MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Third Reading

DR K.D. HAMES (Dawesville — Minister for Health) [2.54 pm]: I move —

> That the bill be now read a third time.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [2.54 pm]: I rise to make some brief comments on the Medicines, Poisons and Therapeutic Goods Bill 2013. We had a good debate on this bill. As I said in the second reading debate, although the opposition agrees with much of what is in this bill, particularly in updating the way we manage poisons in this state, the section of the bill that relates to how we manage issues to do with drug addicts, drug-dependent persons and overprescribed persons has perhaps resulted in one of the most inadequately and incompetently drafted pieces of legislation to deal with such a complex social issue. Despite the lengthy cross-examination of the minister in consideration in detail, we got very little insight into how this part of the bill will work. In fact, the minister was keen for us to rely upon his reassurances about how things worked in the past and not how they might operate in the future. The fact is that under this bill, much of the discretion the minister likes to talk about, which physicians exercise in how they manage people presenting to them with the symptoms of someone with an addiction to a particular drug, will by and large be taken away from them. Under the act, we have largely dealt with issues to do with drug addiction by regulation. These issues have been subject to a small but carefully managed regime. This bill proposes to take these arrangements out of regulations and place them in the body of the act. In doing so, the bill prescribes some specific ways in which a doctor or prescribing person must behave when they are confronted with someone with a drug addiction or who they have a reasonable suspicion has a drug addiction. This gives rise to some serious concerns about how we manage this particularly difficult social problem. Although I have confidence in physicians to manage this properly, I have little confidence in the capacity of this government to draft legislation that takes this forward.

As we heard in the debate, the current register of drug addicts is hopelessly managed and very poorly looked after. We heard little from the minister that would give us confidence that the register is operating properly now or that the minister has any vision for how it will operate into the future. From a detailed cross-examination by the member for Eyre, we saw from the way the bill is put together that there is a very real danger that doctors will be caught up in this legislation, because they want to exercise discretion in the way they manage a particular patient. Under this bill, that discretion will be completely taken away from them. The bill provides for completely over-the-top fines, with $15 000 for a doctor who does not agree with the minister's way of managing someone with an addiction and $45 000 for that doctor's colleagues in the practice. It is for this reason that we were particularly opposed to that part of the bill.

I acknowledge that the minister has come forward with amendments to lower the fine for a doctor who does not report a patient with a drug dependence. I think that is a good outcome. I am very pleased to have been part of the debate that brought that change. I still have a great deal of concern around the definitions of drug dependency. I brought forward changes that I thought may provide greater clarity for the person who might be caught up in this particular part of the legislation. I notice in correspondence from Dr John Edwards from the Cambridge clinic that he, too, shares my concern around that definition of drug dependence and basically says —

> The definition of a drug dependent person is not a DSM definition, which is likely to cause confusion. The definition in The Act is largely determined by a person's desire to continue to take a drug, which might lead a number of people regularly taking drugs in an appropriate way to be seen as dependent and to be inappropriately notified.

That is, notified on the register of drug dependence —

> Most definitions of dependence in clinical use contain reference to aberrant behaviours associated with the drug taking which must be present before dependence could be diagnosed (see DSM IV.5).

I think it is disappointing that the government did not rely upon the tried and true definition of drug addiction, as is in the current act, and has flipped across to this rather broad definition, which, as Dr Edwards has observed, may capture people who would otherwise not necessarily have to be informed to the CEO and have their name entered on the register of drug-dependent people. There are some very real concerns about the interaction that might occur with the doctor on this particular issue. Someone presenting to a doctor will say that they have a drug addiction. That doctor is therefore duty bound to report that person to the CEO of the Department of Health under this legislation and the CEO must then contact that person to let them know that they have been reported as a person with a drug addiction. That gives rise to the very real potential that a doctor may be placed in an unsafe situation with that patient because that patient is now aware that they have been reported by that particular doctor. I made the observation in the debate that perhaps we need a warning on the desk of the doctor

saying, "Please be warned that if you inform me that you have a drug addiction, I am obliged under the Medicines, Poisons and Therapeutic Goods Act to provide your details to the Department of Health for entering on the drugs of addiction record." Maybe then we will have that clarity which would not put that person in that situation.

