MEDICINES, POISONS AND THERAPEUTIC GOODS BILL 2013

Second Reading

Resumed from 7 August.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [3.20 pm]: I welcome the opportunity to speak on the Medicines, Poisons and Therapeutic Goods Bill 2013, which is an important piece of legislation.

Point of Order

Mrs M.H. ROBERTS: I understand that the Medicines, Poisons and Therapeutic Goods Bill 2013 is the responsibility of the Minister for Health, and I would just like to know whether he will be joining us in the chamber.

The ACTING SPEAKER (Mr P. Abetz): That is not a point of order, so please proceed, member for Kwinana.

Mr R.H. COOK: It may not be a point of order, but it is an interesting point. I thank the member for Midland for raising it.

Mr A. Krsticevic: He is on his way.

Mrs M.H. Roberts: The Minister for Health is on his way.

Mr R.H. COOK: Good, excellent; so is Christmas, but not to worry!

Mrs M.H. Roberts: It is the usual practice for the minister to be here.

Debate Resumed

Mr R.H. COOK: As I said, this important legislation has been kicking around for a while. The Medicines, Poisons and Therapeutic Goods Bill 2013 brings together a range of legislation and regulatory requirements, and has been in formation since about 2002, when a review of the Poisons Act was undertaken. Between 2005 and 2010, recommendations went to government and some drafting took place, and from 2011 to 2013 there was some consultation, an exposure draft and a regulatory impact statement. This bill has been in development for quite a while, and is obviously long overdue. Some legal issues have impacted on the drafting of this legislation, because since it began the National Registration and Accreditation Scheme for Health Professions has been implemented, the State Administrative Tribunal has been established, there was the proposed joint therapeutic goods framework with New Zealand to regulate the development and distribution of therapeutic goods between Australia and New Zealand, and the Productivity Commission has reviewed the chemicals and plastics regulations. A range of other regulatory regimes and legal developments have impacted upon the development of this bill. In that respect, it is not surprising that the bill has been some time in evolution.

This legislation has a lot of good aspects. It will modernise the legal framework under which we work. For instance, it takes account of developments in e-commerce in the distribution of therapeutic goods, acknowledges that new professions are constantly being developed in the whole health space, and that new therapies are starting to be practised and subscribed to. There are also new technologies around the actual administration of drugs. I understand that the government has aspirations to utilise medicine–dispensing machines at Fiona Stanley Hospital and that there is currently no legal framework under which someone can dispense drugs or medicines using that sort of automated machinery. In that respect, the legislation will provide a legal framework that will allow these changes and practices to take place.

The legislation also updates the legal framework in which these practices can take place. The Trade Practices Act, of course, captures the activities of corporations that deal with medication, drugs and so forth, but does not capture sole traders. It is important that we provide a legal framework for sole traders, because there are a lot of cottage industries in alternative therapies and other therapeutic goods, and it is important that those activities are also captured. Since the implementation of the National Registration and Accreditation Scheme for Health Professions, it is important that this legislation plugs into that national regime so that we can capture, on an ongoing basis, the development of the medical and health professions.

Changes have also taken place in the administration of poisons. It is my understanding that currently, for instance, an individual has to be licensed to manage poisons; this legislation will allow a corporate entity to be licensed for the management and sale of poisons.

We can look at a lot of this legislation and say, “Not only are these things good, but also they are necessary for the ongoing and continuing administration of medicines, drug and poisons.” For the most part, the opposition does not have any difficulty with this legislation and, but for two aspects about which we have some very sincere concerns, we would be happy for it to proceed. We are troubled by part 7, division 4—“Oversupplied persons”—and we are particularly troubled about how we will deal with drug-dependent persons, which is covered by

clause 97. We have some concerns and we are looking forward to the minister dealing with them; in relation to, particularly, issues around drug-dependent persons. We are not sure, without amendment, how this legislation will ultimately address those concerns. We are looking for solutions to our concerns, and we do not think the government has undertaken the drafting of this legislation with evil intent, for want of a better description, but we think there are significant problems, particularly with the clauses dealing with drug-dependent persons on which we would like a comprehensive response from the minister. We will obviously look very carefully at those clauses in consideration in detail.

I turn first to the issue of oversupplied drugs to persons. We simply want our concerns on the record to make sure the government is cognisant of them. Obviously, under this legislation, once a register of oversupplied persons is established, a particular action will be taken that will curtail the civil liberties of the people to which it is directed. The drafting of this legislation strikes us as particularly open-ended and potentially open to abuse, so we want the minister to assure us that, in the government's opinion, the practice of this part of the legislation will not be open to abuse. For members' information, the clause on oversupplied persons provides for a health professional coming to the understanding that a client of theirs is an oversupplied person. An oversupplied person is defined in the legislation, and I will refer to this very carefully, so I beg the patience of the chamber.

Dr K.D. Hames: Turn us to the page in the bill you are referring to.

Mr R.H. COOK: My first concerns are in relation to page 68. The definition I am referring to is on page 64, and reads —

> ***oversupplied person*** means a person who has over a period of time obtained, or obtained prescriptions for, quantities of drugs of addiction that are greater than is reasonably necessary for therapeutic use;

I understand that retail chemists in particular take care to make sure that people do not gain access to particular drugs. I assume they are schedule 2 and schedule 3 drugs. We are blessed that a couple of doctors are in the house, so I will occasionally refer to them to confirm it, but I think they are schedule 2 and schedule 3 drugs on which chemists collaborate with each other to keep track of how often an individual might be accessing a drug. We have all experienced a chemist asking us for a form of identity or some information so that they can record it and make sure we are not doctor shopping or, in that instance, chemist shopping. My concerns are simply: are we talking about a continuation of the current practice or are we codifying it to make sure we are not overstepping the mark with it? Once a health professional has identified someone as an oversupplied person, that person must report to the chief executive officer of the Department of Health within 48 hours of the health practitioner forming the belief that the person is an oversupplied person. That person will then have their name entered on a register of oversupplied persons and their details will be entered on the drugs of addiction record. Once a person's name has been entered on the drugs of addiction record, the CEO, as defined under this legislation, will then have the authority to provide that name to third parties. From that perspective, this legislation authorises the CEO to take some very crucial steps with the person's privacy. Clause 102(3) provides that before making a decision to add that person's name to the drugs of addiction record, the CEO must inform the person of the CEO's belief and the grounds on which it is based, the CEO's power and the consequences of having his or her name included on the drug of addiction record. The legislation will allow the details of a private act—the activity of this person making a purchase from a chemist—to become public. From that point of view, we will be taking a very crucial step with that person's details.

