all day every day for the next four months.

Dr G.G. JACOBS: My point is that, regardless of whether the practice is owned by a doctor or an outside interest who is not a doctor, those factors are outside these parameters. The same applies to the pharmacist working on the floor of a pharmacy that is not owned by a pharmacist.

Mr J.B. D'Orazio: There might be a decision by a corporate body that they will not stock this brand for commercial reasons, and they do not want that.

Dr G.G. JACOBS: That argument did not wash when the medical profession made it.

Mr J.B. D'Orazio: But you're not providing things that people stick in their mouths; you're just providing a service.

Dr G.G. JACOBS: There is more potential for harm in that situation, because if an outside interest owned my medical practice, he could tell me that I was not seeing enough patients, he was not making enough money and he wanted me to see 50 patients a day not 30; otherwise, I would have to find another job. That was not seen as a significant issue for a pharmacist who owned my practice, but a doctor cannot own a pharmacy.

Mr J.B. D'Orazio: No, but you will be providing a service, so the service you provide is the same. When a pharmacist supplies something that somebody can stick in his mouth, there might be a major problem.

Dr G.G. JACOBS: The member is saying that his duty of care is more significant than my duty of care.

Mr J.B. D'Orazio: I am not saying that.

Dr G.G. JACOBS: I do not wear that. The member for Ballajura must concede that there is an inconsistency. Both the Minister for Health and the shadow Minister for Health have acknowledged that there is some

inconsistency. The emperor does not have a full set of clothes, and we have to say it how it is. Why is the member for Ballajura carrying on about protecting the public by saying that the pharmacist must own the pharmacy or have a substantial interest in it to practise safe pharmacy? It does not wash with me or the medical profession. It did not prevent the national competition policy imposing these rules on medical practitioners. The member is saying that pharmacists are different. He is saying that the potential for pharmacists to do harm is greater than for a medical practitioner because pharmacists could hand out the wrong drugs. I advise the member that the potential for me to do harm is a lot greater than the potential for him to do harm. If I diagnosis a child with gastro and his appendix bursts, I have made a wrong diagnosis simply because I am so rushed. The reason for that is that the owner of the practice says that I must see 50 patients instead of 30. In that situation, I have the potential to do a lot of harm. The member for Ballajura should not over-rate the potential for him to do harm versus the potential for me to do harm. It is a very significant issue.

Dr K.D. Hames: It is not a competition on doing harm.

Dr G.G. JACOBS: The member for Ballajura raised that point and it was an issue I needed to address.

The issue of licences was raised in my town when the local people wanted another choice. The monopoly issue had reared its ugly head.

[Member's time extended.]

Mr J.B. D'Orazio interjected.

Dr G.G. JACOBS: Madam Deputy Speaker, I will address my comments to you or I will not get anywhere.

I want to address the registration and licensing issues and I will give an example of what happened in my town. I hope the codes and regulations attached to this legislation provide for the issuing of licences to be based on commonsense and that the procedure is less tortuous and less restrictive. I would encourage the government to give consideration to this issue. In pharmacy terms, the licensing process is overly prescriptive; it is tortuous. I recognise, and I am sure the member for Ballajura does also, that it has significant quarantine guidelines.

Mr J.B. D'Orazio interjected.

Dr G.G. JACOBS: I ask the member for Ballajura to give me the opportunity to put my argument.

The issue arose because a pharmacist came to town and bought two pharmacies and closed one. The local people, including the doctors, said that they needed to have a choice. After all, it is a town of 15 000 people.

The issue of registration and licence is important. The registration issue, as it refers to this bill, has been discussed. This bill will reduce the possibility of large-scale monopoly ownership by increasing the number of pharmacies a pharmacist can own from two to four. I am sure it makes good sense, but it would be extremely difficult for another operator to open up in competition, even though he might comply with the guidelines.

Previously two standards were applied to the granting of a licence. A person could either meet all the guidelines to the letter or else meet some of the guidelines and, if he had a big pot of money, buy the licence. It is an anomaly. I acknowledge that it is a commonwealth issue, but if we want the delivery of good pharmacy services to the community to be aboveboard, the process must be transparent and fair, and that issue needs to be addressed. If I get an opportunity at a later date, I will address it. There is one rule for one group of people and another rule for another group in the licensing process.

Mr J.B. D'Orazio: The federal government decided to limit the number for a purpose. The more pharmacies there are the more the number of prescriptions being filled increases exponentially. Therefore, the number of pharmacies was curbed. To change that would result in a huge increase in the national health bill. I have no problem with that. What has happened is that artificially those national health numbers are worth $200 000 or $300 000 for no business at all. It is a problem. If it is changed, there will be a national health cost.

Dr G.G. JACOBS: I suggest to the member for Ballajura that because of that policy towns like mine have been caught up in it. Any person who applied for a licence found that it was exceptionally difficult to meet the criteria. A registered pharmacist who applied for a licence had to meet the criteria, which included access to a quarantine area and a watershed area. However, there was another set of rules for a person who had a lot of money. If, for example, a pharmacist in Timbuktu died and his licence was up for grabs, a person could say that he would meet certain criteria and buy the licence because he had the money. It would cost hundreds of thousands of dollars.

Mr J.B. D'Orazio: It would be $300 000.

Dr G.G. JACOBS: Okay, $300 000 to provide a service to people in need, even though a monopoly had been created and there needed to be a choice.

The member for Ballajura said that it does not come under this jurisdiction, but if the member is serious about providing a pharmacy service to the entire community of Western Australia, not only in his electorate but also mine, the member for Wagin's and other electorates, we need to address these issues. We must be conscious that there are inconsistencies in the bill.

I will not oppose this bill. The reason I have put forward my arguments is that not all is great in this bill. I do not accept the spin that suitable practitioners must be able to provide a pharmaceutical service and that is the reason a pharmacist should be the only person who can own a pharmacy. It does not stack up. It certainly does not apply to the medical profession. If we were true to national competition policy, that provision would not be in the legislation. I appreciate the opportunity to comment on the inconsistencies in this bill; however, I will not oppose it.

MR J.A. McGINTY (Fremantle - Minister for Health) [11.40 am]: I thank members opposite for their indications of support for the bill. To the extent that the member for Roe has criticism of any inconsistencies in the bill, he can thank the Prime Minister of Australia, John Howard, for that and direct his criticism to him, because he has personally overseen this package and drawn up some of its key proposals. We are seeking here to implement a nationally uniform approach to these matters. I think people should appreciate the origins of these matters. For my part, I am a deregulator. If we were dealing with legislation in Western Australia in isolation, I think we would have gone some way further, but we have consulted very widely with a range of people to implement what flowed from the nationally agreed approach. This bill gives effect to that.

Having made those few introductory comments, I seek leave to continue my remarks. I do that for a very simple reason; that is, some matters of detail have been raised, particularly by the member for Dawesville, and I would like the opportunity to respond in more detail, perhaps next week.

[Leave granted for the minister to continue his speech at a later stage of the sitting.]

Debate thus adjourned.