I am sorry that I was not here for the debate last night when we —

Dr G.G. Jacobs: We noticed you were not here.

Mr R.H. COOK: I notice that both the member for Eyre and the member for Southern River did a sterling job in cross-examining the minister. From my sickbed at home, I watched them on the computer. If that is not a sickness, I do not know what is.

Dr K.D. Hames: That's unbelievable. How could you do that? That is not good medical advice for you to do that.

Mr R.H. COOK: I know. It is true. I never was particularly good at sitting on the sidelines. I would be very happy to take another leave pass from the opposition Whip after this debate, but I was determined to be here for the third reading, if nothing else.

Dr G.G. Jacobs: What was your assessment of last night? Give us your thoughts.

Mr R.H. COOK: I did receive one text message that said, "There's no opportunity to filibuster; Abetz and Jacobs are doing all the filibustering for us." The member for Southern River clearly shares the concerns that I have and the observation I made to him earlier that this does put someone like Dr George O'Neil and his clinic in a very unique position. I note the minister's reassurances that the department will be working closely with Dr O'Neil's clinic to ensure that we manage it.

Dr K.D. Hames: They already do.

Mr R.H. COOK: It may do at the moment as this is incorporated in regulations under a very modest fine regime. As I have already observed, the discretion will be taken out of this in the future and some very hefty fines will be imposed, albeit with the government's later modifications.

One of the points I was going to raise last night related to the part of the bill that refers to the purpose for which information will be collected by the CEO. I must confess that I did not manage to watch this part of the debate but it concerned the issues around the collection of the information and how that would be used in studies into drug addiction and be kept essentially for the purposes of public policy. Many people have shared their concern with me that this will produce a very unreliable body of evidence in developing further policies on drug addiction. It is not a scientifically-based measure. From that point of view, there are very many more reliable ways in which we can collect information on issues of drug addiction and drug dependence. To say that this is primarily an exercise in wanting to understand the length and breadth of the problem is really deceptive in terms of what this bill really does. Of particular concern is that this bill has the potential to further stigmatise the issue of drug addiction in a way that many people who work in the public health field have been trying to combat for many years. In particular, we know that the representation of people with a mental health issue in the areas of drug addiction is very high and that will further stigmatise those people. I think we have been making some progress in how we treat people with a drug addiction in society. We are taking great strides to deal with it in an informed and sensitive way. This bill does not contribute to improving the way we do this.

That concludes my observations on this bill. I think it is fair to say that it raised some serious concerns in our party room about the way we treat people with a drug addiction. I was given very clear instructions from my colleagues that we should strongly cross-examine and scrutinise this bill, which I think we have done. I wanted to make the observation that I took great offence at the suggestion from the minister that we somehow used the briefing from his department to seek to fire up health stakeholders on this issue. I had a letter from the Australian Medical Association waved in my face by the minister, suggesting that the letter was indeed my fault.

Dr K.D. Hames: I didn't say that.

Mr R.H. COOK: He said, "I'm sure you've got a copy of this letter, member, and this is your doing." The point here is that the AMA, and indeed many groups that I went to, were entirely unaware of the implications of this legislation. I wanted to make the observation that the information I gleaned and then forewarned the AMA about and engaged in with other health stakeholders had nothing to do with the briefing I received from the department. The parts of the bill that occupied the largest part of this debate are on one page of the presentation I received from the Department of Health. It simply said that it will continue existing laws around drug-dependent persons and that there was really nothing for me to see or worry about. I have been a member for a relatively shorter period than most members, and I cannot really say I have ever been "snowed" in such an effective manner in a departmental briefing. Briefings are usually fairly cordial and friendly affairs. I want to place on

record that that will no longer be the case. The information we received from the Department of Health about this bill was particularly inadequate. In future, I will make sure I am better prepared and that I will never make that mistake again.

