PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Tuesday 10 November 2020

REVISED EDITION

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The President, **Mr Farrell**, took the Chair at 11 a.m., acknowledged the Traditional people and read Prayers.

QUESTION UPON NOTICE

Mrs Hiscutt (by leave) tabled the answer to question 46.

46. PESRAC - Tasmanian Residents - COVID-19 Emergency Management Act

Ms WEBB asked the Leader of the Government in the Legislative Council, Mrs Hiscutt -

(1) (a) Are Tasmanians, who under normal circumstances return to Tasmania between semesters, considered Tasmanian residents under current Emergency Management Act COVID-19 emergency powers; and

(b) if not, when did this non-residency classification come into effect and how were those affected advised?

(2) Under what circumstances would permission to return to Tasmania be denied?

(3) What types of evidence of residency, other than those in the evidence of residency list as referred to in the 'Applying to the Deputy State Controller for recognition as a Tasmanian resident' section of the Government's coronavirus website, can returning Tasmanian students provide?

(4) How many times have applications been made where returning Tasmanian students were unable to provide evidence of residency to the satisfaction of the Deputy State Controller and were refused entry to Tasmania?

(5) (a) How many times have applications been made where returning Tasmanian students were able to provide evidence of residency, other than those on the evidence of residency list, to the satisfaction of the Deputy State Controller and were granted entry to Tasmania; and

(b) what types of evidence did these successful applications include?

Answer tabled.

RECOGNITION OF VISITORS

Laura Moore

Mr PRESIDENT - Honourable members, I welcome Laura Moore to the Chamber. Laura is the executive assistant to the member for Rosevears; she has a number of business administration qualifications and broad executive administration support experience gained over many years in the fast-paced media environment. Her previous employment provided her with strong administration, social media and secretarial support skills and enabled her to build

strong relationships with the local business community, service organisations and community groups. Laura's ability to adapt quickly and to connect with a broad spectrum of the community will provide great support to the member for Rosevears. Laura is pleased to join the Legislative Council team and looks forward to supporting the member for Rosevears in her new role.

Honourable members, if you think Laura looks familiar, she was at one time a weather presenter for Southern Cross Television and she joins the Legislative Council's growing stable of fallen media stars.

Laura will be joining us today to observe proceedings. I am sure all honourable members will give her a warm welcome and trust that you enjoy your time with the Legislative Council. Welcome.

Members - Hear, hear.

George and Paul Willows

Mr PRESIDENT - We also have joining us in the President's Reserve this morning George Willows and his father, Paul, who are here for a reason that will become obvious shortly as we move into the first business of the day and that is the special interest speech. To reveal why George and Paul are with us, I invite the honourable member for Launceston.

SPECIAL INTEREST MATTERS

George Willows - English Leicester Sheep Stud

[11.07 a.m.]

Ms ARMITAGE (Launceston) - Mr President, I welcome George and his dad here today. It is wonderful to have them here. Today I speak about an extraordinary young man who goes to school at Scotch Oakburn College in Launceston, George Willows, who is now in grade 6, farms a heritage breed stud of English Leicester sheep at his parents' farm 'Everton', in Evandale. The English Leicester is a very rare breed of sheep first developed by eighteenth century breeding innovator, Robert Brakewell. George describes English Leicesters as being great mothers who have attitude but can handle tough conditions. They are slow growing, but this results in a much more unique and flavoursome meat. Their wool is curly, long and dense and is a sought-after product for crafters, felters and weavers.

At school George is a diligent, conscientious and hardworking student with a particular interest in how to apply learning creatively to his farming practices, such as relating maths investigations to his stock currency and spreadsheets. According to George's year 4 teacher, George is a leader in teaching others how technology can be personalised to learning needs, having conducted investigations into how his own learning could be improved by using novel approaches to the application of certain technologies regarding visual processing.

On the farm, George also takes a leadership role in looking after his English Leicesters. The stud named 'Nant' after his maternal grandfather's Bothwell property, now known as Nant Distillery, has been built up to a flock of 52 ewes, 12 rams and 60 lambs. George's grandfather, Ian Campbell, first bought the stud of English Leicester sheep when he was a student at Scotch

Oakburn in 1945. Before Ian passed away around 11 years ago, he was adamant that his precious stud should be preserved.

At the tender age of eight, George took up the gauntlet and channelled his Dad-pa's passion for the rare breed. George is also not shy to take on the hard work, doing almost all the electronic tagging, vaccinating, weighing, crutching, drenching, milking, feeding, treating mastitis, record keeping and showing.

George is a fierce competitor at the Tasmanian shows, having competed since 2017. Anyone in the industry will tell you how much work goes into preparing for competitions and George is not afraid to take up the challenge. Two months before a competition George will pick his entrants, spend hours teaching them to be handled and walked on a lead, as well as how to stand calmly for inspection. Anyone who has even spent a few moments with sheep will understand just how wilful they are by nature. The fact that George takes the time to get to know his entrants, train them, and positively reinforce their behaviour shows just what a patient person George is.

Closer to the competition, George undertakes all the grooming duties - teeth, feet, ears, faces and noses - and, on the day, George coordinates and organises with his helpers to make sure all his entrants are where they need to be. You certainly get a sense of all the leadership qualities George possesses at school and in competitions, knowing all of the thought and preparation that happens behind the scenes.

In addition to the Tasmanian shows, George has competed in past Australian sheep and wool shows. In 2019, all his hard work reached a high point when his best ram, Benny, was awarded reserve champion in the English Leicester class. This win resulted in George's first sale, and has opened the door to further competitions in the future. Ultimately, I am told, George wants to be a builder and a farmer. He takes a practical approach to his learning on the farm with his dad Paul who, needless to say, is incredibly proud of everything George has already achieved.

Mr President, it is so fantastic to see our young people - particularly George, here - with so much dedication, ambition and skill. George is a wonderful example of a person with humility, achieving great things by working hard, taking responsibility, and leading by example. I am sure we will hear many, many more stories of George's successes in years to come. I commend you, George, on the work you have done, and thank you very much for coming down today.

Members - Hear, hear.

Reclink Australia

[11.12 a.m.]

Ms HOWLETT (Prosser) -Mr President, I thank the member for Launceston for sharing the lovely story of George with us - really lovely. Congratulations, George.

I rise to discuss some of the terrific work provided by Reclink Australia in Tasmania. Reclink's programs are evidence-based, innovative community sport and recreation programs. Reclink engages some of the most at-risk and disadvantaged people in our communities,

including those with mental health illness and drug and alcohol addiction, and those with experience of domestic violence, homelessness, long-term unemployment, social isolation and social economic disadvantage.

Research from the Centre for Sport and Social Impact at La Trobe University shows that every dollar invested in a Reclink sports program generates at least $8.94 million in social value, including improved physical and mental health, employment outcomes, lower crime rates, and reduced risk of suicide.

Reclink works in partnership with more than 450 community, government, and private organisations across Australia, with 74 member organisations in Tasmania. Some of its member organisations include TasTAFE, migrant resource centres, Anglicare, the Salvation Army, Life Without Barriers, City Mission and Colony 47.

Programs are run statewide, working with some of our most disadvantaged and remote communities, such as New Norfolk, George Town, Brighton, Bridgewater, Burnie and Devonport.

Reclink's mission is to respond, rebuild and reconnect. It seeks to give all participants the power of purpose. In the last financial year, Reclink delivered over 650 sport, recreation and art participation opportunities in Tasmania alone.

Reclink's benefits to individuals are immeasurable, and I urge members to read its annual report, which is full of stories about recovery, a lot of personal stories about reconnecting, and ultimately, wellbeing.

I would like to take the time to share a story from a very brave individual named Cameron which reflects on the impact Reclink has had on his life -

- From the age of 8 to 28, my life, and my mentality, have been negatively skewed by the experiences of my childhood, my transition into adulthood and the constant of my environment and those who have I chosen to associate with.

- What I experienced as a young bloke is as traumatic as it gets. And I've always felt like that has been a fair excuse for my choices, behaviors and the gross hatred I have held towards people; the lack of trust I have had for people in positions of authority; my inability to recognize happiness.

- Scariest, saddest, and most important to the last 20 years of my life: I hated myself.

- Booze wasn't enough to mask how low I felt. Ecstasy either. You'd think speed would have pulled me up? Nope.

- Ice is the drug that had me most removed from this world and the pain I was in. And as I made my way through this drug cycle of inevitable doom, my behaviors became more out of touch with a reality that I had never known.

- I stole cars. I robbed people. I was in and out of prison. I became numb to EVERYTHING: love, pain, discipline.

- Living a pain free life, by way of addiction, is great. Numb is a good feeling; but it could no longer be at the expense of hurting other people for my next hit, my freedom, and the one thing I cherish most in this world: a relationship with my kids as a role model and father.

- The decision to walk another path meant embracing my pain and doing it in a clean environment.

- Walking into the Salvation Army Bridge Program was one of the toughest days of my life. My only comfort was that these people knew how to deal with pain like mine.

- I spent 12 weeks as a live-in participant, where I was solely committed to improving myself as a human. The staff, and participants of this program, have been the shining light I required. Shining in their care and positivity. But also shining brightly onto the areas I needed to improve.

- The engagement of a psychologist has truly saved my life.

- As an ice addict, I would often hear from people that I would die if I continued to use.

- Death wasn't even registering as a concern for me, even though on reflection it seemed a likely outcome.

- Being able to verbalise my pain and experiences to someone whose sole interest is helping me overcome the hatred I had for the world, and myself, has been the most powerful thing I could do.

- During a Reclink structured program as part of the Bridge After Care Program - Croquet at Government House – I had what can only be described as a utopian experience.

- The setting of the Croquet green at Government House captivated me in a way I'd never experienced: perfectly maintained grass, gardens and the most magnificent trees - with the shape of their foliage dangling in front of your face for you to sniff and play with.

- I hadn't experienced anything this naturally pure. It was breathtaking.

- I even got to meet the Governor herself. Her Excellency. I remember telling myself 'Her Excellency, don't call her anything else'. So, after I called her 'Darlin, and she didn't bat an eye lid, I was only slightly relieved!! The fact she continued chatting to me as if we were chums from another life only added to the outer body experience I was living.

- After that encounter, I found myself standing back and taking it all in.

- We were joined on this day by a disability group from Li-Ve Tasmania. And what struck me about the staff and participants of that program was the HAPPINESS in which they lived. This group were faced with more barriers and challenges in their life than I ever had. And whilst I had spent decades wallowing in my own pain, these guys and girls were LIVING, through a Reclink sport and recreation structured program.

- I can still remember the feeling of that day. It was the first time in as long as I could remember – my earliest childhood memories - that I was anxiety free. No looping, yelling thoughts of self-loathing. No hate or rage.

- What I was involved in on that day was about more than just this secret garden; this was a realization that I was finally surrounded by an environment that I could be myself in. One that embraced me and would pick me back up if I fell.

- But what had me feeling like I was dreaming, or in some alternate universe, was the fact that I was recognizing HAPPINESS – my own secret garden.

- This was a true turning point in my life, and you know what – I am finally hearing the rest of that song too.

Reclink undoubtably continues to have a positive impact across the Tasmanian community, and I commend everyone involved for their ongoing efforts in changing the lives of so many individuals.

Movember and Mental Health

[11.20 a.m.]

Dr SEIDEL (Huon) - Mr President, the keen-eyed honourable members of this House may have noticed a slight but unusual growth of facial hair on the member for Elwick and myself. I assure honourable members that this is entirely seasonal, but also for a very good cause. It is not intended to be fashionable, although my four-year-old son said just last night, 'Oh, Dada, now you look like a real man!'. It is the season of Movember. Every year since 2003, men around the world grow moustaches to raise awareness of men's health issues. Although we have done this now for a month every year for well over a decade, our work is nowhere near to being done. That is why, in 2020, we are doing it again.

Movember is quintessentially Australian, conceived by Melburnians Travis Garone and Luke Slattery in 2003. It has now become a fixture in the health awareness calendar worldwide.

Back in 2003, though, the two friends inspired others to charge $10.00 for growing a moustache for one month in order to raise funds for prostate cancer awareness. They found 30 of their friends daring to 'Grow a mo'. The next year they already had 450 'mo brothers'; they raised $54 000. In 2005, over 9000 mo brothers raised $1.2 million. The following year, the Movember Foundation was set up as a registered charity. The official tag line 'Changing the Face of Men's Health' soon resonated internationally. The campaign was launched in New Zealand, in the United Kingdom and in Spain. To date, there are active campaigns in 21

countries worldwide. Movember has raised over $730 million and funded over 1000 men's health programs.

Honourable members, growing a mo is prickly, yet fun. Talking about men's health issues is actually neither. We can have a laugh about how somebody looks, but we all turn quite sombre once we look at the statistics on men's health in Australia and in our state in particular. And it is not all about cancer and cancer awareness - coronary heart disease remains the leading cause of death for males by far. Males feel invincible, even on a bad day. A good dose of male optimistic bias means that going to the doctor to have a heart check is just not something my species considers necessary.

Men literally need to be dragged into the doctor's office, often by their partners, friends, their parents, and, increasingly, by their concerned children. The life expectancy of a boy born in regional Tasmania is now 79.2 years, the second lowest in the country. Yet if you were born in Hobart, your life expectancy is an extra year, not too bad for a slightly different postcode in the same state. However, the gap is actually widening, based on the most recent data from the Australian Bureau of Statistics - ABS - released last month. Compare that further to the life expectancy of a boy born in East Melbourne - it is actually an extra five years, just like that. If you want to see hard proof of health inequality, here it is, in black-and-white hard data.

I am not here to accept the status quo. I will not accept we cannot overcome, or at least mitigate, the complex social determinants of health in our state. For that we have our work cut out, for that we have to prioritise health on a policy and political level. Currently, we do neither. Health budgets have become sandpits for creative accountants. Health policies have been written by spin doctors rather than real doctors. Health care has become transactional. The needs of the patient are no longer at the centre. It is about the headline in the media, not the accomplished health outcome. We are failing Tasmanians, and we are failing men in particular.

This becomes even clearer when we look at suicides in Tasmania. More than 350 suicides were reported over five years from 2012 - four times as many Tasmanian men died by suicide compared to women. The highest rate was among those aged 45 to 54 years. But it is not only about adult men. Suicide is the leading cause of death in teenagers and young men between the ages of 15 and 24 years. Imagine a young life lost. At what stage are we getting serious about what our priorities are? At what stage are we getting serious about what matters to our communities?

I will continue to raise awareness on health issues and health inequalities. Every November from this year on, and for as long as I am in parliament, I will grow a mo and update this Chamber on the progress we have made in our state - and progress we will have to make.

I thank the members for Hobart and McIntyre for also supporting this cause through a generous donation this year.

Mr Valentine - I just won some friends.

Dr SEIDEL - I gently encourage other members of this Chamber to follow their example. It is for a good cause. It is for a necessary cause. Let us make this work together.

Riverside High School - Redevelopment

[11.26 a.m.]

Ms PALMER (Rosevears) - Mr President, I thank you for the lovely warm welcome you gave Laura Moore when we first arrived here today. I am exceptionally honoured that a local Launceston businesswoman who is so respected in our community has come on board with the Legislative Council team to work with me in the electorate of Rosevears, which is also her home as well. Laura, lovely to have you here.

Mr President, smell can be quite a powerful stimulant. It can revive long-forgotten memories and take you right back to moments in your life, whether those moments be good or indeed bad. Last month I had the opportunity to tour my old school, Riverside High School. What a privilege for me, as a former student, to share in the completion of the school's huge redevelopment and to have my young son, Charlie, join me. I attended there from grade 7 through to grade 10, commencing in 1983 and graduating in 1986. I did very well in music, drama and English, not so well perhaps in the areas of science and maths. Under the watchful eye of then-principal Ken Hudman, I had the most wonderful memories of teachers who nurtured and inspired, but were also pretty direct and, at times, brutally honest. When my mother went to see my science teacher about my miserable results, he told her not to worry: 'Joanne will never work in the sciences. She is a people person.'.

While many things have changed since those days, the smell of school has not. I was immediately taken straight back to the 1980s, when musk perfume ruled and the cool kids - of whom I was not one - always had little meat pies for lunch. Gone, however, were the old grey lockers and the cold lino corridors - instead replaced with durable carpet - and along the walls were lockers in shades of pinks and blues. The music area looked more like a recording studio, with soundproof booths filled with instruments - vibrant learning spaces with great natural light. As for the canteen, let us just say there was more on the menu than little meat pies and hot cheese rolls. In fact, the school now boasts a cafe, which I believe serves salads.

There is a new foods room, which I used to call the home economics room, which has been designed to meet industrial standards. How incredible for our kids looking at a career in the hospitality industry to have access to such a facility. A new senior school specially designed for grades 9 and 10, to give them a place that is more age appropriate. The beautiful art installations certainly captured the attention of my son.

Perhaps a stand-out for me is the development of a care centre. This provides a student support area, with the name reflecting the school values of courage, aspiration, respect and endeavour. It was awesome watching the current year's prefects hosting all the guests who were enjoying the tour. They were immaculately presented, and they knew their stuff, but it was the pride they had in their school that left such a lasting impression on me. I am so proud of my old school. Along with many other former students from decades gone by, we felt so connected to our old stomping ground, having been given the opportunity to walk the same corridors we walked as kids.

I offer my congratulations to principal Natalie Odgers, and thank her for including all of us oldies in the new beautiful-looking school and keeping us connected to our roots.

One can only imagine how trying it was for teachers and students, and indeed parents, to work and learn in the middle of a building site, but their patience and their ability to adapt has certainly paid off - and now, what an incredible learning space for these young Tasmanians.

My old school of Riverside High has a long history of achievement. Who knows what future leaders, athletes, academics or indeed future educators are currently walking those corridors?

Advancing Women in Industry Program

[11.31 a.m.]

Ms FORREST (Murchison) - Mr President, today I wish to speak about a successful pilot program designed to support women who are interested in moving into the mining, manufacturing and energy sectors. Step In - Advancing Women in Industry is a program that provides participants with an understanding of these sectors, as well as industry-recognised qualifications, which is an advantage when applying for positions in these sectors.

Shannon Bakes of labour hire firm Protech - or formerly of that company - initiated the program when he recognised a problem looming with a shortage of workers for some big projects, which had either just started, or hopefully were soon to commence.

He realised that women were an untapped resource that could help fill the shortfall with appropriate encouragement and support, and so Step In was born in collaboration with the Tasmanian Minerals and Energy Council, Skills Tasmania, Elphinstone, Grange Resources, SRTA Life and Rescue, and Productivity Improvers.

The program was facilitated by Productivity Improvers and involves training in the LEAN method, seminars with industry leaders, and site visits to places including Grange Resources' Savage River mine.

The 20 participants also secured units of competency in working at height, confined spaces and gas detection. The participants were a mix of younger women and a group of older women who wanted to do something for themselves.

One of the participants had already secured a job when the celebration day was held on 11 September to present their statement of attainment certificates. I was extremely pleased to be part of presenting the certificates to these women. That was a job in the sector.

I would like to recognise Shannon and also Michael Bonney, who is the director of Productivity Improvers, for standing with us and supporting efforts to increase the numbers of women in such male-dominated workplaces. It was through the support of others like Shannon and Michael that women are enabled to secure higher paid and often more secure employment.

Sommer Jeffrey from Devonport completed the program and said she has always wanted to get a job driving huge mining trucks, and hopes that Step In will bring her closer to her goal.

When interviewed by *The Advocate* after receiving her certificate, she said -

> If you're looking at a career (in mining or manufacturing), then definitely do this course because it's an amazing opportunity to show up the boys so we can do it too.

The presentation ceremony was held at the Tasmanian Minerals and Energy Council in Burnie, and was hosted by the former commercial manager at Grange Resources, Jess Richmond. She said -

> Make sure you take the opportunities and connections you make through this program and really grab hold of them and drive your own career.

People Improvers and Protech have been keeping in regular contact with the participants since the completion, and are committed to continuing to support the women while tracking their journeys.

Two months after the formal completion, they are pleased to report - and I am pleased to inform the House that -

- five women already are, or are listed, to contract to Grange Resources through contract hire;
- two women have applied for and/or been interviewed by the Hellyer Mine;
- two women have commenced directly with Grange Resources, truck-driving;
- one woman has commenced in construction;
- one woman has commenced in the VET training sector;
- one woman has been interviewed by Hydro Tasmania, and one has been interviewed for an apprenticeship with William Adams;
- one woman is seeking an electrical apprenticeship;
- one woman has decided to return to the field of hospitality on the west coast, where she came from.
- one woman has had an interview with Epiroc, which I spoke about in this place a little while ago, but has decided to pursue a career in dental health instead; and
- one woman is undertaking on a heavy rigid licence for large vehicle driving in construction or logistics.

Undertaking the Step In Program has resulted in 16 of these women having applied, been interviewed, or commenced employment in a sector they previously did not feel equipped for, which is a huge tick for a program that only had 20 participants.

All they needed were some formal qualifications, some encouragement, some introduction and some inspiration. Step In provided all these things. The NW Industry

Inclusion Group intends to build on this amazing work by seeking funding and industry support to deliver similar programs on the west coast and in Circular Head, and working with partners to explore similar programs aimed at years 11 and 12 women.

I hope we will receive support for these programs in Thursday's budget. It is something I will be looking for. People Improvers, as the lead agency, will maintain a mailing list of women around the state who are interested in accessing such training and can be contacted via their website or the Facebook page. I encourage members to take a closer look at this innovative and successful program and particularly commend Shannon and Michael for their commitment to improving employment opportunities for north-west coast women.

RECOGNITION OF VISITOR

Tilly Diane

Mr PRESIDENT - Honourable members, I draw your attention to a very special guest in our Gallery for the first time - the reason being that our special guest is only three days old and is welcome to the Chamber. We had Ivy a short time ago but now we have Tilly Diane [ok] joining us today. I am sure members will welcome Tilly. She may not remember this day, but it is wonderful to see so many young ones coming into our Chamber.

Members - Hear, hear.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020 (No. 30)

Consideration of Amendments made in the Committee of the Whole Council

[11.37 a.m.]

Mr GAFFNEY (Mersey) - Mr President, I move -

> That the bill, as amended in the Committee, be now taken into consideration.

Motion agreed to.

Suspension of Standing Orders

Mr GAFFNEY (Mersey) - Mr President, I move -

> That so much of Standing Order No. 284 be suspended in respect of this bill so as to allow the amended clauses, new clauses and long title references only to be called without a need for the amendments to be read again in full.

[11.37 a.m.]

Ms FORREST (Murchison) - Mr President, I want to speak briefly on that motion because I acknowledge we do not normally do this. Normally, the amendments are read but I do appreciate the work the Clerks have put in to circulate all the amendments as a comprehensive set so we have had time to look at them. Thus, I am happy to support this

motion to suspend standing orders. It would normally require us to read all of them and would take some time.

Motion agreed to.

Mr GAFFNEY (Mersey) - Mr President, I move -

That the amended clauses, new clauses and long title references be read.

Motion agreed to.

Amended clauses, new clauses and long title references read.

Amendments agreed to.

Third Reading

[11.41 a.m.]

Mr GAFFNEY (Mersey) - Mr President, I move -

That the bill, as amended in the Committee, be now read the third time.

Before the bill is read for the third time, I thank very much the members of this place. I believe the Committee stage debate was robust, informative and respectful. Overall, I am very pleased with the outcome and grateful to the members for Huon, Nelson, Montgomery, Murchison, Hobart and Rumney - who caused about 140 of those amendments, thank you for that - for their considered efforts in presenting amendments or new clauses in order to address the evolution of the 144-clause bill to its current form.

