HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)

PUBLIC HEARING—EXAMINATION OF THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2018

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 24 JANUARY 2019

Brisbane

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The committee met at 11.05 am.

CHAIR: Good morning. I declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. The other members of the committee are Mark McArdle, member for Caloundra and deputy chair; Michael Berkman, member for Maiwar; Marty Hunt, member for Nicklin; Barry O'Rourke, member for Rockhampton; and Joan Pease, member for Lytton.

Today's hearing is part of the committee's examination of the Health and Other Legislation Amendment Bill 2018. The bill was introduced on 13 November 2018 by the Minister for Health and Minister for Ambulance Services, Minister Miles. The committee is required to report back to the Legislative Assembly by 14 February 2018.

There are a couple of procedural matters before we start. The committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a nonpartisan approach to its inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the guidelines so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript in due course. This hearing will also be broadcast live on the parliament's website.

BADRICK, Dr Tony, Chief Executive Officer, Royal College of Pathologists of Australasia Quality Assurance Program Pty Ltd

BROPHY, Adjunct Professor Conor, Chair, University Human Research Ethics Committee, Queensland University of Technology

GRIFFITHS, Professor Lyn, Executive Director, Institute of Health and Biomedical Innovation, Queensland University of Technology

WALSH, Ms Anne, Acting Director, Office of Research Ethics and Integrity, Queensland University of Technology

CHAIR: Thank you for joining us. Today we will hear from representatives of the Queensland University of Technology and Dr Tony Badrick from the Royal College of Pathologists of Australasia Quality Assurance Program. Before we move to questions, would one of the representatives like to make an opening statement in regard to your submission?

Prof. Griffiths: I will start off making an opening statement and then I will hand over to Anne Walsh, so we will do this together representing QUT's thoughts in relation to this.

Thank you to the chair and members of the committee for inviting us to the hearing today to discuss the Health and Other Legislation Amendment Bill 2018 as it relates to the proposed legislative changes to the Queensland Transplantation and Anatomy Act 1979. As the committee well knows, this act was originally intended to provide for removal of human tissues for transplantation, for post-mortem examinations, for the definition of death, for the regulation of schools of anatomy and for some related purposes. The terms ‘human tissue' and ‘biospecimens' I will use interchangeably, and quite often are used interchangeably.

Since the enactment of this act in 1979, the collection and use of human tissue or biospecimens for the related purpose of research has evolved substantially. Use of human tissue in research has become a very important resource for scientists in both health and biomedical innovation. In particular, the storage of tissue, biospecimens in biobanks or tissue banks for research purposes is very common, and the range and types of tissue banks are numerous—for example, for epidemiology, for pathology, for genetic studies, for public health, for social sciences.

In Queensland there are two regulatory mechanisms underpinning the use of biospecimens in research. There is a requirement that any research activity using human biospecimens must be reviewed and approved by a Human Research Ethics Committee according to the principles of the *National Statement on Ethical Conduct in Human Research*, which I will call the national statement. Chapter 3.2 of this national statement specifically addresses ethical considerations relating to the use of biospecimens in laboratory based research.

There is also the Transplantation and Anatomy Act Queensland 1979. The proposed legislative amendment provides for authorised donations by an adult of human tissue—this is the revised section 21B—and an authorised donation by a child—which is the insertion of section 21C—provided these donations are used and utilised for the purpose of approved research and that consent is given under the national statement. We would like to comment that we absolutely welcome these proposed legislative amendments. They are absolutely necessary. They will facilitate research. They will also facilitate diagnostics, and we appreciate that those amendments should come in. I will now hand over to Ms Anne Walsh, who is the Acting Director of our research, ethics and integrity office, to continue.

Ms Walsh: Thank you, Lyn. Our submission is also seeking further amendments to the act to address the storage of human tissue that has been donated for the purposes of research in biobanks and the trading of tissue. When I say 'trading' here I am talking about trading for the reasonable recovery of costs associated with removing, evaluating, processing, storing and distributing tissue for the purposes of approved research.

To summarise the key points that we made in our submission that we provided to the committee, the terminology and definition of human tissue under the act is inconsistent with the terminology and the definition of biospecimens as it is defined under the national statement. This has created quite a bit of ambiguity around what constitutes human tissue and a substance extracted as defined under the act, and therefore what types of tissue are subject to regulation under the act. Therefore, we are seeking some consistency with the terminology used in the national statement.

The act's requirement for a ministerial permit under section 42(2) to trade tissue at a cost recovery amount for the purpose of research poses a significant regulatory burden on tissue bank custodians and researchers who are seeking access to biospecimens for approved research. Part of this is due to the national statement's very broad definition of a data bank. It defines a data bank as a systematic collection of data where the data includes information derived from human biospecimens such as blood, bone, muscle and urine. These data banks are not recognised as prescribed tissue banks under the act's regulations and are therefore not exempt from the broad prohibition on trading tissue for the recovery of costs under part 7 of the act.

We also see that these provisions extend to access to human tissue that is sourced from international tissue banks or bought from commercial companies. This further compounds the administrative and regulatory burden of researchers seeking access to human tissue for approved research. We seek changes to these provisions to a regulatory framework that is more contemporary and pragmatic to the use of biospecimens for the purposes of approved research. Professor Lyn Griffiths, Professor Conor Brophy and I are happy to answer any questions that the committee may have with respect to these points and to the points in our submission.

CHAIR: Thank you very much. Dr Badrick, would you like to make a statement before we move to questions?

Dr Badrick: Thank you for the opportunity to present before you. I will start by saying what the role of quality assurance is and that is really to provide a quality framework for pathology laboratories throughout Queensland in particular. The programs ensure that pathologists are proficient in diagnosing disease across a range of subdisciplines and this ensures that patients throughout Queensland and Australia are receiving the highest levels of care. The RCPAQAP, the organisation that I represent, undertakes this endeavour through the provision of small tissue samples to participating pathology laboratories. That is the crux.

The RCPAQAP currently distributes tissue samples throughout Australia, but relying in Queensland on ministerial exemption. The current proposal to create a statutory exemption for quality assurance purposes is strongly supported. It should be noted that the RCPAQAP is strongly aligned with the objectives of the amending legislation. It is, however, necessary to ensure that such a proposal sensibly aligns with what currently happens and is approved through the ministerial exemptions. In the RCPAQAP submission there is little benefit in undertaking these amendments, which clearly acknowledge a significant issue, without tailoring the amendments to ensure that these align with current market practice. As can be seen through the granting of the ministerial exemption, RCPAQAP's program is desirable for Queensland.

In order to ensure that the amendments appropriately encompass quality assurance programs as these typically operate, it is strongly recommended that the requirement that tissue be, and this is the issue for us, processed or treated be removed. In many instances the tissue that is removed from a patient is merely fixed or stained. We often use blood samples as well and blood samples are typically only spun or aliquoted. The definition of processed or treated is the issue that we have. We often do not process or treat those samples. This does not reduce the criticality of these products, nor does it suggest that the inclusion in the scope of the proposed quality assurance exemption is not prudent.

The other issue is, looking forward to what might be requirements in the future, it may well be that we may need fresh tissue. As we look for components such as RNA, which are far more volatile, we might need a different sort of tissue without any processing whatsoever so really this is looking at the current situation and the future situation.

As can be appreciated, anything done to a relevant tissue sample which is to be used for validation or quality control purposes must be minimised so as not to undermine or invalidate the very issue that we are concerned with. That is my submission. Thank you.

CHAIR: Thank you, Dr Badrick. It would be fair to say that evidence based research is key, in particular in medicine. Thank you very much for your submission because you do raise some points, as you have articulated, about having to get a ministerial permit to buy tissue, for storage and trading. To simplify it for people who are not expert in this field, how best can we streamline it? You mentioned proposed amendments to national oversight. Can you unpack that a little bit because I would like to get a better understanding of where the national framework sits as opposed to the Queensland Health minister having oversight or having to do permits?

Prof. Brophy: I am the chair of the QUT Human Research Ethics Committee. All research that is considered has to be considered under this national statement on ethical conduct in human research by a human research ethics committee. A detailed submission is given which says what is wanted to be done and gives details about the donation of biospecimans or where the biospecimans, the tissue, has been obtained from. Throughout the country all human research ethics committees look at that and in really quite considerable detail. It seems that this additional requirement is really superfluous because of the national rules and regulations and processes that already apply. I think what we are wanting to do is to allow for the national statement and review under a human research ethics committee approval to be sufficient to say that this tissue can be used.

Prof. Griffiths: Basically at the moment it looks like ministerial approval is required in order to get samples off individuals or even from overseas, things like cell lines. That would be so onerous for absolutely anything and unnecessary if there is already a national statement which defines the ethical guidelines for what you are allowed or not allowed to do. Something like a HREC is absolutely required to look at any research so if the research is approved it means it is consistent with the guidelines. To then have to do it again at ministerial level would be incredibly onerous.

CHAIR: It does appear to me that it perhaps is a duplication of process. I was going to get your opinions on whether this current process as it stands, and we will hear from the department later on this afternoon, might also stall research from a timing perspective of getting important research done. Is there any capacity for delay on research because of this process?

Prof. Griffiths: Absolutely and totally. Certainly having to put in place a separate ministerial approved permit for every sample or new bit of research that is happening, you would have to face it, it would have to take a significant amount of time unless you could find some really streamlined process but I cannot really see why you need it as well when it is duplicating what is already happening at the HRECs and in the national framework. The other question too is the term trading. I think you might need to still include something in there. If somebody is setting up companies to sell bits of bodies it would not be a good thing. However, for approved research purposes and at a cost recovery—as an example, if you have a tissue bank and researchers want to access it for approved research there must be some costs in having a technician to get that out, to defreeze it, to store it. We are only talking about cost recovery so I think a differentiation between trading and cost recovery is totally needed.