I inform the Minister for Health that I never received a letter from the Australian Medical Association about this. I warned the AMA about the provisions of this bill. It was entirely unaware of it, despite claims by the health department that consultation on this bill had gone far and wide. The AMA was entirely unaware of the size of the fines in relation to this matter. I met people in my consultations who specialise in drug addiction and who had not been contacted by the department at all. That struck me as being an extraordinary development. But once bitten, twice shy; I will obviously never make that mistake again. This bill will obviously continue through this place. The government has indicated that it will not entertain any amendments that we think are important to improve it. There is much in this bill that we will live to regret. As I said, the government has indicated that it will plough on regardless. Let the chips fall where they may.

DR G.G. JACOBS (Eyre) [3.12 pm]: Unlike the Deputy Leader of the Opposition, I think the glass should be half full, not half empty. I believe the exercise we have been through on the Medicines, Poisons and Therapeutic Goods Bill 2013 has been useful. This is not necessarily a perfect space; it is a very difficult space to work in. The current legislation, the Poisons Act 1964 and the Poisons Regulations 1965, is about 49 years old. The sale and supply of medicines and poisons in Western Australia needs review. The legislation has been significantly amended over time. It seemed to be outdated, inflexible and difficult to navigate. Not all our questions were necessarily answered perfectly, but in the particular area where I have worked previously, the area of drug addiction—not wholly, but from time to time in general practice—the issues of oversupply and of dependent drug–addicted persons and the management of those is a very difficult space.

The government recognises it needs to update the changes. Issues exist with the Poisons Act and they do not account for the numerous other new and changed pieces of legislation. The Medicines, Poisons and Therapeutic Goods Bill 2013 will replace the Poisons Act in various areas. One area is domestic and industrial chemicals, although we did not spend much time on that. Another area is agricultural and veterinary agents, which we also did not spend much time on. Other areas are uses of poisons, medicines and regulated therapeutic agents. I would like to thank the Minister for Health and the Department of Health for providing quite a good briefing—to me anyway—to me and some of my colleagues who were interested in this area, including the member for Kwinana. There may be filibustering during consideration in detail—I have certainly done that myself—but we are here to do a job. I believe there are some sincere questions around this area. We need to make the legislation that is put before us understandable, and even better. In fact, the minister conceded the very point that the member for Kwinana made about the fine. We got together on that and applied a more realistic figure of $5 000 instead of $15 000. That is the process about this place. I do not see anything wrong with that. It is an important function that we serve.

A lot of discussion, particularly from me, related to drugs of addiction, particularly schedule 8 drugs. There is a definition of the schedules in the program and the issue of drug-dependent persons. From my perspective, what my medical colleagues will look for and ask about is how this works for them in treating people before them who are drug dependent or in an oversupplied state. We spent a fair bit of time on division 3, "Drug dependent persons". We teased out the issue of a health professional "reasonably believing". After discussion with the minister, I was going to say I was "reasonably" satisfied—I was satisfied with the definition of "reasonably believes that a patient of the practitioner is a drug-dependent person commits an offence if the practitioner does not make a report". If the practitioner reasonably believes a person is oversupplied, and indeed keeps on supplying drugs, this legislation will bring into force some penalties by the director general of the Department of Health. We talked about the 48-hour time frame once someone is thought to "reasonably believe". We took the legal view. I think it was pretty well accepted that "reasonably believes" means that an uninitiated person would look at the situation and would reasonably deduct that in this case a practitioner would have known. We were quite satisfied in the end about those definitions; thank you, minister. They are not there to entrap practitioners; it relates to some professionals who are not very professional and are complicit in the provision of drugs of addiction to drug-dependent people. That in itself serves well in this legislation.