I have genuinely appreciated the contributions of all members in this place throughout the second reading and Committee stages. Mr President, there have been moments of reflection and clarity for all of us as we have carefully reviewed the comments of others. I thank all honourable members for their thoughts, their questions and feedback through the entire process, which I acknowledge has been relatively extensive and has involved considerable lobbying from stakeholders, some with opposing views. I look forward to providing a few brief words after contributions from those members who wish to speak.

[11.42 a.m.]

Ms FORREST (Murchison) - Mr President, I appreciate the fact that we have had some time since our last sitting to fully consider the whole bill as amended. I certainly appreciate that, because, as you have just heard, it was significantly amended. It is not common to have a private member's bill emanate from this place - those that have in the past have not been so complex, nor contested pieces of legislation generally. This House spent many hours - I am sure the Clerks have a full record but I have not counted them up - debating the principle of the bill and the many days, including additional sitting days, to consider the bill in the Committee stage.

Many amendments have been made to this bill. While the overall number is not really important, a number of significant policy issues were extensively debated and subsequently defeated. The debate has been important, informative and on the record for all who wish to

consider it and view it. I think it should be helpful for the other House in considering the bill as it will, I expect, be presented to it.

I also appreciate the fact that members did not support the suspension of standing orders when we last sat, as with such a heavily amended bill we do need time to properly consider the whole bill as amended. I also appreciate the Clerks putting together and circulating a complete list of the amendments that were agreed to. This has certainly assisted in the process of full consideration of the bill as amended before it was finally agreed to and transmitted to the House of Assembly for further consideration.

As I stated in my second reading contribution, I have always struggled with the ethics of voluntary assisted dying and ensuring the rights and safety of vulnerable citizens and health professionals. Throughout this process, this uncertainty has remained. I have done all I can to ensure this bill is as robust as it can be at this time, through amendments and measures to address some of the areas on which I have received consistent feedback. I respect those who hold the view that you cannot make such a process rigorous enough to protect the vulnerable, including those with disability, the aged or who are vulnerable in other ways.

I also acknowledge and respect the views of those who hold legitimate concerns regarding the role of, and involvement of, health professionals in such a process, both those who are willing to participate and those who will choose not to. I appreciate and accept that the majority of Tasmanians want voluntary assisted dying to be a legal option if they are facing death from a terminal condition. I also acknowledge the debate regarding access for residents of aged care facilities, where the owners or operators have stated they will not support voluntary assisted dying in their facility.

I agree that if that is legal, it should be universally accessible and as this bill stands, this is not likely to be the case. Members will recall I suggested a potential option to achieve this but decided not to proceed with proposing additional amendments at this point. This is a matter that could be considered either in the House of Assembly when it is debated there or during the initial three-year review that is part of this bill.

My key concern has been, and continues to be, the role of and impact on health professionals. This concern extends to both those who seek to be involved and those who hold a conscientious objection. I believe that we will see impacts on both these groups of health professionals and it will be vital to be alert to these impacts and to ensure appropriate and adequate physiological support is provided.

It is also important that there is a clear message to the community that even if this bill passes to and through the House of Assembly, access to voluntary assisted dying will still be some time away as we know there is much to be done by government departments, including the establishment of a commission for voluntary assisted dying, development of Tasmania-specific training programs, development of the required processes and forms to record and progress the provisions of this bill, and many other measures that need to be done.

It is also important to assure the public that whilst a person will not, in the absence of an exemption from the commission, be able to formally commence the formal request for voluntary assisted dying at that time, the option to access this can be discussed with health professionals at any time once this becomes a legal option.

As with all contentious legislation where ethics are challenged, misinformation often reigns supreme. I hope all members will be sure to be factual in their communications regarding the reality of this bill when describing it to the members of the community and call out mistruths that we will no doubt continue to see in the debate in the House of Assembly with a range of interest groups. I will not stand in the way of this bill despite my reservations.

[11.48 a.m.]

Mr GAFFNEY (Mersey) - Mr President, I am actually excited to have the privilege of making a brief contribution and provide the conclusion in this place to the third reading of the Tasmanian End-of-Life Choices (Voluntary Assisted Dying) Bill, for many reasons.

To be completely frank, there were times throughout the journey of researching, constructing, preparing and presenting the bill for debate, when I was not completely certain I would have the opportunity at this time. Of course, I was always hopeful the bill would progress to this stage and beyond but there was - and is - no guaranteed outcome. It would not have been wise of me to make assumptions in respect of the responses of members. In some ways, it is almost a 'pinch me' moment. After two years of regular and extensive contact with international, national and state medical, ethical and legal experts, hundreds of hours of drafting and review by the Office of Parliamentary Counsel, community forums across the state, numerous briefings and very rigorous debate in this place, the bill has been strengthened and prepared for the final vote for the members in the Chamber today.

The intent, content and integrity of the bill have been refined and reinforced by valuable amendments that have undergone very thorough debate. Indeed, some amendments and new clauses which were suggested and defeated were debated from pillar to post. It is also an exciting day for so many people. As members and those watching may recall, in my second reading speech - which seems like an eternity ago - I spoke of the extensive history of the bill and its predecessors in this state. It has been a long journey with some considerable bumps in the road since the first bill of this nature was tabled in 2009, or, even before that, when a parliamentary euthanasia committee inquiry was held in 1998.

I acknowledge once again the efforts of those who have worked on the development and presentation of previous bills, and the tabling and discussion of each iteration of voluntary assisted dying legislation that has led us closer to this day. Just a few weeks ago, the bill was voted into the Committee stage which in itself was an achievement. To members in this place, to those who assisted in the research and development phases of the bill, to those who have worked tirelessly to educate and advocate for your community such as Dying with Dignity Tasmania and Your Choice TAS, I say thank you. To Tasmanians who may be listening who may seek assessment for the VAD process in the future, I hope this legislation most importantly allows comfort and solace for the challenges that lay ahead of you.

I thank everyone for their efforts and their patience. To the Premier, to the Government and to the members in the other place, I offer my support and assistance whenever and wherever it may be desired. In recent weeks I have been heartened and encouraged by a number of requests from members of parliament for further clarification regarding the bill, and in recent days I have been able to provide advice and information as requested.

This process has been, by virtue of its seriousness and significance, a substantial and lengthy endeavour. I am grateful to see the bill presented here today for the third reading. For the record, as entrenched in *Hansard*, I want to publicly recognise Bonnie Phillips, my most

amazing friend and work colleague, who has been forever a source of strength, encouragement and reason. Words cannot express my depth of gratitude.

Members - Hear, hear

Mr GAFFNEY - To Mr Phil Spratt, who is a more recent addition to the team, you have assisted us greatly in this process and I thank you. To my wife, Mel and my family, from my heart I thank you for your support through this challenging journey. Like other families in Tasmania, the Gaffney clan will continue to do whatever we can to face the challenges that lay ahead of us. Finally, after a very long road, I have done my job and so have the members, my colleagues and my friends in this Chamber. I am so proud how we have worked and showcased our parliament to the rest of the world.

I encourage the Premier, the Government and members of the House of Assembly to sensitively and effectively progress this legislation in a timely manner so all Tasmanians who have been invested in this journey from the very beginning, can take pride in the Parliament of Tasmania and understand this legislation is simply aimed at helping individuals suffering intolerably to find peace in a manner of their choosing surrounded by their family and friends.

I encourage all members in this place to vote in support of the End-of-Life Choices (Voluntary Assisted Dying) Bill.

Mr PRESIDENT - Honourable members, before I put the question, I commend the member for Mersey for the amount of work he and his team have put into getting this bill to Chamber, and I also thank every member for the respectful way and amount of work everyone put into their contributions for this very challenging piece of legislation. I also mention the wonderful job our Chair and Deputy Chair did of keeping control through what was a very complex Committee stage, as we have been reminded, with the number of amendments, and, of course, our Clerk and Deputy Clerk for doing the work they had to do to get the bill into the order in which it is presented to us today. It shows the Legislative Council in a very good light and all members should be proud of what they have done through this process.

Bill read the third time.

MOTION

International Year of the Nurse and the Midwife

[11.55 a.m.]
Ms FORREST (Murchison) - Mr President, I move -

(1) That the Legislative Council notes:

(a) The World Health Organization has declared 2020 as the International Year of the Nurse and the Midwife;

(b) Nurses and midwives make a significant contribution to all areas of health care, wellness promotion and illness prevention, often working in challenging circumstances;

(c) Nursing and midwifery care is predominantly provided by women;

(d) Nurses and midwives constitute more than 50 per cent of the health workforce in many countries;

(e) The world needs nine million more nurses and midwives if it is to achieve universal health coverage by 2030;

(f) In remote areas, nurses and midwives are often the first and only point of care in their communities;

(g) Strengthening nursing and midwifery will assist in promoting and achieving the United Nations Sustainable Development Goals (SDGs) 5 (Achieve gender equality and empower all women and girls) and 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), and support other SDGs; and

(2) That the Legislative Council recognises, highly values and thanks all Tasmanian nurses and midwives for their hard work, dedication and commitment to all areas of practice.

I am pleased to speak on this motion that recognises the role and contribution of nurses and midwives to the health and wellbeing of all citizens of the world.

When I initially put this motion on notice, it was before the impact of COVID-19 was truly apparent. When the World Health Organization - WHO - made a decision to declare this year, 2020, as the International Year of the Nurse and the Midwife, little did it - or we - know what was ahead for our highly regarded and highly valued professionals, who care for us at our time of need, our highly skilled, dedicated, professional and caring nurses and midwives.

Mr President, I take this opportunity to speak about the challenges this year has delivered to all nurses and midwives, acknowledge their contribution to our health and wellbeing, and speak to other aspects of challenges facing the world, especially in terms of workforce and resourcing challenges facing nursing and midwifery.

In speaking to (1)(a) of the motion, I note, as I mentioned, that WHO has declared 2020 as the International Year of the Nurse and the Midwife. Every year, nurses and midwives are recognised for their work, professionalism and service, through two different events.

International Day of the Midwife is celebrated each year on 5 May. International Nurses Day is celebrated on 12 May, the anniversary of Florence Nightingale's birth. This year was also the 200th anniversary of that date.

In light of the significant anniversary of Florence Nightingale's birth, WHO declared that 2020 would be the International Year of the Nurse and the Midwife. While no-one could have foreseen how this year would unfold when the announcement was made, in many ways it could not have been more timely.

Each year the day is recognised with a theme. This year the theme was, 'Nursing the world to health'. Again, very relevant given that nurses around the globe have been at the forefront of the fight against COVID-19.

Their commitment and dedication to those they care for has significantly, and certainly, been highlighted throughout the COVID-19 pandemic. However, rather than being able to celebrate this international acknowledgement of the professions of nursing and midwifery, nurses and midwives are working harder than ever, in very frightening and challenging and times and circumstances. There was no time or opportunity to have a celebratory event in person as COVID-19 spread quickly and destructively around the world.

Right from the start of the outbreak in Australia, nursing organisations stepped up and were involved in implementing strategies to contain the virus. Indeed, thousands of nurses around the world volunteered to assist, in any way they could, with many coming out of retirement or planned absences from the workplace - a clear and unsurprising demonstration in itself of the courage and compassion of the nursing and midwifery professions. This came at considerable cost, with many nurses and midwives losing their lives.

While we have been fortunate in that regard in Australia, our healthcare workers have concerns regarding the safety of caring for patients with COVID-19, which partly relates to the highly publicised reports of healthcare workers dying from the virus overseas.

This is particularly important in Tasmania where we have an ageing workforce, with many currently practising nurses and midwives at risk of serious health outcomes if they were to contract COVID-19.

The concern has also caused high levels of anxiety in many health workers around the use of personal protective equipment - PPE - outside the government guidelines. Many were seeking exemptions from being involved in the care of patients with COVID-19 in the early days of the outbreak.

I acknowledge the reports of healthcare workers' deaths overseas generally do not actually explore whether the infection was contracted caring for patient or through community contact, or whether appropriate PPE was worn.

However, we do know that in the case of the North West Regional Hospital outbreak, most transmission was within the hospital, in their work setting.

It goes without saying that being in such close contact with COVID-19-positive patients and providing direct health care increases the risk of transmission, even when using all the appropriate PPE. This was demonstrated in the Australian experience.

Of the Australian cases, it was reported that as at the end of August, some 70 per cent of the second wave COVID-19 infections in health workers in Victoria was acquired through their work. Doctors comprise 5 per cent - 106 health worker cases through July and August and 63 doctors are thought to have been infected at work in this period. Nurses make up around 40 per cent, or 922, of those healthcare workers and those who care for older people make up another 40 per cent, 924. It is not because they are not doing the right thing; it is because the risk of exposure and infection are just so very real.

As I stand here today, I note and acknowledge the extraordinary efforts by the Victorian Government in containing its COVID-19 outbreak - it is 11 days in a row of what they are calling the 'double doughnut' - zero cases and zero deaths. I know the impact COVID-19 has had on the mental health and wellbeing of many people in our state, particularly our health professionals. Every day I see those figures, I feel I just want to cry tears of relief again and again and again. Talking to my family in Melbourne, seeing the little boys' faces on FaceTime when they are actually out at the pub having a parmie and chips is a delight to behold that I never thought I would appreciate as much as I do now. I am just hoping to be able to visit them soon.

To think that Victoria can go from 700 and whatever cases down to zero, and stay at zero, with so many tests being done is a true testament to the people of Victoria and the leadership of Dan Andrews, Brett Sutton as his chief health officer and everyone who worked on that. I keep thinking there will be a day when there are one or two. There will be, I am sure there will be, at some stage with returned travellers or whatever, but I want to commend them. So many nurses and other health professionals have been deeply impacted by that. I have a son who is a doctor. He worked on the COVID-19 ward, and he worked in the COVID-19 testing stations. Thankfully, he has not contracted COVID-19, but the risk is very real. Even my family there who could have potentially visited him because they live within the 5-kilometre radius did not because it put them at risk. It has been a really, really tough time for everybody, all Victorians.

Mr Valentine - They have a few more than 500 000 to deal with too, haven't they?

Ms FORREST - That is right. They have all sorts of density issues and people who come from non-English-speaking backgrounds, to whom it is more difficult to get the messages to. We did not have those same challenges in our state, which we can only be thankful for, that we did not have to deal with some of those very difficult challenges. However, I know the pressure that was on the nurses in the North West Regional Hospital and the North West Private Hospital at that time. We can only imagine how that must be even more so for all the medical staff - and the nurses and midwives - who have worked in Victoria during this period.

In Tasmania, we saw all staff from the North West Regional Hospital and the North West Private Hospital and their households quarantined for 14 days during the outbreak on the north-west coast. This was indeed a worrying time for our healthcare workers, but also for their families. During the outbreak - I am sure members will recall the decision to close the two hospitals and the related medical services impacted approximately 1300 staff and their household members, an estimated total of about between 3000 and 4000 people. That is a lot of people in our community. As the Leader knows, it is a significant number of people who were directly impacted; it took a lot of people out of the workforce.

This was an unprecedented action. I hate using that word but it is appropriate at times; it is a bit overused this year. That has never been done in this state before; we have never closed down a hospital. There are some hospitals in this state you simply could not close. You could not close the Royal; you really could not close the LGH. But we were lucky to be able to do that because we were fortunate to be able to transfer the care of the patients who did need ongoing care to the Mersey Community Hospital and the Launceston General Hospital. I am really grateful the Premier was willing to take that action and take it so decisively and quickly. It was not easy for anyone who was impacted by this, but I am eternally grateful that decision was made.

Again, I wish to acknowledge the extraordinary efforts of nurses and midwives at both the Mersey Community Hospital and the Launceston General Hospital who took care of our north-west residents and birthing women at an extremely stressful and anxious time for all. It was really tough on the midwives of the LGH as you cannot put off a birth - those women had to move up with their families to live in a hotel while they awaited the birth of their baby, sometimes with other children. Some of them did not have a lot of family support back on the north-west coast and the children were not allowed to visit their mum in hospital.

Their partner was limited in the support he could provide during that period. The midwives were looking after women from the Launceston area - the normal catchment area - as well as women from the north-west and everyone was anxious, everyone was nervous, everyone was worried about a COVID case coming from the north-west. We were worried about it.

I commend and acknowledge all medical staff in this enormously stressful and difficult time, but we are talking about nurses and midwives, who were looking after cardiac patients who came from the north-west; again, the stress was enormous for all of them. In Tasmania, by 21 April, a total of 114 people had acquired COVID-19 associated with the north-west outbreak, including 73 hospital staff members, 22 patients, and 19 others, including household contacts. We had the highest per head of population infection and death rate at this time in the nation. We were the pariah of the nation.

Unfortunately, this led to some very unfortunate vilification of our dedicated and caring nursing and midwifery staff from fellow Tasmanians and, even worse, the unsubstantiated and untrue public assertions by the national Chief Medical Officer and the Prime Minister. This was a disgraceful slur and significantly impacted all healthcare workers in this region and caused significant harm. I still do not believe there has been a full and proper apology for those comments, but it was the most disgraceful display by the so-called leaders of this country.

Unless you were a frontline worker at the time, you cannot really appreciate the stress and anxiety associated with working in an environment with a deadly virus, especially when many of the health workers were in 'at risk' categories themselves. Mr President, I personally thank all our healthcare professionals, especially our nurses and midwives in this year that was set aside to recognise their work and role in caring for us in our time of need. I believe we should unite and stand behind and beside our nurses and midwives who continue to work under extraordinary pressure at times - in fact, most of the time.

As we know, even before COVID-19, our nurses and midwives were working under extreme pressure through years of underfunding of health services. The rates of overtime, including double shifts, have been for a very long time, and continue to be in many places, unacceptable. This is not at all good for the general or mental health and wellbeing of our nurses and midwives.

The Government has an obligation to properly fund the health system and ensure there is an adequate workforce to avoid the need for double shifts and overtime as the norm. Again, I will be looking forward to what we see in the budget on Thursday in

relation to funding of health services, and then of course budget Estimates. This leads me to point (1)(b) of the motion -

> Nurses and midwives make a significant contribution to all areas of health care, wellness promotion and illness prevention, often working in challenging circumstances;

As I said, this year, instead of celebrating, nurses and midwives around the world are working harder than ever, often in tragic circumstances to care for people wherever they are in the world. Despite this, nurses and midwives have still been acknowledged in other ways.

Here in Tasmania, for example, the Australian Nursing and Midwifery Federation, Tasmania Branch in collaboration with the New Zealand Nurses Organisation held an online candlelit vigil on the evening of 12 May to commemorate the dedication of colleagues lost to the virus all around the world, because we are one united profession.

During 2020, we have been reminded more than ever that nurses play a critical role in health promotion, disease prevention, and the delivery of primary and community care, as well as in emergency settings. In some communities, nurses and midwives may be the only health professionals people see, and so their initial assessment, care and treatment are vital.

We saw nurses and midwives return to the workforce to ensure there were enough to provide the care needed by Tasmanians. They worked in COVID-19 testing clinics outside, in the winter, literally working in wind tunnels, for days on end. The day I had my test in Burnie, before I came back to parliament, the tunnel was direct north to south. The wind was howling through by the old Parkside building.

Mrs Hiscutt - I can confirm it is the same over here.

Ms FORREST - The nurses were there day in, day out, and I commend all the members of the public for fronting up and being tested. It was so important to our effort. These nurses were really finding it pretty tough, because it was winter, and then it was moved down to Wrest Point, which is just as bad down there, because you have that wind straight off the sea. Anyway, it is always cold in the winter.

Nurses also ran drive-through immunisation clinics to ensure as many people as possible could have access to the flu vaccine in a timely manner.

According to the Australian Department of Health National Health Workforce Data, in 2019 the Nursing and Midwifery registered workforce was 399 364, with 5532 non-practising - comprising 300 040 registered nurses, 62 281 enrolled nurses, as well as 22 574 with dual registration, and 5586 registered as a midwife only.

This workforce covers some 27 areas of work, ranging from aged care and medical - which are the main job settings, 80 000 - through to community nursing, child and family health (including prenatal and postnatal care), research and health promotion.

Nurses and midwives are seen as people who devote their lives to caring for mothers and children, giving life-saving immunisations and health advice, looking after older people and generally meeting everyday essential health needs.

We know that maternal and neonatal outcomes are better with care provided that is from a known midwife, providing continuity of care. Maternal satisfaction with childbirth is also greater, and successful breastfeeding enhanced in these continuity-of-care models.

They also play a vital role in shaping the overall health and wellbeing of their communities, and will be a key to the achievement of universal health coverage.

The World Health Organization is a collaboration partner with the global Nursing Now Campaign, which aims to improve health globally, by raising the status and profile of nursing, strengthening the profession, and maximising its contribution to achieving this universal health coverage.

Along with the International Council of Nurses, this partnership released the *State of the World's Nursing Report - 2020* on World Health Day, 7 April. This report provides a compelling case for the value of the nursing workforce globally. Global strategic directions have been set out, with four broad overarching themes to work towards to improve global health. They are -

- ensuring an educated, competent, motivated workforce within effective and responsive health systems at all levels and in different settings;

- optimising policy development, effective leadership, management and governance;

- maximising the capacities and potential of nurses and midwives through professional collaborative partnerships, education and continuing professional development; and

- mobilising political will to invest in building effective evidence-based nursing and midwifery workforce development.

Nursing organisations and other stakeholders have been engaged with this process of shaping the future of health care and will continue to do so.

Part (1)(c) of the motion states that nursing and midwifery is predominantly provided by women. Nursing remains a highly gendered profession, with approximately 90 per cent of the nursing workforce being female, and as such attracts all of the associated workplace biases, such as the gender-based pay gap and few leadership positions in health being filled by women.

There are legal protections in place in most countries covering hours and conditions, but there is not necessarily equity across regions. Nurses and midwives are at the forefront of caring for people who are often very vulnerable, stressed, in pain, and under the influence of drugs and/or alcohol. The risk of abuse and assault is very real.

It is almost horrifying to note that according to a World Health Organization report, only 37 per cent of countries have measures in place to assist in prevention of attacks on health workers.

As with many female-dominated positions, nursing struggles to attract male recruits, although men have been taking care of patients and have been in the health industry all around the world as far back as medieval times, where there is recorded evidence of male skill and care.

Interestingly, there are male patron saints of nursing, among them St Camillus, who came to understand suffering and illness as both a patient and a servant in a hospital for incurables. After becoming a priest, he founded a religious order to serve prisoners and to nurse people dying with the plague. St John of God is said to have turned his life into caring for the indigent, unwanted and infirm. However, the nursing profession itself remains predominately female, and honouring and recognition of women who have given so much in this field is very limited.

The dominance of women in the nursing and the midwifery professions can be attributed in part to issues such as status and pay. It is also a result of the gender-role stereotyping of the profession. Although the number of males in nursing has been increasing recently, feminisation of nursing is still the norm.

Florence Nightingale considered nursing as a suitable job for women because it was an extension of their domestic roles. I am not overly a fan of Florence, I must say. Her image has portrayed a nurse as a subordinate, nurturing, domestic, humble, self-sacrificing individual. I was never so confident as when I was accused of being the most insubordinate person this obstetrician had ever met when I stood up to him -

Members interjecting.

Ms FORREST - We were having a discussion about a particular matter regarding the care of a woman, and he said that to me. Without thinking - it was the middle of the night when he said that - I said, 'Why, thank you.'.

To me it was the biggest compliment he could have paid me - that I was not subordinate to him. I was a professional in my own right, caring for a woman in the way that was most appropriate. He was a locum who should have known better. I do not think he came back. Midwives are terrible, aren't they?

Mr Valentine - Maybe he learned from the experience.

Ms FORREST - I am hoping he did. I could tell you the whole story at another time because it was quite funny.