CHAIR: Thank you very much. I will move to questions.

Mr BERKMAN: Dr Badrick, you raised in your submission and mentioned in your introductory statement concerns about the retention of the words ‘processing or treatment' in section 42AA and the implications in terms of the exemption not extending to trading all different tissue types. We have advice from Queensland Health that in the instance of quality assurance materials it considers

processing covers any action, and I will quote them here, 'even including simply packaging the tissue to enable distribution and examination'. Does that allay your concerns or do you feel there is more clarity required around that?

Dr Badrick: If that is the interpretation that would allay the concerns. It is just that a cold reading of this statement does not suggest that that to me includes processing or treatment.

Mr BERKMAN: That is potentially a point to consider for further amendment. Maybe an additional definition of processing or treatment to clarify that point would suffice.

Dr Badrick: I think that would certainly help. To me packaging does not indicate treatment or processing.

Mr BERKMAN: Thank you.

Mr McARDLE: Thank you for being here today, one and all, in this humble abode of ours. Professor Griffiths or Adjunct Professor Brophy or Ms Walsh, the process in relation to ministerial approval, what is that at the moment? Does it duplicate the current regime in relation to the national statement and the ethical oversight process?

Ms Walsh: If I can answer that in a couple of ways. Firstly, the regulations under the act are about those tissue banks that wish to charge a cost recovery amount. There is a ministerial application required for those tissue banks. Of course, that is important for the sustainability of some of these tissue banks and for the curation of their specimens this is important. My understanding of the ministerial permit application at the moment is that there is an application for a permit to buy human tissue whereby each applicant that wants to request tissue from a tissue bank that wants to trade on a cost recovery amount has to fill out a form specifying why they want the tissue, what they need it for, the purposes, and that then gets submitted to the minister for approval. What we are saying is for that to happen each and every time is quite an administrative burden.

In terms of the national statement, every research project that requires the use of human tissue has to be reviewed by a human research ethics committee. The ethics committee looks at the ethics around the consent of the donors, ethical considerations around where the tissue has been derived and so forth. It looks at similar things but there is a ministerial permit I think more in relation to the trading purpose.

Mr McARDLE: Am I right in saying that the ministerial approval has a limited impact in relation to only trading or is it wider than that? I am trying to get some sort of handle on exactly how wide the approval is required in relation to research matters.

Ms Walsh: The only tissue banks at the moment under the act's regulations that are actually exempt from the requirement for ministerial approval to trade is the Queensland Bone Bank, the Queensland Eye Bank, the Queensland Heart Valve Bank, the Queensland Skin Bank and the Australian Red Cross Blood Service. What we are saying is that under the national statement the definition of a tissue bank is actually very broad and that there is obviously a number of these tissue banks. We want to allow these tissue banks, for their sustainability and operation, to be able to trade on a reasonable cost recovery amount.

Mr McARDLE: You would also argue that the ethical oversight is a very severe body and that they take very strong views in relation to what can and cannot occur and a thorough process is put in place to ensure that is achieved?

Prof. Brophy: Yes, that is correct. The national statement has very detailed advice and guidance about what an ethics committee has to consider in terms of the merit of the research, how a biospecimen has been obtained, whether or not it is consistent with the donor's wishes and how the research which results is going to assist future patients, for example, or the current participants. We consider a range of issues and it is only when there is sufficient merit and all those other factors, beneficence, justice and respect, have been dealt with that we will approve a research study.

Mr McARDLE: I would imagine that the ethical oversight body is staffed by very senior qualified individuals on each occasion.

Prof. Brophy: Yes. The national statement also prescribes the makeup of a human research ethics committee. As well as the chair there are a number of people, including lay members, also a pastoral carer, but researchers who have knowledge in the field of the research that is being reviewed and also people who care for patients and care for other people who have some knowledge of the type of research and the potential implications for it.

CHAIR: Can I quickly ask, is there an ethics committee in each state and jurisdiction?

Prof. Brophy: There are a number of accredited, registered and also certified research ethics committees all of which have to adhere to this national statement. QUT has one but there are a number of human research ethics committees also situated in various institutions within Queensland Health. There is one also at Mater Misericordiae and there are some smaller committees but generally the certified committees, of which there are only 50 around the country, will see larger, multicentres' applications and it is those larger committees, more experienced committees, which tend to receive a range of different research applications for which they are qualified to approve.

Mr McARDLE: To elaborate a bit further on what constitutes human tissue, you have a concern about the definition as we are applying it in Queensland as opposed to the national statement and there are inconsistencies there that you see that we need to address going forward. Again could you give a very short version, and may I just suggest a layman's perspective, on that question?

Prof. Griffiths: The national statement indicates that human biospecimens refer to biological material obtained from a person that includes tissue, blood, urine and sputum, but it also includes any derivatives of those such as cell lines. That is important because sometimes we need to get cell lines from overseas. That is why the international perspective on this is an important component, too. Storage and processing comes into it. Do you want to add anything to that, Anne, or is that right? We are just looking at extending out that definition for derivatives.

Ms Walsh: I have nothing further to add, other than that that seems to be inconsistent with what the act defines as 'tissue', because it includes in its meaning a substance extracted from an organ, blood or part of a human body or a human foetus. It is difficult to know.

Prof. Griffiths: A cell line is something that goes beyond that, so you keep it for a while. You process it and you keep it and it grows.

Mr McARDLE: Clarification would be critical, as far as you are concerned, to eliminate any doubt in your mind?

Prof. Griffiths: Correct. It should be consistent with the national statement that does have those derivatives in it.

CHAIR: You mentioned the ethics committee and I wanted to clarify the oversight in the role that they play. You mentioned that Queensland Health has an ethics committee, as well. Do those committees share information with Queensland Health to brief the minister? Are they aware of what is happening and current trends in research? How do you communicate with Queensland Health?

Prof. Brophy: We communicate with Queensland Health quite a lot. The central office in Queensland Health assists with looking at rules and regulations around conducting research. There are various groups. All the various institutions that set up ethics committees actually join together and come together to discuss common problems. Really, identification in the last few months of the concern around obtaining tissue for research from children has come about through that process of discussion and communication between Queensland Health and ethics committees and researchers. I think the communication is actually very good. I am on a committee that is a Queensland Health generated group that looks at the ethics and governance issues from a strategic perspective. The aim is to keep abreast of the sorts of things we are seeing and the sorts of problems that may come now and in the future. I think the communication is good.

Ms PEASE: My question goes to a comment that you made earlier, Professor, regarding cell lines and the requirement to include that in the definition or altering the definition, because you occasionally have to get cell lines internationally. Can you elaborate on that? Do you use cell lines from a domestic perspective, as well?

Prof. Griffiths: Yes. In Australia, quite often there are researchers who generate cell lines themselves from specific patients with specific disorders. Those cell lines might be useful for research here in Australia on that particular patient or it might be useful for defining a treatment for that particular patient. It can also have implications for overseas patients with similar disorders and vice versa. There might be something from overseas that will help with research here to see whether it is, as an example, the same disorder or the same response to the same treatment. There is a collaboration that occurs with cell lines internationally between researchers. We want to make sure that we facilitate that. As part of that component, we are looking at not wanting to have a ministerial permit for every cell line that might be needed for research purposes.

Ms PEASE: Ms Walsh, excuse my ignorance, but with regards to the trading of tissue and the tissue bank, obviously it takes place currently. Is there no cost recovery process involved at this point?

Ms Walsh: I cannot speak on behalf of every tissue bank, but I do know that there are tissue banks that do want to charge a cost recovery amount or have been but have been notified by the Department of Health that that is in contravention of the act. I also know that there are, though, tissue banks that will allow access by researchers to their specimens on a free-of-charge basis, so they are not trading for a cost or anything like that.

Prof. Griffiths: There is a bit of a problem associated with that, because it means that they are having to wear the cost. Sometimes it could be things such as sending samples from one place to the next and it get can get pretty expensive, or it is the technician support to do it. It is normal to have a cost recovery. You are not charging a profit but a cost recovery for what it costs to actually get a sample.

Ms PEASE: With regards to the tissue banks, do you share the information about what resources you have? Is there some sort of log?

Prof. Griffiths: There is a variety of different things. As an example, there might be a breast cancer tissue bank. There might be tumours that have been taken with consent for research purposes from breast cancer sufferers. That would become a bank. Then information would be available on what samples were available. There is usually a steering committee that would look at a proposal to access some of the tissues from that, providing that there is appropriate ethical approval for that project and it was thought to be beneficial. Then there might be a cost associated with getting out, as an example, 200 samples from various spots with the associated information to help that research group to facilitate it and to access it.

CHAIR: As there are no other questions, I thank you very much. You have articulated your points very well. We look forward to a response from the Department of Health. Certainly it has helped inform us moving forward on this particular section of the bill. I now welcome the Queensland Council of Civil Liberties and the Medical Cannabis Users Association of Australia.

COPE, Mr Michael, President, Queensland Council for Civil Liberties

LYNCH, Ms Deb, Committee Member, Medical Cannabis Users Association of Australia Inc

RANSLEY, Mr John, Representative on drug law reform, Queensland Council for Civil Liberties

SANDS, Ms Grace, Committee Member, Medical Cannabis Users Association of Australia Inc

CHAIR: Thank you very much and welcome. Thank you for your submissions. We look forward to hearing from you in relation to the bill, particularly around the medicinal cannabis section. Mr Cope and Mr Ransley, would you like to make an opening statement before we move to questions?