We talked about how this will implicate practitioners' registration, which was answered quite well. I talked, with some experience as a practitioner, about what tools are available to help manage people who are drug addicted or oversupplied and what tools the practitioner can use to manage that patient and give them knowledge without cutting across privacy laws. Authorised people should be able to access good real-time data to manage people. The minister knows of people who have presented to GP clinics who have hoodwinked us and basically told us great stories about their conditions, even to such an extent that they provide documentary evidence, such as magnetic resonance imaging, computerised tomography scans and reports about the severity of their back condition, of the need for them to have a schedule 8 drug to control their pain. Of course, there is the potential—

this happens to us—for those very people to tell the same story to another practitioner down the road and again to another practitioner around the corner, and practitioners have an inability to know the prescribing patterns for that person. As a practitioner for 25 years in a small town, I pretty much had it stitched up. If someone told me that story, I had only two pharmacies and only two practices to ring: "George, you haven't given this guy any medication in the last month or so, have you?" and "Dr Y, you haven't, have you?" We could stitch up the two pharmacies and know what they were doing, so we could have some sort of control. It might be said that that is a bit draconian, but it is a serious issue. Drug addiction needs to be dealt with, and if it is not dealt with, the consequences are very, very serious—in fact, death. It is important. In a busy city or in a suburb of Perth with multiple outlets, there is potential for patients with a story to doctor shop.

It was very important for us to look at the system. I do not want to steal the thunder of the member for Southern River, who will follow me in this debate, but I think the point is worth reiterating. Clause 106 refers to the drugs of addiction record being kept. If patient A presented to a doctor's clinic today and the doctor tried to access the prescribing patterns and prescriptions of that patient, the doctor could not get real-time, up-to-date data. There is a window of about three months during which data is behind, so doctors do not get real-time data and records on the practices of drug taking and the prescriptions of a potential drug addict who could be doctor shopping. We were very encouraged by the plan to monitor and evaluate services for the control and supply or prescription of drugs of addiction in Western Australia. I suggest to the minister that prescribing doctors in the field are very positive about this aspect and want it to be introduced as soon as possible, because we have a very archaic and slow system. There is a three-month window that does not give doctors the ability to access the most up-to-date data on the drug-taking habits of patients. We were encouraged by that aspect. We were encouraged by the requirements in clause 106 to compile and publish general or statistical information relating to that; to help practitioners conduct health research relating to the use of drugs of addiction; to monitor and enforce compliance with this legislation; and to carry out any of the CEO's functions under this legislation or any other written law. I pressed the minister last night on how long it will take to develop the mechanics of that system and how long it will take to get the software and a computer system to make this work in a doctor's practice in real time. That is very important. The minister gave us a time line of a couple of years to develop the mechanism by which we can adopt the system that this legislation enables.

Unlike the member for Kwinana, I think it has been a useful process to update pretty old legislation to reassure the medical profession that this is not a witch-hunt to try to ping doctors; it is about setting down some guidelines for when or if they are complicit in the drug-taking behaviour of a drug-addicted person or an oversupplied person.

I want to finish with the therapeutic goods component of this legislation. The therapeutic goods legislation that we have at the moment essentially needed to be brought into this bill. It is dealt with in division 7 of the bill. There has been an issue in Western Australia in and around the requirements of the Therapeutic Goods Act, particularly for George O'Neil's Fresh Start program. As I said in Parliament some time ago, naltrexone implants may end up being the gold standard for the treatment of heroin addiction. The Deputy Leader of the Opposition will remember that.

Mr R.H. Cook: I certainly do.

Dr G.G. JACOBS: But, of course, there are certain steps to have the naltrexone implant method registered with the Therapeutic Goods Administration, which is the federal body that registers therapeutic products. I do not think this in any way implicates or places any impost on the Fresh Start program, but it reiterates the necessity for Fresh Start to go through processes to achieve approval by the Therapeutic Goods Administration. What is stated in this bill today in no way implicates or places an impost or any further restrictions on George O'Neil, but it does outline the steps for the Therapeutic Goods Administration process. I understand that. The member for Southern River and I have done some work in this area. Indeed, when I was the Minister for Mental Health, there were significant issues in and around the process of gaining approval for this product. Of course, George's Fresh Start program has a special licence for purpose under the TGA. I would like to see that product gain approval. I understand that George is a very busy practitioner and often finds it difficult to go through the paperwork for the approval process. As I have said, there is a lot of good work in this area. We hope that the therapeutic goods component in the bill justifies that. I encourage George to push on with that therapeutic process to gain full approval for a product and service that may be the gold standard in the treatment of heroin addiction not only in Western Australia and Australia, but also all over the world. As I said, it is not a perfect space and there is no one silver bullet for any of it. Even with a fully approved naltrexone implant under the Therapeutic Goods Administration, there are many facets to the world of drug addiction and drug dependence. Obviously, it is about not only a magic implant but also those other services that we provide to support people through their addiction.