That image that has been portrayed through Florence Nightingale's stance and the way she portrayed nursing has done a big disservice to nursing over the years in that regard.

The social construction of what it means to be a nurse has typically been the opposite of characteristics attributed to men in society. Sadly, and inappropriately, men who enter nursing typically face questions about their masculinity or their sexuality. That is fundamentally wrong and flawed. There are many fantastic male nurses. We just do not have many of them.

An article in the *Health Science Journal* examined gender perceptions for both female and male students in relation to male nursing roles in Turkey, and noted that sociologists had described sex role socialisation as being 'instrumental' for men, and 'expressive' for women.

The characteristics of instrumental socialisation include aggressiveness, and the ability to compete and to lead, and to wield power to accomplish tasks. These are attributes that have traditionally been accepted as male traits, while expressive socialisation includes learning to nurture, to be affiliative, and to be sensitive to the needs of others, which are more often seen as female personality traits. Therefore, in patriarchal cultures such as Turkey, the value given to women and their place in society is naturally reflected in the nursing profession.

This also presents particular problems to the image of nursing as a career. The article concluded that nursing continued to be seen as a female-dominant position, especially by male students, despite the increasing numbers of men in nursing -

> Having physical power was seen as a reason for male students to occupy administrative positions. Masculinity and dominant characteristics of the male students possibly affect their desire to occupy administrative positions after graduation. Further studies need to describe the reasons for males to choose nursing as a career and their positions in their workplaces after graduation.

That is part of the reasons behind the gender pay gap in nursing, that even though it is predominantly a female workforce, more men who take on nursing end up in the higher paid administrative and senior management roles.

A separate study commissioned by the Nursing Now Campaign looked at barriers to health leadership positions and described not only a 'glass ceiling' for women, but also a 'glass elevator' for men, saying men hold disproportionately higher numbers of senior nursing and management roles.

I have spoken regularly before about the gender pay gap and this reality sits below the gender pay gap in a female-dominated sector. While in some industries, the gender pay gap is narrowing, which is a really positive thing, it has increased in the healthcare and social assistance sector, the sector that employs more women than any other.

Financy, a website dedicated to women's finances, said in 2018 that the healthcare and social assistance sector has the biggest pay gap increase of any industry. We clearly have work to do there. While there are significantly fewer men in the sector, they tend to occupy more leadership positions according to the founder of the website, Bianca Hartge-Hazelman.

The *Sydney Morning Herald* reported on this in October 2018, providing the example of a neonatal nurse who was then working in a major neonatal unit in Melbourne. This is where they have the sickest babies. The nurse, whose name was Emma, worked shifts and regularly had to resuscitate really sick tiny newborns as part of her job. This work took a physical as well as emotional toll on her. She believed she was underpaid compared to the male-dominated trades such as construction, because she is paid less than a construction worker.

How can that be the case when she is saving babies lives day in, day out? We saw a little baby in the Chamber here today. Three days old - you know how precious they are. Sadly, it appears gendered notions of nursing and nurses are still standing in the way of efforts to improve the standing and attractiveness of nursing as a career.

A study commissioned by the Royal College of Nursing in the United Kingdom found the pay of registered nurses is 81 per cent of the sector average, which includes health professionals, allied health professionals, health managers and directors, and therapeutic and technical staff.

They found also the pay of registered nurses is characterised by little variation in earnings across the nursing workforce, despite the wide range of roles, responsibilities and levels of seniority. This suggests there is a low scope for progression and higher earnings across nursing careers, and career structure is one of those things that is a significant deterrent.

They also found among nurses the gender pay gap amounts to 17 per cent on a weekly basis - 17 per cent. Female nurses make up less than a third of senior positions.

As a society we continue to see care giving as a naturally feminine skill or characteristic while nursing is a highly clinically skilled line of work, and all nurses are required to have degrees, according to one of the authors of the report I just mentioned.

If we are to meet the increasing need and demand for nurses worldwide, we need to improve wages and conditions and ensure the profession is being sufficiently valued and receives the recognition it deserves.

Point 1(d) of the motion states -

> Nurses and midwives constitute more than 50% of the health workforce in many countries;

Nurses and midwives account for approximately 50 per cent of the global health workforce and as a percentage of total health professionals - that is, medical doctors, nurses, midwives, dentists and pharmacists - nurses make up just under 60 per cent globally.

This workforce is expanding in size and professional scope according to a World Health Organization report. However, the expansion is not equitable and some populations are getting left behind. Data from 191 countries show a global supply of 28 million nursing personnel. This would indicate a density of 36.9 nurses per 10 000 population, but there are wide variations across the regions. Over 80 per cent of the world's nurses are found in countries that account for half the world's population.

In 2018, it was estimated to be a global shortage of just under 6 million nurses, with almost 90 per cent of that shortage being in low and middle income countries, where the growth in nurses can barely keep up with the population.

Countries in the African, South-East Asian and eastern Mediterranean regions and some parts of Latin America have a low density of nursing personnel - less than 10 per 10 000 population.

Australia, most of the Americas and most of the European region have a higher density of nurses ranging from between 75 to 99 to 100 plus per 10 000 population. From 10 per 10 000 population to up to over 100, that is a significant difference in our countries. The international mobility of the nursing workforce is increasing - COVID-19 excepted - which

adds to further challenges to an equitable distribution and retention of nurses in the regions where we need them the most.

One could argue we should not be looking to recruit nurses and midwives from other countries who have limited capacity to educate and train their own, as they are needed in those countries. We should be training and employing more of our own nurses, rather than taking them from developing nations, the same with medical professions. Additional investments in nursing education in lower and middle income countries is needed. We, as a wealthy nation, should support this. The World Health Organization recommends the implementation of a global code of practice to improve the monitoring and regulation on international nurse mobility. This is referred to in the World Health Organization report, *State of the World's Nursing Report 2020*, and supports my previous comment. The report suggests -

> [countries that are] over reliant on migrant nurses should aim towards greater self-sufficiency by investing in more domestic production of nurses. Countries experiencing excessive losses of their nursing workforce through out-migration should consider mitigating measures and retention packages, such as improving salaries, pay equity and working conditions.

We all have a responsibility in that as a country, even as a state, in our recruitment.

There is a chronic undersupply of nurses and midwives that would be needed to achieve universal health coverage. As point (1)(e) states -

> The world needs 9 million more nurses and midwives if it is to achieve universal health coverage by 2030;

The World Health Organization estimates the world needs 18 million more health workers to achieve this, and that is approximately half the shortfall of 9 million health workers who are nurses and midwives. The *State of the World's Nursing Report 2020* calls for an urgent investment in the profession in order to deliver universal health coverage and recognises the unique role that nurses play, as evidenced by the courage and compassion on display around the globe during the current COVID-19 pandemic. It also calls for a massive acceleration of education, training and leadership in the sector.

The following recommendations were made to all countries -

- to increase funding to educate and employ more nurses
- strengthen capacity to collect, analyse and act on data about health workforce
- educate and train nurses in the specific technological and sociological skills they need to drive progress in primary health care
- establish leadership positions, including a government chief nurse, and support leadership development among nurses.

Tasmania has a chief nurse and midwife, which is great, to -

- to ensure primary healthcare nurses work to their full scope, improve working conditions - including safe staffing levels - their salaries and rights to occupational health and safety, and

- strengthen the role of nurses in care teams by bringing different sectors (health, education, immigration, finance) together with nursing stakeholders for policy dialogue and workforce planning.

The World Health Organization report states the global nursing workforce is just under 28 million, of which 19.3 million are professional nurses. The report suggests that despite an increase of 4.7 million nurses between 2013 and 2018, there was still a shortfall of 5.9 million, with the greatest gaps to be found in places including Africa, South-East Asia, Latin America and the eastern Mediterranean region. To meet the United Nations Sustainable Development Goal 3 - good health and wellbeing - the World Health Organization estimates the world will need an extra 9 million nurses.

The report revealed more than 80 per cent of the world's nurses work in countries that are home to half the world's population. One in eight nurses practices in a country other than the one they were born or trained in; as I mentioned earlier, this is problematic. Many high income countries have to rely on international nursing mobility due to low numbers of graduate nurses and the ability to employ new graduate nurses in the health system. We need to focus more on training our own. Ageing also continues to threaten the nursing workforce, with one in six of the world's nurses expected to retire in the next decade.

To prevent a global shortage, the report estimates countries facing shortages will need to increase their total number of nurse graduates by up to 8 per cent per year, along with taking steps to improve employment opportunities and retention. I think that in a wealthy country such as the one we live in, we could actually train more than we need and support them to practise in other countries. Achieving universal health coverage will depend on there being sufficient numbers of well-trained, educated, regulated and well-supported nurses and midwives who receive pay and conditions in line with the quality services and care they provide.

Mr President, point (1)f) of the motion states that -

> In remote areas, nurses and midwives are often the first and only point of call in their communities;

Australian national health workforce data in 2016 showed that 72 per cent of the nursing workforce worked in major cities - 18 per cent in inner regional, 8 per cent in outer regional and 2 per cent in remote and very remote areas. Many remote rural towns have limited or no health services and rely on the health services and health professions from surrounding towns.

In these situations, rural and remote nurses are often the first to respond to offsite calls and medical emergencies and will go above and beyond to give the highest level of care to the bigger, broader communities they work in. They have to cope with fewer resources than in the larger centres. They may work as part of a very small team, often remaining available 24 hours a day, seven days a week. This was referred to in an article from Healthcare Australia from its

website titled, 'What makes our regional and remote nurses so important'. It suggests that nurses who work in regional, rural and remote areas play a vital role in closing the health gap for Australians living in challenging geographical regions.

According to the Australian Institute of Health and Welfare, individuals who live in these areas tend to have a shorter life expectancy and higher levels of disease and injury. They acknowledge that poor health outcomes in these regions are most likely due to a range of factors, including education, employment, lower income and access to healthcare service.

When asked what motivates remote area nurses to be involved in this line of work, the answers vary from experiencing rural and remote cultures to making a difference in disadvantaged communities.

A remote placing offers a rich experience for nurses who get to practise a broad range of skills not offered in an urban practice or in hospitals. *Health Times*, a publication for health professionals, stated the following in an article on remote area nursing, after speaking to a registered nurse on a placement in a township near Uluru that has a small clinic with a general practitioner only two days a week and a rotating staff of three nurses. This clinic mostly deals with the health of tourists and resort staff and any emergencies are flown to Alice Springs, someone comes in, they are often stabilised and transferred out.

When one of the nurses was asked what she considered to be the best and worst part of the job, she said that meeting the local personalities, experiencing the outback lifestyle, driving a four-wheel drive ambulance with the entire family of the sick person in the back, which was very funny, and using car headlights to direct a plane onto a tarmac at some ungodly hour and many other experiences - you have to be all things to all people at that point.

The worst was a plane not being able to land or pilots not available, the lack of equipment, and missing family and friends, but they are very dedicated people who work in these remote settings. When asked what she would change, she said -

> I don't think you can change much. You need more experienced people and facilities out there with more planes and pilots. You need to wait for the transfer of sick patients until a pilot has had the required hours of rest between flights. So there is often delay but most people living remotely want to live there and they understand that there have to be compromises.

Remote area nurses and midwives work in diverse contexts and have a major influence on the roles they undertake. They are usually required to have at least three years nursing experience beforehand, beyond their training or their degrees, and they are already multiskilled and generally highly regarded in their communities.

It is certainly not a work environment that appeals to all nurses or midwives but it can be, and generally is, extremely rewarding work. You just have to make do and deal with whoever presents for care until additional assistance arrives, if it is needed.

Mr President, (1)(g) of the motion states that increasing -

> … nursing and midwifery will assist in promoting and achieving the United Nations Sustainable Development Goals (SDGs) 5 (Achieve gender equality

> and empower all women and girls) and 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), and support other SDGs …

The 2030 agenda for sustainable development was adopted by all United Nation member states in 2015 and provides a shared blueprint for ending poverty and working towards a sustainable future for all countries, developing and developed.

A collection of 17 broad and interlinked goals, known as the sustainable development goals, form part of the 2030 agenda.

For those who may be unfamiliar with the 17 Sustainable Development Goals -

1. No poverty
2. Zero hunger
3. Good health and wellbeing
4. Quality education
5. Gender equality
6. Clean water and sanitation
7. Affordable and clean energy
8. Decent work and economic growth
9. Industry innovation and infrastructure
10. Reducing inequality
11. Sustainable cities and communities
12. Responsible consumption and production
13. Climate action
14. Life below water
15. Life on land
16. Peace, justice and strong institutions
17. Partnerships for the goals.

Two years later, in 2017, these sustainable development goals were made more actionable when the United Nations adopted a resolution that identified specific targets for each goal, along with indicators to use to measure progress against these targets.

The World Health Organization's *State of the World's Nursing Report 2020* identifies that a global investment in nursing education, jobs and leadership is needed, as I mentioned earlier, so that universal health coverage and sustainable development goals targets are achieved, particularly Goal 5, Achieve gender equality, and empower all women and girls, and Goal 8, Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all.

Targets for Goal 5 include ending all forms of discrimination, violence and exploitation of women and girls, and that is particularly important when you reflect on the comment that not all jurisdictions have laws protecting health workers from assault or other forms of violence; eliminating harmful practices such as child early and forced marriage, and female genital mutilation; increasing value of unpaid care and promoting shared domestic responsibilities; ensuring full participation of women in leadership and decision-making; ensuring access to universal reproductive rights and health; fostering equal rights to economic resources, property ownership and financial services for women; promoting empowerment of women through technology; and adopting, strengthening polices and enforcing legislation for gender equality.

In Australia, and Tasmania, we have achieved many of those actions and outcomes, but there are still areas where we need more work ourselves. We should not just be looking to other countries to say, 'Well, you are not doing that so well, are you?'. We need to look inwardly as well.

As nurses and midwives represent a large portion of the women who make up the healthcare workforce, they will play an important role in achieving these targets.

As I mentioned previously, midwifery care includes proven interventions for maternal and newborn health, as well as for family planning, and could avert over 80 per cent of all maternal deaths, stillbirths, and neonatal deaths. If we have enough midwives in these developing nations in particular, they can avert 80 per cent of all maternal deaths, stillbirths, and neonatal deaths. There are still women dying in childbirth around the world.

We must ensure equitable access to midwifery care for all child-bearing women and their families as a priority. This means training and educating locally based midwives who can provide culturally sensitive, quality care and improve outcomes for all women and babies.

Providing women and girls with equal access to education, technology, health care, decent work, and representation in political and economic decision-making processes will also greatly improve global health outcomes.

Being involved with the Commonwealth Parliamentary Association, attending some of the functions we have had, when you are hearing from women from these other developing nations, some of the things they have to deal with in their reproductive rights, and even for a woman to stand for parliament. It was horrifying to hear one speaker, one young woman, talk about how the only way she was likely to get elected was if she provided sexual favours to all the male chiefs. That is the sort of pressure that some of these women are under in these areas. The importance of and value gained through the education of girls and women are significant.

Goal 8 pertains to sustained economic growth and decent work for all. For at least developed nations, the economic target is to attain at least 7 per cent annual growth in the gross domestic product. Achieving higher productivity will require diversification, entrepreneurship, and innovation.

It will also mean ensuring women and girls are given access to education and the opportunity to participate in the economy and the making of economic decisions. There is no doubt that investing in nurses and midwives is good value for money.

The report of the United Nations High Level Commission on Health Employment and Economic Growth concluded that investments in education and job creation in the health and social sectors result in the triple return of improved health outcomes, global health security and inclusive economic growth.

Australia is one of 193 countries that adopted the 2030 agenda in September 2015. Implementation of the agenda is led by the Department of Foreign Affairs and Trade and the Department of Prime Minister and Cabinet, with different federal government agencies responsible for each of the goals.

Unfortunately, Australia is not on track to achieve a sustainable deal on goals by 2030. In 2020, Australia's overall performance in the SDG index is ranked 37 out of 166 countries, down from eighteenth out of 34 countries in 2015. I hope that shocks a lot of members here because it is pretty shocking we have gone backwards. Clearly, we need to be much more focused on meeting our commitments and obligations in these important areas.

I will close with comments related to point (2) of the motion -

> That the Legislative Council recognises, highly values and thanks all Tasmanian nurses and midwives for their hard work, dedication and commitment in all areas of practice.

A lot has changed since this motion was first put on the Notice Paper. The International Year of the Nurse and the Midwife was declared with the intent of it being a year-long effort to celebrate the work of nurses and midwives and advocate for increased investments in the nursing and midwifery workforce. Those needs still remain but we have not had much of a celebration.

The advent of COVID-19, though, has highlighted both of these. Nurses and midwives play a vital role in providing health services. These are people who devote their lives to caring for mothers and children, giving life-saving immunisations and health advice, looking after older people and generally meeting essential health needs every day. They are often the first and only point of call in their communities. But this is not the time for lip-service and merely providing accolades and pats on the back. It is a time to guarantee staffing ratios for nurses and midwives across all sectors and ensuring safe work environments for all our nurses and midwives. This will require legislative and policy support.

We have an opportunity to leverage the evidence in the *State of the World's Nursing Report 2020* and encourage the Government to invest in the education of nurses and health workers to meet domestic demand and respond to changing technologies and strengthen nurse leadership. The report highlights some key areas of concern for many low- and middle-income

countries. However, we cannot become complacent in a high-income country like Australia, where we have an ageing nursing workforce and an over-reliance on international recruitment. Both pose a threat to our attainment of nursing and midwifery workforce requirements.

We should always acknowledge and appreciate the anxiety many healthcare workers have been feeling following the COVID-19 outbreak around the globe, as well as here in Tasmania. The mental and physical health of all our nursing and midwifery staff must be a top priority to ensure they can continue to provide the quality care we all need.

We know and have heard in the Public Accounts Committee inquiry into the COVID-19 response that frontline health workers are at risk of physical and mental consequences directly as a result of providing care to COVID-19 patients. These impacts, particularly the mental health impact, can be enduring if adequate support and care are not provided to our highly valued nurses and midwives.

During the early stages of the pandemic, shortages of drugs and life-saving equipment, as well as a lack of knowledge when faced with a new virus, resulted in high rates of transmission of COVID-19 in healthcare workers. As I noted earlier, we saw this occur on the north-west coast in April. We heard a lot about shortages of protective equipment, which posed a significant risk. Contracting the infection results in missing work days, quarantining and increasing the risk of transmission to family members. Clearly, a combination of increased workloads, shortages of available healthcare professionals, the risk of transmission and any lack of resources severely affects the physical and mental health of healthcare workers and places healthcare systems under extreme pressure.

We saw health professionals in other countries having to make terribly difficult decisions about which patients they could treat and provide the highest level of intensive care to and which ones they had to let die. No health professional ever wants to be faced with such a situation, but they have been in this last few months.

BioMed Central is a UK-based producer of scientific journals which recently ppublished a review of a number of studies on the physical and mental health impacts of COVID-19 on healthcare workers. In one study, out of 230 healthcare workers who responded to the mental health assessment scales, 53, or 23 per cent, had psychosocial problems. Among the 53 medical staff, more females - 90.57 per cent - than males, 9.43 per cent, and more nurses, 81.13 per cent, than physicians, 18.9 per cent, suffered from mental health issues due to the infectious outbreak.

The psychological impact on healthcare workers includes the following conditions -

- overall anxiety: between 23 and 44 per cent;
- severe anxiety: 2.17 per cent;
- moderate anxiety: 4.78 per cent;
- mild anxiety: 16.09 per cent;
- stress disorder: 27.4 to 71 per cent;

- depression: 50.4 per cent; and

- insomnia: 34 per cent.

Anxiety in females was higher than in males, and in nurses higher than doctors. When you have a predominately female workforce, that is a lot of people who are feeling the psychological impacts of COVID-19.

The study found that frontline healthcare workers engaged in direct COVID-19 patient care were at greater risk of depression, anxiety, insomnia and stress. That is not surprising, but I think we need to recognise it.

Nurses generally spend more time at the bedside of these patients, which is likely to contribute to that reality. We need to be aware of this, and alert to the ongoing needs of nurses and other health professionals placed in this situation.

With the opening of borders here in Tasmania, there is a high anxiety among health workers. We must ensure they are adequately resourced and that they have plenty of staff available - including surge capacity to meet any increased need and demand. We must ensure adequate supports are in place, including to support the mental wellbeing of all our health professionals.

Mr President, I am sure you and all members join me in thanking all our nurses and midwives for their selfless commitment to caring for others and the quality care they deliver; for their professionalism and dedication to high standards of care and practice in a year that has been like no other we have seen in our lifetime, when nurses and midwives have been required to step up rather than celebrate.

Let us thank them all from the bottom of our hearts.

As we thank and acknowledge them, let us commit also to ensuring they are adequately supported and resourced to continue to provide the quality care we all expect, and that we educate and employ as many nurses and midwifes as we need to avoid the need for double shifts and overtime wherever possible.

I personally thank all my nursing and midwifery colleagues of the past. They are a very special bunch. I look forward to other members' contributions.

[12.47 p.m.]

Mr GAFFNEY (Mersey) - Mr President, my contribution is not quite as long as the member for Murchison's, but I thank her so much for that really in-depth position on the International Year of the Nurse and the Midwife.

I am pleased to add my support to the motion, as the proud uncle of a Tasmanian health services registered nurse who is completely committed to her vocation, and indeed her patients, and as a member of the community who continues to be thankful for and incredibly impressed by the efforts of our nurses and midwives in this state, and across Australia and globally.

It is a well-known and oft-repeated fact that those who serve as nurses across so many fields of expertise - ICU, recovery, emergency, medical, surgical, theatre and maternity to

name but a few - are regarded as being among the most trusted people in our communities, and there are many good reasons for that.

When people are giving birth, or are sick or injured, they are at their most vulnerable - sometimes separated from loved ones, and in need of support and a sense of safety. In addition to the expert and professional healthcare that nurses and midwives provide to patients, their ability to read people and assist in a supportive and tailored manner are what patients often remember the most about these interactions in hospitals and clinics.

In an open letter to midwives commemorating the World Health Organization International Year of the Nurse and the Midwife, Her Royal Highness, the Duchess of Cambridge, wrote -

> The founder of modern nursing, Florence Nightingale - whose 200th anniversary we celebrate … once said: 'I attribute my success to this: I never have or took an excuse' and it is that mantra that I have seen time and time again in all of my encounters with you. You don't ask for praise or recognition but instead unwaveringly continue your amazing work bringing new life into our world. You continue to demonstrate that despite your technical mastery and the advancement of modern medicine, it is the human to human relationships and simple acts of kindness that sometimes mean the most.

According to the Australian College of Nursing, 2020 is the first year the profession has been recognised on a global scale. Mr President, with the events of this year, could there ever have been a better time for a reminder of the vital contribution that nurses and midwives make in our communities? I imagine that our healthcare professionals have not been in such sustained and crucial need since wartime. The pressure these men and women have been under for such a long period cannot be underestimated.

It has been an extremely challenging year. These are people who, in their daily practice under ordinary circumstances, are regularly required to work extended hours in sometimes less than ideal clinical settings, and with rapidly changing priorities. We know 2020 has been an extraordinary and difficult year for so many - but what have those who have been on the front line have been dealing with in terms of the unknown, patients' fears, the greater risk of self-contamination for many, the inability to save a patient - whether due to lack of equipment or dealing with a presentation too advanced to treat - is almost unimaginable. The physical and mental load is something most of us will never experience or understand. I salute our nurses and midwives and associated personnel for their incredible efforts.