Mr Cope: On behalf of the council, I thank the committee for the opportunity to appear before you this morning. I will hand over to Mr John Ransley, who is a longstanding member of the executive council; in fact, he is a life member of the council. He will address the committee on behalf of the council and answer questions.

Mr Ransley: Thank you for your invitation to the council to appear before the committee. The council welcomes the abolition of the 2016 medicinal cannabis legislation that completely failed in its stated objective to 'create a new regulatory framework under which medicinal cannabis products may be prescribed and dispensed to patients in Queensland'. It is understood that by late last year less than 50 applications had been approved by Queensland Health, including multiple products for the same patient or repeat prescriptions.

The council's principal submission on this occasion is that the new arrangements will also fail because of the prohibitive cost of the private pharmaceutical-style medicines. Additionally, the council sees almost zero prospect of those medicines being placed on the PBS any time soon. Even if Epidiolex—the favoured candidate—succeeds in getting placed on the PBS at an affordable price, this would be of extremely limited benefit because the concept of a one-size-fits-all generic medicine is a very bad fit for cannabis.

In recent decades, the underground medical cannabis movement has delivered effective cannabis medicines to thousands of people at a fraction of the cost of potentially equivalent pharmaceutical products—personal communication. These unregulated medicines have repeatedly demonstrated symptomatic relief in a surprisingly wide range of medical conditions, either solely or in conjunction with mainstream therapies. Apart from obvious candidates like glaucoma, chemotherapy side effects, epilepsy and chronic pain, the list of conditions that have benefitted includes most cancers, Parkinson's disease, trigeminal neuralgia, Crohn's disease, excema, glioma, MS and fibromyalgia.

In an Australia-wide program, state police forces have systematically arrested and prosecuted the compassionate suppliers responsible for this industry in an attempt to force patients into mainstream medicine with below par treatment options. Unfortunately, governments of all political persuasions seem eager to adopt the pharmaceutical industry. The increasing rates of police arrests for minor cannabis offences in Queensland is one symptom of this.

It is worth emphasising that many users of unregulated products would happily change to legal, affordable and effective medicines just for the protection against arbitrary arrest and prosecution, but the legal medicines are prohibitively expensive. They are also so expensive that no person in their right mind would be trying to get a prescription for recreational reasons. Until the cost issue is fixed, the council's submission is that this new legal environment for medicinal cannabis will not work any better than the previous legislation.

CHAIR: I know you are discussing something there, Mr Ransley. I am mindful of the time. We will try to keep opening statements to five minutes, to allow the other guests to speak.

Mr Ransley: If a solution is eventually found, the council has another suggestion to add to the list of practical suggestions in our submission. I will finish there.

CHAIR: Ms Deb Lynch and Ms Grace Sands, would you like to make an opening statement and then we will move to questions?

Ms Lynch: Thank you for the invitation to speak at this hearing today. The MCUA members in Queensland are pleased that the Queensland government is considering a repeal of the Public Health (Medicinal Cannabis) Act 2016, but we believe this action alone will do little to make legal access

easier and/or affordable for the great number of patients who are using S9 cannabis now. Current users of S9 cannabis are estimated to be over 100,000. We believe this to be a very conservative estimate, as numbers grow rapidly on a daily basis as word spreads to the wider community.

Patients are using S9 cannabis with exceptional results, even though the official description of S9 says that the drug has no medicinal value. There are a number of people with an array of medical conditions who would beg to differ with that description and who chose to run the legal gauntlet to get access. This is the case currently with two Queensland members of our committee who are both facing criminal actions for producing cannabis unlawfully. I am one and I strongly believe that if I had had an unfettered supply of cannabis oil I may not have lost my leg just a few days before Christmas. On the two occasions when I was able to obtain activated CBD oil through illegal means, I saw inflammation and pain reduction and a marked improvement in the colour of the skin within hours of taking it. Unfortunately, through an inability to obtain supply, my condition went backwards and deteriorated very quickly, and the lower leg amputation was the end result.

The vast majority of patients use cannabis for pain relief of some kind. Apparently Australia is leading the way in pain stimulation therapy. This could be a likely reason for the reluctance by pain specialists to prescribe cannabis. These specialists are trialling this treatment on behalf of pharmaceutical companies and recommending it to patients in Queensland. This is a costly and invasive procedure that requires some risk and requires upkeep and maintenance by doctors. It requires TGA approval and is supported by health insurers. Again, a majority of our members with chronic pain would be unable to afford this treatment.

Doctor reluctance remains the biggest hurdle to legal access. Doctors are being asked to sign conditional waivers for patients or possibly face increasing premiums on their indemnity insurance. It indicates that insurance is playing a part in doctor reluctance. They are happy to refer people to the cannabis specific clinics but, again, it is cost prohibitive for the majority of patients.

It was revealed in a video on social media last week by one of the corporate cannabis specific clinics that at least one private health fund is subsidising cannabis medicine. The video did not say which fund or how much the subsidy would be, but the majority of patients in our membership are on low incomes and rely on Medicare. They see health insurance as a luxury they cannot afford, so this again is useless to them.

We heard a quote last week by a minister of the Queensland government that the Queensland government has no intention of changing its policy on illicit drugs. S9 cannabis is in that category. While this remains the case, the majority of medical users will be targets of the police and will be caught up in the criminal justice system. This is an unnecessary waste of taxpayer funds. We endeavoured to get an estimate of the costs involved in these prosecutions, but we have been waiting quite some time for the police minister to get back to us with figures. I think Grace is going to expand on that.

Cannabis users regularly write to members of parliament at both levels of government asking for changes to be made to laws governing access to cannabis. The common message we get from all members is that the federal government say it is the state's responsibility and the state says it is a federal government responsibility. This is not good enough for people who are facing daily suffering or early death. It is no help to those facing court and criminal actions because they are forced to obtain supply through illegal means.

We are of the belief that the best and quickest way to achieve access and affordability is to consider the requested amendments to regulations made in our petition of 2018 that would give amnesty and access which allows patients to take responsibility for their own health and health choices. The response from the health minister to our position was yet another example of buck-passing and regurgitation of the state and federal processes that we are all too familiar with. His response did not in any way address the requests made by the people of Queensland.

Polls across the country taken by mainstream media following the Greens' announcement of their policy to legalise cannabis for adult use in mid-2018 saw over 80 per cent of the respondents agree that it should be legal. The propaganda has largely been debunked by international science based research, and results in jurisdictions where it is legal have shown that the worries and concerns of prohibitionist influences have been statistically proven to be unfounded.

For experts and politicians who actively campaign against creating this sort of access, we say to them: 'If you don't want to use it you don't have to, but don't deny others the choice.' By keeping the status quo, the will of the people of Queensland is not being addressed.

Ms Sands: To expand on the issue of the cost of policing cannabis, the cost for the police and the courts, we still do not have a response from the police minister. One of the staff members called and said that the police department do not differentiate between the cost of policing cannabis and other drugs. He is still trying to get something to me. Once I get that I will forward it to the committee. The Attorney-General's department has sent a response. They have said that those costs come under the Privacy Act. I did not ask for individual court cases. I asked for all of the indictable matters across-the-board that go to the District Court and Supreme Court. We do not have any costs to justify why the government is keeping in place a policy which is causing a great deal of harm to patients and parents and other carers.

CHAIR: Respectfully, you are starting to go outside the scope of the bill that is before us which talks about streamlining. We have heard your views this morning and we thank you for your opening statements. A lot of it seems to be around cost. You mentioned the PBS, Mr Ransley. Of course, the Pharmaceutical Benefits Scheme sits within the federal remit. We have a couple of members here who were members of the committee in the previous term of parliament which dealt with medicinal cannabis and the observation is that this bill is about streamlining the process. You note in your submission that this amendment does in fact go to streamlining the process for approval. I take on board the cost issues and access issues that you have raised. Ms Lynch, I think what you were trying to articulate was the use of non-medicinal cannabis—if I am correct?

Ms Lynch: Yes, the S9.

CHAIR: I do not know if you want to speak to any of those points and then we will move to questions.

Mr Ransley: On the issue of cost, according to the medicinal cannabis portal, the Tasmanian government has an arrangement whereby people who are approved for legal pharmaceutical medicines are prescribed through hospital pharmacies. That is according to the website. I am not sure whether that has been changed or updated. The price of the medicine through that system, through the hospital pharmacies, is equivalent to the PBS for a similar medicine. I do not know but I understand that that could be less than $10 per prescription, which would be a million miles from the pharmaceutical products that you normally have to purchase.

Lanai Carter, who has put in a submission but could not be here, says that to provide all of the medicines for her very seriously ill son would cost her about $48,000 a year. That is just mad. Of course she is mortgaging her house and all of that kind of thing, but most people cannot do that. It would be worth the committee following up whether the Tasmanian system is working. I understand from a personal communication that apparently seven people have got through the hoops in Tasmania and have been prescribed medicines. It would be very interesting to see whether they have been prescribed medicines at a PBS level apparently subsidised by the Tasmanian government.

CHAIR: We will take advice from the Department of Health to see whether they can better inform us on that as a comparison.

Ms Sands: Queensland Health has a scheme called the individual patient approval scheme. It is up to the individual doctor in a public hospital to make an application to the head of the hospital to fund any unregistered medicine. I am aware of some people who have had their medicine funded under that. The issue is that it is not promoted enough. We put up posts on Facebook. Patients like Deb asked about it and she was given the run around. A huge area is the cost and also the reluctance of doctors in the public system to prescribe cannabis. There is a huge reluctance of those doctors to prescribe cannabis. A lot of them say they do not understand it or they are not allowed to do it. There are issues there. It is not necessarily a legal issue. It is policy or lack of education or an unwillingness of the doctors to write the prescriptions.