When I have spoken to people within the health sector about this, I have found that they take it very seriously but people are widely relaxed about the way this will work because there are already some practices in place. We simply seek guidance and clarification from the minister about how taking a record of the details of someone who is identified as an oversupplied person will work in practice and how it will be administered. I understand that it is important in our current environment to have a way of managing people who shop extensively for drugs. From that point of view, the people I spoke to about this also believe it is important that something is in place so that we can manage that chemist-shopping process. We seek clarification from the minister on that.

Another aspect of this legislation gives us even greater cause for concern—the register of drug-dependent persons under clause 97 on page 65, which reads —

> An authorised health professional who reasonably believes that a patient of the practitioner is a drug dependent person commits an offence if the practitioner does not make a report in accordance with subsection (2).

Proposed subsection (2) reads —

> A report must —
>
> (a) be made to the CEO within 48 hours of an authorised health practitioner forming a belief that a person is a drug dependent person; and

(b) set out the grounds on which the belief is based.

When a patient walks into a doctor's rooms, that person has a right to expect that their privacy and the information they provide to that doctor will be treated with the utmost care and that their privacy will be guarded. This legislation compels the health practitioner, within 48 hours of believing that that person is drug dependent, to make a report to the CEO that the person is a drug-dependent person. To get some guidance on the sort of information that doctor would provide about the person, I looked at the form appended to the Drugs of Addiction Notification Regulations 1980. I note that the doctor in this instance must provide to the CEO of the health department the full name, address, occupation and date of birth of the person; the drug or drugs upon which the doctor thinks that person has a dependency; the estimated period for which any drug of addiction has been taken and whether it is an addiction or a dependency that has grown out of medical treatment; and the name, address and telephone number of the doctor. A great deal of information therefore would be passed on to the CEO of health about this particular person. The CEO would be then authorised to provide the details of that person to other persons that the CEO believes is necessary to carry out the objectives of this bill. The consequences of this, I think, are very grave. It strikes me as a very clumsy and very backward way of managing the drug dependency of a person. The degree to which this would bind the doctor is found in the penalties for not disclosing the full details of this person. That is, if someone walks into the rooms of the member for Eyre and says, "I think I have a drug problem", the member for Eyre would have 48 hours to hand over the person's details to the CEO of the department.

Dr G.G. Jacobs: I have to have a reasonable belief, though.

Mr R.H. COOK: That is correct. The member for Eyre would have to have a reasonable belief. He would not even have to be sure in his own mind; he would just have to have a reasonable belief.

Dr G.G. Jacobs: I might not have a reasonable belief.

Mr R.H. COOK: That is right.

Dr G.G. Jacobs: You might come in and say that.

Mr R.H. COOK: Let us consider that someone comes in to see the member for Eyre and says, "I've got to be honest with you, I've been taking these drugs for this bad back for six months and I think I'm taking them for the wrong reasons now. I've got to be honest. I'm really worried because I get up in the morning now and I feel, even though my back is not hurting that much, I've got to have one of these drugs. I've got to have some of my medication. And then because I'm agitated and I'm anxious, I get a bit jittery if I don't. And once I've had them I feel much better. Is something going wrong?" The member for Eyre would have to say, "Of course something's going wrong. You're developing a dependency on this drug." The member for Eyre then has 48 hours to inform the department. If it comes to pass that the member for Eyre has not informed the department in 48 hours, he stands at risk of receiving a fine of up to $15 000. Does that not strike the member for Eyre as extraordinary? We are actually looking at a situation whereby, whether or not the member for Eyre likes it, he has to contravene the relationship he has with this patient.

Dr K.D. Hames: Yes, but you want to make sure that they are not going to see the doctor down the road and getting more of the same drugs. I have had people do that in my surgery and I have had no idea that they have been doing that to get drugs, not just from me but also from others.

Mr R.H. COOK: That is correct. As I said, I do not think this is an exercise in some sort of skulduggery or anything like that. I think this is a poorly crafted technique for managing people's increased drug dependency.

Dr K.D. Hames: I think you got the letter from the Australian Medical Association slightly before I did.

Mr R.H. COOK: No, I did not, unfortunately. The AMA said it would send it to me but I have not received it yet.

Dr K.D. Hames: I only got it today and it says exactly what you are talking about.

Mr R.H. COOK: That is right; the AMA shares my concerns.

Dr K.D. Hames: Could it be the other way around? Did it offer its concerns and you thought that, yes, you agreed with it?

Mr R.H. COOK: No. The scenario went like this: there is a bill before me and it has been second read in Parliament.

Dr K.D. Hames: It has been out there since 2012.

Mr R.H. COOK: No. The bill had been second read in Parliament and I thought I should make sure I understood it. Obviously, as shadow Minister for Health, I was staring at the sum total of my research capacity.

Dr K.D. Hames: Ask the AMA.

Mr R.H. COOK: I went out and spoke to all the major stakeholders. It would not surprise the Minister for Health to hear that the AMA is one of those health stakeholders. I suspect the minister catches up with the AMA on a fairly regular basis as well.

Dr K.D. Hames: I do. I meet it every day, and I got this letter today that reflects exactly what you are saying.

Mr R.H. COOK: That is right. So I said to the AMA, "Look, there is this bill and it does this. Is this your reading of it? Is this correct?" The AMA said that it had not really paid much attention to it and it would have a closer look at it. I also had a chat with the Western Australian Network of Alcohol and other Drug Agencies; I checked with the WA Substance Users Association; and, obviously, I checked with the Pharmacy Guild of Australia, as this issue will impact on it as well. So, absolutely I went to all these people. I said, "Are you guys okay with this, because my reading of it is a bit odd, but if you're telling me that it is okay, it is." And that is what happened, for instance, with the issue of oversupply to a person. Most of these stakeholders said, "Yes, we're aware of that, we've had some discussions about that and it's okay." On my reading of it, it seems okay as well. All I am saying is that some concerns have been voiced and we are looking forward to the minister's clarification of them.