As members may be aware, 2020 was selected by the World Health Organization as the International Year of the Nurse and the Midwife in honour of the 200th anniversary of Florence Nightingale's birth, and to recognise the critical contribution both professions make to global health. A number of events, conferences and forums were scheduled to celebrate and recognise nurses and midwives in every country. The Australian College of Nursing is currently heavily involved with the three-year Nursing Now Campaign, and the Nightingale Challenge, which is a leadership and development program for nurses and midwives under 35. The aim is to encourage 20 000 young nurses. Pleasingly, 27 295 nurses and midwives from 719 employers and 71 countries have accepted the Nightingale Challenge.

The challenge seeks to promote work at the top of the scope of nursing practice, raising the profile of the profession, and, as mentioned, leadership development through formal courses, mentoring, shadowing, or learning from other professionals or sectors. I feel sure that the ripple effect of initiatives of this nature will be felt throughout our hospitals and health sector for years to come.

It is a pleasure to make this brief contribution in genuine support of the motion, and indeed our hardworking and dedicated nurses and midwives during this, the International Year of the Nurse and the Midwife. I thank the member for bringing this motion to the Table, and offer my gratitude and encouragement to Tasmania's nurses and midwives.

[12.52 p.m.]

Mr VALENTINE (Hobart) - Mr President, I, too, support the motion. It was quite fascinating to listen to the member for Murchison bringing out some of the statistics and issues that nurses are facing in our community.

For the World Health Organization to declare this year, 2020, as the International Year of the Nurse and the Midwife, I do not think there would be any other year that would be as momentous as this, if I can put it that way, where the work of our nurses and midwives - and nurses in particular, because the COVID-19 situation has certainly put a spotlight on how much we need the nursing profession.

Nurses are the first to hold us when we come into this world, and quite often I am sure they are the last to hold our hand as we go, in many cases.

We look back on our moments in hospital, and I am sure every one of us has had time in hospital, where it has been so comforting for us to have a listening ear. You have the doctors coming in and providing their prognosis, then the doctor has to go to the next person on their round. Quite often, it is the nurse who is left to perhaps explain a little more, or be there in a sense of being a comfort for those who might have some bad news that has just been delivered to them. We just need to recognise the value of that particular profession.

The honourable member talked about the staffing ratios. How many times have we all been in hospital and nurses have just been run off their feet? I have had a few sessions over my life, some more serious than others, and the nurses have always been there. With the amount of demand on the nursing profession, it is important they can actually undertake their role in a way where they can deliver quality care and not be overrun or have to limit the level of care they are able to provide simply because there are too many patients or the demands on them are too high. We need to understand and make sure we are providing the right level of employment for people at their highest level of need when they are in hospital.

As a community we can all benefit if we have good staff ratios. Often, nurses are the closest to us on our medical journeys. They are often there to administer drugs the doctors have prescribed and to make sure that is properly controlled.

They sometimes have the toughest jobs as people lose capacity. Through the voluntary assisted dying bill, we have heard so many different stories about people's last moments and last weeks in their life with examples brought or sent to us of what people have had to endure. Quite often they lose capacity and where they cannot properly look after themselves, it is the

nurses in our hospitals providing essential support. Sometimes, providing the support they provide is just not easy.

I am sure they go home at night and it affects them. It must affect them. Their mental health is really important. So we are not talking only about the staffing ratio - we also need to look at their access to support when they need it when they find themselves in those mentally challenging circumstances and finding it hard to cope with. Maybe they have avenues of support, because I know from my own trips to hospital, there are other patients you can hear are getting to a really difficult stage and it is the nurses who are there to help them through it.

I simply want to say to nurses in support of the motion: thank you for your dedication to your patients; thank you for your commitment to due process to keep us safe; thank you for your resilience when it does not all go to plan; and thank you for who you are and your resolve to make a difference when it matters.

I support the motion.

[12.59 p.m.]

Dr SEIDEL (Huon) - Mr President, I know we do not have much time, but of course I will support the motion of the member for Murchison.

Mr Valentine - There is always after lunch.

Dr SEIDEL - Very good. Well, I might start by saying nurses are the backbone of our healthcare system. Full stop. They are.

Without our fabulous nurses, what do we actually do? I do not think much. I am not just saying this - it is what the evidence suggests: a health system focused on very strongly trained nursing workforce has better health outcomes. Full stop. In any environment.

My best teachers in my medical career were actually nurses. Not doctors, they were nurses -

Ms Forrest - A smart medical student listens to them.

Dr SEIDEL - My medical students do listen to them and, to be frank, some of my most intimidating teachers were midwives - mmost intimidating, and now I am sitting next to one again. You are telling me off again - some things never change.

Ms Forrest - We just want to make good doctors.

Sitting suspended from 1.00 p.m. to 2.30 p.m.

QUESTIONS

Medicinal Cannabis - Eligible Conditions - Post-Traumatic Stress Disorder

Ms RATTRAY to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.31 p.m.]

Mr President, I think this question is quite timely, given the member for Windermere's notice of motion. He must have been reading my mail.

With limited access to medicinal cannabis for various medical conditions -

(1) Can the Leader please advise if PTSD is one of these conditions that is not identified as an eligible medical condition?

(2) What are the eligible medical conditions that qualify for access to Tasmanian prescribed medicinal cannabis?

(3) Can the Leader please confirm that Tasmania is the only state not to allow general practitioners to prescribe medicinal cannabis for PTSD sufferers?

ANSWER

Mr President, I thank the member for McIntyre for her very timely questions.

(1) The Medical Cannabis Controlled Access Scheme allows Tasmanians with a serious illness that has not responded to conventional therapies to access unregistered medical cannabis products when prescribed by a suitably qualified relevant medical specialist. The CAS is specifically designed to support the safe and appropriate use of unproven medical cannabis products through the rigorous assessment of applications informed by evidence and expert clinical advice. This is the same process applied to all other unproven medicines accessed through the public health system in Tasmania.

(2) To protect patient safety, Tasmania's scheme requires that standard evidence-based treatments be exhausted before any unregistered and unproven medical cannabis is tried. The CAS is not condition-specific and any relevant medical specialist present and practising in Tasmania may make application to access these unproven medical products for their patients in accordance with the scheme requirements.

(3) It is important to note that the Tasmanian Government is the only government in Australia to subsidise the cost of highly expensive, unregistered medical cannabis products and make their potential benefits accessible to all Tasmanians, not just those who can afford to pay. Tasmania continues to work collaboratively with the Commonwealth and with other states and territories to encourage the development of high-quality, evidence-based clinical guidelines to ensure access to these medical cannabis products is safe and effective.

The requirement for CAS applications to be submitted by a relevant medical specialist ensures that patients are reviewed by an expert in the relevant field of medicine. This ensures the management of their condition is optimised with existing proven therapies before resorting to unapproved medical cannabis products. This is not uncommon for highly specialised products such as some cancer medications.

The Department of Health advises it is not in a position to comment on the precise prescribing requirements in other states or territories for PTSD medications although it would appear at least one other jurisdiction recommends referral to an appropriate specialist.

Ms Rattray - No consistent approach?

Mrs HISCUTT - Tasmanian GPs remain engaged in the CAS by virtue of the referral of a patient to a relevant medical specialist when a medical condition is unresponsive to evidence-based proven therapies. This is the established clinical practice pathway for assessment of any treatment of a refractory medical condition, not just unapproved medical cannabis products.

This approach was strongly supported by public health experts and key stakeholders, including the Tasmanian branches of the Australian Medical Association and the Royal Australian College of General Practitioners during the development of the scheme.

Launceston General Hospital - Survey - Queensland Consulting Firm

Ms ARMITAGE to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.35 p.m.]

Will the Leader please advise - and this is a question I have asked a couple of times, and I am really hoping to have a straight answer this time -

(1) Why was a Queensland firm called Insync engaged to conduct a survey on behalf of the Launceston General Hospital Emergency Department - LGHED - attendees earlier this year, instead of engaging a Tasmanian firm?

(2) Will the Leader please further advise -

(a) When was Insync engaged by the department?

(b) What is, or will be, the term and total cost of their contracted work?

ANSWER

Mr President, I thank the member for her Launceston for her question.

(1) and (2)

The LGH Emergency Department conducts annual experience and engagement surveys as a mandatory requirement under the Australian Commission on Safety

and Quality in Health Care, National Safety and Quality Health Service - NSQHS - Standards Action 1.13.

The NSQHS Standard Action 1.13 stipulates the mandatory requirement for health services -

- to have processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care;

- to use this information to improve safety and quality systems.

Benchmarking and comparison to other health services nationally is also a mandatory requirement under the NSQHS Standards.

Sourced as part of a quotation process by the Tasmanian Health Service, the current provider is able to provide benchmarking with other healthcare services to ensure comparison of quality of care, and identify specific areas of improvement to dedicated services such as emergency departments.

Presently, the Emergency Department's survey cost component per annum is $12 911, excluding GST. This arrangement ensures the LGHED staffing resources are focused on patient clinical care as much as possible. I am advised that patient experience surveys have been undertaken by Insync in 2019 and 2020.

I am advised that if Emergency Department staff were required to attend to the distribution, collection, correlation and reporting of ED surveys, it is estimated it would cost approximately $30 000 to $40 000.

Launceston General Hospital - Survey - Queensland Consulting Firm Supplementary Question

Ms ARMITAGE to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.38 p.m.]

I am sorry to have to stand again, but that last comment - I do not think the question has been fully answered, which means that I will, unfortunately, have to ask another follow-up question.

To insinuate that I am expecting Emergency Department staff to do the survey themselves, when I mentioned last time that it was insulting, is again an insult - please take back to the minister that I would not expect the department to do its own survey.

My main question was, and my follow-up question will be, whether a Tasmanian firm - basically your answer, and it is a shame we do not have the answers given to us when you are actually reading them out, which would be very useful, to actually know what was said.

The fact that Insync is capable of doing it - I am sure many Tasmanian firms are capable of doing it as well. I will do some follow-up questions about the tender process.

Mrs Hiscutt - Can I just assure the member that I will take a copy of that *Hansard* to make sure the minister gets it?

Hydro Tasmania - Annual Report 2019-20 - Generation Asset Writedown

Ms FORREST to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.39 p.m.]

As noted in Hydro Tasmania's recently released 2019-20 annual report, a significant writedown of generation assets are recorded due to reductions in future expected revenue.

Hydro Tasmania's overall book value declined by $219 million in 2019-20. Hydro's balance sheet suffered further loss following a $249 million decline in 2018-19. This means Hydro has lost $467 million, or 23 per cent, of value in two years. These losses are not attributed to trading losses.

The annual report 2019-20 notes Hydro's generation assets were marked down by $870 million, to a figure below cost - incidentally, the same level recorded 15 years ago when Basslink commenced.

Losses are also associated with the onerous contracts, with the latest value of Hydro's onerous contracts being $260 million -

(1) Please provide a detailed explanation of the $870 million writedown of generation assets in 2019-20.

(2) What triggers the need for generation assets to be revalued?

(3) As noted in the annual report statement of corporate intent, huge returns to government will require increases in borrowings - what impact is the current dividend policy having on upgrade maintenance and investment in generation assets?

(4) (a) With regard to the onerous contracts that make up the $260 million-contract value noted in the annual report, how many contracts comprise the total of onerous contracts?

(b) Please indicate what has been purchased by each of the contracts - for example, large generation certificates for electricity and gas et cetera.

(c) Do the contracts noted in (4)(b) cover specific quantities to be purchased? If yes, what are these quantities? If no, please provide details to clarify in each instance.

(d) What is the value of each onerous contract which comprises the total of $260 million.

ANSWER

Mr President, I thank the member for Murchison for her question.

(1) The writedown of generation assets was the result of lower market and forecast energy prices. The market and energy prices used in the valuations are subject to volatility causing movement of the valuation of the generation class assets.

(2) The trigger is a requirement to be compliant with the relevant Australian accounting standard.

(3) Hydro Tasmania has invested over $1 billion into maintaining and upgrading its generation assets since 2008 and is planning to spend more than $1.1 billion on those assets over the next 10 years. Sustaining the performance of the existing Hydro power asset base for the long term is fundamental to Hydro Tasmania's primary purpose and underpins the shareholders' energy policy.

Borrowing levels are driven by the planned expenditure mentioned above, coupled with the forecast operating performance of the business. The amount of dividend paid under the policy is a product of the underlying performance and does not impact the level of investment on upgrade maintenance and investment in generation assets. Hydro Tasmania will continue to work with its shareholders to ensure these investments are made in a financially prudent manner.

(4) (a) There are 52 contracts that comprise the balance of onerous contracts.

(b) Onerous contracts include gas contracts, lease liabilities and large generation certificates.

(c) The onerous contracts that relate to the wind power purchase agreement - the LGCs are for the four wind farm outputs, so the quantities will fluctuate due to the wind variability. All other volumes are specific to each individual contract. Details regarding the contracts are commercial-in-confidence.

(d) Contracts involving third parties and specific details of each contract are commercial-in-confidence.

Cigarette Vending Machines

Mr DEAN to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

(1) How many cigarette tobacco vending machines are there in the state?

(2) Where are they?

(3) How are they policed so that they are only accessed by persons 18 years and older?

(4) How much are the machines used? What is the quantity of product either monthly, annually accessed through those machines?

ANSWER

Mr President, I thank the member for Windermere for his question.

(1) The answer to this question is zero. The last cigarette vending machine in Tasmania, which was located in the Huon Valley Council area, was removed in February 2020.

(2) to (4)

The answer to question (1) means that the answer to questions (2), (3) and (4) is 'not applicable'.

Dorset Community - Access to Antenatal and Midwifery Services

Ms RATTRAY to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

[2.44 p.m.]

This is a follow-up question in regard to Dorset community access to weekly antenatal and extended midwifery services at the North Eastern Soldiers Memorial Hospital and the minister's answers received on 21 October.

(1) Can the Leader advise when the community will be advised of the outcome of the review of the fortnightly trial to determine whether clinical and community needs are being met and when will the outcomes be relayed to the community?

(2) Regardless of any review outcomes, I ask again on behalf of the Dorset community, will the minister guarantee access to midwifery services will not be cut entirely from this community?

ANSWER

Mr President, I thank the member for McIntyre for her question.

(1) The Tasmanian Health Service advises that the review of the fortnightly clinic trial is expected to be completed in coming weeks, and any outcomes will be publicly communicated.

(2) There is no intention to discontinue the provision of midwifery services at the North Eastern Soldiers Memorial Hospital.

Marinus Link

Ms FORREST to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

It is noted in Hydro Tasmania's recently released 2019-20 annual report, a significant writedown of generation assets was recorded due to reductions in future expected revenue.

Noting that the Marinus Link business case is based on estimates of future electricity price -

(1) Will TasNetworks review the business case, and if not, why not?

ANSWER

Mr President, I thank the honourable member for her question.

(1) TasNetworks has recently reviewed the economic case for the Marinus Link. Details of this work are contained in the Regulatory Investment Test for Transmission Supplementary Analysis Report.

The updated modelling undertaken by TasNetworks clearly demonstrates the role that Marinus Link can play in the future National Electricity Market - NEM - which is consistent with the findings of the 2020 ISP.

The benefits provided by Marinus Link are predominantly in providing access to Tasmania's dispatchable hydro capacity and high-quality wind resources, which will lead to price savings for customers in the NEM compared to a situation where Marinus Link is not commissioned.

Screen Tasmania - *Wild Things*

Mr DEAN to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT

According to the answers provided by the minister, Ms Archer, on 24 September 2020, the Screen Tasmania-funded documentary *Wild Things* engaged eight Tasmanian filmmakers and one emerging filmmaker attachment. Additionally, the minister advised in her answers that producers are contractually required to make the film in accordance with an approved script, budget and schedule. Will the Leader please advise -

(1) The dates, times and location when filming for the Tasmanian element of the film was undertaken?

(2) The scheduled dates and milestones and/or events?

(3) The names of the eight Tasmanian filmmakers and the emerging filmmaker attachment?

(4) Was any of the $50 000 paid by Screen Tasmania to 360 Degree Productions paid to the Bob Brown Foundation or any of its staff and/or associates?

ANSWER

Mr President, I thank the member for Windermere for his question.

(1) Ascertaining exact dates and times would be administratively onerous, involving the producer reviewing two years of invoices, production diaries and accounts.

However, we can provide the following general information of Tasmanian filming, if that suits you. If you do not quite like the answer, you might want to rephrase it and put it on the Notice Paper -

- December 2018 - Tarkine rain forest blockade
- February 2019 - Huonville fires aftermath
- March 2019 - Tarkine marathon and Launceston Airport
- April 2019 - Stop Adani convoy departure
- October 2019 - Tarkine Big Canopy Campout event; various Tarkine blockade protests and a Hobart event.
- November 2019 - BioBlitz at the Tarkine
- February 2020 - several days in the Tarkine
- March 2020 - Magistrates Court and doctor's surgery
- April and May 2020 - drone filming in the north-west forests.

(2) The key schedule dates for the filming productions are as follows -

- December 2018 to December 2019 - incidental critical filming
- January 2020 - commenced the principal photography
- April 2020 - commenced post-production
- June 2020 - complete rough cut
- July 2020 - complete fine cut
- July 2020 - commenced sound post-production
- September 2020 - physical delivery
- November 2020 - final acquittal.

(3) The names of the Tasmanians who worked on the film is personal information within the meaning of the Personal Information Protection Act 2004 and the Right to Information Act 2009, and will not be released. Screen Tasmania understands that at least 11 Tasmanian crew members were hired by the production, in addition to the emerging filmmaker attachment. The funding contract commits the filmmaker to a minimum spend on Tasmanian goods and services, including on personnel.

(4) Screen Tasmania funding was a contribution of less than 10 per cent towards the total project budget. The producer has advised that no person from the Bob Brown Foundation was employed on the production, and no payments went to the Bob Brown Foundation.

However, the production filmed one event in the Tarkine organised by the Bob Brown Foundation, to which a small amount was paid for accommodation and meals, only for crew members who stayed at the independent facility at which the event took place during filming.

MOTION

International Year of the Nurse and the Midwife

Resumed from above.

[2.51 p.m.]

Dr SEIDEL (Huon) - Nurses are, of course, health professionals in their own right. They are not just a supporting act for doctors or other healthcare providers, yet we often take them for granted. Work hours, pay, professional support, career development - too often nurses are being told to put up and shut up. It desperately needs to change. Double shifts are too often expected, and too often the norm.

Honourable members, how do we expect our nurses to function in a high-pressure environment? Normal shifts and normal working hours in any health environment are pretty much full-on already. Double shifts must be the rare exemption, and unfortunately they are not. Professional support, counselling and CPD too often come short, due to the commitment to provide clinical nursing services. CPD time and training time must be protected. Support and counselling must be offered.

I do not want our nurses who work at the coalface to burn out. I do not want them to leave their profession because they do not feel supported. The member for Murchison already mentioned the substantial pay gap. How can we allow that to be the case? It is 2020, after all.

Good health systems are built on the foundation of a strong nursing workforce, but what we do is actually workforce guessing, not workforce planning. Too often we rely on agency nurses and on nurses who have trained overseas as a quick fix. Overseas-trained nurses are now subject to certain visa requirements; often they are employer-sponsored. Those nurses feel that they are not allowed to complain, regardless of shift allocation or pay. They deserve much better than that.

Nursing as an academic discipline is under-represented in academic discourse. I call it academic discrimination. We need more academic leadership programs for nurses, and we certainly need more conjoined university appointments. It is time to take the academic career path in nursing seriously.

Workforce planning usually does not feature in media headlines, but we need to do a far better job here. For example, in a previous question time, I asked how many nurse endoscopists were employed by the THS over the last five years. I asked that in the context of waiting times for bowel cancer screening. The answer was zero - zero nurse endoscopists were employed, yet we could have trained up nurses to do exactly that over the last five years. Why didn't we?

Why do we not appreciate nurses as a solution to the problems our health system has been facing for years? It is not only nurses in our hospitals. Our community nurses, our child health nurses, our palliative care nurses are doing an outstanding job, day in and day out. They need support and a genuine career path.

The member for Murchison raised nursing ratios in aged care facilities. You do not need a royal commission to tell you that this should be different. We cannot expect our nurses to care under the most challenging of circumstances. It is time for our nurses to expect parliamentarians to care. That is why laws should be legislated here in Tasmania and nationally. It is time for us to give back to our fabulous nurses and our fabulous midwives. It is time to change the conversation and it is time for us as parliamentarians to show we care for them too.

[2.55 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, 2020 is the International Year of the Nurse and the Midwife, and I thank the member for Murchison for bringing this motion on and for her comprehensive and extensive coverage of her motion. It was very detailed.

When the World Health Organization designated 2020 as the International Year of the Nurse and the Midwife, I doubt that it would quite have known how appropriate this year would have been for that due recognition.

We have seen nurses and midwives all over the world bravely leading the global response to COVID-19 from the front line, attending work while the rest of us were staying home, throwing themselves headlong into the care of patients facing unprecedented illnesses.

The theme for the year is 'A Voice to Lead - Nursing the World to Health'. It is a wonderful theme that goes to the very heart of what it means to be a nurse and a midwife.

To all the nurses in Tasmania, as well as around Australia and the world, we all say thank you. You do such an extraordinary job and we owe you such a debt of gratitude in this year of all years.

Nurses and midwives are so often the face of our health care. They are the professionals interpreting medical information for families and loved ones. They provide emotional support, coordinate services for their patients and take it upon themselves to ensure their patients are feeling supported and comforted.

Put bluntly, health services simply would not and could not function without the crucial role they play. In Tasmania, we have over 8500 nurses and midwives, and I am advised that we are blessed with one of the highest proportions of nurses and midwives as a percentage of population in Australia.

These nurses and midwives work across a range of healthcare settings, primary health clinics in our EDs and our ICUs, within our immunisation clinics, our aged care facilities and the list goes on. Within these care settings they undertake a variety of roles: delivering care, educating the next generation and, taking lead roles in managing the services of our hospitals. Again, we could go on here for hours about what they do.

The point is that the role of a nurse or midwife is clearly not a one-track career. Nursing is a varied, exciting and challenging profession. We must encourage and support the next generation of nurses and midwives, and I can assure the Chamber that this is exactly what the Tasmanian Government is committed to doing.

The Tasmanian Health Service has added more than 850 FTEs of nursing workforce since 2014. It is an extraordinary rate of recruitment, I am sure you will all agree, strongly supported by the Office of the Chief Nurse and Midwife within the Department of Health.

In particular, I am proud of the way our Government has expanded the number of graduate nurses that we take on. These extra positions mean more opportunities for Tasmanians, and we are looking at how we can create more opportunities for nurses and midwives to upskill and pursue their chosen field, especially in the nurse practitioner space which I know the member for Murchison is very passionate about.

This year in the International Year of the Nurse and the Midwife, we acknowledge the extraordinary work of our nurses and our midwives. We applaud them for their bravery every day but especially so in the face of the COVID-19 pandemic. We are so lucky to have every single one of them in our health system and in our community, and we thank them all once again for their efforts in 2020.

The Government certainly notes the member for Murchison's motion and the comprehensive coverage of her motion.

[2.59 p.m.]

Mr DEAN (Windermere) - Mr President, I strongly support this motion. Like just about every other Tasmanian, I respect our nurses and our midwives and all those people working in this area. They do an incredible job. They work in extremely difficult situations, which has been borne out over previous months dealing with COVID-19 situation we are confronting.

I have spoken to Emily Shepherd - most people here would know Emily, who is doing extremely well in her position in the union. Listening to some of the issues they are currently confronting, it is just quite incredible that they can continue to do their work and do it to the best and the high standard they do. They are doing wonderful work, wonderful things, and I certainly commend them. They are, I might say to the member for Huon, considerably higher on the status ladder than are we.