Ms Lynch: In my own case I have a written letter from my specialist stating that it is the Queensland laws that are stopping him from prescribing for me. I qualify on many levels to be able to be prescribed, yet I still cannot get a prescription.

CHAIR: We will open up to questions.

Mr BERKMAN: Will these changes that we are looking at in any way affect your doctor's capacity to prescribe? The streamlining, as I understand it, is a step in the right direction. Will that smooth out your prescription barriers?

Ms Lynch: I am not really sure. My doctors have told me that they have been warned off from prescribing. One specialist told me that he was told, 'If you rock the cannabis boat and go against policy, you will be looking for another job.' That is not good enough when he is supposed to be taking care of my health and not putting policy first.

Mr BERKMAN: We have identified cost barriers—I think we have dealt with that in some detail—and cultural barriers within the medical profession—the reluctance, lack of information or willingness to prescribe. What other administrative or legislative barriers do you see that we might address as a state government? In terms of the question of decriminalisation of cannabis more broadly, while it is a conversation I am very much interested in having, we will maybe steer away from that for the purposes of the current committee's consideration.

Ms Lynch: Grace is probably the best person to answer that question.

Ms Sands: I think the reluctance of doctors, as Deb pointed out, seems to be from above and that is filtered down to all of the doctors. It is not in writing. As you know, any product can be prescribed—any age, any condition. It in the Children's Hospital, for example, the doctors there have outright refused to prescribe whole plant cannabis. They have only been willing to prescribe Epidiolex. Queensland Health entered into a contract with GW Pharmaceuticals for the supply of Epidiolex for 30 children only. That was to the exclusion of every other child in the state. I think there have been a few more children added since then. Those trials were announced in 2015. We are going on for almost four years that Queensland Health have accommodated 30 children for Epidiolex while every other parent out there has struggled. I am aware of a lot of parents who have tried to get other cannabis medicines besides Epidiolex prescribed at that hospital and the doctors refuse to prescribe it.

I think you have a submission from Steve Peek. He went to great lengths to try to get alternative medicine for his daughter Suli. I have seen all the documentation where they were just unwilling to prescribe anything but Epidiolex. That is costing children their lives, I believe—a lot of us believe. Our health should not be dictated to by contracts. This is not about patients' health and their health needs, it is being driven by corporate influence. I think that really needs to be addressed.

There is also the government. Queensland Health has some confidential agreement, which we are unable to get those documents through the courts or FOI or RTI, with Zynerba, the synthetic cannabis trials. That was also initiated in 2015. We have basically had year after year of Queensland Health holding up access to cannabis from the other suppliers. I know that there are now cannabis clinics and the regulations have been changed so people have got through, but over the past two years, while this legislation was in place and before that the identical provisions were in the Health (Drugs and Poisons) Regulations, anyone trying to get access to an alternative whole-plant cannabis product or from an alternative supplier, the applications were delayed sometimes up to six to 12 months to get state approval.

It is good that the state is moving out of the way with these changes, but it needs to be recognised that the doctor still needs to get TGA category B approval; the federal government is not allowing the suppliers to supply through category A, only category B. The doctors still do need a federal approval which can hold it up and cause reluctance once again. There are a lot of patients who are going to be left out and will need to continue having to break the law and relying on raising defences like Deb is in her court case and I think that is very unfair.

Ms Lynch: Also the recommendations that we gave to the Queensland Health minister back in November would give every patient in Queensland not only access to cannabis immediately it would also exempt them from prosecution. I think those recommendations that we handed to the health minister really should be looked at again.

CHAIR: Just to clarify, that is not medicinal cannabis, that is cannabis whole plant?

Ms Lynch: No, that was medicinal cannabis.

CHAIR: Thank you. I will move to the member for Nicklin for questions.

Mr HUNT: Mr Ransley, I was just reading your submission in relation to the New South Wales Medicinal Cannabis Compassionate Use Scheme. The scheme provides guidelines for New South Wales police officers about using their discretion not to charge adults with a terminal illness for possession of cannabis not lawfully prescribed. How does that operate practically? Use their discretion seems to be not a definitive policy rather an allowance for the police officer to use their judgement at the time. How does that work?

Mr Ransley: I have not been able to find any definitive information on that aspect, but the system of compassionate access, which, just to make clear, means that someone with a terminal illness who accesses an underground product or an illicit product to treat whatever symptoms—cancer or chemotherapy symptoms or so on—and is arrested or is attended by police, put it that way, under that scheme the fact that the person has a terminal illness is a complete defence, it is supposed to be a complete defence. That is not really clear in the way that the provision is written as I

understand it and I think it was streamlined after it was reviewed last year. I think you have to get a letter from the New South Wales Department of Health to give to the police or something in that situation.

My personal view, and the council's view, would be that if the person has a terminal illness that should be enough and you just need a doctor to say yes they have a terminal illness and that should be a complete defence. I really recommend that being taken up in Queensland. It seems to have worked fine in New South Wales. When they reviewed it after a couple of years, I think it was first introduced in 2015 and it was reviewed at the end of 2017, the report came back and said yes it should be continued because the problem is that people cannot get access to medicines from overseas under the arrangements that have existed up until now. That seems to be still in place and I imagine will stay in place until it becomes much easier to access legal medicines.

CHAIR: I thought the former police officer might pick up on that. We only have 10 minutes left. Deputy Chair?

Mr McARDLE: Can I summarise the perspective as I am seeing it from the submissions and your oral statements here today? We agree that duplication being removed is a positive step. As I see it, it is the cost of the drug, it is the cost of medical bills in obtaining the doctor's approval to suggest cannabis is used, plus the reports that are required that come with that, the cost of ongoing assessments as well as time goes by to justify further use, the time to get the drug from the source from which it derives and the doctor's reluctance generally speaking to prescribe medicinal cannabis. Can I ask this one question: as I recall, most of these drugs, medicinal cannabis, came from overseas, they came from Canada et cetera; is that still the case?

Ms Lynch: Yes.

Mr McARDLE: There is still no state or Commonwealth basis to obtain access to medicinal cannabis from an Australian source based in Australia, you still have to go overseas to access it and am I right in saying that that body may say no?

Ms Lynch: Yes.

Ms Sands: The Commonwealth government is allowing a lot of the suppliers now to import in bulk supplies. There is cannabis here basically on the shelves. There are probably about 20 suppliers and it is all imported. The product that is actually being cultivated locally, last year the government also allowed to be exported. Because it is so difficult for the suppliers to supply their medicine through this scheme, a lot of these suppliers are actually exporting overseas.

Mr McARDLE: I am going to ask Queensland Health these same questions as well. I want to understand the process of supply. International corporations are importing large quantities of these drugs into Australia and they are warehoused. Therefore, does that then streamline the length of time to access the drug and is there now no longer a requirement that approval of the country that prepares the drug is required, it is done by the TGA?

Ms Sands: That's correct. The products are here in Australia. The doctor still needs category B approval. The federal government is not letting doctors notify through category A. The TGA are saying there is a two-day turnaround for that. But the issue is with doctors. As patients it is difficult to find out what products are available and the prices. The ODC has a policy that the suppliers have to deal with the doctor. To get the information that is another thing. Doctors have to call up all the suppliers, ask for the product information and the cost and then consult with the patient. That is another onus on doctors.

Mr McARDLE: This is not strictly within the confines of the bill, you understand that, but I do understand that this is a matter that you have been progressing now for a lengthy period of time. The length of time to actually get the medicinal cannabis has now shrunk dramatically once all the approvals are in place?

Ms Sands: Yes.

Mr McARDLE: I can recall evidence of six months, eight months, 12 months, but now it is down to maybe as little as two days; is that right?

Ms Sands: Yes. As long as the doctor puts in all the information the TGA are saying two days and there has been an increase in the number of approvals, but across Australia wide we are still talking 1,000 to 1,500 a year. It is still not a lot. A lot of those approvals could be for the same patient having a repeat approval or multiple products. Australia wide it is not a lot of patients being looked after.

Mr McARDLE: Thank you very much.

CHAIR: I thank all submitters. We are out of time unfortunately. We certainly appreciate your time this morning and we look forward to a response from the department going forward.

Proceedings suspended from 12.10 pm to 12.34 pm.

GRAF, Mr John, Resident, Pebble Beach Retirement Village

LYONS, Mr Robin, Partner, MinterEllison

McCLEAR, Mr Wayne, Resident, Pebble Beach Retirement Village

McCORQUODALE, Dr John, President, the Domain Residents Association Inc.

SHORTHOUSE, Mrs Lynette, Secretary, the Domain Residents Association Inc.

SMEED, Ms Brittany, Solicitor, Human Rights and Civil Law Practice, Queensland Retirement Village and Park Advice Service, Caxton Legal Centre Inc.

WILLIAMS, Ms Jen, Queensland Deputy Executive Director, Property Council of Australia

CHAIR: Good afternoon. Thank you for joining us. I know that you have all made submissions. We would ask you to make an opening statement.

Ms Williams: Thank you for opportunity to appear before the committee today. The Property Council has worked closely with the government since 2012 on amendments to the Retirement Villages Act and throughout this time has been the industry's voice on proposed changes as well as offering free legal and technical advice on the practical implementation of amendments, even in situations where we disagree with the policy intent.

