

Network Healthcare Holdings Limited

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Netcare Analysts Day

Web cast – 07 August 2007



Richard Friedland – Netcare: Chief Executive Officer

We have got two more presentations and please bear with us. I know that we are running slightly late. I'm very pleased to formally introduce to you Adrian Fawcett who is the Chief Executive Officer of General Healthcare. He has flown in overnight to be with us today and tomorrow in Cape Town. As you'll know Adrian joined us on the 1st May. Prior to that I was acting as the Chief Executive in the United Kingdom. Adrian comes from a background that is not healthcare. I think it is important that he talks to us a bit about who he is. We decided we wanted a fresh approach. When we looked at candidates it was a pretty staid market in which most people had rotated through the NHS and other competitors. And Adrian coming from a background of Chief Operating Officer of Punch Taverns, running some 8000 pubs, understands scale and sales. We're not going to put a 6 pack in every patient's bed, but I'm going to leave it to Adrian to talk a bit about himself and where we are going in this very important division of ours in the United Kingdom. Thanks very much Adrian.

Adrian Fawcett – General Healthcare: Chief Executive Officer

Our hospitals may be a glorified hotel but the worst thing that can happen in a hotel is that you lose your wife on a bad game of poker. The reality here is that this is a business that the guys have bought that they should be damn proud of. I've been with it since 1st May. I'd like you tell you a little about myself, the business, the background and what we're going to do with it. Is this mic working? In process terms I flew in this morning. It is probably one of the rare times that you look as bad as your photo on the passport. So with bags under my eyes like hand luggage, I think some of the services that we can offer in our hospital may be nearer to me now than ever.

My background is in consumer activities, and most recently in multi-site retail. I've just run 9500 pubs across the UK and bought about 7500 of those, which has a lot of common similarities with the business we have now. I had Holiday Inn hotels for a while, ran a Vodafone and telecoms business and also engaged in breweries buying breweries for Interbrew. Arguably I have spent more people into our hospitals and I've just chasing them down. Right. We're going to cover the following topics. The market is slightly different, but all the things you've heard today are almost identical in the UK. There is just a slight interpretation that the NHS, the government provided service, is there for free and it can do all we have spoken about. However if you read the press you have a 28% chance of the ward you go in infecting you. You have to wait more than 18 weeks and on average it isn't available close to you. So there is a damn good reason why private healthcare can exist in the UK despite the NHS having an offering. In fact if the NHS was any other brand or product you probably wouldn't want to

trust it or drink from it or wait the 18 weeks to get your thirst quenched. So in reality there is an opportunity for us to extend the business that we now own.

Back to me. We're looking at a business which is people-centric. It is also scale business. Just like running 9000 pubs you have to understand the people coming through the door. It's not the brand proposition but understanding the motivations of why people want to come that is important when you are constructing your business model. Importantly we are also a big property player. Managing those assets and making sure you get a return on your capital investment is also very important. Just the same as if you're running leisure industry businesses. We've got a big leadership challenge and management integration. Over the last 15 weeks we have integrated Netcare UK and BMI hospitals together. So GHG is one company and one organisational company with two front ends. So that drives some efficiency but also gives us clarity over the propositions that we have. We've got a big challenge on interdependent growth. We have about 4500 consultants in our business. They are self-employed. They come and tender their wares in our facilities. But to make it unique we have to do something different that elevates us above and provides us with confidence to use our facilities over someone else's.

That uniqueness may be as simple as geography, because you are near their customers. And therefore their customers can get to your hospitals. And as the largest private hospital company in the UK we have the opportunity to leverage off our scale. We have to have consumer orientation. That patient journey is so important because it reinforces repeat visits. Word of mouth is probably the most important referral pattern that you'll ever get. You'll see an advert for something and you may respond off the page. But more important is if you speak to four or five of your friends and they all say the same thing about their patient experience. If they think it has been tailor-made for them they are more likely to vote for it next time and refer to other people. On average ladies will tell at least eight people if they have a good experience. 16 people if they have a bad one, so we have to bear that in mind. We have also got to work with our industry partners. This is not just plain sailing. The UK market is not without its challenges and we will talk a bit about those. The similarities between leisure retailing, trying to extract from consumers' disposable income, is very much the same as healthcare. Nobody wants to spend money on healthcare until you need it. A rich guy will happily spend as much money as he has to try and retrieve his health. A poor guy would never swap his health for money. And that is important for us to realise in the UK, because we're competing against the NHS which is there for free.

