Response to Senate Inquiry:

Aged Care (Living Longer Living Better) Bill 2013;
Australian Aged Care Quality Agency Bill 2013;
Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013;
Aged Care (Bond Security) Amendment Bill 2013;
Aged Care (Bond Security) Levy Amendment Bill 2013

Healthcare, Corporate Banking
Level 29, 100 Queen Street, Melbourne VIC 3000 Australia

Thank you for the opportunity to comment upon the proposed Living Longer Living Better legislation.

ANZ is the largest bank debt financier to the aged care sector with in excess of $2 billion of committed debt facilities funding providers for their development projects, acquisitions and their working capital requirements.

Accordingly ANZ has an obvious and acute interest to ensure that the proposed legislative changes advance the industry to improve both services to consumers and the financial sustainability of ANZ's clients, the service providers.

ANZ's position on the draft legislation is broadly supportive with one qualification being the proposed new accommodation bond regime.

Positive aspects of proposed legislation:

A number of aspects of the proposed legislation are welcomed:

- The removal of the distinction between high care and low care residential licences. This will ensure that high care residents with means (assets and income) will now pay an appropriate accommodation charge based on the amenity of the accommodation and their capacity to pay. This should remove the current cross subsidy from low care bond paying residents and improve industry viability.

- Increasing the accommodation supplement by $20 a day for supported residents for new facilities and significantly refurbished facilities. This should see a material improvement in the amenity of residential facilities accommodating supported residents.

- The significant increase in home care packages. This should enable many more of our elderly to achieve their wishes by accessing care and stay longer in the family home.

Negative aspect- changed regime around accommodation bonds

Whilst we acknowledge the above very positive initiatives in the legislation, ANZ is concerned at parts of the legislation which are likely to adversely affect refundable accommodation bonds as the principal source of capital funding for the industry. In turn, industry viability and investor and bank confidence may well be put at risk until these uncertainties are resolved.

The proposed legislative changes for accommodation payments introduce a number of mechanisms to improve consumer choice and equity with respect to paying for accommodation by:

- cooling off periods on choice of payment,
- financial equivalency provisions,
- my aged care website advertising, and,
- accommodation bond price capping.

Healthcare, Corporate Banking
Level 29, 100 Queen Street, Melbourne VIC 3000 Australia

The policy intent is to allow residents and their families appropriate time and information to choose between paying either a daily accommodation payment **(DAP),** a fully refundable accommodation deposit **(RAD)** or a combination of both.

But underlying the proposed changes would seem to be an implied policy change that over time RADs are replaced by DAPs. A significant shift from RAD to DAP would potentially have adverse consequences for the financial viability of many providers as well as curtailing investment appetite.

The most obvious proposed change which may see DAP preferred over RAD are changes to the asset and income test whereby in determining the proposed care co–contribution, the family home will be included to a value cap of $144,500 but no such cap applies to a RAD – this proposed differentiated treatment of the family home versus the RAD is not logical. A likely consequence of this will be that a better financial outcome for many resident profiles will be either to pay a DAP (retain the family home - home not sold to pay a RAD) or alternatively a reduced RAD is paid and topped up by a DAP. This seems to be the view of expert financial planners who caveat this conclusion on the basis that the proposed income and assets test changes are yet to be fully disclosed.

It is critical that full modelling and analysis of these asset and income test changes are conducted so that the likely shift from RAD to DAP can be more properly understood and industry and bank concerns allayed. DOHA and Centrelink have available the financial profile of current residents and this can be overlayed against the new asset/ income tests as a means of assessing the financial implication of DAP versus RAD in terms of predicted resident choice.

The Government understandably is concerned that the RAD bond pool is currently circa $12 billion. DAP bonds are less than 10% or circa $1 billion in notional value. The government guarantees the providers' RAD liability to repay residents upon leaving a residential facility. Treasury apparently sees this $12 billion RAD liability as an unacceptable contingent liability of Government.

But such Treasury contingent liability concerns need to be weighed against strong counterpoints to ensure that any shift from RAD's to DAP's is only modest and gradual and can be absorbed by the balance sheet of providers. These strong counterpoints supporting that the continuation of the current ratio (>90% RAD/ < 10% DAP) are:

- The current $12 billion of RAD bonds have been the dominant source of funding for building new aged care facilities, rebuilding old dated facilities and allowing large operators to acquire smaller operators who have chosen to exit the industry for viability reasons. Without capital raised from RADs, there would have been little construction of beds or other capital activity in the last decade.

- Bank debt supporting the industry is estimated at circa $4 – 5 billion. A material reduction in RAD bonds replaced by DAP bonds will inevitably require significant bank funding. If so, this will need to be gradual and measured so the bank market can be engaged with proper planning and consultation.