We had some significant concerns about the register of drug-dependent persons and when I tested those concerns by getting advice from stakeholders, they confirmed them. It appears to me that we could have the following scenario. This is my scenario. A member of the public walks into the consulting rooms of a doctor or member of the medical profession and talks about the problems they are having; for instance, with a pain medication that they have been using for six months. Perhaps they talk about the sorts of symptoms the member for Eyre referred to and they present as someone who has got on the wrong side of their pain medication. Within 48 hours the doctor must report that person to the department on the basis that they have reasonable grounds to believe the person has a problem. That person has just told the doctor they have a problem, so clearly the doctor has reasonable grounds to suspect the person has a problem. Within 48 hours, under clause 97, the doctor must tell the department about this particular person.

Dr K.D. Hames: Of course the legislation is designed largely around pharmacists, not around doctors. The definition of "client" on page 64 of the bill is in relation to a pharmacist, a veterinary surgeon and any other authorised health professional. It does include doctors, but the legislation to catch people doctor shopping is designed largely around people who present prescriptions to pharmacists, as they will have a much better idea than an individual doctor of this collective shopping. It presumably applies to doctors as well, but it relates largely to pharmacists.

Mr R.H. COOK: But the minister agrees that it captures doctors.

Dr K.D. Hames: Yes, as far as I know.

Mr R.H. COOK: The medical profession must offer this person's details to the CEO, because that is what clause 97 of the legislation requires; and without doing so risks, under clause 132, incurring a fine of up to $15 000. In addition to this, the member for Eyre in his rooms might say to a colleague, "I had someone in my rooms today who is clearly a drug-affected person. I am looking forward to looking after them in the future. I know I should give up their details to the department but I am not going to because I care about this person and I am managing their addiction." The member's colleagues in the surgery may then say, "Good on you. That is great and we are pleased you are doing that". But later it may transpire that the member for Eyre has not declared this person and he will be subject to a $15 000 fine, and his surgery colleagues in general practice will also be subject to a fine of upwards of $45 000. I am not an expert—I am not a lawyer and, as the minister often reminds the public, I am not a doctor—and I am happy for this to be explained to me otherwise, but in the discussions I have had with the minister's own union and with others in the health sector, no-one so far has told me I am wrong.

The scenario goes on. Under clause 100(2) the member for Eyre would not be able to prescribe other drugs to this person to manage that addiction. Presumably the legislation is telling us that once there is a reasonable suspicion that a person is a drug-dependent person the doctor must declare it to the department, but the doctor is then not allowed to offer them other pain relieving drugs to relieve their condition. One assumes, therefore, that leaves only the methadone program to go on. So that person has gone from back pain medication to methadone, because clause 100(2) states —

> A person who supplies a drug of addiction to, or prescribes a drug of addiction for, a person whose name is included on the drugs of addiction record as a drug dependent person commits an offence …

Then the member for Eyre would be liable for a $30 000 fine under clause 132. I am happy for that to be explained otherwise, but that is what the legislation tells me.

Clause 99 of the legislation then provides that the chief executive officer of the Department of Health can forward that information to other members in the community—I assume other medical professionals—which would, therefore, destroy any conversation the member for Eyre has had with his patient. If the patient says, "Look, this is wrong, I should not be on this particular register," the patient can, under clause 109, remedy that by going to the State Administrative Tribunal to argue his or her case. I do not know what is envisaged in relation to that, but it strikes me as an extraordinary state of affairs that that person has to go to a tribunal to explain the situation. This person has gone to the member for Eyre for assistance and help. The person's doctor—it might be the member for Eyre—then tips this person into a legal process when all they wanted was some assistance with their medication.

This will be of particular interest to you, Mr Acting Speaker (Mr P. Abetz). One assumes that, under this legislation, anyone who walks into Dr George O'Neil's clinic must be reported to the CEO, because the only people George O'Neil has in his clinics are people with drug dependency problems. It means that Dr O'Neil risks a $15 000 fine and a $45 000 fine for his clinic, because every person who walks through his door almost by definition has a drug dependency problem and those people will have to be referred to the department within 48 hours. That is moving into the world of the absurd. I have spoken with one particular doctor who specialises in drug addicted patients, and his core business is essentially dealing with people whom he will have to add to the register. That strikes me as over the top. Why is the fine set at $15 000?

Dr K.D. Hames: Because it was $1 000 in 1980 and they have extrapolated what $1 000 in 1980 is worth in 2013.

Mr R.H. COOK: Thank you, minister, because that takes me to my next comment. All of this is in relation to the current register of drug addicts, which has been around since about 1980 in the Drugs of Addiction Notification Regulations 1980. Those regulations define a person who is considered to be an addict at regulation 3(2) as —

(a) he —

I guess that is the way we worded things back then —

> … under a state of periodic or chronic intoxication produced by consumption of a drug of addiction or any substitute therefor;

(b) he is under a desire or craving to take a drug of addiction or any substitute therefor until he has so satisfied that desire or craving; or

(c) he is under a psychic or physical dependence to take a drug of addiction or any substitute therefor.

The regulations go into some detail on addiction. We are talking here about someone who is clearly in a state of chronic intoxication, as the regulations suggest. The current drugs of addiction register is, firstly, specific; secondly, sets the bar quite high; and, thirdly, has been around since the early 1980s when the world was a very different place. The current regulation 5(2) states the four ways a person can get off the register —

(a) the person referred to in the register has died;

(b) after 2 years, the Director, Alcohol and Drug Authority has advised that the person referred to in the register has ceased to use drugs;

(c) the entry was, for any reason, false or incorrect; or

(d) for a period of at least 5 years, the person referred to in the register has no contact with the Department, either directly or indirectly in relation to their use of drugs of addiction.

I am informed that one of the implications of this regulation is that some people's names have been entered onto the drugs of addiction record without their knowledge, or it was registered when they were an addict much earlier in their life, a life they have long since left behind, yet when they front up to an emergency department with a broken leg they can be told they cannot be treated for pain because their name is on the drug addict register.

Dr K.D. Hames: That is not how it works, you can give drugs of dependence to people who have been drug dependent but it depends on the medical circumstances.