There has been an effective handover between Richard and I and the business is in good shape. In terms of reconfiguring this business we have looked at it just like you would do in coming into any other organisation. What are the priorities? Sales, costs, cash and asset utilisation. If you go through

the presentations you've seen today on the South African business you can pull those same threads out. The challenge for the UK is on the sales line. What we are doing well is cost and cash control, and now we've got to reconfigure these assets. Maybe of these hospitals have been there for 30 years, and have evolved from Victorian nunneries to their current position today. In reality that means they have been invested in. Healthcare has moved on. Many of the operations that were done ten years ago and took a week to recover from are now done in a day. Therefore the configuration to the mix between the number of theatres and number of beds is no longer necessarily relevant because you don't need as many beds, you need more theatres. So understanding that, we've had to put in a new reporting mechanic and try and get transparency over what the issues are, both at hospital level and as a company on those four measures.

We have integrated the back offices. We have established a working business plan for every hospital, and that is critical and important. Hospitals are local to their community. People travel a certain distance for a specialist, and we saw tremendous stats in terms of 124 km in the hospitals here. The important thing is that they are embedded in their local community. And that just like hotels or pubs it is providing a service and it affects a population of a 30 mile radius around it quite simply. To go outside of that you have to start marketing because word of mouth slowly deteriorates or it's the specialists they are coming for. So the hospital's local identity is so very important. And therefore each hospital needs its own business plan. And we have put those in for the year ahead which starts in October. We have established a solid organisational structure. We have had a bit of reorganisation and tried to make sure that we've got the best structure and we have evaluated the team. We are raising the benchmark for the team to hit the challenge that is required.

Our working strategies follow very similarly the strategies that you have seen here in South Africa. Consultant and GP engagement is the biggest priority if you are looking to increase your inpatient and outpatient numbers. We're going to see about one million patients this year, but only about 220 000 of those are long-term in-stay patients. The rest are walk-in or day patients. So we touch a lot more people than the bed utilisation that we actually are demonstrating. We've introduced some national consumer products and we're starting to get some momentum on those. That is important for that level of confidence about what GHG hospitals stand for. It's consistency. And the reason the brand is important is that you're buying consistency of purpose. Like a beer brand, you are buying Miller because of the level of confidence that sits behind it. It's not that it is wildly different from other products but you're getting that guarantee. And that is important is you're going to put out national products and brands within our organisation. In our top line we are delivering this year by managing our efficiencies, and our bottom line will be as indicated.

In terms of a working strategy it clearly falls into these four areas as to how we can extend the business offering, very simply, by broadening our network coverage. We don't have hospitals everywhere in the UK. It would be nice to participate in healthcare activities where the population is but we don't have a facility. We have two choices, either to bring the population to us by getting them to transport themselves those 124 kilometres or to try and access facilities closer to them. They may be primary care, hospital or other. But we need to participate if we're going to have national coverage. We are close but not quite there, and there are some opportunities to look at that in the future. Broadening the spectrum of care there are some massive learning's we can bring out of this here in South Africa. You operate at a far higher level than we do on average. In the spectrum of care in the private sector it is broadly elective. You choose to go there because you pay for it. So from pimples to botox through to major organ replacement we are in a narrow spectrum in the middle, which essentially is hips, knees and joints and things associated around. They are not life-impinging but they raise the standard of your life and you choose to take that moment on. There is no reason why we can't extend that offering using the confidence and experience from here in South Africa.