Healthcare, Corporate Banking
Level 29, 100 Queen Street, Melbourne VIC 3000 Australia

- RAD monies have funded the creation of aged care infrastructure. So for the majority of providers, the bond money received is no longer held in cash. If a RAD bond of say $250,000 on a resident's exit/ bond rollover is replaced by a DAP of $50 per day (notional DAP value of $250,000), the provider in most cases will not have $250,000 in cash (typically only a 10 - 20% liquidity reserve is maintained). In this instance the provider will be required to borrow from the bank at say 6% but the replacement DAP only earns 7%. Banks will lend to providers to cover a modest shift from RAD to DAP – but if there is a material permanent shift (say > 10% of a provider's bond pool), banks will not lend on a 1.1X debt service ratio – at least 2.0X is the normal debt service ratio required.

  So an equity injection will be required.

  It is unlikely that providers have access to such equity pools.

  The solution is to allow providers to convert the value of a RAD into a DAP at their weighted average cost of capital (WACC) of circa 14 -16%. WACC is the rate of financial equivalence for a provider which should be applied when converting a RAD to a DAP. Unfortunately, the proposed policy likely to be embedded in the new legislation is that the conversion rate should be the Maximum Permissible Interest Rate (**MPIR**), currently 6.95%, which is set at a fixed margin above the quarterly average 90 day bank bill rate.

  In summary, RADs in the balance sheets of providers work as an effective hybrid source of capital – contributing around 50 -55% in debt and 45 – 50% equity. Only when after a material reduction in RADs and an offsetting increase in DAPs will this be properly appreciated.

  If $12 billion of RAD's were replaced tomorrow by $12 billion of DAP, it is estimated that an equity gap of around $5 billion would exist in the industry.

  It should be noted that "for profit" providers have been the most active in building new residential care beds. This is not likely to change. "For profit" providers traditionally have relied very heavily, if not totally, on RADs to fund their capital works spend – reliance on DAPs to pay down debt on Greenfield developments inevitably will see further delays in the construction/ completion of much needed new beds to meet the increasing demand for residential beds from Australia's frailer elderly.

Benefit of bonds in high care

The Government's position is that the above concerns as to a potential reduction in RADs are misplaced as the proposed legislation by allowing bonds in high care, providers will benefit from a material cash flow windfall with a significant increase in the RAD bond pool.

Healthcare, Corporate Banking
Level 29, 100 Queen Street, Melbourne VIC 3000 Australia

We presently are unable to accept the Government's proposition as we are yet to see any financial modelling which:

- Validates in terms of timing and quantum the government's macro view that there will be a net increase in the total RAD pool as a result of bonds in high care.

  Behaviourally, it is counter intuitive that high care residents will pay RADs - instead it is much more likely DAPs will be paid. High care residents' typical length of stay is 6 -12 months given higher frailty whereas low care residents who presently pay RAD bonds typical length of stay is 2 -3 years. So the time period available for high care residents to be organised to pay RADs is much reduced compared to current RAD paying low care residents. Further low care residents typically take significantly longer to arrange their entry to residential care (thus greater planning time) given their lower acuity and greater ability to continue residing in the family home. Conversely, high care resident admission is much more event driven (sudden ill health, sub acuity event etc) and planned sale of the family home before admission is much less likely.

- Notwithstanding any macro view or hypothesis, what is the modelled range of potential cash flow impacts for individual providers? Straw man modelling is imperative. Those operators with a majority of high care beds and minimal bonds collected to date will inevitably benefit from bonds in high care. Whereas those providers operating with a current high ratio of bonded beds to residents and at the minimum concessional ratio are unlikely to materially benefit from bonds in high care. These typically are our clients.

DAP as the proposed primary reference point for bond pricing

A further unnecessary and avoidable complication in the proposed new bond regime is that DAP is to become the primary reference point for quoting a bond price and the RAD is derived by applying the MPIR. The policy logic is that using DAP as the primary reference price is somehow more consumer friendly or palatable – the basis of this policy logic is not obvious. This is the opposite of current practice where RAD is the primary price reference and DAP is derived.

The proposal to adopt DAP as the primary price reference has the unintended consequence that in a rising interest rate environment, RADs will reduce and DAPs stay fixed which will further exacerbate a provider's liquidity shortfall in the event that consumers elect to shift to DAP from RAD as a result of the likely change in the asset/ income test, as highlighted earlier.

We welcome the opportunity to discuss the proposed legislation in early course.

Healthcare, Corporate Banking
Level 29, 100 Queen Street, Melbourne VIC 3000 Australia