We met with Malcolm Smith, the director of Teen Challenge, at a breakfast meeting this morning. He runs a drug addiction program, with one of the outlets of Teen Challenge just 30 kilometres from my town. That program provides an avenue for people, usually young people, to come off drugs. As Malcolm says, it is not one

silver bullet that makes all this happen. Firstly, the person has to come to a point in their life at which they say, "I've got to do something about this. I'm almost at the bottom and I must do something about it." The first thing that Malcolm tells them when they come into the centre is that they have to leave the blame game at the door. It is not about whether their parents did not love them, they got in with the wrong crowd, a drug dealer pushed it on them or whatever. Of course, there might be many factors, but on the path to rehabilitation the first thing they must do is stop the blame game. They cannot keep blaming someone else for where they are or they will never face the issue and get through it. I know that the Fresh Start program would recognise this. It is a multifaceted approach in a very, very difficult area. A lot of the discussion that we had in and around this bill has been very useful. The legislation was never perfect and I think it needed some updating. I thank the house and the Minister for Health for the opportunity to make these few comments, both now and in previous stages of the bill.

MR P. ABETZ (Southern River) [3.33 pm]: I would like to make a small contribution to the third reading debate on the Medicines, Poisons and Therapeutic Goods Bill 2013. As we have been told, this bill was a long time in coming. It has been in process, and the previous act has been reviewed, since 2009 with quite a bit of consultation taking place. As has also been pointed out, quite a few people were unaware of it, but certainly the Pharmacy Guild and some of the other professional bodies have been very well consulted and they are very happy with the content of the bill.

It is one thing to pass a bill, the other aspect of course is enforcing it. The test of some of the things, particularly those relating to oversupplied and drug-dependent persons, will be to what extent this will actually function. It will be dependent on the degree to which it is enforced. It will be interesting to see how it works in practice, especially the subtle distinction between an oversupplied person and a drug-dependent person. In the popular mind they are one and the same. Whether a person is oversupplied on the basis of what is commonly called "doctor shopping" or getting hold of extra prescriptions of opioids and painkillers, or whether they buy the drugs on the street, in the common mind it is a case of being a drug addict or drug-dependent person. With these subtle differences, it will be interesting to see how it works out in practice. It is certainly good to see that an attempt is being made to address the problem of doctor shopping.

Ultimately, the best way forward to prevent doctor shopping will not be within the confines of this bill, but will actually be a federal matter; that is, pharmacists need to be connected in real-time to a central database whereby if they issue a prescription for OxyContin or whatever, that is recorded in real-time on the database so if someone then goes to another pharmacy half an hour later, it is already on the database. A check is done by the pharmacist by typing in the person's name before the script is filled, so they will see that the person picked up another script half an hour ago. The pharmacist can then tell them that they cannot have the script filled. If that was done, it would not only reduce the ability of people to doctor shop, but it would also save the federal government billions of dollars every year from what it spends on the Pharmaceutical Benefits Scheme because, generally, these drugs are fairly heavily subsidised by the PBS. One of the things I would like to see happen, which would supplement what this legislation seeks to do, is to have a federal government–provided function under Medicare or whichever department looks after the PBS.

Dr G.G. Jacobs: The Health Insurance Commission.

Mr P. ABETZ: The Health Insurance Commission looks after that. If that kind of a system was in place, it would certainly make it a lot more difficult for a person to become oversupplied. It would also make it more difficult for some people who doctor shop not for the purpose of using the drugs themselves, but to sell them on the black market. The street value of OxyContin is far greater that what it costs in a pharmacy.