Mr R.H. COOK: The current register, pursuant to these regulations, has 14 128 individuals registered. If, as I said, there are four ways to get off this register, I ask government how many people have actually managed to get off the register using one of those four mechanisms. The answer is 70 people. This figure is based on currently available records—so it sounds like they have only been kept since 1997. There are 14 000 people out there who have their names on this register. The minister cannot tell me that only 70 of them have died; received

therapies or treatment from the Drug and Alcohol Office; are people whose names should not have been there in the first place; or are people who have not had contact with drugs of addiction for five years.

Dr K.D. Hames: You need to understand how valuable that register is to us as general practitioners. You get people coming in with all sorts of stories, and incredibly clever stories, and knowing that that person has been registered as someone who is a drug addict in the past, is a huge assistance in working out what sort of treatment you give to the patient. It may still be a drug of addiction, depending on what you believe is the right treatment for the patient. But if you don't know that, you can have the most amazing stories you could ever believe and you don't know if it is true or not.

Mr R.H. COOK: Yes. Before a practitioner would have to be convinced that that person was an addict and now a doctor just has to have a reasonable suspicion to believe that they are drug dependent.

Dr K.D. Hames: Sometimes with a patient who you think may be an addict, you ring up and say, "Look, I'm not sure if this patient is an addict or not. I just want you to have their name there, so if you get a call from three or four other doctors with the same suspicion, you can know that I am a bit suspicious." That is how it can work.

Mr R.H. COOK: That is how it can work, but it is not how this legislation sets it out.

Dr K.D. Hames: It is the same outcome. This is the 1980 legislation that has been in place for 33 years.

Mr R.H. COOK: They are regulations. What is clear is that it is essentially a dysfunctional list of over 14 000 people —

Dr K.D. Hames: Why is it dysfunctional?

Mr R.H. COOK: The minister cannot tell me that of those 14 198 people only 70 have been knocked off, so it is now 14 128.

Dr K.D. Hames: People don't necessarily have to have their names knocked off. If you cease being an addict, you don't care because you are not seeking drugs anymore. Your name could be there for 20 years and what does it matter?

Mr R.H. COOK: Then a person on the register fronts the emergency department and they say, "No, you are on the record of addicted persons."

Dr K.D. Hames: You don't say no, you say that you know the person has in past been addicted to drugs, and you make a judgement according to what weight you put on that record.

Mr R.H. COOK: In a care situation the person is not going to be left, the carer is going to make a call.

Dr K.D. Hames: You make a judgement call.

Mr R.H. COOK: The person will make a judgement and they may or may not be right but they are in a care situation and may risk a $100 fine.

Dr K.D. Hames: I have risked that many times before.

Mr R.H. COOK: Indeed. Now, the person making that judgement call is going to risk a fine of up to $30 000. I suspect minister is putting doctors in a very invidious position, in which they will have to make that call on the basis of an extraordinary fine.

Dr K.D. Hames: There is nothing that prevents a doctor providing the treatment that he believes is the appropriate treatment. That's right isn't it Graham?

Dr G.G. Jacobs: It is reasonable.

Mr R.H. COOK: No, not now. I am not asking about now. If I were in that position, I would not give a toss if I were going to be fined $300, I would help the person out.

Dr K.D. Hames: You are not going to get fined because it is within your legal right to make a judgement call about the treatment of your patient.

Mr R.H. COOK: Let us have a look at how well this register is working and regulating the administration of drugs of addiction to people with addictions. How many doctors have been prosecuted in relation to prescribing drugs of addiction to people whose names are already entered on the register? It will not surprise anyone that there have been none. There have been no prosecutions at all. Why is there the need to take the fines from between $100 and $500 to up to $15 000? What is the requirement to put in place this great element —

Dr K.D. Hames: I am happy to look at the $15 000. It wasn't my figure and I am happy to consider whether that is an appropriate figure during the course of our debate.

Mr R.H. COOK: I am sure, and that is what I have assured—sometimes I think the minister is a bit too honest in this game—the stakeholders as well. I said that I am sure there is an explanation for this and we can use Parliament to get that explanation. I am sure, as the minister has done in the past when we have this type of legislation, he will say, "Yes, that's probably not exactly right" and we will move forward.

There is a great deal of concern around the issue of utilising the definition that someone is a drug-dependent person rather than the previous description of someone being an addict. That seems to me to have been borne out by the definition that has been provided to me from the *Diagnostic and Statistical Manual of Mental Disorders IV* that describes substance dependence as —

> The essential features of Substance Dependence is a cluster of cognitive, behavioural, and psychological symptoms indicating that the individual continues use of the substance despite significant substance related problems.

If we come back to the person with the back pain, this person needs a substance every day beyond simply the remedying of pain. The definition continues —

> There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behaviour.

I have been informed about the issue of opioid induced hyperalgesia; that as someone becomes more and more drug dependent, they become more and more sensitive to the physical needs of pain management.

Dr K.D. Hames: It is true that no-one feels a needle for a flu vaccine more than someone who has been a drug addict and is off their drugs for the time being.

Mr R.H. COOK: Yes. The scenario of a person who has an increasing drug dependence that cannot be treated by their physician actually has an enhanced need for potential drugs of addiction to treat their addiction. However, under this legislation that particular position risks a fine of $30 000. That seems to me to be a ludicrous way to proceed.

The minister might be able to show me otherwise, but I also asked various health stakeholders how the drug of addiction register works in other states. No-one could actually find me a state where there is such a register. That is another issue around which we seek some clarification. People have said that this system does not work in any other state, yet we have it here and there must be some justification for that. If it is in another state —

Dr K.D. Hames: That would surprise me because I thought it was a commonwealth–managed list of people. We used to ring a commonwealth number to get the people on the list of addicted persons. But I will check.

Mr P. Papalia: The second reading speech said it was an Australian first.

Dr K.D. Hames: No, this is to expand what we are doing, to try and catch the people who are not just addicted to morphines and codeines and the like, but particularly to pick up those who the project stopped with, such as pseudoephedrine. There are lots of other drugs that people will take and be addicted to that we want to have much better control of. It is a great first. It is something that is leading the nation. But I am pretty confident that the list of drug addicts is Australia wide. But I will find out.