To open more routes of access we make sure we engage with GP's. The activities you saw here on where people are referring from, we are doing the same in the UK. In other words which geographies have high penetration of referrals and which don't? Is that a marketing exercise? Is it they didn't go to college with the guy and train with him or is it they believe we haven't got the right surgeon? So each of the hospitals needs a marketing plan for the highest state of GP's around it that we can muster. And that is a challenge in the year ahead. That provides you a solid platform of referral going forward and allows you to sell your wares. We're also going to establish more opportunities in associated markets. A big thing in the UK ten years ago was fitness gyms. Most people paid for the gym and didn't go. And therefore they have a big base of people. If they could bring them back and re-engage those people with a value-added service such as a health check, or if people could leave hospital and go to gyms and we could make income streams from that, it would be a sensible view of the marketplace, to participate in more touch points of the consumer's involvement in their health awareness. They are getting more aware in the UK because the press is helping us enormously.

It is a great company. It has transacted a couple of times, so in really it has been a bit like churn for the staff. The important thing is to bed that down. And what Netcare brings is a massive solidity around healthcare. It is not a financially engineered business; it is a healthcare-centric business. And that immediately gives pride in the organisation which affects the local staff and physically touches the patients. So suddenly the cleaners of the hospitals are engaged in patient welfare, because they're interested in healthcare because that's the language that is used in the organisation. And suddenly your standards start to rise across the piece. We've got to participate in the healthcare spectrum. So

the NHS (National Health Service) and PCT's (primary care trusts). These have evolved and essentially we are now in a position where the government has moved from 350 primary care trusts in the localities to 150. They consolidated and they are becoming real decision-making points because they hold the budgets allocated for the whole spectrum of healthcare from GP's, mental health, hospitals and other. And they are increasingly charged with trying to commission work. So our opportunity is to be a low-cost provider to them in geographies where they need help, because the waiting lists are longer than 18 weeks or because the population have a particular medical need. And the department of health is reducing its role in this local commissioning by setting up central contracts that we have participated in and asking these local PCT's to manage the local market. Quite often some areas don't need the contracts.

We've also got to work with PMI (private medical insurance) funders. Broadly speaking the private medical insurance base is flat and has been for the last five years. We've got to find more innovative ways of why the British public would want to take out private medical insurance, because it is still deemed expensive. It's damned good value when you need to use it, but when you're healthy month in and month out it doesn't seem as good value. We need to find innovative access routes for private medical insurers to increase that and work in partnership with our funders to bring that about. What are we doing then? Sales are a bit of a promise always, but operating efficiencies are always certainties. We are doing the following. We're on with a ward labour initiative and that is already delivering. Essentially in its simplest form it means we have the right level of staff for the operations and activities that are being done on the ward. So lowering your base run line level and putting in more variable staff to compensate when you have peaks and troughs. Some hospitals are busy all the time, and others have big cyclical weeks. The start of the week is often a lot emptier than the end. Because for people to minimise the number of days they take off work they check in on a Thursday and Friday and try to have their operation done so they can recuperate and be back at work the following week. It's an odd scenario but that's what people want to do.

Theatre and outpatient labour initiatives are equally as important because you try to put that into the cycle as well. From our perspective it is slightly harder to do. It's harder to shift people in and out when the consultant is there, so it takes more planning, but we're on our way with that. Non-clinical labour, which is back office admin and the whole support function around the hospital. We have 49 primary sites and a lot of things are done 49 times when they could be done once in a central location for everybody. So we're looking at what we are duplicating 49 times that is inefficient. Remember the consumer acts and thinks locally, so the front of house people needs to be local. But a lot of back office activities need to be done centrally. Procurement we talked about earlier and very important for

us is to make sure our purchasing is right in price and quality of product. We will look at that when we talk about extended choice network later on.