Another interesting thing, which perhaps is not directly related to this bill but to the issue of oversupplied persons, was a situation described in an email one of the pharmacies in my electorate sent to me just the other day. One of the staff looked at a script for pseudoephedrine and thought it looked a bit dodgy. The staff member rang the doctor's surgery and said that they wanted to check a script. The doctor's surgery receptionist said, "Oh, no, not another forged script." Apparently, someone had stolen a prescription pad, filled it in and was going around to different pharmacies trying to get pseudoephedrine. The pharmacist thought it was criminal offence, that it was fraud. They rang the police and tried to keep the customer in the pharmacy for as long as possible to give the police a chance to get there. The pharmacist told the customer that they could fill the script, it was not a problem, but they just needed to get the okay from the doctor who was busy. They asked the customer to wait a few minutes until the doctor rang back and then they would fill the script. The young fellow was getting a bit agitated and after about 15 or 20 minutes, he bolted. Five minutes later the police arrived—a little late. To deal with issues like this seriously, the police also need to give this the kind of priority that it really deserves. Although it might not seem to be a big thing to have a forged script, and perhaps the dollar value might not be particularly large, these things have a habit of multiplying, and when a person is drug dependant, it often becomes a bigger and bigger problem.

During consideration in detail, I was very pleased to hear the minister say that the obligation of the chief executive officer to inform a person before they are placed on the register does not need to be in the form of a

letter to the person saying that they will be placed on the register but can be in the form of a letter asking the person to contact the Department of Health, at which time the interaction can then take place. I was also very pleased to hear the minister give an assurance that he certainly is not in favour of having heroin-injecting rooms in this state, as is currently the case in New South Wales.

This bill will make the commonwealth Therapeutic Goods Act effectively operational in Western Australia. That will put us in line with the other states and provide uniformity throughout Australia, and that will have obvious benefits.

The member for Eyre indicated that the registration process for naltrexone implants, which come under the jurisdiction of the Therapeutic Goods Administration, will continue to proceed. It is good that the government has given some support to that proposal. Now that Dr O'Neil's factory for the production of naltrexone implants is almost ready to come back into operation after the fire, that process should be able to move forward.

It is interesting that although the Therapeutic Goods Administration has responsibility for these things, sometimes bodies such as the National Health and Medical Research Council can be misused by people who are pushing a particular barrow. We saw that with the review of naltrexone implants that was published towards the end of 2011, when some very outdated and in fact incorrect information about naltrexone implants was put onto the NHMRC website. Professor Gary Hulse from the University of Western Australia wrote to the NHMRC to complain very strongly about the fact that his research had been grossly misrepresented on that website. When I wrote to the chairman of the NHMRC, he indicated that the NHMRC had no intention of removing that seriously flawed literature review from its website, and it had no intention of updating its website. Those sorts of things cause us some concern.

I am digressing a little from this bill. This bill is certainly a step in the right direction. I believe this bill is a positive step forward and I look forward to seeing it work out in practice.

DR K.D. HAMES (Dawesville — Minister for Health) [3.44 pm] — in reply: I thank members for their comments on the Medicines, Poisons and Therapeutic Goods Bill 2013. I would particularly like to thank the two members from my side, who have made a strong contribution. I thank the member for Eyre in particular, because, as a fellow doctor, it has been very good to go through the debate on this bill with our joint understanding of the management of patients and to discuss issues that are common to us both. In fact, it has given me a better understanding of some of the components of the bill and how they will operate.

I want to raise three points that the shadow Minister for Health, the member for Kwinana, missed in his assessment of what is contained in this bill. Firstly, this bill was initiated by the former Labor Party Minister for Health, Hon Jim McGinty, who started the process of putting this legislation into a more modern form. A lot of that early work was around determining what changes needed to be made to the legislation and what should be contained in the bill. Secondly, although there are some new things in this bill, a lot of the stuff in this bill was also in the old bill. Members would have noticed that last night when we were debating the clauses of this bill, we were advised that a lot of the things that members were objecting to were in the old bill that was in place in 1964. Therefore, a lot of the arguments that were put by the shadow minister about things that are wrong in this bill were actually about things that have been in the bill since 1964, or at least the vast majority of them.