Ms Forrest - We have taken a significant dive.

Mr DEAN - I certainly strongly support this motion, Mr President.

[3.00 p.m.]

Ms FORREST (Murchison) - Mr President, I thank members for their contributions and their support of this motion. I know that even those who have not spoken would support the motion, I am sure, in principle. It was only at lunchtime - we were having lunch together, as it turns out, but it made me think back to any time a group of nurses gets together, the stories flow, and we started telling a few stories related to midwives during lunch.

It is funny, whenever I used to go out before I was in this role, even on holiday with my family somewhere on the mainland, if you got chatting to another mum because she had little kids, they would say, 'What do you do?' I would say, 'I'm a midwife' and so you would get the whole birth story, without fail, because there is almost a sign on your forehead, 'Spill your guts here.'

I used to say that to lots of people and I used to say it all the time because that was the thing - nurses have that approach where we are counsellors, we are people who always listen and do not judge because you cannot judge. If you are a judging person, you are in the wrong profession as a nurse and midwife because you have to take whoever comes through the door. That is why we are lucky in Australia to have a universal healthcare system that provides for that. I was reflecting on how we can go for many, many months and not see each other, and you can pick up as if the last conversation you had occurred only a couple of days ago.

When I think about some of my midwife friends on the mainland at the moment - a woman, Andrea Quanchi, a fabulous midwife who does an enormous amount for midwifery and midwives in terms of homebirth. Her daughter is now a homebirth midwife as well. The work she did advocating for women and the role we both played in the College of Midwives trying to promote models of care for women including continuity of care and care from a known midwife has had more beneficial outcomes for mothers and babies.

An enormous amount of work has been done. There is still unfinished business in terms of professional indemnity insurance. Midwives still cannot get professional indemnity insurance even if you had a million bucks to pay for it. Why? I will not go into all that now, Mr President. It is a matter that really needs a separate debate because it is an important issue that prevents so many midwives being able to operate in homebirth and even birth centre birthing, which should be an option for a lot of women in our country and our state.

Luckily, my own daughter gave birth in Launceston Birth Centre almost a year ago this week. I was lucky enough to be there and share that really special occasion with her, but they had almost closed the centre down because of a lack of midwives to support and continue to work in it because of some of these restrictions.

Whilst support has been provided to enable midwives to continue to practice, there are so many restrictions. Effectively, you have to have no assets at all so that there is nothing - the family home has to be in the partner's name to try to protect the assets of the midwife because she cannot get insurance. This is not because midwives are negligent - they are not. There are negligent midwives, yes; there are negligent doctors, yes; there are negligent nurses, yes. They are by far the minority and they should be held to account, but the midwives who offer this sort of service are not that -

Ms Webb - We should not restrict women's choices through that kind of mechanism.

Ms FORREST - That is right, yes. The choices are restricted way too much. I am really grateful my daughter's midwife, Emma, who moved from Melbourne to work at the birth centre in Launceston, was able to provide that opportunity for her. As the Leader said, there is so much work to be done in the area of nurse practitioners. I worked at a national and state level in the College of Midwives; I was state president for a number of years, and I was also on the national executive for a period - those things I gave up when I joined this place. At times an enormous amount of work goes on with very little reward. We cannot seem to break through on some of these areas. When I first started, you could get professional indemnity insurance, then it dried up overnight.

I thank the member for Windermere for mentioning the fact that it is a really well-regarded profession, right at the top of the tree. It is interesting there is so much respect for nurses and midwives in our broader community. The majority are women, but we see so little respect for women in our community in so many areas. We did not have to watch much on television last night to understand how bad this is at the highest levels in our Parliament of Australia. It does not make sense to me. We have huge respect for nurses and midwives, the majority of whom are women, and generally almost zero respect in the highest places in our country for women.

What is that about? Anyway, it is getting slightly off the track of the International Year of the Nurse and the Midwife, but they are such highly regarded and respected professionals.

The gender pay gap - I thank the member for Huon for raising that - is absolutely an area that needs to be addressed, as are the career pathways within nursing and midwifery. They are at a very flat structure with very little opportunity. Workforce planning and workforce matters like that, as well as career pathways, absolutely need further work.

As we celebrate the role and participation of nurses and midwives in our community, let us not forget those really important aspects. Let us not forget they work in extraordinary circumstances. You never know, particularly at the front line in the Department of Emergency Medicine, whether one of your family members could be brought in in really bad shape and you could be working at the time. In Tasmania, we know so many of our patients personally. You have a friend or woman who comes in to birth who has a tragic outcome or serious complication, and you are required to go and assist even though they may be a friend of yours, because that is the nature of our small communities.

There are enormous pressures and strains. We cannot afford to overlook this. As we celebrate this year, there will perhaps be a lot more reflection next year, hopefully. I ask all members - and I am sure all of you know a nurse or midwife - to contact them today and just say thank you. Just text message, phone, whatever, just say thank you, and ask them to pass it on to their colleagues, because that way they will know our parliament respects and thanks you. I ask all of members - just one nurse, one midwife, and send a message to them and thank them, not just for what they have done in the past, but for what they will do in the future.

Thank you, Mr President, and members for their contribution to and support of the motion.

Motion agreed to.

MOTION

Medical Cannabis - Legalisation

[3.09 p.m.]

Mr DEAN (Windermere) - Mr President, I move -

> That the Legislative Council calls upon the Government to further consider the legalisation of medicinal cannabis having regard to laws which apply in other Australian jurisdictions, with a view to allowing the prescribing of medicinal cannabis under proper process to those patients whom it would benefit, and also prevent these patients and carers from having to act unlawfully for treatment.

Mr President, I thank the members for giving me the time to give notice of this motion on Friday, 30 October. I thank members for that. I did that because this is a fairly important issue. It is one of those fairly emotional matters when you start to look at some of the issues and some of the concerns people have been confronted with around this state. When you talk to somebody who is involved in it and they are talking to you in tears, it does get to you. You cannot help but feel for them.

As members would have assumed, this motion follows the emotional email I received from Lyn Cleaver regarding the tragic reality of caring for a son, now 29 years of age, suffering from severe refractory epilepsy. No legal drug has been able to provide help or relief for the management of this severe illness which, sadly, is aggravated by an acquired brain injury.

However, I have given much time to the subject of this motion over a longer period. It is not just coming from the letter I received from Lyn Cleaver. I have been looking at this for a long time and I have discussed it with a number of people and with other members of parliament as well, both in this and the other place. It is a matter of great concern.

I refer members to my adjournment speech of 29 October this year. While I would like to read it again, because it sent a powerful message to all, and hopefully to the Government, I will not do so other than to repeat some of the substantial points coming from it to put my position forward in what I believe is to be the right way.

Lyn Cleaver is no different from all mums and dads in wanting what is the best care and treatment of her son. He is in a desperate situation, requiring the most effective management of his most serious illness, which has gone on now ever since he was six years of age. It has gone on over many years.

Jeremy has trialled many anticonvulsant medications, many of them without success. His carer and loving mum has now taken a course to care for her son that could see her incarcerated. This is the desperate situation she finds herself in. The fact is medicinal cannabis, cannabinoid, gives Jeremy relief and it gives the family relief. It is without known side effects.

Jeremy has been treated by specialists, neurologists and by everybody else right to the top of the medical services in this state, and wider. There was support for the family to access medicinal cannabis for his care but while supported by the TGA - the Therapeutic Goods Administration - it has not been supported by Tasmanian Medicines Access and Advisory Committee, known as TMAAC.

On 29 August 2020, Lyn Cleaver was made aware that the latest application by another neurologist, Dr Aaron de Souza, had also been rejected. I understand the TGA - and that is how I will refer to the Therapeutic Goods Administration from hereon - gave its approval to the application - that is, access for Jeremy to cannabinoid medicine. As I said, my understanding is that it was rejected by TMAAC.

It is important to look at the TGA position and how it sits in this whole thing. The TGA is Australia's regulatory authority for therapeutic goods. It carries out a range of assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard, with the aim of ensuring the Australian community has access within a reasonable time to therapeutic advancements.

I understand that after several applications, access to this form of medication was approved by the TGA.

I now take a look at TMAAC's position. When I first started to look at TMAAC I googled it to do some research but it was difficult to find anything about TMAAC. I was frustrated and my staff were too. We contacted the Parliamentary Library; whose staff I commend for the work they do and the way in which they went about this. They too were stumped to some degree in getting good information. In fact, they went back through *Hansard* to previous discussions that had taken place in relation to this body. They came up with some evidence and information out of those processes and -

Ms Rattray - TMAAC - you said 'Therapeutic Goods Administration'.

Mr DEAN - I have moved on from the TGA; I am now on to TMAAC, which is the Tasmanian Medicines Access and Advisory Committee. Sorry about it that.

Ms Forrest - Who found it for you?

Mr DEAN - You did, and I appreciate and thank you for that because it was just a difficult situation. Yes, I thank you, member for Murchison, for providing some support here as well in trying to get to the bottom of this.

Ms Rattray - I thank the member for that clarification and apologies for missing that transition.

Mr DEAN - Thank you. I went ahead and using that information, I wrote what I thought was a reasonable position and understanding of TMAAC. Among all this, I also wrote to the Department of Health through the minister to find out more about this organisation. Lo and behold, this morning I received some documentation from the department or the minister, and I thank them for that. However, that was a couple of weeks ago so it has taken a little while for the information to come through. I just want to quote the information that came back. I think it is fairly important to put this on the record -

The Tasmanian Medicines Access and Advisory Committee is -

- The Tasmanian Medicines Access and Advisory Committee (TMAAC) is a multidisciplinary committee consisting of statewide representation of medical, nursing, pharmacy, consumer and Department of Health

representatives. Medical representation is from a variety of medical and surgical specialties and TMAAC will also nominate additional specialists who may be consulted and/or co-opted, when relevant.

- TMAAC oversees the use of medicines within the Tasmanian Health Service (THS) by providing direction, advice and recommendations on the safe, quality and cost-effective use of medicines, utilising evidence-based principles.

- The committee considers application for new medicines to be added to the Tasmanian medicines formulary, including assessing the risk associated with any pharmaceutical company-funded medication access program.

- When a required medicine is not formulary-listed and the prescriber considers a formulary application for a patient group is not warranted, a THS prescriber can apply to TMAAC to use the medicine for a specific indication in a single patient (individual patient application that is known as an IPA).

- TMAAC has delegated authority from the secretary for Health for review of applications made under the Controlled Access Scheme for unregistered cannabinoid medicines. These applications are assessed in line with established TMAAC processes for assessing applications for unregistered medicines. Unlike other medicines these applications are concurrently assessed by a delegate of the secretary for Health under the Poisons Act 1971 to streamline both of the necessary application processes required for cannabis access in Tasmania.

- Approved IPAs are valid for a time period set by the committee or may be approved for ongoing use. Extensions to time limit approvals are considered by the committee on request of the prescriber after the initial approval period. Importantly, TMAAC approval of medicines via either approval of a formulary listing or an IPA allows for supply of the medicine through a THS pharmacy. This supply mechanism ensures that patients are able to access medicines at a subsidised cost equal to the cost of a Pharmaceutical Benefits Scheme (PBS)-listed medicine. This pathway is only available to THS specialists and supply can only occur through a THS pharmacy on prescription from a THS prescriber.

- The TMAAC process allows equitable access for THS patients to non-PBS medicines which have been approved to be prescribed in safe, efficacious and cost-effective circumstances.

The next dot point is -

- TMAAC is Tasmania's representative on the national Council of Australian Therapeutic Advisory Groups (CATAG).

- Adoption of a CATAG guiding principle for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals ensures

that the activities of the committee are in line with nationally agreed best practice principles.

And the last dot point is -

- The Chief Medical Officer within the Department of Health is the executive sponsor of the committee, and the committee has reported obligations to the chief executives of the THS hospitals.

I thought it was fairly important to put that on the record because, as I said, we have to understand it. It is not easy to understand the position and where it sits, and what is happening. It has the right to overrule the Therapeutic Goods Administration.

I can skip the next few pages I have written - and thanks, as I said, to the library.

If we get back to Jeremy's issue, TMAAC clearly stated that Jeremy - this is on my advice - must trial and fail all conventional medicines before being considered for a medicinal cannabis prescription. On my advice, he still had not tried three available drugs. The evidence is that these drugs cause agitation, behavioural issues and suicidal ideation. Lyn Cleaver also says that Jeremy is extremely medication-sensitive, and previous drugs taken have caused serious behavioural problems. The family has had to work with that - and in fact Jeremy has had to work through that as well.

One remaining drug to be trialled has a warning of possible blindness. Jeremy is noncompliant and non-verbal, so any eye testing would be useless to monitor his eyesight. Again, this is all on advice I have received, and I have no reason not to accept it.

I ask a rhetorical question: would you take this risk, with your son or daughter already suffering serious health issues, when another product is working - albeit it is an illegal product, as in their case?

In 2014, the Legislative Council Government Administration Committee A inquired into the use of medicinal cannabis. The member for Murchison and I think the member for Hobart and others would have been involved in this robust inquiry. It generated quite a large report, which is available if members want to look at it. I had a good look at that report.

I am just going to refer to one or two recommendations from that report. Others might want to talk more about it. The committee made the following recommendations -

(1) The Tasmanian Government introduces legislation to immediately provide protection to individuals who are currently using medicinal cannabis from criminal charges associated with possession and administration of medicinal cannabis on compassionate grounds.

Ms Forrest - Before you go off (1), the Government did not support that. Its response was that the police will not progress a charge, a prosecution, with it. If you have a law that the police are going to ignore, that is just stupid.

Mr DEAN - Absolutely, I could not agree more.

Ms Rattray - I think it is pretty clear what the member for Murchison thinks about that.

Ms Forrest - Thinks of that first one, that is correct. Nothing has changed since.

Mr DEAN - The second recommendation was that -

> (2) The Tasmanian Government develops a legislative framework to enable the use of medicinal cannabis under medical supervision, including the preparation, cultivation and supply of medicinal cannabis.

This is all about the medical profession having a big say, a big involvement, in this. It is not a matter of a family member simply saying, 'We do not want to try these other drugs. We are not interested in that. We are going to go down the illegal pathway.'

That is not the case. That is not what is happening. It just is not. I think probably some people in the Government who are opposed to it are probably looking at it from that perspective, or that point of view. I would ask them not to.

Ms Forrest - They did not support that one either, if you read the response.

Mr DEAN - The third recommendation was, and I quote -

> (3) The Tasmanian Government support a cooperative approach between Tasmanian research institutions and mainland jurisdictions to facilitate clinical research in this area.

Once again, I am not sure where they went there, but the member for Murchison might tell us a little more on that.

Ms Forrest - The third recommendation was supported.

Mr DEAN - That is great.

The fourth recommendation -

> (4) The Tasmanian Government adopts a cooperative approach with other states and territories in relation to the legalisation of the prescription, administration, possession and cultivation of cannabis for medicinal use.

Medicinal use: it was not quoted twice there, I have repeated it a second time.

Recommendation (5) -

> Cultivars of cannabis containing low levels of THC should not be treated in the same way as cultivars of cannabis containing high levels of THC, in terms of the national classification system of scheduling of medicines.

The last one -

> (6) The Tasmanian Government engages with companies which have the appropriate expertise and capacity to progress the cultivation, extraction and processing of cannabinoids within the existing and/or future regulatory framework.

These are the committee's recommendations. The committee called many witnesses as part of the inquiry it conducted back in 2014, and we have not seen much progress since.

A Senate committee held an inquiry into current barriers to patient access to medicinal cannabis in March this year. Well, that is when the inquiry came out, I think. In March this year the final report was handed in.

I will just refer to two of the recommendations from that report.

Recommendation 11 -

> The committee recommends that the Tasmanian Government immediately join all other jurisdictions in participating in the Therapeutic Goods Administration's single national online application pathway for accessing unregistered medicinal cannabis and reducing state-based requirements for medicinal cannabis approval.

A very strong recommendation made by the Senate, by that committee - again, supported by much evidence in that committee making that recommendation.

Recommendation 20 from that inquiry -

> The committee recommends that the Australian Government, through COAG, encourage a review of state and territory criminal legislation in relation to:
>
> - amnesties for the possession and/or cultivation of cannabis for genuine self-medication purposes; and
>
> - current drug driving laws and their implications for patients with legal medicinal cannabis prescriptions.

A very, very strong recommendation, and it speaks for itself.

Mr President, why is Tasmania so different to the rest of the country when it comes to accessing medicinal cannabis?

This is a sad situation. If Lyn and Jeremy lived in another state, other than Tasmania, they would have access to this medicine. The family would be able to live close to a normal life, and without Jeremy suffering in the way he would without access to an illegal substance that his mother is prepared to put her credibility and reputation on the line for, as I said, in risking prosecution and jail.

She fears, Mr President, a police car driving up her laneway. She fears that, because she has openly said that she produces this product, and produces the oil for medicinal reasons. She does not hide that.

She fears when that police car will drive up her lane one day and confiscate a product, which is a medicine, and is helping.

Of course, with a substance that has only been legally available in Australia for a fairly short period of time, there are multiple Commonwealth acts that apply to medicinal cannabis. Even though it is a short time, there are multiple acts.

I will refer to some of those and in doing this, Mr President, I refer to the Victorian health legislation where they have put a succinct explanation together on their website -

> Commonwealth legislation
>
> Commonwealth legislation restricts the cultivation, manufacture, supply and use of narcotic drugs in accordance with international obligations in these areas. It also ensures that therapeutic goods sold in Australia meet suitable standards of safety, quality and efficacy, and places restrictions on the importation of controlled medicines.
>
> Commonwealth legislation and standards regulating medicinal cannabis in Australia include:
>
> - The Narcotic Drugs Act 1967

That is administered by the federal Office of Drug Control -

> - [It] provides the Commonwealth government with powers to meet international obligations relating to the regulation of drug manufacture.
>
> - The Narcotic Drugs Amendment Bill 2016 amended the Narcotic Drugs Act 1967 to allow for the cultivation and manufacture of cannabis for medicinal and related scientific purposes in Australia.
>
> - Establishes a comprehensive national licensing and permit scheme to regulate the cultivation, production and manufacture of cannabis in Australia for medicinal and scientific purposes.
>
> The Therapeutic Goods Act 1989 -
>
> - Administered by the Commonwealth Therapeutic Goods Administration, TGA
>
> - Provides a regulatory framework to ensure therapeutic goods supplied in Australia (such as medicinal cannabis) meet acceptable standards of quality and safety.
>
> .

- Sets out how to apply for a medicine to be approved and registered in the Australian Register for Therapeutic Goods (ARTG) in order to be legally supplied in Australia

- Provides a number of mechanisms to enable access to unapproved therapeutic goods, including the Special Access Scheme and Authorised Prescriber Scheme.

- The TGA have also compiled Therapeutic Goods Order. No. 93, defining the quality requirements required by all unapproved medicinal cannabis products available in Australia.

What is the position in other states and territories? I will keep this fairly succinct. In Victoria -

- any doctor in Victoria can prescribe medicinal cannabis for a patient with any condition - any condition - if they believe it is clinically appropriate and has the necessary Commonwealth and/or state government approvals - that is, TGA approval in their case.

- New South Wales - any doctor in New South Wales can prescribe medicinal cannabis for a health condition if they believe it is an appropriate treatment option and they have obtained the relevant approvals. You need to see the New South Wales government's Centre for Medicinal Cannabis Research and Innovation for more details. There are a lot more details there to cover that -

- Queensland - any registered medical practitioner in Queensland can prescribe medicinal cannabis for any patient with any condition, if they believe it is clinically appropriate and have obtained the required Commonwealth and/or state approvals.

- South Australia - patients in South Australia can access medicinal cannabis on prescription from their authorised medical practitioner, if appropriate. The medical practitioner must have the relevant approvals.

- Western Australia - any medical practitioner in Western Australia can prescribe medicinal cannabis if they believe it is suitable for the patient and again, they have the necessary approvals.

- Australian Capital Territory - the health practitioner can prescribe medicinal cannabis if they believe it may be effective for the condition of the patient they and have Commonwealth and territory approvals.

- The Northern Territory is a little different. Patients in the Northern Territory can access medicinal cannabis through an Australian doctor who is authorised by the TGA. The Northern Territory's Department of Health recommends that patients are referred by a GP to an appropriate specialist, who may be based outside the Northern Territory for assessment.

Ms Rattray - That was the reference in the question that I asked at question time, where it said at least one other jurisdiction recommends referral to an appropriate specialist. That would be the Northern Territory.

Mr DEAN - In Tasmania, a GP can refer you to a relevant medical specialist. The medical specialist can then prescribe medical cannabis in limited circumstances, where it is clinically appropriate and conventional treatment has been unsuccessful. The specialist must receive the relevant approvals, must be approved by the TGA, then, it appears, by the state committee of TMAAC. It appears it can override the TGA - if the Leader is able to provide any response the Government might want to make.

Ms Forrest - Do you know who the TMAAC members are?

Mr DEAN - I do; I have the list here somewhere but I am not sure if I can find it quickly. I certainly have it.

Ms Rattray - Perhaps in your summing up.

Mr DEAN - The member is absolutely right; that is where I will address it if I can.

We will go now to the Royal Australian College of General Practitioners. It has said that further research into the safety and effectiveness of medicinal cannabis products is needed because the current evidence is limited. I think we all accept that. It then goes on to say -

> … but the organisation does suggest there is a possible role for medicinal cannabis products in a number of areas.

Ms Rattray - It is well respected.

Mr DEAN - Yes, absolutely well respected. You cannot get any rungs higher on a ladder than where the RACGP is. I am a great one on this status level.

I want to quote from an article on thegreenfund.com website, 'Why Are Tasmania's Weed Laws so Strict?', and refer to some of the issues it raised -

> As the recent senate inquiry into barriers facing the Australian medical cannabis landscape outlined, Tasmania is now the ***only*** state which doesn't utilize the online, expedited and simplified application process that is SAS-B Portal route.
>
> As a result, Tasmania's medical cannabis prescriptions are seriously lagging, as is their latest information. The most recent patient data available says that as of November 2018, only seven patients have been prescribed medicinal cannabis products.

It has gone up from there; I am not quite sure what it is, but once again the Leader might be able to come up with the current figures as of today or yesterday -

> To put this number in perspective, Althea Group Holdings, one of Australia's leading medical cannabis companies, is prescribing between 500-600 patients across the country every single month.
>
> By not adopting the online SAS-B Portal method, Tasmanian patients who desperately need medical cannabis products have largely been unable to do so.
>
> One of these patients was Jeremy Bester, a 28-year-old Tasmanian man who suffered from severe refractory epilepsy. Jeremy began using cannabis as a treatment in 2014 as a last resort when all other medicines had proved ineffective, and to his and his mother's surprise, cannabis use resulted in an immense improvement in Jeremy's condition. This prompted Jeremy's mother, Lyn Cleaver, to begin purchasing the plant online, and eventually, growing it herself.
>
> Ms. Cleaver gained firsthand insight into the difficulties that arise when trying to follow the legal route to be prescribed cannabis in Tasmania, as her applications have been rejected on numerous occasions. Moreover, even if she were approved, she would be looking at a '$60,000 to $100,000 annual price tag for a legal prescription for Jeremy' while her home-grown method 'costs as little as $20 per week.'

Perhaps an unexpected benefit of Tasmania being so far behind the rest of the country is that we have been afforded the opportunity to watch and learn about what is - and what is not - working around the country where access is not as restricted. We can learn from that. I am not sure we need to continue learning from it for the next 20 years. There comes a time when you have to say, enough is enough. You have enough information, you have enough evidence and you need to move forward.