Mr R.H. COOK: I have very grave concerns about the operations of the register of drug-dependent persons, the way in which that will be administered and the powers the chief executive officer enjoys to use information—the names on the register. I asked people with some clinical experience in this space how they would manage someone who has drug dependence or addiction while they continue to receive medication for pain or as part of the process of bringing them off a particular drug. I was told, first of all, that the definitions needed tightening so they were not so open-ended that a health practitioner, someone like the member for Eyre, would be under threat of a significant fine. I was also told that we would be much better off with a system by which a person, rather than going on a register as a person who is drug dependent, is simply required to receive their schedule 8 drugs from only one physician, and that physician would then be in a position to measure and control their patient's access to those drugs.

We are confronted with a number of issues in how this legislation will work, and the opposition will seek some clarification from the minister on the issue of oversupplying drugs to people. We want to see some changes to this legislation that will significantly tighten the processes around which we treat people who are drug dependent and significantly tighten the processes around any sort of register that contains people's details. We want the fines for doctors over their decision on what is appropriate care for their patient to be significantly reduced, and we want to see the relationship between the doctor and the patient preserved. Ultimately, we want to understand why we need to administer the register in this way, whereas we can invest significantly in the relationship the physician has with their patient, and to allow access to schedule 8 drugs for that patient to be managed by their doctor.

As I said at the beginning of my presentation, this is an important piece of legislation because it will significantly update the regulatory regime around poisons, medicines and drugs. But we do not want to see this legislation put in place if it condones a practice that unnecessarily exposes someone's personal details on the register or if it exposes a doctor unnecessarily to draconian fines for what they believe is in the best interests of their patients. The bill should not take away the rights of the patient to have their privacy respected and to have an appropriate regime in place to deal with the issues they are confronting.

The ACTING SPEAKER (Ms J.M. Freeman): I was going to call the member for Esperance!

DR G.G. JACOBS (Eyre) [4.13 pm]: That might upset a few people because I have a very much larger area than Esperance, but I thank you very much.

I am glad to make a few comments in and around the Medicines, Poisons and Therapeutic Goods Bill 2013, which is a very good bill. What I like best about this bill is in the area of controlling the potential misuse of hard drugs. In all the regulations that the Deputy Leader of the Opposition talked about we must keep in mind the ravages of hard drugs and, indeed, oversupplied drugs, on a person's life—the mortality and morbidity—and the often deep nature of this dependency and addiction.

The Deputy Leader of the Opposition talked about these laws as though they are new. I was practising medicine, essentially full-time, until coming to this place in 2005 and the laws we are talking about have been in place since 1981. The drug-dependent group that we are talking about is already subject to existing laws, which are similar to the laws we are debating today, which I practise under. I have to tell members I was never pinged for not reporting a person who I believed was a drug-dependent person.

Mr R.H. Cook: No-one ever has been. Could you have been pinged before? I do not think the regulations allowed you to be pinged.

Dr G.G. JACOBS: As the member described, there were issues over the fine, but there was a fine. I will not take the role of the minister in responding to the member.

Mr R.H. Cook: He needs your protection!

Dr G.G. JACOBS: No, he does not need my protection! If the member recognises the significance of the problem, and without believing these laws and regulations are draconian, these laws are attempting to deal with what is a very serious ingrained problem that is enormously difficult to treat and manage. The current laws came into existence in 1981 and they read very much the same as now with a practitioner being required to inform the chief executive officer of the drug-dependent status of the patient and reference to the authorised health professional who "reasonably believes". A lot of these situations rely on a clinical assessment, balance and looking at all the factors.

Mr M.P. Murray: Can that assessment be wrong?

Dr G.G. JACOBS: Clinical assessments can be wrong.

Mr M.P. Murray: So I can go on the register on someone's wrong assessment?

Dr G.G. JACOBS: I suggest to the member for Collie–Preston that they are decisions that are made on balance. These clauses do not preclude that reasonable clinical assessment and belief. To be quite pragmatic, if my decision as a practitioner turned out to be wrong, I could say from a clinical point of view that at that particular time, with the information I had, that was a reasonable assessment. I do not believe it is a draconian measure to dump on doctors. Essentially, the law has been in place since 1981 and it recognises that clinical assessment is based on a clinical belief. As with a lot of art or science—we can call it what we like—it is often a balanced assessment after considering all the factors. The drug-dependent persons' group is already subject to existing laws. Yes, drug dependence does require reporting and a record to be kept as current. The member for Kwinana, the Deputy Leader of the Opposition, is perhaps a little concerned about the issue of privacy. He talked about a person going on a list or a record that is kept for eternity and then used against the patient in the future. I take the scenario in which a person presents to an emergency department. I think it is really important—not to the disadvantage of the patient and not with any stigma attached—to have some clinical record of that patient's history, because it impacts on the treatment. If the patient has a history or propensity to dependence and addiction, a record is really important for the clinician. The record does not have any stigma attached, but ensures that the clinician makes an assessment, diagnosis and treatment—particularly the treatment—that is not to the detriment of the patient. It does not—this is not a medical term—inflame the past. It allows the clinician to then tailor the treatment, cognisant that on balance, perhaps, he must be careful of those potentially addictive medications.

Mr R.H. Cook: I'd rather leave that to you than to the department.

Dr G.G. JACOBS: But I need to have that history. If a patient presents whom I have never seen and I do not know, I have to have some means of accessing his record to know his history. That is why it is important to have

a record, but I agree that the record must be current. I do not believe that there is an extension to the scope or intent of reporting in the existing 1981 provisions in the legislation, but I believe there is more transparency and fairness. It is really in the drug-dependent or oversupplied person's interest to manage what is often a very difficult condition that has a serious impact on their life, serious mortality figures and serious morbidity figures. We have to be quite serious about it, without being draconian and without, if you like, jeopardising a person's privacy or introducing stigma, but treating their issues in their best interest.

From a practitioner's point of view, doctor shopping is very irksome and difficult. It would be the bane of office general practitioners. If it is the bane of my life in a relatively small town with only three pharmacies, imagine what it is like for a practitioner in a busy practice in the metropolitan area. From a practice point of view, someone comes to me and sits in front of me, and as the minister has described, gives me an elaborate story about the need for this particular medication—let us take the example of OxyContin. A patient visits me and says, "Doctor, I have had this chronic back condition. Here are my X-rays", the whole story. "I'm travelling. I haven't got any medication."