The other point that I think members have missed is that this bill is about the best interests of patients, not necessarily the best interests of doctors. Although the best interests of patients and the best interests of doctors should always be pretty well aligned, not all doctors do the right thing. The purpose of this bill is to look after the best interests of patients by ensuring that people who are addicted to drugs get off the drugs or get off the oversupply and do not supply drugs to other people. This bill may do that in a stricter manner than has been the case in the past. However, it is absolutely in the best interests of patients to do that.

I am amazed that the member for Kwinana talked about how the departmental people in their briefing of him did a snow job on him. I can tell the member that the people who briefed him are exactly the same people who briefed our party; in fact, they are exactly the same people who briefed me. So, if they did a snow job on the member for Kwinana, they also did a snow job on me and on the members of our party. There have been no instructions from me to the department about what they should say to the member and what they should say to our party.

Mr R.H. Cook: I never said there have been.

Dr K.D. HAMES: Why would a group of three bureaucrats want to make the shadow minister think something is the case when it is not? Why would they want to do a snow job on him? The member for Kwinana said that he will not let them do that again. I can tell the member that the reason he will not let them do that again is that they will not be briefing him again—it is a different group every time.

Mr R.H. Cook: No, it is not.

Dr K.D. HAMES: Maybe when we get to the new health bill —

Mr R.H. Cook: When will we ever get to that bill?

Dr K.D. HAMES: The first half of next year.

The bureaucrats in the Department of Health have no interest whatsoever in trying to convince the member for Kwinana that something is correct when it is not correct. Quite recently, when they provided advice and discussions to our members, our members asked questions and went through those issues, the same as the member did. The only comment I raised related to the letter that I got. I got that letter on the day we were debating this bill. The amusing thing is that that letter said that there were urgent problems with the bill, and the member for Kwinana then got up and talked about exactly the same things that they had said in their letter. I did not care whether the member for Kwinana talked to them or they talked to him; it was just amusing that those comments were identical.

Mr R.H. Cook: It was a very good source of information.

Dr K.D. HAMES: I remind the member that we approved the drafting of this bill in 2009. I will also remind the member of a comment from the second reading speech on 7 August 2013, which states —

> Since that time we have embarked —

"We" meaning the health department —

> on an extensive consultation process of major stakeholders, culminating in an exposure draft being circulated in September 2011.

That was two years ago. People have said they were not aware of it, consultation did not occur, and they did not know this was coming. I am sure that when we talked about bringing in the health bill, we talked also about bringing in the poisons bill. That was years ago. We were in fact pretty late in doing it, as the member for Kwinana knows, because he has been criticising us for it. But I am pretty sure we said about four years ago that we would be bringing in these bills. The second reading speech continues —

> The stakeholders consulted included health professional registration boards, —

One would assume that included the AMA —

> health professional organisations, consumer groups, other government departments, chemical and poisons industry organisations, and areas of the state public health system.

That is a pretty broad consultation on a draft bill that went out there. I think some changes were made as a result of that consultation, but it did not come from me; it came from people within the system who thought that changes needed to be made. So, far from trying to do a snow job on the shadow minister, or trying to bring in something in a hurry, the absolute opposite has occurred. The member got three things from the people who drafted the legislation, who had been consulting for two years and who made sure that the member and other people were aware of what was going out. Clearly, it slipped through the cracks a little with the AMA, to get a letter of objection on the last day, and I agreed with its objection. The $15 000 was not something that I picked up and I think it was a reasonable complaint. As the member knows, we changed that.

