Institute
and Faculty
of Actuaries

DP18/10: Patient Capital and Authorised Funds

IFoA response to the Financial Conduct Authority

28 February 2019

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The Institute and Faculty of Actuaries (IFoA) is a royal chartered, not-for-profit, professional body. We represent and regulate over 32,000 actuaries worldwide, and oversee their education at all stages of qualification and development throughout their careers.

We strive to act in the public interest by speaking out on issues where actuaries have the expertise to provide analysis and insight on public policy issues. To fulfil the requirements of our Charter, the IFoA maintains a Public Affairs function, which represents the views of the profession to Government, policymakers, regulators and other stakeholders, in order to shape public policy.

Actuarial science is founded on mathematical and statistical techniques used in insurance, pension fund management and investment. Actuaries provide commercial, financial and prudential advice on the management of assets and liabilities, particularly over the long term, and this long term view is reflected in our approach to analysing policy developments. A rigorous examination system, programme of continuous professional development and a professional code of conduct supports high standards and reflects the significant role of the profession in society.

Q1: Do the category limits strike the right balance between enabling retail investments in patient capital while ensuring investors can redeem their investments in a timely fashion? If not, what changes should be made to existing structures?

Although the category limits are broadly appropriate, the current limits for NURS funds do not necessarily ensure that investors can redeem their investments in a timely fashion in all market conditions as other measures are required for commercial property funds during periods of market volatility (e.g. the Market Valuation Adjustments which were applied during the volatile market conditions in 2016) and/or spikes in investor subscriptions or redemptions (e.g. fund suspension).

Q2: Is there retail investor demand for a new type of authorised retail fund which can, for example, invest all its capital directly into patient capital assets?

We do not believe there is great demand for a new type of fund amongst most retail investors, certainly not the majority of members of workplace pension schemes. If it is not possible for NURS funds to hold materially more than 20% of their assets (e.g. 50%) in transferable securities then there may be a case for another category, although in practice this would probably diminish the attractiveness of NURS.

Q3: If authorised funds marketed to retail investors were permitted to hold more patient capital, what safeguards do you think are needed to adequately protect investors?

The IFoA supports the overall direction of the Discussion Paper, provided that the existing or new funds that make use of this flexibility have appropriate safeguards in place. We suggest that key safeguards should include:

- Having appropriate warnings in place for investors;
- Appropriate disclosures of the key risks and features of these types of assets, including spread costs and the potential impact of basis swings on fund price/valuations;
- The suspension of redemptions in the case of constrained liquidity at a fund level;
- Guaranteed liquidity in the case of “life events” including death, retirement at a pre-specified date, serious ill health or divorce settlements;
- Funds should not be forced to offer guaranteed liquidity to investors for voluntary switches, because any such fund that offers higher liquidity than the underlying assets will not necessarily be treating remaining unit holders fairly in the event of material volumes of redemptions.

Additionally we believe providers should not be put off developing such funds by overly onerous due diligence of potential investors (including the threat of retrospective mis-selling allegations). The overriding priority must be for appropriate products to be developed, otherwise the entire initiative will fail to deploy sufficient capital to make a difference, which would be a missed opportunity.

Such products will only be suitable for a subset of retail investors. This is clear from the experience with directly invested unit-linked property funds where, although the risks and potential restrictions on withdrawals/switches have been disclosed, they have clearly not been universally understood. A similar point applies to bid/offer spreads and the reaction of customers to the impact of a swing in pricing basis.

Q4: Should NURSs have a broader ability to finance infrastructure projects than is currently possible under our regime? If so, what changes do you think are necessary to our handbook?

As noted under Q2, we suggest that NURS funds should be able to invest significantly more than the current limit of 20% on holdings in transferable securities. We would also welcome a review of the rules that govern direct investment in immovables. If the scope for such investment is broadened then the FCA should consider how the investment in infrastructure projects would be valued during the construction phase.

Q5: Do the current rules governing QIS's provide professional and sophisticated retail investors with sufficient access to patient capital? If not, why not and what changes do you think are necessary to our handbook?

Yes.

If our rules do not provide sufficient access for QIS's to fund patient capital please suggest which handbook changes could be changed to address this.

Q6: If QISs are permitted to hold more patient capital, what safeguards do you think are needed to adequately protect investors?

The safeguards listed in Q3 would be needed, although some disclosure requirements could potentially be relaxed.

Q7: Do the current diversification rules strike the right balance between investor protection, by requiring a prudent spread of risk, and sufficient access to patient capital? If not, do we need a different or more flexible approach to diversification rules? Please provide an explanation of your answer.

Our view is that the current diversification rules should only be applied for each holding at the point of investing in the asset. Any subsequent upward drift in allocation due to investment gains or fund redemptions would then not lead to a breach of the diversification rules. However, to avoid the portfolio becoming excessively concentrated over time, for example due to a fund being in long term outflow, there should be an additional requirement at an aggregate level for the fund to maintain a reasonable level of diversification.

Q8: If authorised funds' scope to invest directly into patient capital assets other than immovables is increased do we need a remedy similar to the proposed mandatory suspension to avoid investors being treated unfairly?

We agree that suspension rules are needed

If you agree that suspension rules would be appropriate, please set out your suggestions as to what such a remedy would look like. If you do not think suspension rules would be appropriate, please explain why not.

One possible remedy would be that proposed in DP17/1 for assets to be valued by a specialist valuation service, where the valuation is based on expert judgement.

Q9: Why do you think the specialised funds have not been used in significant volumes?

High minimum investment sizes and investor restrictions lead to these product types being unpopular with providers. Hence they have had poor traction due to low product issuance. In addition, institutional investors can directly arrange these sorts of deals through segregated mandates, without the need for collective investment schemes to access these asset classes.

Q10: Are there specific features of these funds which prevent fund managers or investors from using them to invest in UK patient capital?

There are no adverse features, but low issuance levels mean that the patient capital initiative should focus on other product categories to be successful.

Q11: Are there other areas where the current regulatory framework creates unnecessary barriers, either directly or indirectly, to investing into patient capital?

Opening ISA assets to investment in patient capital could widen the potential pool of investors. This reflects the fact that many younger investors in particular will have predominantly ISA investments. We recognise that in practice such assets may only be appropriate for a minority of these investors, and generally as a component of a multi-asset fund.