You have no doubt read our submission and will know the basis of our concerns. You will note from our comments that the Property Council does not support the extension of what are referred to as the buyback provisions to include freehold property. We disagree with the explanatory notes and we dispute comments made in the media by the minister that the original amendments made through the Housing Legislation (Building Better Futures) Amendment Act 2017 were intended to capture all tenure types. Indeed, the term 'buyback' would imply that a unit was previously owned by the entity required to buy it. In the case of freehold it was not necessarily owned by the village operator and it would be more appropriately referred to as a compulsory acquisition. As you would know, there are significant differences between leasehold and freehold property, and as such we see this bill as legislative overreach that impinges on the property rights of those currently owning and residing in property in freehold retirement villages in Queensland.

As you have read in other submissions lodged and will no doubt hear from other witnesses today, the proposed amendments will have a negative impact on many of the residents they are intended to protect. It should be noted that the buyback proposition will have the greatest impact on villages in smaller regional areas of Queensland, particularly those run by small village operators and those which are effectively owned and run by residents' associations or bodies corporate. More broadly, the legislation may have a suppressive effect on the entire freehold village market. There has already been significant media attention surrounding amendments, and once they commence any media scrutiny surrounding units being bought back by operators will impact the overall perception regarding demand for—and therefore the value of—freehold retirement villages. As Rachel Lane noted in her article in the *Sydney Morning Herald*, where an operator has bought back a unit there is little chance it will be sold again as freehold, thereby limiting the future supply of this housing type in Queensland. There are numerous amendments proposed in our submission, but I would just take this opportunity to draw your attention to our five biggest issues with the drafting and practical implementation of the legislation.

Firstly, our greatest concern is with the retrospectivity of the legislation and the date from which it is proposed to take effect. Retrospectivity breaches fundamental legislative principles. With such significant financial implications for everyday Queenslanders it is hard to believe that the government would agree to make this proposal retrospective to over 12 months ago effective from 10 May, or just six weeks after the commencement of the act. The village operators who are affected by the proposed amendments have not had adequate time to prepare their own business practices, let alone source any additional finance that would be required to buy back unsold units. On a practical level, the legislation has not yet passed. Elements such as standard contracts have not been made available for consultation and the regulation has not been made. Providing all of the required information within a time frame that is practical from an implementation perspective should be paramount.

Secondly, the bill refers to the termination of a resident's right to reside as being the trigger for the 18-month buyback period. This terminology relates to leasehold. In a freehold unit the right to reside derives from ownership of the title by the resident. Accordingly, there is a lack of clarity in the legislation as to the trigger for when and how this 18-month period will begin in a freehold village context. Should the bill proceed, it is recommended that an express mechanism be introduced for the resident to give notice to the operator of the termination of their right to reside in their freehold unit, after which time they will be required to vacate and reinstate the unit in a timely way so that the sale process can begin.

Thirdly, unlike for leasehold, the operator currently has no automatic right to be involved in the sale of a unit or to operate as the sales agent unless they are specifically appointed by the seller. How is it fair for the operator, who had no involvement in its sale or marketing, to be required to purchase an unsold property? The operator is undoubtedly in the best position to act as the sales agent for a unit within their village, and the resident choosing then to cut them out of the process often provides a significant disadvantage to the sales process and would raise questions regarding whether all avenues had been explored in attempting to sell the unit. At a minimum, the legislation should be amended to ensure the operator is given the first opportunity to sell the unit.

Fourthly, given the significant financial burden the buyback obligations impose on operators, it is important that the proposed legislation appropriately address the need for former residents to cooperate with the sale process. Before a unit is able to be effectively marketed the former resident needs to vacate the unit, complete reinstatement and cooperate in agreeing the resale value or asking price at which the unit will be advertised for sale. The bill currently does not place clear enough obligations on former residents to do these things. Expiration of the 18-month period should be suspended by any period during which a former resident fails in these obligations in order to appropriately motivate the resident to cooperate with getting the property to market as soon as possible.

The proposed section 63A(6) does not impose these obligations on former residents, nor does it operate to suspend the buyback period in the event that a former resident fails to cooperate in doing these things. It is only fair that the bill be amended to do so. There is a requirement in the legislation that the operator and seller attempt to agree on a retail value in order to start marketing and then review the resale value every three months while the unit is for sale. Where they cannot agree, an independent valuation will be undertaken to determine the resale value. The buyback period should also be suspended by any period during which a valuation is being sought because the former resident and operator are unable to agree on the resale value.

A question also rises about those who wish to opt out of a compulsory buyback. Take the example of a small regional retirement village that may be in the midst of an economic downturn. We all know that many communities saw a significant drop in property values post the mining boom, with many only now just recovering. A resident in this situation may not want to take the current value of their unit and wish to hold out longer than the 18 months to see if the market improves. There is no express option for this to occur. For clarity, an opt-out provision needs to be included.

Finally, the Property Council is keen to understand if a regulatory impact statement has been undertaken and as a result what budget the government has put aside to step in as administrator when the inevitable situation of villages going under arises. Hardship provisions within the legislation allow for an extension of time for an operator to fund a buyback but do not remove the inevitability of a village having to pay out a resident. Particularly in the case of small resident-operated schemes, should multiple units come up for buyback at the same time it is highly unlikely they would be able to pay. Seeking hardship would be the death knell for many villages, as would public awareness of their inability to pay former residents. Who would buy into that village in the future, particularly knowing as a resident that they would be required to help fund any future buybacks?

If a comprehensive RIS has not been undertaken, it is recommended that the government take this as a first step before passing the legislation, to further consider the financial obligations it may be under to fund buybacks for villages entering administration. As you know, we do not support the extension of the buyback to freehold property. It should be noted that we did support it for leasehold and have significant concerns with the drafting and time frames for implementation.

I have with me here today Robin Lyons, a partner at MinterEllison. He is well known as the best retirement village lawyer in Queensland. Either of us would be delighted to help with any questions you have today.

CHAIR: No pressure there, Mr Lyons. We will hear from others, but I have one question relating to the Property Council submission. On the last page, you state that other jurisdictions have forms of buybacks, albeit they are not compulsory purchase. Can you advise which jurisdictions?

Mr Lyons: There are certain limited buyback rights in Victoria, South Australia and New South Wales. They are limited to the extent that they are really limited to people who move into aged-care facilities and require the bond in order to enter aged care, and the extent of the payback is limited to the amount of the aged-care bond requirement. In New South Wales, the buyback obligation is limited purely to contract types where the resident is what is classified as a non-owner resident. They have a form of contract that involves them receiving less than 50 per cent of the capital gain on resale and/or have a licence rather than a lease. The philosophy behind that is that they are not really like a true freehold owner in that they get capital gain and, therefore, they are treated differently in that legislation. There is nothing as broad as this proposed legislation and certainly not applying to freehold in any jurisdictions; only leasehold or licence type tenures.

CHAIR: That is interesting. At the moment we are looking at aged care in relation to another matter. That is something that we will take on board. We will take opening statements from our other guests and then broadly open up to questions for everyone. Go ahead, gentlemen.

Mr Graf: Good afternoon. My name is John Graf. I represent the Pebble Beach Retirement Village, which consists of 151 freehold units. I, as well as other unit holders, purchased our units as freehold property. This meant that we would not be liable for any exit fees and would also avoid buyback provisions adopted by some scheme operators. When the time comes to vacate the village, I have the right to sell my unit on the open market without any restrictions by the scheme operator or any new legislative requirements. The current proposed amendment should recognise the significant differences in the tenure types and make allowances for freehold villages, which the current amendment proposal does not.

If the changes were adopted, it certainly would have detrimental financial impact on the unit owners such as, firstly, it would cause significant financial hardship to our owners, and most of them are in their very senior years. Secondly, it could create a situation, as explained in our submission, where the village may have to obtain loans to fund the purchases of the vacant units, thereby imposing a levy on the remainder of the unit holders. Thirdly, it would have a very adverse knock-on effect to the prices and, in fact, the saleability of the properties. Lastly, it could force the village to relinquish its status as a retirement village, which would not really be a desirable option certainly at Pebble Beach.

We do understand that there needs to be protection to all the residents of the retirement village sector. However, in this instance we believe that an exemption is warranted for freehold villages as such that have no exit obligations. Therefore, I and we as a village would respectfully ask the committee to consider the facts and grant an exclusion to this tenure type.

CHAIR: Thank you very much. Dr McCorquodale?

Dr McCorquodale: My colleague Mrs Lyn Shorthouse and I thank you and your committee for the opportunity to give evidence concerning the recently introduced Health and Other Legislation Amendment Bill. Three other members representing the executive committee are also in attendance and are seated to my right. They are Mr Graham Newman, who is the Domain Residents Association treasurer, Mrs Margaret Gampe and Mr John Quinn. They are also available to respond to any questions you may wish to address to them. We all appear as the elected representatives of the approximately 420 residents of Aveo's the Domain Country Club Retirement Village at Ashmore on the Gold Coast.

I must apologise for incorrectly stating in our submission that there are 488 residents; that represents the capacity of the village. The most recent survey of residents conducted there late last year shows that no less than 43 per cent are on a full pension and another 29 per cent on a part-pension, which is a total of 72 per cent of all residents. 61 per cent of the residents are female and live alone, 33 per cent are male and six per cent are couples. 31 per cent are aged in their 70s, another 42 per cent in their 80s and another 17 per cent in their 90s. Only 10 per cent are in their 60s or less. Of the total resident population in the village, 40 per cent are in freehold, 34 per cent are in leasehold, 12 per cent are under Aveo Way contracts in either freehold or leasehold, and the remaining 14 per cent are in assisted living/serviced apartments.