Dr K.D. Hames: They got stolen.

Dr G.G. JACOBS: The stories that the minister and I have not heard—we have heard them absolutely all! "I lost my script." "I lost my packet of medication." "The dog ate them." "They blew out the window of the car."

Mr N.W. Morton: Like you did with your homework when you were at school.

Dr G.G. JACOBS: That is right!

Mr P. Abetz: The dog ate it!

Dr G.G. JACOBS: The dog ate it!

Mr R.H. Cook: Just on that point, is it not true that nowadays there is real-time monitoring in relation to that stuff?

Dr G.G. JACOBS: No, that is the real point I am getting to, and that is what I said I like best about this legislation. For the first time we are implementing a system to identify and regulate doctor shopping—a system that identifies a person who presents at a number of different medical practitioners, seeking medication for their personal addiction or for resale to others. In the scenario of a person in front of a doctor, and the doctor having an index of suspicion, how does the doctor check whether the patient had gone to the guy next door or down the road to a clinic, got a script and then had come to him for another script? In a small town I have it tied up, because I will ring Dr Richard and ask, "Dr Richard, have you seen this guy or this girl in the last 24 hours?" I only have one other practice to check and I have basically tied things up. There are only three pharmacies, so I can tie that up without too much problem.

Mr R.H. Cook: It sounds like there are some competition policy issues down there!

Dr G.G. JACOBS: I want to know and I have a responsibility to the patient to confirm they are not double dipping. However, in the metro area it is impossible to check. What does the doctor have in order to check this? Maybe someone genuinely needs the medication; that is what the doctor has to think of. However, they also have to think about whether the patient is trying to hoodwink them. There is a responsibility for the doctor to identify the patient's addition or oversupply and do something about it, because in the natural course of events, it is not good. The Whip is not interested in my discussion and he is leaving!

Mr R.H. Cook: I was going to say that your Whip seems to be lacking in the discipline he demands of his colleagues!

Dr G.G. JACOBS: What is in that bag?

A member interjected.

Dr G.G. JACOBS: I have it here!

What means does a doctor have to check the drug history and the prescription history? There is a state register that can be looked up. There is only one problem: it is not real-time and there is a three-month window. I can look up what happened three months ago and the register will tell me, but it does not tell me what happened in the last three months. The patient could have been down the road the day before or the week before and I would not know.

Mr R.H. Cook: I think it is just a manual system as well.

Dr G.G. JACOBS: Yes; it is very cumbersome.

Mr R.H. Cook: A person could have got married and changed their name from Aardvark to Zulu, and you would have trouble finding them in the whole system!

Dr G.G. JACOBS: The only other ability is through the PBS system on special authority. The person might have a special authority with this medication. For example, he or she is allowed a prescription of 30 Oxycontin. But on a special authority, a person can ring up the health officer in charge and say, "It's Dr Jacobs here." They will ask for the doctor's prescriber number, 404499, and will check it using their computer records —

Several members interjected.

Dr G.G. JACOBS: That is a case in point. After that call, the officer understands my bona fides. I will then ask, "Look, has this person had a special authority script recently?" The officer's response will be, "Doctor, we can't tell you that." After asking the officer why he cannot give me that information, emphasising its importance, the answer will be it is because of the privacy laws. It is very difficult to know the prescribing habits and the drug habits of a person if they are misusing these medications. As I said, there are a lot of good things about this bill, and I do not believe they are necessarily draconian.

[Member's time extended.]

Dr G.G. JACOBS: The bill sets up a record of persons who are legitimately prescribed drugs of addiction, schedule 4, reportable, and schedule 8. The registered health professional can check the record before prescribing to determine whether the patient has been recently—not three months ago, but recently—prescribed the same or similar substance. I say to the Minister for Health that I believe this will not happen overnight; the provision has to be implemented; that is, it has to be actually introduced. But this is the legislation for which we can set up and implement a system. I will refer to the minister's second reading speech, which states —

> … Department of Health monitoring of the record identifies persons doctor shopping, there is a responsibility to intervene and warn those persons of the risk of such behaviour, as well as inform particular health practitioners —

That is doctors, such as me, who are sitting in front of the patient—when it is in the person's best own interests.

There are some very good things about this bill. In closing, when the member for Kwinana talked about the 14 000 people on the list, it does say something about the nature of a drug condition, and it does say something about the fact that if a person has a history, it is really important for the practitioner to know about that history when he is prescribing treatments in the future. I will now sit down and give the floor to the member for Collie–Preston. I commend this important bill to the house; I will be obviously supporting it in any way that I can contribute towards some of the detail, particularly with the fines, with the minister, who has indicated that perhaps there would be some modification. In essence, it is about treating a very difficult condition but in the best interests of the patient.

MR M.P. MURRAY (Collie–Preston) [4.33 pm]: While having heard and certainly respecting the views of the member for Eyre's background, I beg to differ. The Medicines, Poisons and Therapeutic Goods Bill 2013 will drive people away and leave them to source their "medication" on the street. I have a huge concern about that. People may wish to come in, see their local doctor and get some help. The word "help" covers whatever the doctor prescribes. If that person then knows that after several visits to their doctor they are going to go onto a register that would then tag them as a drug-dependent person, I am sure that some, but not all, will be very reluctant to do that.

I have seen and heard about it from a personal experience when a person was alcohol and drug tested out on the road. The person refused to take the test. Upon being asked why, the answer was, "You want everyone to know that I'm a drug addict because I would've failed the drug test." There are various and many different meanings of the word "addiction". Will we have the same sort of register for the person who buys too many cartons of beer a week because we know he or she is alcohol dependent? Will we do that? Is that our next step? It is no different. The person is dependent. There are many different examples we use within the community about what a person's dependency is. To me, that is a bit hypocritical to say the least, when we know one of the biggest problems in our society is alcohol and alcohol abuse. The difference is that people do not actually go to the doctor to say, "Give me something, I want to get off this alcohol dependency."