Medicinal cannabis products are incredibly expensive. For example, the neurologist advised Lyn Cleaver that a legal cannabis prescription would have cost the THS between $60 000 and $100 000 annually. I am not quite sure where that figure comes from but that is what I have from my research. These costs are prohibitive for patients, with many of them being on a disability support pension. The cost varies for the condition being treated and some people are managing to afford their medicinal cannabis product. Many patients are not refilling their scripts due to cost and are returning to the green market. That is not what we want.

There is no reason to think it will be any different in Tasmania. Many patients will not be able to afford the products. The clinics operating on the mainland are sometimes charging several hundred dollars just for the consultation and application processes, with an added cost for the medicine. Some of the products are quite weak and patients are consuming more, higher cost prescriptions. Supply is inconsistent with the imports, with patients sometimes waiting days or weeks for the medicine or not getting it at all and having to change brands or medicine types. Identifying a willing GP or specialist is also difficult.

While I accept we need to demonstrate care in the prescribing and use of medicines, there comes a time in the life of a person for some element of risk to be taken to bring relief from suffering and to restore some quality of life. The risk levels need to be minimised and that is the position we have with medicinal cannabis. There have been many trials, much research

has been done and it is being used to provide support, relief and control of illnesses where traditional medicines have not successfully worked.

It is accepted - I accept it, and I think we all do - that more research is required in this area and that is being done. Nobody is saying we should stop our research. Nobody is saying that at all.

I will talk about a personal situation. Very briefly - and I do not want to identify the person - I have a good friend suffering from a terminal sickness whose life expectancy is very short and who has had access to medicinal cannabis. The family says that has given him relief and some improved life quality. It is not good but an improvement on where he was. My position is, 'Isn't it good in that situation that a person can get some relief, some better quality in their life at that stage with what is happening?' Does it matter? In my view it does not. It is helping.

Ms Rattray - Having it in a controlled environment or a controlled process would have to be a better outcome.

Mr DEAN - That is the ultimate and that is what these people are about. They are saying there needs to be a controlled proper access to this product. That is what they want. They do not want to have to sneak around as Lyn Cleaver probably does, and has said she has done, looking to see who is next coming up the laneway. That is not what should be happening.

Ms Rattray - Also having access in that controlled process, you would expect it would assist in the research because people would possibly be willing to partake in the research. It would add value to the information.

Mr DEAN - I go back to this family because they are well known now in Tasmania for what is happening, and to some extent on the mainland.

Lyn Cleaver said to me the other day - and I went to her about this motion again, as I should have done and I did - 'Ivan, I have to say that when your name was mentioned I really had second thoughts about going anywhere near you because of your background.'. She said, 'I did not know -

Ms Forrest - Once a cop always a copper.

Mr DEAN - whether I should do that or not.'. She explained to me how uncomfortable she felt about doing that. I am very pleased she did and, as she said, she is pleased she did as well in all those circumstances. I think I can blame our past member for Rosevears for that, who also was assisting the Cleavers in going down this path. I think it was Kerry who recommended Lyn have a talk to me, that I would see things not in the way of the law, as it were, when I was a police officer.

People ask me whether I support cannabis use generally. No, I do not, not at this time; not at all. I cannot support that; I experienced many cases as a detective where in many instances cannabis was the cause of a very serious crime because a person was either high or they was committing a crime to access cannabis or the money to get cannabis. I experienced quite a lot of that, but the jury is still out on that. That is where I sit: I support medicinal cannabis use, properly authorised by doctors - those people who have the background

knowledge to understand and to prescribe it and know what traditional medicines are doing. I support that.

It is not good enough for us to fiddle while Rome burns, knowing people are suffering and that we have people prepared to act in a criminal way to relieve that suffering. I urge the Government to treat this issue as a high priority and to make access to medicinal cannabis - with a doctor or medical intervention - realistic and achievable and in doing so to also consider the laws in place in the rest of the country.

In conclusion, I paraphrase a request made by a provider of medicinal cannabis for a demonstration of humanity and support for those people forced by an uncontrolled love of a family member to defy the law; I am just paraphrasing comments passed to me -

> It is important we voice the need for a patient register exemption for medicinal cannabis and for self-supply of cannabis therapy whereby patients would register with the support of their treating doctor and be known to police, with documentation. I understand patients who have recently been raided were advised that if they could supply documentation to police that their medicine had been supported by way of medical intervention, it would be protected from confiscation. If such course is taken on this advice, if correct, the medicine (medical cannabis) would be protected from confiscation and patients and carers would also be protected from charges of possession, cultivation and administering medicinal cannabis. We would also like a review of the controlled access scheme and medicinal cannabis access in Tasmania. We need a roundtable where all stakeholders can come together and discuss medicinal cannabis access generally in Tasmania. So far, the end user has been ignored in this whole process.

That was the end of that conversation and my paraphrasing of that position.

This was raised with me by a family in a very desperate situation. In my opinion this is a sound position, and I call on the minister and the Government to bring together all stakeholders for the purpose of a comprehensive discussion on medicinal cannabis before more carers and parents are hurt and continue to suffer. Please do not procrastinate on this matter any longer. We know of one family openly defying the law because of a love for a family member. There would be others and it is not an acceptable situation.

I commend this motion to the House and ask members for their support.

[3.50 p.m.]

Ms FORREST (Murchison) - Mr President, I thank the member for Windermere for bringing this motion on for debate. It has been a matter raised again recently after many times, not just by the Cleavers, but by others who have an interest in this area.

The member for Windermere referenced a number of the recommendations made by our committee inquiry in 2014. That is six years ago and the government at the time made commitments to participate in the trials with New South Wales. This in many respects made sense, because it is a bigger jurisdiction and you could do with more people and all that sort of stuff.

But what has happened since then?

In Tasmania, a big fat zero. Why, if there was ever a policy intent - which clearly there is not, and it is definitely a policy issue. It was a policy issue of the then minister for Health, Mr Ferguson, not to progress with a legislative framework - he was also minister for police at the time - even to deal with providing some relief for those who are already using illegal product to care for their young children with intractable epilepsy or older young adults, as in the case of Jeremy Cleaver, but there were also others.

The sad reality about all this is that the people who are using medicinal cannabis are often at the end of their life, wanting it for the treatment of symptoms like intractable nausea with chemotherapy, to stimulate their appetite when they are on chemotherapy because they cannot eat. It is also used for pain in the end-of-life care and for intractable epilepsy where almost all of them have tried almost every medication, if not every medication, without or with limited relief. The side effects of medication have been such it is not worth them taking it because it has such a negative impact.

These medications we are talking about are really toxic medications. They are not a bit of Panadol here or something like that, which can be toxic in its own right, but these are really heavy duty drugs causing really serious side effects - the member for Windermere talked about some of those side effects.

If you get any medicine, there is always an insert in the packet that tells you about the side effects and all drugs have side effects. Panadol has side effects. Aspirin has side effects. Antibiotics have side effects, but we take them when we need them. I am aware of that. It is a risk assessment you make with your health professional that it is the most appropriate medication.

The contraceptive pill has side effects. So is having a baby if you do not take it, for example. You have to weigh those things up. Here we have a situation where through a policy position, we have people who have generally tried a whole range of other toxic substances and we are saying no. Well, the Government effectively through its policy settings is saying no, you cannot take this substance. There is, in some schools of thought, limited research around the overall long-term effects of this, whereas there is a lot of research as our committee found about the shorter term use and shorter term effects. Of course, you cannot get long-term effects unless you can do studies over a long period and if it is an illegal product, how do you do long-term studies?

It is like chasing your tail all the time. The fact that these people generally are using it because they have run out of other options - it is, I suggest, disgraceful we are not offering this option. We offer to treat the cancer, for which they often need or want to take medicinal cannabis to manage the side effects. Chemotherapy is totally toxic. It is designed to kill cells; that is what its purpose is. But you take medicinal cannabis, which is not high-THC marijuana - and for those who have read the report, which some of you would not have done, there are two main components of cannabis.

One is THC, which is the hallucinogenic aspect, and the other is the CBD. There are other cannabinoids in medicinal cannabis, but CBD does not have the hallucinogenic, addictive sort of impact that THC can have. If you go back in history, even to biblical times, cannabis was used back then but it did not have the high THC levels. It had a higher CBD and lower

THC. It has been bred over the centuries, because when someone figures out, 'This has a nice effect,' you breed your plant to make sure you get more of a nice effect. You do not have to do that. You can breed the plant to have different proportions of THC and CBD.

Most of these people with intractable epilepsy do need some THC in the medication, but it is not at a level that causes the big high you can get from a high-THC product.

I think the member for McIntyre, through interjection, mentioned about the consistency in a regulated environment. I cannot understand why the Government will not proceed down the path of a regulated framework for people under the care of their medical practitioner, as we suggested in our committee report. It is not like a person just going out and growing their own.

You would have a product produced that is consistent, that is tested, so every time you purchase that product, you know what you are getting. You know the concentration of CBD and THC, for example.

Without any regulation, what you get is people growing it - because they have no other option - with no quality control, and you really do not know what you are getting because seasonal variations can occur, as well as different plants - it depends on where you are buying your seed, or your seed stock. You can get different levels of CBD and THC, so you do not always know what the effect will be.

Ms Rattray - How much water is put into the plant.

Ms FORREST - Yes.

Ms Rattray - And, as you said, the season, Mr President.

Ms FORREST - Yes.

Ms Rattray - It all contributes to the quality.

Ms FORREST - If you have a regulated product, you know what you are getting, and you get prescribed the product that is fit for your condition.

Of course, it will be different if you have it to treat intractable epilepsy than it would be for treating nausea and vomiting and suppressed appetite, for example.

It makes no sense to actually force people into a situation where they are growing their own, with no quality control, rather than having a regulated product with limited access - and that is what we are asking for here. We are not asking for a free-for-all. We are asking for limited access.

The other contradiction, Mr President, is at the time of the committee, I know we were not actually growing any medicinal cannabis in the state, and there is a very strict regulatory framework for facilitating that. You have to get Commonwealth licences and state licences, and it was a fairly convoluted process.

But now we have people growing medicinal cannabis in this state. No Tasmanian can use it, but it is being grown in the state, and we are supplying Canada - so where is the sense in that?

Mr Valentine - Up around Bishopsbourne, I think.

Ms FORREST - Well, there is some just out near Bagdad, or Brighton, or wherever it is out on the road there, and there are others as well.

There are so many contradictions in this. It just beggars belief we have not been able to progress - even with the research and the pilot stages that have been done - to a sensible approach. It is purely a policy setting of this Government.

It is like access to termination of pregnancy. We have the right law, but we have the wrong policy setting. It is a policy setting of this Government. This Government can change it.

I know the member for Windermere was not able to give me the names of the TMAAC members at that point - the Leader may have them - but I am interested in whether the minister -

Mr Dean - The first paragraph gives you the areas.

Ms FORREST - All right. Whether the minister has any power over TMAAC - I will just read - and I appreciate the member for Windermere providing this -

> The Tasmanian Medicines Access and Advisory Committee (TMAAC) is a multidisciplinary committee consisting of statewide representation of medical, nursing, pharmacy, consumer and Department of Health representatives.
>
> Medical representation is in the form of a variety of medical and surgical specialties, and TMAAC will also nominate additional specialists who may be consulted and/or co-opted when relevant.

It does not actually name the members, but that is okay. From that description there is a wide range of expertise on this committee. So, what is the problem?

Can the minister influence this - and I want the Leader to see if she can respond to that - and if so, what influence does the minister have in this? Or is it purely that we have such ridiculous policy settings in this area that it just becomes a moot point, and this committee cannot - I mean, they have other roles besides medicinal cannabis, obviously. They have a range of roles in assessment of other medication, and things like that.

It also says here -

> TMAAC has delegated authority from the secretary for Health for review of applications made under the Controlled Access Scheme for unregistered cannabinoid medicines. These applications are assessed in line with established TMAAC processes for assessing applications for unregistered medicines.

Who sets those processes? Does the committee set them, or does the minister, or does the department under the oversight of the minister set them?

Something does not seem to be making sense here to me if you are going to apply a consistent approach federally, as the federal government in a Senate inquiry has called for, and other states appear to be adopting.

There are a lot of unanswered questions, and I just wondered where this influence is.

It goes on to say -

> Unlike other medicines, these applications are concurrently assessed by a delegate of the secretary for Health under the Poisons Act 1971 to streamline both of the necessary application processes required for cannabis access in Tasmania.

We have access in Tasmania to some cannabis products, and the name of the medication escapes me. Anyway, it is in the Poisons Act - the cannabinoid medications are listed there. They are very limited; there is also a synthetic form, as I understand it generally.

It is not like this is a completely foreign concept. What we are talking about here is providing controlled access to a regulated product that is consistent in its dosage and its purity, to provide to - what I understand the request is, and has always been - a small number of patients with specific conditions that do not respond to other conventional medicines.

The requirement is that Jeremy Cleaver has to try every medication that is available before he can use this, when they have tried so many others. They know medicinal cannabis does work.

I visited the family and met Jeremy. I think it is really sad. If he were your child, what would you do?

When Lara Giddings was trying to get some progress in this area, she was advocating on behalf of families with young children with severe intractable epilepsy, a similar sort of thing. Those families were also using medicinal cannabis because it was the thing that worked.

It is not like we are creating a whole generation of drug abusers. I do not know why we get stuck in this mentality.

Anyway, it is good to see an old former copper supporting this sort of approach. As I said, by interjection, it is nonsense to think that you have a law that the police will ignore most of the time, if not all of the time, because it is a silly law.

You deal with that. You change the law. That was the case back in 2014 when we debated this committee report. Why keep a law that is being ignored in a category?

We are not asking for a free-for-all there, either. We are asking for limited access - people are already using it - to give them the comfort of not having the police drive up the

driveway and arresting them because it is illegal. We know that. If it was your child, what would you do?

Mr President, I support the motion. I hope that we will get to see some action on this - not just for Jeremy Cleaver and his family but for all others who currently use and need it and those who may in the future - and to take a more strategic and consistent approach across the country. Sure, you could continue the research and looking at the long-term effects, but you cannot assess long-term effects unless you actually use it long term. This whole argument about potheads and things like that - we are not talking about drug abuse. We are talking about medicinal use. That is what we need to focus on.

I thank the member for bringing this motion on and I look forward to other members' contributions.

[4.05 p.m.]

Ms ARMITAGE (Launceston) - Mr President, I also thank the member for Windermere for bringing this motion forward. It has been an ongoing issue and we have all had representations from many constituents over a long period of time. There is no predetermined list of conditions for which a cannabis medicine can be prescribed. However, the Commonwealth department of Health indicates numerous health conditions potentially can be treated by the use of such medicine, including epilepsy in children and adults, multiple sclerosis, chronic non-cancer pain, chemotherapy, induced nausea and vomiting in cancer and palliative care. Quite a significant range of conditions and associated symptoms could potentially be treated and alleviated by allowing sufferers access to cannabis medicine.

The Therapeutic Goods Administration, which currently oversees the administration of access to cannabis medicine, specifically refers to such treatment as not being a cure-all, but one which is evidence-based and considers the patient's individual circumstances. The TGA says evidence suggests that when used in conjunction with other treatments, medicinal cannabis may benefit some patients with specific conditions. Moreover, the TGA stipulates the provision of cannabinoid - CBD - is on a last-resort basis and only to be approved when other treatments options have been tried and failed.

At present in other Australian jurisdictions, CBD is available by prescription only, made by a registered medical professional. A doctor makes his professional judgment by assessing the patient's symptoms, family history, and other treatments that have not had the desired effect on their symptoms. To me, these are reasonable and fair conditions to apply to access to an apparently very potent medicine, which is also still very much in the experimental stages of research.

We cannot, however, ignore the direction the current levels of evidence point us. Cannabis medicine can have manifestly positive benefits on a variety of conditions, something which is supported by both quantitative and current scientific evidence. This is not helped, however, by the fact there is no authoritative high-quality evidence on the safety, effectiveness of unregistered cannabinoid products for any medical condition. As a result, in Tasmania, the medical cannabis Controlled Access Scheme requires relevant medical specialists on referral from a patient's general practitioner to apply for an authorisation for each patient they wish to trial the product. This is clearly a quite significant undertaking which takes a lot of time and resources. I understand little research has been done into examining the long-term effects of

medicinal cannabis on a person's health considering all the variables at play, including the long-term effects of a significant illness on a person's long-term prognosis.

It is understandable that reliable evidence, one way or another, will take a long time to come through; however, this is exactly what sufferers of these illnesses lack - time and care for the long term. These people are sick and in need of relief now. It is important to emphasise just what a significantly positive effect cannabis medicine has for some people. A constituent some time ago sent me pages and pages they had kept on their child's neurological condition. Over time, this person suffered dozens - perhaps hundreds - of grand mal seizures, incontinence, dribbling, difficulty in speaking and slow movement. On one day alone, this person suffered 14 grand mal seizures. This does not even begin to consider the mental and emotional toll these physical symptoms had on this person's life and that of their family and carers.

At the time these constituents came to see me, their GP had advised them that while the prescription of CBD would likely have extremely positive effects on this person's condition, the process, under the Controlled Access Scheme, was just beyond them. Of course, this person was on a cocktail of other medications in an attempt to treat their primary and secondary symptoms. These included valium, a relaxant; prednisolone, a steroid; phenobarb, a barbiturate; and an assortment of others, each with their own side effects. It is difficult to comprehend why the process to acquire one medicine to go off these others, which were not working anyway, was so difficult, and why we could abide letting this person continue to suffer this low quality of life.

Early in 2020, the Senate Community Affairs References Committee handed down a report into the current barriers to patient access to medicinal cannabis in Australia. Of the 20 recommendations of this committee, I will refer to just numbers 10 and 11.

Recommendation 10 was that the Council of Australian Governments Health Council develop a national framework for medicinal cannabis access, to set out goals for further harmonisation of related federal, state and territory laws. Recommendation 11 was that the Tasmanian Government immediately join all other jurisdictions in participating in the Therapeutic Goods Administration's single national online application pathway for accessing unregistered medicinal cannabis and reducing state-based requirements for medicinal cannabis approval.

The same Senate inquiry estimated that of the unknown number of people who have tried to legally acquire medicinal cannabis through the Tasmanian Controlled Access Scheme, only 17 patients have been granted access to the medicine. This follows a very detailed process. First, a person seeking medicinal cannabis must be referred by the GP to a specialist, who must then make application to the Tasmanian Department of Health for assessment by a multidisciplinary expert panel of clinicians. If the prescription is authorised, the medicinal cannabis product must then be dispensed through a Tasmanian hospital pharmacy.

As an aside, I note that this scheme is fully funded and patients who receive access pay only the Pharmaceutical Benefits Scheme co-payment amount. However, despite this, the Senate inquiry report states -

> It was a widely held view that not allowing Tasmanian patients to access medicinal cannabis outside of the CAS is putting them at a significant disadvantage to the rest of the country.

Many patients, their families and carers simply and understandably do not have the wherewithal to go through the entire CAS process, only to be rejected at the end.

As a result, many Tasmanians feel compelled to obtain cannabis unlawfully. We should not allow the state of Tasmanian law to criminalise people who are seeking help. That is neither productive nor just. A further benefit of lowering the barriers to access medicinal cannabis is also the particular scientific type. As I understand it, cannabis bought from drug dealers, for example - that is, marijuana grown hydroponically or outside, then smoked or ingested - contains higher levels of THC, the part of the drug with psychoactive properties. Medicinal cannabis in the form of oil or pills, I believe contains lower THC, but higher amounts of CBD. This has the twofold benefit of delivering the symptom-alleviating properties that the cannabis possesses without inducing the psychoactive high that a person gets when they smoke regular cannabis.

We should remember that people who are seeking medicinal cannabis are not doing so in order to get a high. They are doing it to access the symptom-relieving effects it has on conditions which significantly impair their quality of life. It makes complete sense to reduce barriers to access medicinal cannabis if we have appropriately robust legislation and guidelines overseeing that access. I do not understand what value is added by the Tasmanian CAS requiring a specialist to assess a patient's suitability for medicinal cannabis when a person's general practitioner knows them and their conditions better, and has done for a longer period of time.

Reducing these barriers also makes financial sense, not just for people who are legitimately trying to access this medicine, but also for the state, which subsidises access for many people to access these specialists. What are we also saying about our GPs if we do not trust them enough to exercise the appropriate level of professional judgment in assessing a patient's suitability for medicinal cannabis? It all seems very inconsistent to me.

What I am saying is that for the limited use of that CBD that is being proposed here, the evidence we have now is probably enough. For the purposes of making laws that will benefit the class of people it is supposed to, bringing Tasmanian legislation in line with other jurisdictions - that is to say that GPs are trusted as the medical professionals they are to prescribe cannabis medicine - and it will have the benefits that are intended.

We are in the unique position to learn from the approaches taken in the other jurisdictions and to implement quickly, efficiently and appropriately a CBD prescription scheme in Tasmania that will have the added benefit of freeing up resources being expended on the current processes under the Tasmanian Controlled Access Scheme.

This is not to say that prescription of cannabis medicine should be taken lightly, nor should a very liberal approach be taken to implementing a prescription scheme in Tasmania. Many factors need to be considered; however, I definitely support an approach that takes a cautious, reasoned approach which relies on current best evidence that could bring life-changing relief to some people in the shorter term.

I certainly support the motion before us.

[4.16 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, today's motion is concerned with medicinal cannabis. It asks the Government to further consider the legislative framework regulating the access and use of medicinal cannabis in Tasmania.

As members are aware, medicinal cannabis has been able to be prescribed in Tasmania since 2017 in accordance with a Controlled Access Scheme - CAS. The scheme allows patients to access medical cannabis lawfully for treatment under well-established processes for all unproven and unregistered medical products.

Under the framework established by the Tasmanian Poisons Act 1971, medicinal cannabis in the form of cannabinoid is regulated as a restricted substance. Medicinal cannabis in other forms is regulated as a narcotic substance. In each case, approval by the secretary of the Department of Health is required for patients to access these products.

This process supports the safe and responsible use of medical cannabis products through the rigorous assessment of applications informed by evidence and expert clinical advice. This process is required because unlike other medicines, most medicinal cannabis products have not been assessed by the Therapeutic Good Administration as safe, efficacious or of sufficient quality to permit inclusion in the Australian Register of Therapeutic Goods.

Therapeutic goods can be lawfully supplied in Australia through two main pathways. Medical cannabis products entered to the Australian Register of Therapeutic Goods may be accessed in accordance with the framework established by the Poisons Act and regulations.

The Therapeutic Goods Act provides the standard for the uniform scheduling of medicines and poisons, also known as uniform standards.

The uniform standards reflects decisions made by the secretary of the Australian Government Department of Health about the classification of medicines and poisons into schedules. The schedule and classification sets the level of control on the availability of medicines and poisons in Australia.

Tasmania's poisons legislation adapts the uniform standard and reflects this classification. Medicinal cannabis products that are not entered to the register may be accessed by the the Therapeutic Goods Administration Special Access Scheme, Authorised Prescriber Scheme or in clinical trials.

In Tasmania, approval through CAS is required and that complements the Therapeutic Goods Administration Special Access Scheme. The Controlled Access Scheme is a well-established mechanism to support the safe and responsible use of unregistered medicinal cannabis products in Tasmania. It allows Tasmanians with a serious illness which has not responded to conventional therapies access to unregistered medical cannabis products when prescribed by a suitably qualified relevant medical specialist.

The CAS is specifically designed to support the safe and appropriate use of unproven medical cannabis products through the rigorous assessment of applications informed by evidence and expert clinical advice.

This is the same process applied to all other unproven medicines access through the public health system in Tasmania. It is important because the Therapeutic Goods Administration does not vouch for the quality, safety or effectiveness of unapproved products assessed through the Special Access Scheme.