I cite these statistics to indicate to you the hybrid nature of our village and the challenges on so many fronts that that presents. I should like to deal with those challenges in respect of the first three categories, namely, freehold, leasehold and Aveo Way contracts. Our freehold residents join with us in recording our deep appreciation of the robust response of Minister de Brenni to close what industry representatives, particularly Aveo, have maintained is a loophole in respect of the 2017 legislative amendments regarding the 18-month time limit for the payment of exit entitlements. As mentioned in our submission, we support in their entirety the provisions of the bill now under consideration.

The major benefit in freehold is that it will ameliorate the financial burden for ex-residents or deceased estates to pay ongoing sinking fund levies, council land and water rates and electricity charges until settlement of the sale of the subject property. In our village, in some cases this has been known to take up to five years. While the 2017 amendments brought some much-needed changes to the new Aveo Way leasehold contracts introduced in April 2015, we should like to see further amendments to improve the lot of existing freehold or leasehold residents on contracts entered into before this date. In fact, the Aveo Way programme heralded for us a brand-new set of requirements not included in our pre-Aveo Way contracts. First, Aveo now insists that all units be vacant before the sales process can even begin. This places extreme emotional and financial pressure on those relying on the sale to finance their new living arrangements, whether serviced apartment/assisted living, nursing home or other alternative.

Secondly, the contractual requirement to reinstate the unit to a marketable condition, as defined in the Retirement Villages Act, means generally repainting, re-carpeting and any needed repairs, all at the expense of the vendor and costed by Aveo generally in the range of $16,000 to $20,000. However, Aveo now suggests that refurbishment also is required to bring the unit to what Aveo considers a marketable condition. This additional work is usually a complete remodelling of the kitchen, laundry and bathrooms, new light fittings, insect screens and door handles at a total additional quoted cost to the vendor, in some cases that we have seen in our village of between $60,000 and $95,000. Once exit fees and legal expenses are also deducted, the balance payable to the outgoing resident is considerably reduced. In the last five years, the calculation of exit fees imposed by Aveo has increased from 25 per cent in some cases of whichever is the greater of the resale price, the in-going contribution and the resale value—depending on the contract entered into—accruing over the first 10 years to the current 35 per cent now accruing over just the first three years.

Thirdly, we have seen how Aveo Way residents living in a body corporate area where Aveo is the owner of the lot are paying up to $150 per month more than an Aveo Way resident living in a purely leasehold area of our village. As we mentioned in our submission, Aveo has been unable thus far to offer any plausible reason for this discrepancy, our repeated requests for the same over the last three years notwithstanding.

The final injustice is when the freehold unit is sold. On the settlement day, Aveo interposes itself between the outgoing resident from whom it acquires the unit and then instantly sells to the incoming resident a 99-year right-to-reside lease. The only money that changes hands is from the incoming Aveo Way leasehold resident to Aveo and from Aveo to the outgoing freehold resident. We have no means of telling if the two amounts are identical. To us it is an acquisition by stealth, because Aveo is enriching itself by acquiring title to a considerably enhanced capital asset at virtually zero cost to itself. We consider that a more equitable solution would be for Aveo to purchase outright the unit and refurbish it to its desired standard and entirely at its own expense before granting an Aveo Way lease to the incoming resident.

We understand that there are presently more than 19 separate iterations of a lease in force in the village, with little consistency between one and another. Toward the end of last year we had the bizarre situation when two elderly female residents on separate leases suffered the loss of their hot-water systems on the same day. Aveo replaced one system but not the other, relying instead on the strict letter of the contract in respect of the one who missed out.

That brings me to the vexed issue of Aveo's *Capital Replacements Philosophy*. For many years it was the practice in our village for Aveo to replace fixtures, fittings or appliances in licence and leasehold residence contracts, irrespective of what the contract stipulated once they had become defective or beyond their effective life within the guidelines issued by the Australian Taxation Office and which the DRA successfully negotiated with Aveo in 2014 to adopt. This was then enshrined in a document entitled *Capital Replacements Philosophy*, signed by Richard Andrews, then Aveo's Territory Operations Manager and issued on or after 19 October 2015. This continued to be applied until 4 July 2018 when one of Aveo's senior managers—

CHAIR: Excuse me, Dr McCorquodale. I appreciate that you have articulated the points very well, but I think we are starting to wander away from the scope of the bill when it comes to Aveo and their practice management. In consideration of the time available, we might move to Caxton Legal Centre and then open up for questions.

Dr McCorquodale: Thank you, Mr Chair.

CHAIR: Thank you, Ms Smeed.

Ms Smeed: I am a lawyer with Caxton Legal Centre's QRVPAS, which was formerly known as PAVIL. Caxton is an independent, not-for-profit community organisation that provides free legal advice, social work, information and referral services with a focus on assisting disadvantaged

persons. Within Caxton, QRVPAS is a specialist service for Queenslanders living in retirement villages and manufactured homes. Since 2014 we have provided legal advice to nearly 2,000 individuals and delivered education sessions to over 6,500 participants at parks, villages and community groups. We were involved in the consultation regarding the recent changes to the Retirement Villages Act and we continue to work with other resident advocacy groups through the Right Where You Live initiative. For these reasons, we believe we are uniquely placed to comment on the legal issues that are encountered by residents of retirement villages.

Like many resident groups, we were pleased to see the introduction of the 18-month mandatory buyback period. In our view it was always apparent that the policy intent was for these provisions to extend to freehold villages, and we welcome the introduction of further amendments to clarify this situation. As is set out in our submissions, we believe these changes are necessary to ensure that all retirement village residents are able to exit their village on fair terms.

It is our understanding that, while freehold retirement villages comprise only a small percentage of the market, many of those villages have residence contracts that impose restrictions on how residents' freehold homes can be sold. In addition, the act empowers operators to evict residents from villages in certain circumstances. This means that, notwithstanding the fact that some residents may have freehold ownership of their homes, they are still vulnerable during the termination and resale process.

To give you an example, I recently spoke to someone who was acting under a power of attorney for their elderly parent. The parent had had to move to aged care for health reasons, and their freehold unit was left vacant and waiting to be sold for a significantly long period of time. This person who was caring for their parent was expecting to receive a mandatory buyback in May this year so their exit entitlement could go towards the aged-care costs for their elderly parent. I had to explain to that person that the mandatory buyback period would not apply in their situation under the current version of the legislation simply because the home was freehold. That person could not understand why they were being treated differently because of what seemed to them to be an arbitrary distinction under the legislation. I think most people who are involved would agree that this is clearly an unfair outcome.

We appreciate that a number of concerns have been raised by industry groups and by some residents who fear that these amendments will have unintended consequences. With regard to the industry perspective, it was always anticipated that there would be complaints about the retrospectivity and the financial threats to the viability of operators. However, I believe these concerns are already addressed within the act itself which provides special exemptions for financial hardship and also a review mechanism to ensure that the impact is assessed in the near future.

The reality is that these amendments are merely seeking to balance the financial viability of the industry with the need to ensure our seniors have secure and affordable housing. To an extent we do agree with the suggestion that some of the proposed amendments could be better worded. For example, we acknowledge that there may be some circumstances where residents with freehold units already have complete control over the manner in which their home is sold. They may not have to vacate before the home can be reinstated or placed on the market. They may retain capital gains and may not have to pay exit fees. In that situation it could be accepted that those residents may not benefit from the mandatory buyback. However, to address these concerns I submit that the committee could consider amending some definitions. For example, the definition of freehold property could only extend to homes that are the subject of termination or resale obligations. Similarly, the term ‘scheme operator' could be further defined to ensure the act compels only operators and not residents to cover the costs of any buyback.

In addition, operators should be prohibited from passing on buyback costs to residents. Alternatively, if a village is effectively being run by residents as a body corporate, I believe concerns about mandatory buyback obligations could be better addressed by seeking deregistration of the retirement village itself. Thank you for considering our submissions and I welcome any further questions.

CHAIR: Thank you very much, Ms Smeed. We will open up to questions.

Mr McARDLE: Thank you for being here today, and thank you for your submissions and your documentation. There is a contrast between the Property Council and Caxton Legal Centre as to what took place during discussions, submissions and then consultation, and I suspect at the hearing of the last bill. It would have been better, I think, if this bill had gone back to that committee. We are not that committee. We will do our very best, but to my way of thinking this should have gone back to the committee that dealt with the initial bill in 2017. They have the history of this matter; we do not. Ms Smeed, you made the comment that there are certain freehold property owners who enter into an arrangement that they will sell their freehold in a certain manner.

Ms Smeed: Yes.

Mr McARDLE: That is by choice, is it not?

Ms Smeed: It is.

Mr McARDLE: Correct. What we are doing here, though, is imposing upon people who have not taken that option to sell their freehold property. I am concerned that one of the basic tenets of our land registration and land ownership is the right to hold property in freehold, and to restrain that is running contrary to many of the tenets that we hold dear in common law through to Australia in the Torrens system. I do not understand why we are now taking away a right unless you have already given that away.

Ms Smeed: To begin with, when you say that people are entering into these arrangements by choice I think there are a lot of factors at play which limit the ability of people to make informed choices, and that is one of the issues that the act is intending to address. Also, when we look at people with freehold interests in retirement villages, the residents of Pebble Beach are perhaps an example of those who did make an informed choice for a specific reason and who understood the consequences of purchasing a freehold unit. However, we also have residents here today from Aveo and those residents are very limited in the way that they can exercise their rights as a freehold owner. While technically they own the property on a freehold basis, they are still constrained by Aveo and the way in which Aveo places restrictions on the sale process—how they can sell the home and even the manner in which someone else can purchase the home and acquire an interest. In my view, that means freehold ownership of a retirement village unit is not really the same thing as freehold ownership of a property in body corporate, strata arrangements or other types of freehold interest.