Another point to make about the issues raised, the debate with the shadow minister and the amendments that he moved, is that I think we provided pretty good arguments, particularly about his use of the word "diagnosis", and that they were pretty solid arguments, particularly with regard to definitions that clearly related to pre-existing definitions and were perfectly explicable. I did not draft those terms; I think the staff who gave me that advice provided very good explanations as to why those terms were in there and why they did not agree. It was not a case of me not agreeing with the member's amendment; the staff recommended to me that his amendment was not appropriate, correct, or whatever it was. I quite rightly take their advice, given their expertise, although not in all things; as I said, their advice was that the $15 000 would be appropriate, and I did not take that advice. But in respect of the amendment moved by the shadow minister, once they had provided that explanation to me and I understood what they were saying, it made sense to me, and I would have thought that it made sense to the shadow minister also.

I turn now to the matter of oversupply versus addiction and the issues around that. Oversupply and addiction are quite clearly totally different things. That is not to say that they cannot be interchangeable, or that an oversupplied person cannot also be an addicted person, but oversupply would tend to relate more to some of the schedule 4 drugs, like Diazepam and Stilnox—whatever its chemical name is; I can never remember—and things like OxyContin, which are morphine derivatives. Quite clearly, people may be addicted to those, but they might just be selling them. Last night we covered the price people can get for a packet of OxyContin. It might cost them six or seven dollars, but they can sell a box for $2 000-something; I forget the exact price. People do that. Sometimes heroin addicts will have access to drugs like OxyContin and they will sell them so that they can buy

more heroin. It helps provide the money they need to gain access to the more serious drugs of addiction—schedule 9 drugs—that they want to use. So they get schedule 8 or sometimes even schedule 4 drugs, to sell them and then get schedule 9 drugs. Interestingly enough, that also relates to the story about pseudoephedrine. Of course, people do not actually need a prescription for pseudoephedrine, so I do not actually know why it would be in a script; it can be bought over the counter. Quite clearly, this project is designed to stop people buying large quantities of that; I understand they use it to make ice, although I am no expert on all that. It is my understanding.

I turn to the issue of timing. The member for Eyre talked about the ideal circumstances for something to go straight onto the listing, so that as soon as someone gets an oversupply, it will be listed straightaway.

Dr G.G. Jacobs interjected.

Dr K.D. HAMES: Yes. The point is well made, and that is why the legislation is there—to provide for these things in the future. That is obviously the ideal circumstance and it is what we want for the future—an electronic linkage that allows us to know immediately when someone has been either getting a drug of addiction or, indeed, being oversupplied. It is something critical, and although we are still probably a couple of years away from that, we have only to look at how little time we have had our iPads, and how often we use them now, to recognise how fast things can change. With national identity health cards and all those linkages we are getting in terms of individual identification of our medical history, all those things that are coming soon, we are getting to the stage where we are able to do that; it cannot be too far away.

We made changes in two areas. We clarified the issue of notifications to patients, so that a patient who is put on the list will not get a letter to say that they are a drug addict; they will get a letter to say that they should contact the department.

Mr Acting Speaker, the clocks are different; I am not sure which clock I am supposed to go on! If I were to go on that one, I would sit down now, but the other one still has four minutes! Can I go on this one?

The ACTING SPEAKER (Mr I.M. Britza): I cannot see that one, minister!

Dr K.D. HAMES: I think the Acting Speaker should twist his neck around and look up to that one, although neither of them are correct according to my watch, which shows only five minutes! It is a shame that it is three minutes, because I am pretty well finished! That one is about to click, and we have to have a vote first. I hope the people in the gallery think this is amusing, but if the opposition can give me something to say for the next minute, I can get to the end!

I would like to thank the members of this house for their support of this bill. I am amazed that the shadow minister would think that this bill was of such great importance that, at home on his sickbed, he chose to get on the internet and listen to the debate on it! Unfortunately, he did not last the whole way; he tried very hard and got through a fair chunk of the bill, but he did not hear all the fantastic comments from our two members, who provided great contributions. This is an important bill; it has taken a long time for us to get it through, and I would have much preferred to have done this earlier in our time in government. To go through two years of consultation is a long time, but we got there and I thank members for their support of this bill. I commend the bill to the house.

Question put and passed.

Bill read a third time and transmitted to the Council.