There is a contradiction in really stark, black and white terms that there are two different standards for two different addictions. Why? I am not totally sure. But if the person is street dependent, will he or she go to a doctor knowing that they will be reported; that they will be put on a register? I do not think so. They do not want that stigma. They might be suffering with addiction, but they are not totally brain addled. They understand that their name could come up. When the day comes that they are short of a particular drug and they go in and the doctor says, "Oh, you're on here, I can't give you that", it becomes a pointless exercise. Under that scenario, they will go back on the street and take junk to try to fix their craving for their addiction. They will take junk, which could be anything from the street again, instead of coming in and getting something that in our terms might be helpful, clean and far less damaging to that person.

I have huge concerns about where this measure is heading; it has not been previously monitored properly. I have huge concerns about the bill itself—where it says that the CEO has a huge extraordinary amount of latitude to do what they wish to do and where they want to go; whether they want to call the police in; whether the CEO wants to talk to someone about having a bust on someone's house. It is in the bill under this legislation. I think it is well over the top of the role of a CEO in any of those matters. Because of the time factor, I certainly would welcome an interjection from the minister. I hope he can see what I am trying to point out. This comes back to the discretion of a CEO. I think that is wrong. The member for Eyre, who certainly understands country living, would know that the stigma for someone living in a country town is probably far greater than for a person in the city who could not be found and has more anonymity. I also think about the processing of the patient record. Where and how will that be done? Will there be two secretaries on the way through before the CEO gets the report, so it is typed out a couple of times and is all over town? Especially with country towns, will we allow that to happen? When someone goes into town and mentions to their best friend, "Look, such and such has just been put on the register; they're a drug addict", the response will be, "I didn't know that! Oh, I better tell my mum!"

Dr G.G. Jacobs: That would not happen.

Mr M.P. MURRAY: Why? Tell me why.

Dr G.G. Jacobs: We are talking about a central register.

Mr M.P. MURRAY: Yes.

Dr G.G. Jacobs: There is confidentiality between the patient and doctor.

Mr M.P. MURRAY: Someone has to type it out on the way through, and there is a chance for leakage in that process. That is what I am saying. Do not tell me it does not happen—Christ! If we have a look at that, everyone knew my wife was pregnant before me in my country town!

Several members interjected.

Mr M.P. MURRAY: But members can see what I am saying about how that happens!

Several members interjected.

Mr M.P. MURRAY: Yes, apparently I was supposed to count, and did not! But members can understand what I am saying about going into a chemist —

Mr F.A. Alban: Member, how old are your kids?

Mr M.P. MURRAY: I counted backwards!

I am trying to point out the vulnerability of people with dependencies who live in smaller communities, and about how that can be leaked very, very quickly, and how that does not apply to people with other dependencies—the obvious one being alcohol. If someone goes down to get a double dose of Panadol or something like that, they are not put on a register. It is about the way we do things. We have had different debates here previously about the mandatory reporting of children. Yes, there were two different sides to that, and it was very difficult to work through. This one, I think, is far more clear-cut in that the person who is ashamed to go to a doctor for fear of being put on that register is doing themselves more harm than they realise. The system is causing that harm, not the individual doctor. On the street, people pass information on faster and know more about this than most of us in this room. That is what gives me great concern.

Say someone wishes to see a doctor to get a substitute drug—I think the member for Kwinana mentioned a couple of drugs there that could be substituted for their original addiction—that allows them to go to work. The Medicines, Poisons and Therapeutic Goods Bill 2013 could stop that happening. Many of those people live a normal lifestyle, because they get their medication that enables them to function normally. I am sure that we have in our midst people from the top end of town who have problems but are not on a register, even though they may be being supplied a drug that allows them to function normally. My concern is that the legislation will capture the chief executive officer of a company. When we think about drug addiction, we look down to the bottom and tend to generalise it as relating only to street addicts, but that is not accurate. Many addicted people do not fall into that category. People with chronic pain regularly go to the doctor for pain management. They are questioned about whether it is actual pain or whether it is an addiction. Those sorts of people will be driven away.

I say this tongue in cheek, but, the way this bill is headed, will we be putting a tattoo on these people next so that they are easier to identify, rather than putting them on a register? Maybe the member for Eyre might want to put an ear tag on them, because that is what they do down in country towns, especially down in sheep country.

Dr G.G. Jacobs interjected.

Mr M.P. MURRAY: They can have an ear tag put in them—a red one for one dependency, and a blue one for another. That is where our society is headed. It has been proven.

What also disappointed me a while back was a system—I am sure the two doctors in this place could help me out on this—that would have medical records hooked up through technology so that a button could be pressed and doctors would be able to identify people who were not even on a register because their medical history would come up. I am of the understanding that that was in the process —

Dr G.G. Jacobs: You would have to be an unauthorised user, though.

Dr K.D. Hames: It is only with their permission—with their card they provide that has their full history on it—or in hospital; we have it in hospitals.

Mr M.P. MURRAY: Why, again, do we need to go over and above that and have a register? Why is that not sufficient?

Dr K.D. Hames: Because, as the member for Eyre said, we get lots of patients who come in —

Mr M.P. MURRAY: Doctor shopping.

Dr K.D. Hames: — who we have never seen before, and they have the most extraordinary stories of hard luck, and harm and hardship, with X-rays to prove a severe disc prolapse, and of course they had the tablets but the script blew out the window and they are desperate and they are from South Australia —

Mr M.P. MURRAY: But that still comes back to —

Dr K.D. Hames: They are not even from this state. Then you call the centre and ask whether this person is on the list. They say that they are, and you find they've been doctor shopping for these drugs over and over again.

Mr M.P. MURRAY: But these days we cannot get a mobile phone now unless we have five pieces of identification—bills et cetera—but the Minister for Health is saying that people still may be able to put one over doctors even though there is a system? Surely some checks and balances can be put in place—those people all seem to have a mobile phone!

Dr K.D. Hames: But that is what it is; that is what the register is.

Mr M.P. MURRAY: But the checks and balances should not be —

Dr K.D. Hames: That is the check.

Dr G.G. Jacobs: It is authorised usage as well.

Mr M.P. MURRAY: But it is an addiction register. I am very, very —

Dr K.D. Hames: You could not ring up and get that information.

Dr G.G. Jacobs: No, you can't get it.

Dr K.D. Hames: Only me as a doctor, or a pharmacist, could ring up and get that information.

Mr M.P. MURRAY: But it still comes back to tagging people, and that is the basis of my concern. The way society is going, people will end up with an ear tag or a big earring or a little earring —

Dr K.D. Hames: But nobody knows except the doctor or the pharmacist.

