15 March 2019

Mr Jaye Smith
First Assistant Secretary
Residential and Flexible Aged Care Division
Department of Health
GPO Box 9848
CANBERRA ACT 2601

FFBCONSULTATION@health.gov.au

Dear Mr Smith

Thank you for the opportunity to comment on options for strengthening regulations for managing prudential risk in residential aged care canvassed in the discussion paper *Managing Prudential Risk in Residential Aged Care*.

We note that options to strengthen prudential arrangements are being canvassed in parallel with the Australian Government's decision to introduce a retrospective levy to recovery RAD repayment defaults that exceed $3m in any year, and in the context of the increasing value of refundable accommodation deposits held by residential aged care providers. These factors together make the review of current prudential arrangements timely.

In assessing options for strengthening prudential regulations, we had regard to their simplicity, efficiency and propensity to encourage 'right behaviour'. The latter is a fundamental tenet of the stewardship approach taken by Catholic services which emphasises a prudent and conservative approach to capital financing and business operations - to the extent that no Catholic provider has ever been in a default situation.

Having regard to the above, the following sets out Catholic Health Australia's position on the options canvassed in the discussion paper.

1. Require approved providers to report their corporate structures, including significant changes in beneficial ownership.

   Supported

2. Allow providers to report on a single entity or consolidated basis.

   Supported subject to continuation of the current requirement for segment reporting of residential care in the General Purpose Financial Reports (GPFRs), and consolidated reports being allowed to include related entities not involved in aged care.

3. The value of assets transferred outside the approved provider (which must be supported by a loan agreement) is not to exceed 80% of the value of the underlying asset.

   Supported in principle but we query the suitability of a percentage threshold given variability in the quality of different assets and their valuation. We would support instead the sub-option included in the paper which stipulates that transfers outside the approved provider must:

   - Be adequately secured by appropriate security, such as a mortgage (ranking below bank secured debt);
   - Have a clearly outlined loan agreement with repayments conditions clearly stated;
   - Be reported on clearly through the GPFR, including the purpose, terms and obligations of transfer/loan;
   - The GPFR including documentation relating to the transferor and transferee must be available to the Department if requested; and
   - If the asset transferred is a physical asset, there would be an independent valuation of the asset and appropriate remuneration for the transfer and reported in the GPFR.

4. Set a liquidity standard as a defined percentage of RAD money held by the provider (10%)

   Supported, but instead of six or ten years to achieve the threshold, providers be given two years. If after two years they have not achieved the threshold, they be required to submit a plan to achieve the threshold to the Department. Liquidity would be defined as real liquid or accessible funds being cash in the bank or a bank facility.

5. Introduce a capital adequacy metric, such as 20% equity.

   Not supported. Capital is subject to definition and valuation which would introduce administrative ambiguity and complexity. Moreover, we question the need for this measure on top of the other options, especially the enhanced liquidity standard.

6. Require providers to notify the Department of a change of circumstances that materially affects a provider's ability to be a provider of aged care within 14 days "after it happens", rather than the current 28 days.

   Not supported. The EY study found that information required by the Department is often delayed. It is not clear, however, that changing the timeframe for notification from 28 days to 14 days "after it happens" would make any difference. Identifying and assessing circumstances that can be considered as materially affecting a provider's ability to be a provider of aged care is not always simple to discern, and can take time to assess.

7. Prior consent of the Department to be given to material changes in the legal ownership and control of an approved provider.

   Supported

8. Require providers to adopt an industry standard on disclosure

   Not supported. The other options being considered in the discussion paper to strengthen the management of prudential risk supported by CHA would cover most of the disclosure requirements envisaged under an industry standard. Adoption of an industry disclosure standard in addition to the increased disclosure and regulatory requirements embodied in the enhanced prudential arrangements would likely introduce unnecessary additional and duplicated reporting obligations.

9. Develop a governance standard which includes generally accepted corporate governance principles, such as those adopted by ASIC, APRA, ASX and the ACNC), and impose an obligation for approved providers to produce a corporate governance statement which describes the extent to which they have complied.

   Not supported. The larger for-profit providers already have reporting requirements (ASX, ASIC), as do the not-for-profits (ACNC). Reporting against a governance standard would add to regulatory costs, with limited benefit.

10. Require providers to disclose to recipients of care and their families how RADs will be held or used, when it will be refunded and how recipients rank on a winding up of an approved provider.

    Catholic Health Australia notes that resident disclosure arrangements are already subject to regulation and law. Accordingly, Catholic Health Australia would not object to an agreed template of words to be used by the sector which explains to consumers the regulatory provisions concerning permitted uses of Refundable Accommodation Deposits (RADs), regulation of draw-downs, refund provisions and related matters. As RAD payers are unsecured creditors, any plain English document would need to outline the Bond Guarantee Scheme and prudential arrangements.

    Desirably, any template should be a Government-branded document.

11. Limit or phase out discretionary trusts

    Catholic Health Australia supports the phasing out of discretionary trusts.

12. Compliance with new liquidity and capital adequacy standards

    As advised earlier, Catholic Health Australia does not support the introduction of a capital adequacy standard. With regard to the liquidity standard, compliance provisions should require a non-complying provider 60 days to submit a plan for returning to compliance with the standard. CHA notes that the injection of additional capital is not a realistic option for most not-for-profit organisations.

13. Assessment of financial viability of providers by the Department

    Catholic Health Australia does not object to this option subject to:

    - Action by the Department to assess the viability of a particular provider by seeking additional information is taken only when there are evidenced-based concerns about viability.

    - Action should not take the form of a screening tool to which all providers would be periodically subjected, and should not require additional reporting by all providers.

14. Migration of all providers to Tier 1 financial reporting

Not supported. This regulatory requirement would result is a level of reporting for most not-for-profit entities that is not justified. Not-for-profit entities are not publically accountable to investors and the other options supported for strengthening prudential arrangements are sufficient to address risks associated with the timely repayment of RADs.

Thank you again for the opportunity to comment on the options for strengthening management of prudential risk. Please do not hesitate to contact Nick Mersiades (nickm@cha.org.au or 0417 689 626) if you wish to discuss any matters arising from this letter.

Yours sincerely

Nick Mersiades
Director Aged Care