To protect patient safety, Tasmania's scheme requires standard evidence-based treatments to be exhausted before unregistered medicinal cannabis products are trialled.

The CAS is not condition-specific and any relevant medical specialists present and practicing in Tasmania may make application to access these unproven medical products for their patients in accordance with the scheme requirements. The CAS is supported by robust processes applied to unregistered medicinal cannabis in the same way they are applied to other costly medicines with limited evidence. Importantly, the Tasmanian Government is the only government in Australia to subsidise the cost of highly expensive unregistered medicinal cannabis products and to make their potential benefits accessible to all Tasmanians, not just those who can afford to pay.

The most any approved Tasmanian patient will pay for an unproven medical cannabis product under the controlled access scheme is the applicable Commonwealth PBS patient co-payment each time the product is dispensed, which is $41 or $6.60 for concessional healthcare patients. As identified in the Senate inquiry, one of the major impediments for patients accessing unproved medicinal cannabis products experienced in other jurisdictions is the cost, which has been reported to be thousands of dollars for some products.

Public health advice has consistently been that the safest and most responsible way these products can presently be prescribed is through a specialist referral model. This ensures the management of a patient's condition is optimised with existing proven therapies, before resorting to unapproved medical cannabis products. This is not uncommon for highly specialised products, such as some cancer medications. The implementation of the Controlled Access Scheme does not change the status of cannabis as an illegal drug in Tasmania, when grown without a licence or possessed without having been prescribed by an authorised specialist medical practitioner.

As members may know, it is an offence under the Tasmanian Misuse of Drugs Act 2001 for a person to cultivate, possess, use, supply or sell cannabis. The Australian Government's Criminal Code Act 1995 also makes certain dealings in relation to cannabis unlawful. Of course, any decision regarding offences and prosecutions is a matter for Tasmanian police and the Director of Public Prosecutions. Since the Controlled Access Scheme was implemented in 2017, approval to access the medicinal cannabis products in a clinically sound way has been granted to Tasmanian patients demonstrating the scheme is working as it was intended, striking the right balance between access and safe prescription of unproven and unregistered products for vulnerable Tasmanians.

The Government is committed to ensuring Tasmanians have access to medicinal cannabis in a sensible, responsible and evidence-based way. We have cleared the path on this issue and the Tasmanian approach has received strong support from stakeholders during the development

of the scheme, including the Australian Medical Association, the Royal Australian College of General Practitioners Tasmania and Epilepsy Tasmania amongst others. The Tasmanian Government will continue to support the judgments of our specialist clinicians and always take advice from public health experts on how we allow access to unproven and unregistered medical products. We will also continue to work collaboratively with the Government, other states and territories to ensure access to these unproven products is safe and consistent with high-quality evidence-based clinical guidelines.

A question was asked about the numbers; since November 2017, 39 applications under the CAS have been submitted by relevant medical specialists for 27 patients, resulting in 17 approvals for 16 patients. One patient was approved following re-application when the original approval had lapsed.

The other question was related to the TGA and the TMAAC approvals processes. To be clear, the Therapeutical Goods Administration and the Tasmanian Medical Access and Advisory Committee serve different purposes and approval processes, but operate concurrently. The TGA is responsible for scheduling assessment and registration of medicines in Australia, including approval to import unregistered products through the Special Access Scheme. Individual assessments of patients are not conducted by the TGA when assessing applications. TMAAC is responsible for ensuring the quality and cost-effective use of medicines in Tasmania through the Tasmanian hospital system. An individual risk or benefit assessment of applications occurs to ensure experimental use of unregistered medicines is safe and appropriate in the clinical setting and allows for subsidised treatment.

This assessment informs the secretary of the Department of Health's approval. I thank the member for bringing on his motion. I am sympathetic to the reasoning behind the member putting the motion forward and recognise the many challenges faced by Tasmanians suffering debilitating medical conditions. However, the Government does not support the motion, but rest assured it has been noted.

[4.26 p.m.]

Ms RATTRAY (McIntyre) - Madam Deputy President, I rise to place on the record my support for the member's motion and particularly thank him for bringing this forward today. This is something that obviously has, as the member for Launceston indicated, been raised with many members of parliament over many years.

When I saw this motion, my mind went back to a constituent of mine. We all received a letter back in 2014 from Beverley Rubenach and her family - Beverley and Peter - for their son Tim, who lived at St Marys. They shared their story about Tim's condition and his challenges living with having epileptic seizures as a result of a brain injury. He was about 28 years of age and had been prescribed a range of anticonvulsant medications.

Sadly, Tim passed away on 22 May 2018. He had to access his medicinal cannabis through friends who provided that substance to him, and that supported his family to be able to cope with Tim to stay at home. Tim stayed at home and his family cared for him right through until May 2018. The Rubenach family has been very proactive in their support for medicinal cannabis to be made available to people who need it under circumstances that have been spoken of quite eloquently around this Chamber so far on this notice of motion.

They also made representation through end-of-life choices and they attended the St Helens seminar. The member for Mersey will remember Mr and Mrs Rubenach being there, sharing and indicating their support at that time, given what Tim had experienced in his life.

I pulled out the letter and will not go over it in any fullness, just to again thank the Rubenach family for continuing to support others in the community and share their story of Tim's challenges in not being able to access legally medicinal cannabis in his time of need. That was the momentum for me to support at that time, but also to continue to support this approach today.

Members will note that in question time I received some answers, because I had recently had representation from a constituent of mine who is accessing medicinal cannabis through a doctor in Sydney, and the medication is dispensed through a pharmacy in Melbourne, then sent through to this particular person in Tasmania.

This is not the approach we need. Again, by interjection, when the member for Windermere was presenting his contribution to his notice of motion, I said we need a consistent and controlled approach here. That is what we need. The member for Murchison talked about the fact that you do not know what level of THC you have when you are buying it or sourcing it from wherever.

I, by interjection again, said it might depend on how much watering a crop has had, or the conditions of the season, all of those things.

We should be able to source that medication in a consistent way. You should not have to be finding your source, and as the Rubenachs said -

> … due to the generosity of friends and acquaintances, we were able to acquire a sample of cold processed (THC has not been activated) medical cannabis oil [for Tim] to try.

The Rubenachs should not have had to do that for their son, Tim.

My constituent should not have to get it through somebody in Sydney, then have the medication dispensed in Victoria and sent over here.

That should not be happening for our constituents. There should be that consistent approach.

Again, I support everything said by the previous speakers - with some exceptions to the Leader, who did not support the motion on behalf of her Government. That is its right.

Mr Valentine - That is why this motion is before us.

Ms RATTRAY - That is right, because it is the policy. I note in the response to my questions and the answers provided - and some of what the honourable Leader has just read out was in the contents of the answers. I thank the honourable Leader for providing me quickly with a copy of that. You cannot take it all in when you are listening.

It said that it is important to note that the Tasmanian Government is the only government in Australia to subsidise the cost of highly expensive unregistered medical cannabis products and make their potential benefits accessible to all Tasmanians, not just those who can afford to pay.

We just note with the numbers that there are only 17 people accessing it - 39 applications and only 17 accessing. What are those other 22 people doing, plus all the other people in our communities who are doing exactly like the Cleavers and finding it, using friends and acquaintances if need be, or growing it themselves?

Mrs Hiscutt - Through you, Mr President, the reason there was a remainder was that they had not exhausted all conventional - whatever it is - medicines for their condition at that stage.

Ms RATTRAY - I acknowledge that is the Government's position, but I recall the member for Murchison talking about the fact that some of those traditional medications are actually worse than what the person is dealing with. They have more negative side effects to what they are dealing with. Nobody is going to go through the CAS process if they have not at least gone through the process with their GP.

In the last few weeks we have put so much faith in the medical fraternity, in our doctors, when we discussed the End-of-Life Choices (Voluntary Assisted Dying) Bill, and the role that doctors play in the lives of their patients. We have talked about that.

Why would they not know and have that understanding of whether their patient is going to receive the relief they need from traditional medicine, or in this case from accessing medicinal cannabis? They would know that, because we trust those doctors who look after their patients to know that, to have that level of understanding.

I believe that if we are going to trust them in that way, we should at least be in line. I know I am not always a supporter of a nationally consistent approach, but in this case I would have to say that when you hear - and I thank the member for Windermere for going through the different states, and outlining which ones have the right process in place - that Victoria, New South Wales, Queensland, South Australia, Western Australia, Australian Capital Territory and Northern Territory are doing things a little differently, and here is Tasmania lagging at the bottom of the pack.

My particular constituent - because the questions I asked were around PTSD, certainly not the epilepsy path - but still, this particular person is able to have a more normal and functioning life because of the access to medicinal cannabis.

Again, as I said, a doctor in Sydney, a pharmacist in Victoria. That was the basis of my questions. I do not believe I have enough answers to go back to my constituent at this point, but I believe that, as a House of parliament representing our community, this is a really useful process and vehicle to continue to push the Government to look at their policy.

I know the Leader will make sure that the minister and her Government take on board the contributions made by members, because we are representing our communities. I absolutely do not support the use of drugs in any way, shape or form, other than for medicinal purposes. That is what we are asking for here.

We are asking for access for medicinal purposes.

The reason the Government has been so generous in subsiding - the only government in Australia to subsidise - the cost of highly expensive unregistered medicinal cannabis products, and make their potential benefits accessible to all Tasmanians, not just those who can afford to pay, is because we hardly have any, I suggest.

I believe that if a contribution were needed, a lot of people in the community would not be at their properties hoping they do not see a police officer coming up their driveway, and feeling very anxious. They would much rather pay some level of money, whether it be subsidised to the level that the Government has been so generous thus far, or whether it be at perhaps a higher level. I expect there would be family who would be willing to support their family member in these circumstances, rather than have their loved ones feeling anxious every time they see a police officer in and around their neighbourhood, wondering if somebody has dobbed them in, or somebody has suggested that their particular loved one may be using, illegally using, cannabis for medicinal purposes.

I do not think I need to make too many more points about this. From what I am hearing, it is very obvious that there is support in our communities, very much so, for the access to and the use of medicinal cannabis where a GP has made a decision that their patient meets the criteria.

Mr Dean - In Tasmania's case, a specialist.

Mrs RATTRAY - We talked about access to specialists, weeks ago. For the last however many weeks.

Mr Dean - I have been trying to access a specialist now for about three months.

Mrs RATTRAY - And who knows their patients best? Their GP.

It should not need a referral to an appropriate specialist. We talked about the value of a GP, your own local doctor or your doctor, whether they be local or whether they be a locum, or whatever they be. If they are your GP and they know you, and you meet the requirements, and you have done what you can through traditional medication, and it is not working for you, you should be able to access medicinal cannabis, in my view.

Again, I congratulate the compassionate former copper on his devotion to this, and certainly representing the Cleaver family, in this regard. I again thank the Rubenach family which has continued to advocate for those in our community so that they do not have to live through what the Rubenachs had to while their son, Tim, was on this earth.

In respect for the Rubenach family, I need to support this, and I will continue to support this particular avenue that the member is asking the Government to support.

We will not give up on this.

[4.42 p.m.]

Ms PALMER (Rosevears) - Mr President, when I was doorknocking during my election campaign, in the beautiful part of Rosevears, Grindelwald, quite a quaint and peaceful part of the electorate, I knocked on the door of Scott and Katinka Hudman. At the time our conversation was totally based around voluntary assisted dying. Katinka shared with me about her mother's journey in that space.

Since then we have exchanged a number of emails and the issue of medicinal cannabis has come up. Now it has not come up just out of interest on the matter, but out of desperation for Katinka who has multiple sclerosis, to stop the constant spasms that occur throughout the day and that keep her awake at night.

I can certainly relate to this, Mr President, having watched my own dad suffer from very painful spasms, also as a result of MS. It was a daily task, where he would yell out from his chair or his bed for my brother and me to run to him to push his foot against the spasms to try to stop the pain.

So, I contacted Katinka, and I asked her if I could share a little bit about her story in this place today. She agreed to that.

In 1992, at the age of 42, Katinka, a registered nurse of over 20 years' experience working in rehabilitation, was diagnosed with relapsing-remitting multiple sclerosis. Like many MS patients, her disease progressed to secondary progressive MS. That means Katinka is steadily and slowly deteriorating without any possibility of recovery.

We move forward now, some two decades, and this is a snippet of her daily life, her daily challenges in her own words -

> I have learnt to live with continuous pain, spasms, fatigue, incontinence and severely reduced mobility. I have learned to cope with my ever-changing limitations with the use of scooters, splints, incontinence aids, and many adaptations to daily living arrangements requiring walking frames and learning to accept help.

Katinka has been very clear in what she has sent to me. She is not looking for pity. She does not want or need pity. What she says she needs is help to reduce the intractable nerve pains and spasms, especially in her legs and feet, because she just cannot sleep. Her nights are continuously broken by pain.

The only time in Katinka's life where she has found relief was a period of time when she lived in Europe. Here, she was able to access medicinal cannabis through the Netherlands MS society. Unfortunately, after she moved, this was no longer available to her and she recommenced taking numerous drugs to try to maintain some quality of life.

The list of drugs is quite long and to be honest I actually cannot pronounce half of them. The only drug that actually stood out to me was Baclofen, which was a drug I remember hearing as a child that my father had used.

I understand this is a muscle relaxant, an antispasmodic agent and the side effects can include daytime drowsiness, nausea and issues with bladder control. After Katinka shared her

story with me, I contacted our Health minister, Sarah Courtney, to ask where the Government was at with medicinal cannabis and its availability in Tasmania.

The minister responded to our request for help in this area, setting out the pathway for Tasmanians to access treatment with these unregistered products. The member for Windermere has already touched on this process but I would like to refer to the response I received from the minister.

It begins with a general practitioner consultation, then a referral to a specialist medical practitioner in a relevant field of practice. Public Health advice has consistently been that the safest and most responsible way these products can presently be prescribed is through a specialist referral model. This ensures the management of their condition is optimised with existing proven therapies before resorting to unapproved medical products, and the member for Windermere touched on this.

This is the established clinical practice pathway for assessment of any treatment of a refractory medical condition, not just unapproved medical cannabis products. Once the specialist medical practitioner considers an unregistered medical cannabis product is safe and appropriate for the patient, they then seek legal authority from the secretary of the Department of Health to prescribe and it is reviewed by the Tasmanian Medicines Access and Advisory Committee.

Unfortunately, Katinka hit a hurdle at the very first jump. Katinka told me her GP was unable to help her in this space so her journey continues and tonight, again, she will have a night with broken sleep.

All medicines can be used for good or for bad. Endone is a highly addictive pain killer. Yet at times it is the only way my mum can actually control the extreme pain in her leg following her hip replacement surgery. Pseudoephedrine used in amphetamines, great as a nasal or sinus decongestant, is also found in numerous filthy party drugs.

There can be great goodness and certainly relief found in medicinal cannabis products. I am pleased the Tasmanian Government is continuing to diligently and carefully move in this space. In 2016 the Tasmanian Government commenced the Controlled Access Scheme, which the Leader spoke about, allowing relevant medical specialists the option of considering unregistered medicinal cannabis products. The CAS is not condition-specific. Any relevant medical specialist practising in Tasmania may make application if the illness or condition has not responded to conventional therapies, and it is considered by the specialist that the use of an unregistered medical cannabis product is safe and appropriate for the patient.

The CAS continues to support the safe and responsible use of unregistered medical cannabis products informed by evidence and expert clinical advice.

Of course, I deeply sympathise with Tasmanians suffering chronic and challenging medical conditions and I acknowledge the struggle that they face on a daily basis. While the Government does not support the motion, it has been noted and the minister for Health and the Government will continue to work to improve health services and to do all they can to support our fellow Tasmanians. I will be watching closely and supporting the Government's movements in this space because I believe Tasmanians are counting on it.

Before I sit down, I have one more answer on behalf of the Leader. This is for the member for Murchison. The question was in regard to ministerial influence on TMAAC and the list of memberships. TMAAC members provide clinical advice based on their relevant expertise. The committee membership is based on the specialities required for the application and may change depending on the expertise required. The committee membership is made up of representatives from infectious disease, oncology, haematology, psychiatry, gastroenterology, rheumatology and paediatrics as well as specialist pharmacists and consumer representatives, which reflects the scope of applications routinely assessed by the committee.

Ms Forrest - From the ministerial interference?

Ms PALMER - I beg your pardon?

Ms Forrest - Did you want to talk about the ministerial control or input?

Mrs Hiscutt - I am sorry we are not able to answer that at the moment.

[4.51 p.m.]

Mr GAFFNEY (Mersey) - Mr President, I rise to speak with a feeling of great sympathy for the predicament Jeremy Cleaver and his family faces on a daily basis. I thank the member for Windermere for raising this issue in the place so we may offer our thoughts. It is interesting listening to all the previous speakers - and I thank them for their contributions - but I thought, well, I should take that out and take that out and if I take all those parts out, it will not make sense in my speech.

So, I apologise if I repeat things, but, hopefully, I will be able to provide some more information. Like a number of members, I was part of the inquiry committee that investigated the use of natural botanical medicinal cannabis flower and extracted cannabinoids for medical purposes. As members may recall, this inquiry was brought to a close in light of developments at a national level in consideration of the use of cannabis in a medical context - namely, the introduction of the Regulator of Medicinal Cannabis Bill 2014 as a joint private members' bill with cross-party support and the subsequent referral of this bill in 2015 to the Legal and Constitutional Affairs Legislation Committee for inquiry and report.

Additionally, the New South Wales Government established a planned series of clinical trials to explore the nature of cannabis for medicine purposes. Trials are ongoing and I can only imagine the impact of the current COVID-19 pandemic on the management and conduct of this essential research. Looking into the broad terms of these trials, we see stated on its official website that the New South Wales Government has provided over $9 million towards clinical trials in three areas to evaluate the safety and effectiveness of cannabis medicine to -

(1) reduce seizures in children with severe treatment-resistant epilepsy through a partnership with the Sydney Childrens Hospital Network;

(2) improve appetite and appetite-related symptoms in adult palliative care patients with advanced cancer;

(3) prevent chemotherapy-induced nausea and vomiting in adult patients where standard treatments have proven ineffective; and,

(4) improve the control of symptoms including pain, nausea, and lack of appetite in advanced cancer patients.

They state that sufficient evidence collected from these high-quality clinical trials could help lead to registration of a cannabis medicine by the TGA, listing on the Pharmaceutical Benefits Scheme and, potentially, patient access at a subsidised price. Thus, there is hope that robust clinical data will emerge from these trials that can inform future policy and regulation.

In the meantime, we face the problem of how to allow safe access to what some see as a life-changing naturally occurring remedy that can improve the management of their condition against what many consider to be a gateway drug into potential dependency and criminality. Maybe the impact of medical opiate dependency is an additional and intangible factor in official reticence to open up access to cannabinoid remedies.

I am mindful that since our inquiry, the Tasmanian Government has developed the medicinal cannabis Controlled Access Scheme to allow defined medical specialists the opportunity to prescribe medicinal cannabis in the form of unregistered cannabinoid products where conventional treatments may have failed to give relief. Although only in limited circumstances - and, as the member for Windermere describes for his constituent - only when all conventional treatments have been tried and failed.

The Government appears to be unique in Australia in that it has, in its own words, heavily subsidised the cost of the commercially produced cannabis medicine product. Interestingly, a quick search finds such a medical specialist in Hobart advertising an initial consultation fee of $199 with the special offer of the conditional promise of guaranteed approval or your money back on your first consultation.

Maybe this is not necessarily the nature of a heavily subsidised service the Government or potential patients and their families envisage. What we also see are reportedly very low numbers of people actually accessing these services, with a recent media report suggesting only 16 applicants to the CAS scheme have been approved. This is from a total of 35 applications in just over three years the scheme has been operating.

In essence, have we created another set of barriers whereby legal access requires a bureaucratic and regulatory framework that could be said to focus on the needs of regulators over that of patients? One of the recommendations from the inquiry reports was to decriminalise possession and administration of cannabis products on compassionate grounds for people using them for medical purposes. This was a recommendation the Government declined to support on the grounds there is the absence of a regulated framework to support this, as it is an illicit drug in law. Any police officer is compelled to investigate and report and/or seize any material thus discovered.

However, it was pleasing to note that Tasmania Police has stated it will not actively pursue people who make claims to be using cannabis products for medical purposes. It does, however, place such normally law-abiding people in the legally conflicted limbo the member for Windermere described. If we look to New South Wales as a host state of the clinical trials, we see it does have in place a medicinal cannabis compassionate use scheme that perhaps offers a model that could be adapted and enhanced for Tasmania. To quote from its website -

> …the Medicinal Cannabis Compassionate Use Scheme provides guidelines for NSW Police officers about using their discretion not to charge adults with a terminal illness for possession of cannabis not lawfully prescribed if they are registered with the Scheme, as well as up to three registered carers.

With this comes a series of helpful resources and registration forms for both medical practitioners and potential applicants available from April this year. It allows a GP to authorise the patient and carers to retain and administer cannabis-based products by confirming the patient's terminal diagnosis, whilst not being required to endorse the use of the cannabis as a treatment option, thus neatly sidestepping the conscientious objection issue that can cause barriers to equity of access. The provisions in both New South Wales and Tasmania in no way allow an individual to cultivate cannabis for such use, a route that would allow a possibly lower cost option for both patient and government, although it comes with the perception the cultivation of high-THC cannabis could lead to inappropriate use by others.

However, as we are only talking about just over 11 applications to the CAS scheme in a year, half of which were unsuccessful, it does not seem to be a huge issue for the Government to find a way to accommodate the expectations and hope of those in genuine need. In these cases, hope may well be a powerful restorative to someone in need of relief. There are many anecdotal reports of patients accessing CBD products via unconventional routes, some of which do put people at risk of prosecution. However, it is gratifying to see a recent media article pointed to a recent interim decision from the TGA proposing low-dose CBD products be classified to be available to Australian patients in consultation with their pharmacist.

I genuinely hope this option is one that can be adopted by the Government, as it does relate to CBD as a cannabinoid derivative that has no psychotropic effect on a person. Additionally, I have heard anecdotal reports CBD products are often sought out by people in pain as another option to try as a potentially low or no-risk plant-based remedy. Some of which suggests for a person with an eight out of 10 pain, a CBD product may reduce it to a six out of 10. This is not to say there is a suggestion it is a consistent effect or one based on clinical trial findings - it may offer potential relief for some and nothing at all for others - on an experimental 'try it and see' basis.

Within all this, we face another current conundrum whereby legal access requires a bureaucratic and regulatory framework that can be said to be system-centric rather than patient-centric. I can understand the concern of medical and research professionals that these products need to be properly regulated with consistent treatment and dosage protocols in place, together with an understanding of any possible side effects. It could also be argued that black market CBD material is apparently a loose and unregulated product that possibly borders on the anecdotal nature of the efficacy or not of homeopathic remedies. What we have is a complex issue where there seems to be no absolute right or wrong answers, just suggestions that we need to ask further questions to establish what is appropriate.

I fully support the Government's approach in terms of working collaboratively with the New South Wales clinical trials, but at the same time I wonder if there is the opportunity to revisit its opinion of the findings of our inquiry into legalised medicinal cannabis.

There was a suggestion in the final report that we might keep a watching brief on the developments of this subject, both at the federal level and in other jurisdictions. Five years

have now elapsed since our inquiry reported its findings and made a number of recommendations, some of which have been accepted and enacted while others have not.