Mr M.P. MURRAY: Sorry?

Dr K.D. Hames: Nobody knows except the doctor. It does not go to someone in Collie.

Mr M.P. MURRAY: No, the Minister for Health missed the point of what I said earlier about living in a country town.

Dr K.D. Hames: But it doesn't go to anyone in a country town.

Mr M.P. MURRAY: Someone has to type it out as part of the process.

Dr K.D. Hames: No.

Mr M.P. MURRAY: Someone has to enter it in.

Dr G.G. Jacobs interjected.

Dr K.D. Hames: No. The doctor gets on the phone and rings the centre in Perth.

Mr M.P. MURRAY: Reasonable-sized communities have a problem with information leakage.

Dr G.G. Jacobs: The practitioner does not go out to the waiting room and say to the receptionist, "Hey, register this person on the drug addiction record." No.

Mr M.P. MURRAY: No, but if the person goes across to the pharmacist, they can be exposed in that sense. I know people who will get the script from the member for Eyre and will go down to Bunbury to get it filled for some anonymity. The member for Eyre is saying that because of the new reporting system, they will come back all the time.

Dr G.G. Jacobs: You were talking about people in the country town knowing that someone was on the record.

Mr M.P. MURRAY: Yes, that is right, but there are two parts to it. They can be exposed.

Dr K.D. Hames: They would be exposed if they are addicted. If I give them a drug for something and they go to the local chemist and get it, and then the next day they are there with their script from another doctor, the chemist will know and the staff seeing that guy getting those drugs will know. That is how word will spread, not by the register.

Mr M.P. MURRAY: Okay; I follow that, but they can dodge that by going to another pharmacist 60 kilometres or 80 kilometres away.

It still comes back to the tagging of a person and a person with health issues avoiding going to a doctor. The number of people who go to the back window to get Fitpacks and those sorts of things at country hospitals—I use Collie as an example—is quite enormous. But those people are not on the register —

Dr K.D. Hames: True, but if they go to a doctor —

Mr M.P. MURRAY: — because they are using street drugs. When they get ill or down to the bottom, they do not want to go to a doctor because they say, "No, he will put me on the register. I don't want to be on that." Do not ever forget they still have a brain.

Dr K.D. Hames: If they go to the doctor and they are not asking for drugs of addiction, the doctor will not even check to see whether they are on a register. He will just manage the problem.

Mr M.P. MURRAY: When there is a dry-up on the street, they look for something. If they do not jump fences or break into pharmacies, they go to the doctor.

Dr K.D. Hames: Sure.

Mr M.P. MURRAY: Then if the doctor says that he is putting them on there —

Dr K.D. Hames: No; if they came to us and said, "Look, I'm a drug addict, I'm coming off and I'm desperate for something", we might give a nocturnal sedative.

Mr M.P. MURRAY: I am taking on board the minister's words because he is in the field. When they go to a doctor, do they say, "Look, I've got a pain in the side"?

Dr K.D. Hames: Sure, but if they come with an excuse to get a drug, I need to know they are a drug addict, otherwise, all I'm doing is perpetuating their addiction. If they tell me they are a drug addict, I don't want to just give them drugs; I want to help set them up with a plan to get them off them.

Mr M.P. MURRAY: I accept what the minister is saying but I will move on. If a person has been clean for two years, how will they get their name off the register? A drug addict is never cured completely. I have seen people who have been clean for five or 10 years and then, bang—they are gone again. Do they have a chance —

Dr K.D. Hames: No; they don't get off, do they?

Dr G.G. Jacobs: It's the serious nature of the condition.

Mr M.P. MURRAY: That is right. How do they get their name taken off the register, because a person could be clean for five years and want a medical certificate for a job or whatever? What will a doctor put on the medical certificate if the person wants it for work?

Dr K.D. Hames: If they see a doctor and they are not asking for drugs of addiction, the doctor will treat them for whatever their condition is. Nothing will be said about being on the register.

Mr M.P. MURRAY: Even if I go to another doctor and ask for a certificate for work, will that not come up? Is that what the minister is telling me?

Dr K.D. Hames: Yes, unless they ask for a drug of addiction; otherwise, the doctor will not check.

Mr M.P. MURRAY: It seems a bit pointless.

Dr K.D. Hames: No; we get on the register and check.

Mr M.P. MURRAY: Someone might be down in the dumps for three years; they tidy themselves up and go for the next five years without asking for any drugs but their name remains on the register because they might need one script to get them through. Then they will be back on the street again.

Dr G.G. Jacobs: I refer you to clause 107, "Amending information in drugs of addiction record", which reads in part —

(a) the amendment of information on the record relating to the person; or

(b) for the removal from the record of identifying information about the person.

They can apply for it; it is in the bill. It says, "may … apply to the CEO".

Mr M.P. MURRAY: Here we go again. I can imagine how hard it will be to go through the system to apply for that, and therefore how hard it will be to get their name taken off the register. I am sure it is not just a matter of writing a letter and saying, "Please take my name off the record; I have been very well for the last two years." It will not be that simple. I am sure the member will agree with that.

Dr G.G. Jacobs: There is an ability, though.

Mr M.P. MURRAY: It will be very difficult. It is hard enough to get a driver's licence after a drink-driving offence; the person has to undergo a medical examination et cetera.

Mr R.H. Cook: If you are going to entertain the member for Eyre, you might want to extend your time.

Mr M.P. MURRAY: I am trying to say that I see this as a backward step that will make people stay on the streets; rather than get clean drugs, they will pick up junk and use rubbish because they cannot get help or they are too embarrassed because their name will be put on the register. How many are on there?

Mr R.H. Cook: Fourteen thousand.

Mr M.P. MURRAY: There are 14 000 people already on it. Out of those, how many doctors have been fined for abusing it?

Dr K.D. Hames: Zero.

Mr M.P. MURRAY: Is it worthwhile passing this legislation, when we know that there are not only doctor shoppers but also doctors who will write out a prescription very quickly, without undertaking adequate checks, because they are busy and under pressure with another 20 people in the waiting room? If no-one has abused it during that time, we should forget about this clause.

Debate adjourned, on motion by **Dr K.D. Hames (Minister for Health)**.

House adjourned at 4.53 pm