Implementation of [unclear] is looking at electronic imaging and making sure we capture this electronically rather than hard film, and slowly be able to move that to centres of excellence as well as our reporting is able to bring up the images where ever we want them. And that patient file that we talked about here in South Africa is slowly coming about in the UK. So you will have one file that is accessible from multiple sites. In terms of the top line we have a fantastic perito curve here. The top 5% of our consultants generate about 25% of our revenue. It would be sensible if we could increase the number of people who were bringing around large income streams like that. So we also have a large tail. Over 3000 of our consultants do very little private work at all. It is differentiating between those that do one or two of their five hundred operations in our hospitals and those who only do one or two operations full stop. It's a very fragmented marketplace. So the segmentation that we talked about for South Africa needs to apply here as well, and we also need to raise the standards so that we get the best consultants into our business. So a big area of focus. We are launching partnership schemes to bring this about. Very simply that is where the hospital enjoys profitability from the consultant's work coming to us and we share in the overall profitability with the partner consultant if they are growing their business with us.

It is done on a hospital level because there are all different reasons why people rise and fall with their practises. You cannot pick on people just on maths; you have to treat them as individual consultants. They need understanding. To cater for that we've started to develop what we're calling practise development groups. We are bringing consultants together who have a certain set of expertise and are the best in their field at that and their ancillary services. So if it for hips and knees it would be best to team up with physio's and anaesthetists and make sure you've got the best possible team from the start of the patient journey all the way through to the end. We are grouping those together and then marketing them as individuals. Somebody pointed out quite rightly that people don't just refer to the hospital, they refer to the centre of excellence and that's perceived as the individual. So why fight against that? Why not jump on the train and harness it as a strength in the business. Just like holiday companies. You may go to Thomas Cook or [unclear] but you still go to the same hotel. You go to that hotel in Marrakech but you go with a different operator who provides a different package around you. And that is what we are pushing.

Here is an example of Priory Hospital which is in the middle of Birmingham. It has demonstrated over the last two years that by harnessing consultant groups that the income extrapolated. And there is no reason why that can't be replicated. If you look at the happiness scores of consultants they also go up

because they are being respected for the skills and expertise that they have, and they don't feel their business is being compromised. Introducing new products and procedures. There are a certain number of products and procedures that the NHS is increasingly not wanting to provide. They may be minor things like varicose veins, or they might be indulgence items like cosmetic surgery. We want to make sure we have national products. So if the consumer is having trouble accessing them on the NHS his easily deferred, transparent and visible option is to see we can provide it as a package. We've got some here. Back pain for spines, cosmetic surgery, varicose veins and weight loss. Weight loss is the fastest growth year on year. So despite less than 1% of our population being involved in farming we seem to be getting fatter and fatter every year. Clearly this is not exactly the same as my previous job. The closest we get to facial surgery in my previous job was offering someone a flaming sambuca. But in reality you are trying to make sure you are matching what people want. And increasingly people's wants relate to their disposable income.

As incomes rise, people's wants fall into healthcare. They've got the DVD, the camera and the house etc and healthcare suddenly becomes an indulgent product that is mainstream. And that is increasingly happening in the UK as lifestyle magazines have enforced it, especially in middle aged women. And we are seeing the increase in their spend on healthcare in the UK. Imaging in simplest terms is something the NHS is not doing well. It is often the diagnosis and the start of the process. You have to join the waiting list. Imaging is a bit thing so you can get your early diagnosis. What you then do with it is up to you. So we've got to target imaging and make sure that we have the right equipment. This involves part of our cap ex programme to make sure that every outlet we have is equipped to meet that. Partnering with the NHS. You've seen this graph before I believe, but essentially it is an independent view of the independent sector's opportunity for NHS work, whether that be spot purchases, central independent sector provider contracts or whatever. The light blue chart there is something called ECN. And the government has brought out choice for the consumer in nearly every aspect it can. If you want a choice of doctor and a choice of hospital and location they are trying to present that to all consumers so they no longer end up being vindictively picked on by geography. Your service is not available in your area; sorry you can't have your leg fixed. You are given a wider range of choices. So access to healthcare is widened as a result.