Mr McARDLE: Can I get a comment from the Property Council on that?

Mr Lyons: I do not quite understand your comment that residents of freehold villages do not have a right to sell their unit. The reality is that it is not possible to contract in advance under the Queensland laws of Property Occupations Act to be engaged with an agent to sell a freehold interest at the time a resident signs their resident's contract. At the time they wish to leave a village, every freehold resident in Queensland has absolute freedom to appoint who they wish to sell their unit, and any contractual arrangements that would seek to change that position would be unlawful. This is the very point the Property Council is making: in a freehold context a resident can choose whichever agent they wish to sell their unit. They can sell it themselves. The operator has no right to be involved unless they have the cooperation of the former resident or the resident who is leaving, and therein lies the issue.

If we are going to put a legislative provision in place that says, 'In 18 months time the operator has to pay the resident back the value of their unit,' it would be extremely unfair if an operator had to sit on the sidelines and not see that unit being properly marketed or marketed at all, because in this legislation there is no obligation on a former resident to do anything to promote the sale of their unit. That is fundamentally unfair. Frankly, if this were to go forward the way it is I think it would be an extremely unsatisfactory piece of legislation. I do support your views that there is something fundamentally contrary to the tenets of freehold property ownership that we have a position here where the Queensland government is looking to legislate a compulsory sale of a unit to an operator or compulsory acquisition by an operator. There is no legislation like that in the whole of Australia.

Mr McARDLE: Can you confirm, Mr Lyons, that there is no jurisdiction in Australia that replicates the freehold buyback as outlined in this bill?

Mr Lyons: Correct.

Ms Smeed: May I respond to some of those points?

Mr McARDLE: Of course.

Ms Smeed: When I was talking about restrictions on the sale, it is not just about who you can appoint as the sales agent. There are restrictions where people might be required to vacate their freehold home while it is placed on the market and sold. That is not the normal process with people who own freehold properties who usually continue living there until they find someone to buy it.

Mr McARDLE: If I have to go into a nursing home, I might vacate the property before it is sold and sell the daily rate but I am not occupying the house.

Ms Smeed: That is correct.

Mr McARDLE: I might be in the home for six months but the freehold property is vacant so it is not quite right to say they remain in the home. In many cases older people go into a nursing home and the house could be on the market for a lengthy period of time. Then they sell the property.

Ms Smeed: That is correct.

Mr McARDLE: There are many circumstances that we should be considering, are there not?

Ms Smeed: If that did happen and it was a freehold property—a house, let us say—then you would have the ability to rent it to someone else or to let someone else live in the home which you do not have for a property in a retirement village.

Mr McARDLE: The principle, though, is that I am out of the property and what you are saying is that does not happen. It does happen. How you use the property is beside the point.

Ms Smeed: I am not saying that does not happen. What I am saying is that you then have houses sitting there vacant that cannot be used by other people and they are subject to these restrictions on how they can be sold.

The other problem I highlighted was the ability of the village to evict people. If you own a freehold property you normally have a right to live there and that is not subject to someone else coming in and telling you that you can no longer live in that home. That is another restriction that affects how people can live in retirement village homes.

Mr McARDLE: Do you want to make a comment, Mr Lyons?

Mr Lyons: The essence of a retirement village is that it is a community of retired or older people. It is important—and the legislation supports the view—that are some restrictions on whom units can be sold to, because it would not be appropriate for, and most residents in retirement villages would be very unhappy about, 21-year-olds to move into retirement units. There are naturally appropriate restrictions in residents' contracts around the qualifications of who buys in so they need to be suitable.

The Retirement Villages Act itself says that operators can choose lawfully to not accept applications from incoming residents where the unit is not suitable for them—in other words, they may need care that is beyond living independently or the type of unit that is available at the village and/or are of a particular age. The Retirement Villages Act specifically acknowledges that age discrimination will not apply in a retirement village context for that very reason. The typical residents' contract does limit who can buy in but in very appropriate ways that suit the broader resident community. I have not known that there have been any significant concerns about that amongst the resident communities because they would be very unhappy if it were otherwise.

Ms Smeed: I appreciate that. What I am trying to say is that is a fundamental way that freehold interests in villages differ from freehold interests in other types of property.

Mr Lyons: In response to that, though, I am not sure that that difference would justify such a significant piece of legislation that requires an operator to buy a unit back that they have never owned in most cases.

Mr McARDLE: Dr McCorquodale, I have read your submission. Is Aveo the organisation that hit the media about 18 months ago when their contract terms and conditions were scrutinised? It was. When reading your submission it appears to me that it is Aveo involvement which is causing major concerns in your village; is that right?

Dr McCorquodale: That is correct.

Mr McARDLE: This committee is not looking at the contracts per se in relation to Aveo or other providers. We are looking at the right of freehold property owners to sell. As a matter of principle, would you accept that a freehold property owner should have the right to sell?

Dr McCorquodale: In a pure freehold, yes.

Ms PEASE: I would like some clarity around the comments that have been shared here by Brittany and Robin regarding the contract and sale and that, if you are in a retirement village, there is a requirement to use a prescribed sales agent. Dr McCorquodale, can you comment on what Brittany and Robin said? Is that the case at Aveo? In your particular circumstance we are talking about Aveo, but in other retirement villages if you wish to sell are you required to use a sales agent, or not? What is the position there?

Dr McCorquodale: If I may, I will ask Mrs Shorthouse to respond.

Mrs Shorthouse: As a freehold resident myself, I am in the unenviable position that at some time further down the track if my husband becomes infirm and needs to go into a nursing home, for example, I would have to move both of us out of our unit before I can sell it to finance him to go into a nursing home. There is no way in the world I can afford to do that. I would have nowhere to live.

That would take all of our capital. By law we are allowed to choose our outside agent and we can sell through whoever we want to. In our situation if I sell my house as a freehold, on the day that it is sold Aveo steps in and takes ownership of that property gratis and sells it as a leasehold. We do not have a choice as to who buys the property. Aveo buys the property, and they sell it on and sell it on as a right to live ad infinitum. From our point of view we are fine. We would just like to say that if they want to use the argument they should not be forced to buy the property, they are going to anyway. But they do not pay for it: we pay for it.

CHAIR: Mrs Shorthouse, some of the concerns I have read in the submissions relate to the valuation of property. Given that Aveo has control over this, are there any issues in that regard as opposed to an outside market representative valuing the property? Do you have any concerns about the valuation process?

Mrs Shorthouse: No. There are clauses in our contracts which state that we are allowed to question AVO's initial valuation on the property. Because it has to be an agreed valuation, if we do not agree we are entitled to bring in an independent valuer, at which point Aveo then needs to agree on the value price. This gives rise to another instance. I know of two different contracts, my own and someone else's, which state that because we have 100 per cent capital gain in our property, if we make a capital loss some of us have to make that difference up to Aveo. Why? They did not buy the property. They did not sell it to us. We bought it from somebody else who gained the 100 per cent capital gain. There are so many anomalies in the contracts that we do not understand. That is where we are getting confused. Our biggest problem is the fact that, if we are forced to move out, some of us just cannot afford to do it. We are stuck there. It is like they said in that *Four Corners* program. The only way most of us will get out of that place is in a pine box and it will be left to our estates to fight out.

Dr McCorquodale: At the moment we have 53 units for sale in our village. Only two of those have been with outside agents. The rest are with Aveo, or are likely to be. The vast majority at the moment are.

Ms PEASE: How long have you been living in your complex?

Mrs Shorthouse: I have been there 12 years.

Ms PEASE: Did you sell the family home to move into the residence at Aveo?

Mrs Shorthouse: I did.

Ms PEASE: You stayed in your private residence and you were able to live there until the contract was settled with Aveo?

Mrs Shorthouse: That is right.

Ms PEASE: Was the unit empty when you looked at it?

Mrs Shorthouse: It was. I believe the previous owner had passed away, and it was on the market for two years before I bought it.

Ms PEASE: You were able to sell your family home to move into an empty facility?

Mrs Shorthouse: Yes.

Ms PEASE: With regard to the expectations and costs involved for you to make good at Aveo—we have talked about that with the Pebble Beach retirement village—do you have those sorts of requirements at your complex?

Mr McClear: I am sorry, I missed the first part of that question.

Ms PEASE: We have heard from Aveo that there is a requirement to make good, bring the unit up to a certain standard. I know that complex is run a bit differently. It is a residents' association. Are there any expectations from the residents' association that before a property goes on the market it meets a certain standard?

Mr McClear: No, we have no control over that at all.

Ms PEASE: With regard to the residents' association that runs your complex, Brittany from Caxton said that you are registered as a retirement village. What are the benefits of that rather than just as a normal body corporate? Is there a certain benefit for you to be registered like that?

Mr McClear: There is. Under the Retirement Villages Act we can decide who comes to live in the village. Through the scheme operator company we can enforce the over-50 condition, for instance. You have to be over 50 to live in that village. You have to be an owner occupier. That is probably the limit to which we can control who lives in that village. I think it was said that when you

go into a retirement village you expect to be living with a cohort of like-minded people of a similar age. A lot of single women, for instance, or single people move into a retirement village situation for security. If we had to jettison our retirement village status, that would cause considerable concern to a fairly large percentage of our village. They go there for a reason; it is simple.

CHAIR: There is a certain percentage of the market that is freehold versus leasehold. To avoid the financial burden and all of the other things that have been spoken about in your submissions, is there a process to move from freehold to leasehold? How long does that process take? Is there an avenue to move out of freehold? How do you do it? How would you go through that process? Would you have to sell?