We have an opportunity to revisit what is appropriate in a modern-day world that is coming to terms with the implications of the long-term impact of the COVID-19 pandemic. Additionally, if we sought to do this on a formal basis, we would need some fresh terms of reference, and perhaps a new committee of inquiry. Maybe now, or in the very near future, is a time for this. Its terms of reference could also be broadened to include a holistic review of pain management and support service options within Tasmania, especially those within our outlying regions.

If a new inquiry as an extension of the learnings from our last one is not deemed to be the appropriate next step, the very least our current Government may need to revisit is how Tasmania's legislation may be more symbiotically aligned with that of the Australian Government and our fellow state and territory jurisdictions.

Perhaps this needs to be actioned as a matter of urgency, as we all have constituents who need our support in helping them to improve their wellbeing and enjoyment of life, especially those who are struggling to cope with seemingly irresolvable medical conditions that come with a range of difficult-to-manage chronic medical issues, including persistent pain and other forms of suffering that inhibit their daily lives.

I thank the member for Windermere for bringing on this motion, and I am pleased to add my support.

[5.02 p.m.]

Dr SEIDEL (Huon) - Mr President, I did not prepare a formal speech, but please allow me to make a couple of comments, because it really is an interesting area we are dealing with. When we talk about health legislation and regulation, I think we should focus on one thing and one thing only - and that is the patient. We have to be committed to ensure that the legislation and regulation are meeting the needs of patients. That is all - it is not that hard.

It is clear, listening to members, that the scheme we currently have in Tasmania certainly does not meet the needs of vulnerable patients who have tried everything else in the medical textbooks and do not find answers there, and therefore are looking for alternatives and find relief in medicinal cannabis products that currently are unapproved and unregulated.

It is fair to say, and I have mentioned this before, that prescribing, regulating and accessing medicinal cannabis in Australia is pretty much a basket case. It is what it is. For years, I have been asking for a nationally consistent regulatory framework for access and prescribing medicinal cannabis. It should not be that hard.

Realistically, when I was national president of the college of GPs, we had positive meetings on a federal level with the federal Minister for Health, the honourable Greg Hunt. He was committed to introducing a nationally consistent regulatory framework. To do that, you would need to get the states on board, so my role was to speak to respective state health ministers on that.

I did not have much luck with the Tasmanian Health minister at the time, Michael Ferguson. It did not make any sense to me at the time why you would consider unnecessary

barriers and create unnecessary burdens, considering that we could focus on the national body - and TGA was proposed as the one-stop shop for approving medicinal cannabis products. It did not make any sense, so we progressed it in January 2018.

Other states, like New South Wales, committed to a framework, and reduced their barriers. In March, New South Wales decided just to have the TGA as the one-stop approval point, and it was meant to be discussed at a Council of Australian Governments health ministers' meeting in April 2018. I know they did discuss it, but unfortunately Tasmania stood quite firm and said, 'No, we are not going to be involved; we do what we do.'.

And here we are in 2020 when it does not seem to work and it is completely unnecessary.

I am getting a bit upset when I am hearing, 'Well, but we have a special access scheme and compassionate access scheme, and we are the only state in the Commonwealth that subsidises medicinal cannabis when approved.'.

That is fair enough, but it is almost like a spin doctor talking rather than a real doctor talking, because you could do this so much easier. You just commit to subsidise each and every medicinal cannabis product that is also approved by the TGA. End of story. The secretary of the Department of Health could do that, or her delegate could just stamp 'Approved'.

There is no need for an extra committee. There is just no need, because the product is already approved. The application has been made to the TGA; the TGA has appraised the application; and if the TGA approves it, because it feels it is appropriate for this patient to have access to medicinal cannabis, why would you need to have another body approving what is approved? That body in Tasmania could just say, 'Yes, if it is approved by the TGA, we subsidise it.'. That is it.

If we want to reduce red tape, we can do this now. We do not have to wait for anything. Trust the TGA to do the right thing - and it is doing this nationally in each and every state anyway.

To be frank, cannabis is not that special. It is just medication, you know. It is not that special. It is not that different to other medicines, really.

Ms Forrest - It is a lot less toxic.

Dr SEIDEL - I will come to that in a minute. If we look at things that are readily available - like opioids, for example - that seems to be straightforward. Anybody can prescribe it. Junior doctors can prescribe it.

Ms Forrest - It is much more harmful.

Dr SEIDEL - Much more harmful, but I remember when I went to medical school, we were told nobody should be in pain, and the solution for pain is to prescribe opioids. When I was a GP, we got called out because GPs were not prescribing enough opioids.

Ms Forrest - Look at the opioid crisis all around the world now.

Dr SEIDEL - And we were told it is safe, and we should be prescribing more, and how dare we GPs - we are not educated enough because we do not prescribe opioids? That was the big industry push, and pain specialists were trained and pushed us GPs to prescribe, and see what happened. We were told the evidence was great. All the guidelines said the evidence is really strong - and 20 years down the line, we have another problem. A huge issue, and it is getting worse.

Now we know opioids do not work for chronic pain, but we prescribe it regardless, and we approve it regardless, and the PBS subsidises it regardless.

It does not make any sense, but for medicinal cannabis, which is not a panacea for all, but might well be the appropriate medication and treatment of last resort for a small number of people - a last resort for a small number of people - we just create these unnecessary artificial barriers. It does not make any sense.

It does not make any sense from a scientific point of view. It does not make any sense from a medical point of view. It does not make any sense from a commonsense point of view.

We are failing our patients, and we have heard the stories over and over again, and it is sad.

Honourable Leader, when the Tasmanian scheme was introduced, I certainly referred a patient of mine with chronic pain. We had tried everything - absolutely everything. All the standard medicines. We did acupuncture, we did psychology, we did exercise physiology - you name it, he has done it.

I referred him for an assessment to consider medicinal cannabis, and I had a handwritten letter back, 'We do not offer that service', and then the patient stays where he is.

He said, 'Well, I will just have to grow my own then', because he was not going to use any of the other stuff I have tried. I have tried the lot.

So again, it is not many, but there are patients out there that the current scheme as we have it now is failing. We continually say we are the only state that financially subsidises medicinal cannabis, but I am not sure that is going to fly.

I will talk a bit about what we are looking for with evidence. I heard what the member for Mersey said with regard to more trials, more science. Yes, scientists and medical researchers always ask for more trials and so forth and that is great. But I want to put on record there is conclusive evidence that cannabis or cannabinoids are effective in outcomes for the treatment of chronic pain in adults, as an antiemetic in the treatment of chemotherapy to reduce nausea and vomiting, and for improving patient-reported multiple sclerosis spasticity symptoms - conclusive evidence.

Mr President, that is not my opinion - right, it is not my opinion - it is the opinion and the conclusion of the National Academy of Sciences in the United States of America, which published its seminal work on the health effect of cannabinoids in 2017. Now, remember, that was not a quick review; it was not a hush job, because since 1999, when the initial institute's report was released, an additional 24 000 articles were published and reviewed by the National Academy of Sciences. They reviewed and appraised each and every one of them, and so they

should. There is really nothing the academy can do better tha n appraising evidence - that is what it does. It is a great institution, founded in 1863, funded through a $500 million endowment. It consists of 2000 members and 1000 staff, and 190 of the members have received a Nobel prize. If there is anything it can do, it can establish scientific facts. We certainly have the highest level of evidence, which is from 2017.

Yes, you know there have been more reviews and more science and more research papers since then; of course. There have been. Science is always going to evolve, and it should, but I want to be quite clear we have just one area where there is absence of evidence, which does not mean there is actually absence of evidence either. We have to be really quite mindful of that. It is a difference between absence of evidence and the evidence of absence. Realistically, we in health are doing off-label prescribing already; it is a common practice. Routinely, we are doing off-label prescribing. We are doing this in particular for people at risk, and children. Most of the medicines we use for children have not been through rigorous randomised control trials; they just have not.

We are prescribing based on the safety profile of the medication. We are prescribing based on surrounding science. That is why the member for Murchison is right, cannabidiol is one of over 100 chemicals in the marijuana plant; it is actually very safe. It is impossible to overdose - you would need half a ton of cannabidiol; it is not going to work. You would be crushed rather than poisoned by it - that is how much cannabidiol you actually need. With regard to THC, it is a bit of a different story - there are potentially psychotic effects, mental health effects; we know that.

But again, we can distinguish that it is entirely reasonable. Cannabidiol has been well studied and we know it is safe. So, if you know it is safe and we know it is indicated, why are we not allowed to prescribe it? It really should not be that hard. We can do this now. Again, we could go on and on. How do we monitor for long-term effects and long-term trials? That has all been discussed extensively. We can do n-of-1 trials; we can do a central register - it is all possible, the models already exist, it can be done tomorrow, it is not that hard. I welcome the availability now of low-dose cannabidiol products as scheduled for pharmacy-only medications. It is a good starting point. It also indicates to the wider public that those medicines actually are safe.

But again, what I also do not want is that patients are now going from one pharmacy to another pharmacy to another pharmacy just to get more and more of those low-concentration drugs. Let us have a commonsense approach here - regulate appropriately and remove unnecessary barriers. The scheme we currently have in Tasmania is a barrier; there is no benefit for it. If you want to subsidise medicinal cannabis, great - subsidise each and every drug that has been approved by the TGA. The TGA now has a turnaround time online of less than four days. GPs could directly refer to the TGA for an approval process. That is how it should work, it is not that hard.

I certainly commend the member for Windermere for his motion and I fully support it.

[5.15 p.m.]

Mr VALENTINE (Hobart) - Mr President, I found it quite fascinating doing a little of reading and research about this topic.

I thank the member for Windermere, who is not in the Chamber at the moment, for bringing on this motion.

It has been interesting to listen to the different opinions, especially those of the member for Huon.

It seems to me there would be a lot of sense in having a national approach to this, because people do not stand still. They move from one state to another. They take their condition with them, and I think it is important, using that patient-centric approach, that it ought to be a decision that covers the nation as opposed to just individual states.

In reading some of the information, I know the member for Windermere went through and talked about the situation in each state. The research done for me looked at professional, private and other aspects that exist around the way medicinal cannabis, or cannabis actually, is dealt with by the different states.

I want to highlight those differences by reading out some of them out.

In Victoria, privately medicinal cannabis can only be legally accessed through your doctor. Growing your own cannabis, or smoking illicit cannabis, for medicinal purposes remains illegal.

In New South Wales, individual patients cannot apply to obtain approval to import and access unapproved cannabis medicines.

In Queensland, you cannot legally produce your own cannabis for medicinal use. Queensland does not have an amnesty scheme.

In South Australia, it is not legal to grow or use cannabis for non-medical purposes, nor do they legalise the cultivation of cannabis or its use outside of regulated medicinal purposes.

Some extras in South Australia. Exemptions apply in South Australia for patients aged over 70 years of age and terminally ill patients, whose doctors have notified the Drugs of Dependence Unit (Notified Palliative Care Patients).

In Western Australia, you cannot grow your own medicinal cannabis. Smoking cannabis is still a highly regulated drug, and it is still illegal to use recreational cannabis.

We know about Tasmania, but the information that came to me through this research is that the scheme does not affect the status of cannabis as an illegal drug that causes significant harm in the community. All Tasmanian offences for cannabis cultivation, possession and use still apply.

In the Australian Capital Territory, people cannot legally cultivate their own cannabis for medicinal use. Possession and supply of all other non-approved cannabis, whether for medicinal or recreational use, remains illegal in the ACT.

In the Northern Territory, the growing and use of the cannabis plant, and all parts of the cannabis plant, is illegal under the Northern Territory Misuse of Drugs Act 1990, which is the responsibility of the Northern Territory Department of Attorney-General and Justice.

An extra there in the Northern Territory - cannabidiol CBD products are Schedule 4 and prescription only, the same as medicines used for medical conditions such as high blood pressure, diabetes, epilepsy et cetera. The prescriber does not need a Northern Territory authorisation or to notify that they have prescribed an S4 CBD medicine.

You can see there is nothing, you would say, that is wholly consistent. In doing the research, I was provided with something from a page of the Alcohol and Drug Foundation. I do not always agree with the Alcohol and Drug Foundation and its stance on different things, but I thought it dealt with this in a significant way.

I will preface it by saying that the note on its page says -

> The information given on this page is not medical advice and should not be relied on in this way. Individuals wanting medical advice on this issue should consult a health professional.

I have not had a chance to verify what I am reading and it is information that is being provided for the record. They go into 'What is medicinal cannabis?' -

> Broadly speaking, medicinal cannabis is cannabis prescribed to relieve the symptoms of a medical condition, such as epilepsy. It is important to make the distinction between medicinal cannabis and recreational cannabis. Recreational cannabis is the form of cannabis people use to get 'high'. For some people suffering from chronic or terminal illnesses, conventional medicines do not work or do not work as effectively as medicinal cannabis. Also, for some patients, conventional medicines may work but cause debilitating side effects that cannabis can help to relieve.

The member for Huon pointed that out very carefully for us -

> What are cannabinoids? The main psychoactive ingredient of cannabis is tetrahydrocannabinol (THC), which acts on specific receptors in the brain known as cannabinoid or CB1 receptors. Research has found that the cannabis plant produces between 80 and 100 cannabinoids and about 300 non-cannabinoid chemicals. The two main cannabinoids that have been found to have therapeutic benefits are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).

Which other members have talked about -

> There have been claims that a number of other cannabinoids have therapeutic properties but these have not yet been proven. The main difference between the two cannabinoids is that THC has strong psychoactive effects, meaning it makes a person 'high', whereas CBD is thought to have an anti-psychoactive effect that controls or moderates the 'high' caused by the THC. CBD is also thought to reduce some of the other negative effects that people can experience from THC, such as anxiety.
>
> The psychoactive effects of THC, such as euphoria and feeling relaxed or sleepy, are well known, but THC has also been found to have analgesic, anti-

> inflammatory and antioxidant properties, as well as being able to prevent and reduce vomiting.
>
> Research is being conducted into CBD for its potential to treat epilepsy, schizophrenia and other psychotic disorders, type 2 diabetes, inflammatory bowel disease, some tumours and drug dependency.
>
> …
>
> The endocannabinoid system is a unique communications system found in the brain and body that affects many important functions. It is made up of natural molecules known as cannabinoids and the pathways they interact with. Together, these parts work to regulate a number of activities, including mood, memory, sleep and appetite. It is thought that medicinal cannabis can treat various illnesses by acting on the endocannabinoid system.
>
> Types and forms of medicinal cannabis. There are three main forms of cannabis that can be used medicinally: pharmaceutical cannabis products that are approved by an organisation such as the Therapeutic Goods Administration, including nabiximols, [marketed as] Sativex, and synthetic cannabinoids such as Dronabinol. Sativex, which comes as a nasal or oral spray, has been approved in over 24 countries for treating spasticity due to multiple sclerosis; controlled and standardised herbal cannabis (plant products) such as the products produced in the Netherlands; unregulated and illegal herbal cannabis (plant products) which contains unknown concentrations of cannabinoids and potentially harmful impurities, such as bacteria and mould (USA only).

It is quite clear to me when I read through those sorts of things how important it is to make sure that whatever patients are taking is properly regulated. We would all agree with that. It is so important they know that the medicines they are taking are not harmful. Who knows in an environment where people are making money out of a product, be it medicinal cannabis or otherwise, what that product has in it? Whether it has additives to bulk it out. Who knows what happens in that circumstance? So it is important, really important, that these sorts of products are properly regulated.

One of the links provided to me was to the notice of interim decisions on proposed amendments to the Poisons Standard, the ACMS and joint ACMS-ACCS meetings of June 2020. This was included because it is basically the Therapeutic Goods Administration making an interim decision in relation to cannabidiol (private application) and cannabidiol (delegate-initiated) and this is what they have come down with in terms of an interim decision -

> In relation to the proposed amendment in the private scheduling application it made an interim decision not to amend the current Poisons Standard to exclude cannabidiol from scheduling and allow its general sale.

So, in the interim, it is not allowed to be sold generally, basically. Secondly -

> In relation to the proposed delegate-initiated amendment, it made an interim decision to amend the current Poisons Standard to down schedule

> cannabidiol to allow greater access through a new Schedule 3 entry in accordance with specified requirements and with additional supply requirements specified in appendix M to allow it to be provided by a pharmacist.

This decision has basically been made and it was in June 2020, so just recently. The proposed Poisons Standard entry in relation to CBD is as follows, the amended entry -

> Cannabidiol in and preparations for therapeutic use where CBD comprises 98 per cent or more of the total cannabinoid content of the preparation; and any cannabinoids other than CBD must be only those naturally found in cannabis and comprise 2 per cent or less of the total CBD content of the preparation.

Ms Forrest - CBD refers to cannabidiol and cannabinoids, so there are differences in that.

Mr VALENTINE - Well, cannabidiol is CBD and cannabinol is the THC one, according to the information. When I say CBD, I am talking about cannabidiol, to be clear for the record. Quite clearly, this is something moving along and, indeed, as it turns out, it looks like it may - and I say 'may' because we have to wait and see - become, rather than an interim decision, an actual decision in June 2021.

Things are happening in this area. The important thing about the member's motion is that Tasmania is on board with it, and to make sure we are taking part in the national conversation, to make sure that people who live in this state, albeit not many of them, who access or need to access this - hence the reason the Government is happy to help fund them because it is not going to cost them an arm and a leg, whereas it might in some other states.

It is important we try to have a national approach. I thank the member for bringing this motion forward. I appreciate the need - you can only try to imagine what it is like for anyone, a parent especially, who may need these products. Particularly for children who are suffering - and imagine what it would be like for a parent knowing this particular product can assist and make such a difference, but they simply cannot get it or it is not allowed to be sold or prescribed to them. I support the motion.

[5.30 p.m.]

Mr DEAN (Windermere) - Mr President, I will move -

Answer to Question

Mrs HISCUTT (Montgomery) - Mr President, by way of clarification, before the member starts: the member for Murchison earlier asked a question about ministerial influence over TMAAC.

The Chief Medical Officer was in a meeting so we could not get the answer then, but we have it now. He says the minister has no influence on the committee's decision-making ability which is evidenced and clinically based.

Mr DEAN - I thank the Leader for that.

I thank all members for their contributions on this motion. In my view, they were some of the most powerful contributions I have heard for a long time on a motion on a specific point. We get great contributions in this place, which is one of the benefits and advantages of this House - we all come from different walks of life, which is shown in this place.

There were very strong contributions by everybody. If a government were listening to them, and if it could still say, after all that, that it is doing enough in this area, it is just taking no notice and shutting itself off from what is happening here. That is how strong this debate has been. It really has been strong, and I invite the Government to look at what has been said, Leader, and what has been pointed out by all members who have made a contribution. I think it would probably support this in any event. I would be very surprised if it does not.

I cannot say enough about that and whatever I say now is not going to come anyway near that standard of contribution, and I say that genuinely.

I want to make one or two comments briefly. Our doctors are pivotal in this whole issue, as they were in the previous matter we were dealing with over a long time. Doctors are on the very top rung of that status ladder I keep referring to. The public has the absolute utmost faith in our doctors. This motion is not about wanting access to this product without a proper process in place and without the medical fraternity having a major part in this whole thing.

We come back to doctors and, as I said, we admire them and have the greatest amount of faith in them.

I thank members for raising this issue. We should not take any course that pushes people towards illegal access to this product, and that unfortunately and sadly is what we are doing. I have a problem when they say every product, every medicine, on the shelf should be trialled in the first place before TMAAC will sign off on providing access to medicinal cannabis. That worries me from a number of perspectives, and I have raised one of those issues already. It has also been raised here by a number of members that some of these medicines have severe side effects.

I was recently on one medication that had tremendous side effects and I had to give it away and put up with the problem I had. The problem I had was much better than the medicine I was taking to try to control it.

Ms Rattray - That is exactly the point that needs to be made. The side effect is often worse than the ailment.

Mr DEAN - That is right and a lot of these medicines - the three outstanding medicines - are still yet to be trialled and have severe warnings on them of side effects, and one has a sign it could cause blindness.

If you trialled heaps of medications - which is what has happened in the Cleaver case - and you come up with a medication that gives you relief, why would you then keep trialling other medications with side effects? Why would you force people down that path? That is my point - we should not do it. To me it is irresponsible; it is wrong, and we should never go near it. In my view, it is just not right for us to do that.

Ms Rattray - It would be interesting to know how many different types of products there are that supposedly have the same effect that you have to try as well.

Mr DEAN - One thing I have not asked the Cleavers is just how many medications they have trialled, other than to know that they have trialled many. I do not know the number, and I am not going to have a guess at that, but that really concerns me.

The Rubenach story is a very strong one. I remember when the member for McIntyre started referring it to us. We know exactly what happened there, and the impact on that family was just enormous. You know why they went in the direction they did, and good on them for doing that.

What we are doing - and I have said this before, and other members have said it - is making criminals of people. That is what we are doing. We are making criminals of people. Whether they are caught or not, that is what they are. They are criminals, because they are acting contrary to the law - growing, cultivating, manufacturing. Really, that is what they are.

You know what should happen here? I urge the police to start taking action against these people, because once that happens, there will be an absolute outcry. There will be protests and everything else will be occurring, because you are taking a medicine away from a person who needs it, one which is giving them control and is helping them and so on.

I think if that happened, we would have action taken very quickly. People would not put up with it. I am not sure that would not be something that should happen. I would feel sorry for those people involved, but that might be a way we would get the stronger action we want today.

I was trying to get the point where the Leader of the Government said it needed to be evidence-based. Something about the Government supports the use, but it has to be sensible and evidence-based to support it - words to that effect were said.

Well, this is evidence-based, Mr President. How much more evidence do you want? It is there and it is sensible. I just want to raise that point. It is there. We do not need any more evidence. We really do not.

How many levels of approval do you want? I think the member for Hobart and the member for Huon mentioned this. How many levels of approval do you need? You have the Therapeutic Goods Administration. I would have thought that organisation, with its background and what it does, would have been sufficient, but, no, we have TMAAC on top of that. I am surprised we do not have somebody else on top of TMAAC.

Where do you go? I just question at times some of the things we do, and why we do them.

We cannot legally cultivate cannabis here. We cannot legally do that. You have to have a licence and permits and so on for that to happen.

I think somebody mentioned medicinal versus recreational. That is not what this is about. This is about medicinal cannabis. We are not talking about recreational cannabis at all. That

does not come into this. In no way should that come in here, to have some impact on what this motion is calling for and asking for.

The member for Hobart was certainly right when he said it needs to be regulated, and that is what we are all saying. It needs to be clearly regulated and controlled, and that is clearly not the position at this present time.

Mr President, having said those words, I urge all members to support this motion, and I ask that the Government - yes, it is paying lip-service to it, it is noting it, but cannot support it. I really have concern about that. If the Government were to go back and look at all the information that has come through here this afternoon in relation to this matter and still take that course of action, in my view it is missing the point, and missing the point miserably. It really ought to take a good look at where it is and what it is doing here.

Please, Government, please help people. Have a look at this and start an action that will help these people move forward in the right way. I thank members for their contributions and I commend the motion to the House.

Motion agreed to.

ELECTRICITY, WATER AND SEWERAGE PRICING (MISCELLANEOUS AMENDMENTS) BILL 2020 (No. 40)

First Reading

Bill received from the Assembly and read the first time.

ADJOURNMENT

[5.42 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

> That the Council, at its rising, adjourns until 12 noon Wednesday 11 November 2020.

This will enable members to attend the Remembrance service at the front of the building. A notice was sent around by the Clerk. The service has been moved to the lawns and will happen at 11 o'clock for members who wish to attend that service, and then the Legislative Council will sit at 12 noon. I also remind members that briefings will start at 9 a.m. in Committee Room 2, and we will roll through those if everything aligns.

Motion agreed to.

The Council adjourned at 5.42 p.m.