The stated mandate is that they're saying 15% of procedures will be done by the private sector. If you extrapolated that it would give you something greater than what the graph shows. The reality is that the primary care trusts who are commissioning have to pay for that. So essentially a tariff is being created. So if I don't want to see my NHS doctor and I want to see the one at the private facility the tariff is already set. So the doctor has to make himself available at that fixed tariff. And if that activity happens at the hospital it also has to happen at that fixed tariff. The difficulty for the primary care

trusts is if the patient selects to go privately they still incur some of the fixed cost of having their own facilities down the road. They don't save in entirety because there are still some fixed costs behind them. So the cost of these people going private is not just the tariff but also some of the fixed costs left behind. And therefore I think the primary care trusts will be very varied on how they roll out extended choice network. Some of them who have got capacity issues will run onto it quite quickly seeing that the private sector is able to sort this out. Others that are cash constrained and don't have capacity issues will be more constrained and continue to use more varied NHS options. So I don't think it's going to be a flat 15% from day one. I think it is going to be a growing thing through time but it won't be homogenous across the country and it won't be consistent. We need to be aware of that, because if we are planning our business to accommodate this we will be naïve in my opinion.

So looking forward, what is ECN? Essentially we've got 21 of our hospitals IT enabled. We will have them all IT enabled by the end of the year so we will be able to offer slots for GP's to refer people to our hospitals. Some of our hospitals we will not want to offer slots to because they are full. And in reality you would be cannibalising high margin work with low margin work and that would not make commercial sense. Others where we have high utilisation availability it would be sensible to offer the slots. There does come a point where you don't want the whole hospital to be ECN because it is no longer a private hospital, demonstrating the Intercontinental Hotel skills we were talking about earlier that become the Holiday Express or the Travel Lodge. People perceive that and would not respect the value of the services they are getting in private. So importantly for us we are doing it in a measured approach. We are rolling ECN availability out in line with our utilisation requirements and where we see the PCT's being most able to enable. So we are on course but cautious.

Netcare UK contracts I think you are familiar with. They are all in place. No real issues to report on any of those. Dealing with the NHS is always difficult. Even when you are in the contract, because the population is changing over that five year term of the contract quite often they are asking if we would have more cataracts and less knees, so there are always changes going on. Broadly speaking those are all on course. These ones are sitting on the conveyor belt at the moment. They're all at different stages as a result of a combination of the change of government ideology on this moving from central towards local. They are needed and they will happen but there is a slower gestation period. Others are not needed anymore such as the Kings Cross walk in centre. They just decided that there is enough capacity there. They though two years ago when they came up with the idea that they needed it but they now say they don't. So the challenge over the next six months is to bring these to a head and knock them off the conveyor belt or not bother. At the same time we must get around those active 152 PCT's that are overlooked and make sure we are the service partner of choice. The key anchor in doing that is making sure we do a good job in these, and we are.

The outlook then. In line with Ryan's slide I'll just talk to revenue. I think we have talked to most of these points. We have national products focussed on making sure there is an increased ease of access. If you asked the UK population if they would go private, even if they've got private medical insurance, they would say no. Not until I have asked my GP. So people's perception of how easy we are to get into is a lot different than most consumer goods sectors within the self pay market. And we have a job to do to fix that. We've got a big focus and we're reorganising the organisation to take back office roles and cost out of the business and refocus it into front of house selling and marketing roles. And we need to accelerate that process in the year ahead so that we are representing ourselves on the front face with more people involved at consumer or patient touch points. So take out non-value added consumer roles and putting them into the value-added consumer roles. We have a set of products and services that we would like to extend our footprint on. That is in more serious surgery and less serious surgery such as cosmetics.

A big thing at the moment is the management and maintenance of margins by cost control, wage and labour maintenance, capital expenditure and all the routine things. Forget this is a hospital company at the moment. You would do these things if you were running any company and that is what we are doing. Positively, from a capital point of view there are an awful lot of capital investment projects where we can invest productively in our existing assets - whether that is reconfiguring the hospital to reduce the number of wards and increase the number of theatres or to bring new equipment and facilities into the hospitals. So we have our own organic growth investment strategy as well where we can generate good returns and good yields for our cash flow in the business. We are in good shape but you've got to be realistic about the challenges. The analogy is if you're pushing a shopping trolley and you let go, how quickly it slows down before you have to give it another push. There are a series of things that even as we're filling the trolley are causing this thing to slow down, and that is that the insurance market is relatively flat and we're coming under tariff pressure. If it is flat the insurers themselves are going to make more money by taking off more money from the people they are insuring or trying to save money by spending less on us. And as we know the population is getting older and the number of medical interventions is getting wider. The natural consequence is the insurance ends up more expensive. So the pressure is on the insurer and they want to share that burden with us.