Mrs Shorthouse: Yes. The new Aveo Way contracts, particularly the certainty ones, allow you to transition from freehold to leasehold within the same village. You can move from freehold to a serviced apartment within your own village, another village or anywhere like that, but you pay extra each year. It is called a membership fee, which is in the form of about $2,000 to $2,500—I do not know exactly off the top of my head—per year uncapped for the time of your residency. That goes some way to covering that, but there is no set process in place for a transition within the Aveo guidelines. They do, and have done occasionally when serviced apartments are undercapacity, offered residents within The Domain the opportunity to move out of freehold into serviced, but you sign your leasehold agreement out, you pay your exit fees, you go into the serviced apartments, you make a new contract and you go under the Aveo Way. You basically end up paying exit fees every time you move.

CHAIR: Have any of The Domain residents considered doing that, or have they done it?

Mrs Shorthouse: We have people who are waiting at the moment to move into serviced apartments but they are being told, 'I have cash buyers out there. You sell your unit and I will talk to you.'

Mr BERKMAN: Ms Williams, you mentioned some elements that you thought should be added to the bill if it is to proceed. If I recall, some of those were around the need for notification on the termination of a right to reside. There were a few others, and maybe you could remind me of those. Given that we have heard so much about the many and varied contractual terms that dictate terms of engagement between scheme operators and residents, are those issues that could simply be dealt with in contracts?

Ms Williams: I would say no. As Robin said before, under freehold in Queensland you cannot sign away at the beginning who you are going to sell with years later, so there are some amendments that cannot be dealt with in contracts. They have to be dealt with in the legislation itself.

Mr BERKMAN: I do recall the comment from Mr Lyons, and maybe you could elaborate on what that restriction is specifically. For example, in my own personal experience, having dealt with a sale upon the death of a family member, I am supposed to be a lawyer and I do not know what the nature of the tenure was on that unit because it was such a bizarre contractual arrangement. There was a portion of the capital gains that her estate may have been entitled to keep. I suppose there were within that contract a whole bunch of obligations and entitlements for the scheme operator which seem in some ways quite fundamentally inconsistent with our notion of freehold. I am really just curious to know: what, if any, of those issues that you think require redress in the bill cannot be dealt with under contract?

Ms Williams: There is a huge list of them at the back of our submission. It would take all day to go through them line by line. There are a lot of them that cannot be dealt with by contract because of freehold. I have not seen the contract that you were referring to, but I know that a lot of these would need to be dealt with in legislation and cannot be part of a contract under the current laws in Queensland.

Mr Lyons: To elaborate, there is a difference between freehold and leasehold in relation to the selling rights and the way that real estate licensing laws work in Queensland. In Queensland, given the nature of freehold title, if someone is going to act as an agent to sell freehold title they need to be a licensed real estate agent, particularly for reward, and in this context there would be an element of reward in an operator doing that. Under the real estate laws you need to be appointed formally under an agency appointment, which has to be for a limited period of time. You would be familiar with the normal real estate market.

When you are signing up a resident to live in a village where they will be for five or 10 years, it is not possible to contract with them that you will be the sole agent to sell their unit when they leave. That is a decision that has to be made at the time, and I am confident that Aveo does that because I

know they do. The resident always has the choice at the point of sale as to how they want to sell their unit and who they want to sell it to. They can go down the road and use Ray White, Richard Ellis or any agency they wish. Aveo is an example of an operator that has a real estate company, and some operators do. The reason they choose them is because they are specialists at selling retirement units. They know the sector. They sell well because that is what they do. Like any specialist, they often get a better result. Residents often choose operators who have the ability to sell under real estate licensing because they get better outcomes, but they are not obliged to under any circumstances.

The other elements that are critical for me in this exercise is if we are going to impose such a significant financial burden on an operator we need to make sure that they have 18 months to sell. That is the theory behind this: that an operator has 18 months. If the unit is not sold in 18 months then they buy it back. If that is going to happen we have to look at what might be an impediment to that happening, and there are a number of ways in which residents are required to cooperate with that process. One is that it is very hard to sell a unit properly if it is occupied—to market it really effectively. If there is going to be such a significant burden, is it not only fair that an operator, or whoever the agent is, is able to bring someone in to a well-presented premises that is going to maximise its ability to sell? There is also reinstatement.

There have been all these discussions about reinstatement. The Retirement Villages Act imposes obligations about reinstating every retirement unit in Queensland. The philosophy behind the act is that the government has imposed an obligation on units being reinstated on rollover for the very reason they do not want retirement village units in Queensland to diminish in quality and standard, and that is embedded in the Retirement Villages Act. The Retirement Villages Act dictates who must pay for that reinstatement and in the freehold context traditionally until the recent amendments the Retirement Villages Act specified that the freehold resident owner was responsible for the cost of reinstating their units. That was a statutory imposed obligation on residents. It was nothing to do with operators. It is reflected in their residents' contracts because that is what the law is. Reinstatement is another point. It is very hard for anyone to sell a unit effectively if it needs reinstatement—if the carpet is in poor quality, if it needs repainting, if the kitchen is damaged or if the benches are damaged. It is not going to sell well. It is important that those reinstatement obligations are undertaken quickly so that, again, in the 18-month period the unit can be properly marketed. That is the other very significant one.

The other one is agreeing the resale process. It is not an uncommon situation in a retirement village setting where operators have a lot of difficulty in agreeing resale prices with former residents and their estates. It is not uncommon for vendors of properties to have unrealistic expectations about sale prices. It happens in the broader community all the time, and real estate agents are constantly trying to make vendors realistic about sale prices. It happens in the retirement village industry. If there is not agreement about resale price, an operator or any agent cannot even begin to sell because they have no price to advertise at. That is the point we are making: if we are going to have this compulsory acquisition process, there need to be some obligations on residents and former residents and their estates to cooperate in that process. It has to go through a process of evaluation where the value has to be agreed between the former resident and the operator. That is also in the RV Act. If they cannot agree, it has to go to the chief executive who will nominate a valuer.

That whole process will take weeks and weeks and weeks. All of this time the unit cannot be marketed properly and your 18 months is being eroded and eroded. It is not uncommon, and I see it all the time, where six to nine months down the track the operator or whoever is selling the unit has not been able to start marketing. What the PCA is saying is that if this is going forward more thought needs to be given to putting proper motivations in place for former residents to cooperate in all of that process. If they do not, that period needs to be stayed or extended so that the 18 months is fundamentally used for marketing and selling and not significantly eroded by all these delays. That is very important.

CHAIR: Thanks, Mr Lyons. Brittany, did you want to respond?

Ms Smeed: The comments made by Mr Lyons do not accord with my experience, and that is because we approach this from a different angle. I do not understand this concern that residents would not cooperate with the sale. They are waiting to get the money back on their investment. They have other expenses they need to cover. I do not see any incentive for them to purposely delay the sale of their home or sit back and wait the whole 18 months. Most people I have spoken to are struggling during the whole 18 months to afford their living expenses while waiting for that buyback period to kick in.

In terms of having the village operator as the exclusive sales agent, I have seen many circumstances where particular operators will delay the sale because there is no incentive for them to proceed with the sale at least for the first six months while they still sometimes receive general services contributions. There is really no opportunity for recourse for former residents if the village is not proactively marketing the unit.

The village operator also occupies a position of power where it is very difficult to use another agent, not always because the village operator is so skilled and experienced at selling homes of this type but because they have physical control over the environment where the home is being sold. They can make it very difficult for other agents to enter the village, invite people in to inspect the home, and they can also make it much more inaccessible to sell a home through other agents because they do not have a sales office like the village does. It is really a question of what power they have over that process and I can see potential for abuse if they have full control over the sale up to the 18-month period. I can see the potential for that to be significantly delayed not because of residents but because of operators' actions.

CHAIR: Thank you very much. Unfortunately, we are out of time.

Mrs Shorthouse: Can I make a very quick comment?

CHAIR: You have one minute.

Mrs Shorthouse: I believe this sort of delay could be simply prevented by the scheme operator stopping insisting on people moving out before it goes to the sales process. This negotiation can be done before the person is required to move and the sales process begins.

CHAIR: I agree with the member for Maiwar. I think those situations could potentially be resolved in the contract.

Mr McARDLE: Is there a review underway of these contracts? I thought from the publicity that came out of Aveo some time ago there was a review underway about the terms of these contracts and the breadth of the term of these contracts. They differ so dramatically from contract to contract, and you need a law degree to understand page 1 let alone page 400. Is a review underway, do you know? I am trying to work out whether there is a way forward to capture the concerns—

Ms Smeed: Yes, I am aware of some village operators who are proceeding to review their contracts and make them more consumer friendly. However, that is in the context of how complicated they are already. The industry is also attempting to say that it can self-regulate through the proposed retirement village code of conduct which I believe is an initiative of the Property Council of Australia. However, my concern is that the ability to self-regulate is not there and that has been demonstrated over the history of how the industry has operated.

Mr Lyons: As part of the 2017 amendments, there is a stage 2 of implementation yet to occur in coming months. That includes the review of residents' contracts in terms of maybe prescribing by regulation permissible terms, prohibited terms and potentially a standard form contract. I think that is still under consideration, but there is certainly ability in the regulations now for those changes to occur if the government sees fit.

CHAIR: That is certainly something the committee will consider. I thank all of you for today. We have gone over time. We are all a bit more informed about retirement villages. I think we have all agreed that the leasehold side of it is good, but there are some issues as you have raised and articulated with the freehold side of it. I declare this session closed.

The committee adjourned at 1.38 pm.