We've got to be aware of real competition. Most of the hospital groups in the UK have transacted and are now owned by venture capitalists or the like. So Bupa is now in ownership of Cinven who are used to private healthcare. They're not going to sit there and say you guys do what you want and we'll take the crumbs that are left. We are now in active competition. We need to differentiate in the way that we

go about things for staff, access, sites, investment, equipment, consultants, GP referrals and so on. Because they're also going to be doing things to compete with us. Not a problem because it raises the stake slightly across the piece and that is a good thing for the British consumer and the industry. Medical advances are reducing bed nights. Our income comes from activity and stay. If stay is reducing you end up with your income reducing over time. We therefore need to move up the scale and find other sources of income. Increasingly we are seeing utilisation with day patients and self pay. Our self pay market, just like here in South Africa, is in growth in the UK. I would predict that some of the minority activities will continue to bring strong growth in the years to come.

We've talked about potential consultants. Some consultants will do the activities and buy the services from the hospital. So the reverse, rather than us offering the package the consultant coming to do the work, the consultant will arrive mid the work and say what he would pay the hospital to allow us to have him in his premises. So it is exactly like a tour operator coming and saying I'll take a hundred bed nights from you. They haven't sold those yet but they are now going to go and sell them. The reality is, there isn't a reason why that should be allowed to happen, but we might want it to in areas where we can't access the right consultants otherwise. There is economic uncertainty. I was listening to the inflation figures. There is a slight up tick in inflation, long-term cost of borrowing of money and a level of uncertainty over the impact on banks. We are slightly less insulated than your banks on that because we have a lot of our retail banking involved in very complex financial lending structures. So the ramifications take a while to feed through. I would expect base rates to continue to rise in the UK as that is stabilised over the next six months. So between now and January I would expect not much improvement in the current financial situation. Post January I think it will stabilise as underlying property wealth will remain there, provided there isn't a cap crash and people continue to service it.

Any pressure on disposable income for a highly mortgaged society means that their discretion has to go on the mortgage first and that is where you get squeezed. So we have to be aware of that and plan accordingly. We are doing restructuring in the company but we have a reasonably good team. I want you to take out of this that this is a business in reasonable shape. It understands the marketplace. The challenges are similar to those that are there, but importantly we have a team that can go and do something about that. For the next year if we continue to activate these hospital business plans in line with the strategy that we have it will not be a bad thing. We just want the mandate to get on and do it. From our perspective Netcare are a brilliant partner for us in doing that, and the GHD can grow accordingly. That's me.

Richard Friedland – Netcare: Chief Executive Officer

Adrian thank you very, very much for that. Are there any questions ladies and gentlemen?

Audience member

You didn't really mention choose and book. As far as I understand it Cinven's motivation for buying the Bupa hospitals was to try and capture this choose and book process that is coming through. You eluded that to a degree but if you go to a GP and it flashes up five hospitals you can attend, and one of those is private, how many of your hospitals are you going to put into that network? Do you have any idea of the number of people that are going to come through? Are you going to advertise as Cinven is? Bupa has a strong brand in the UK whereas you guys don't really have a brand.

Adrian Fawcett – General Healthcare: Chief Executive Officer

The hospital brand locally, the name of the hospital – the Park Hospital, the Priory, the Rose Mount, the Churchill, and the Princess – is probably a stronger brand than any other brand of hospital within that footprint. So it's not the Bupa which is almost the global band for healthcare. At a local level people want to go to that hospital. So the catchment area is fine provided people have visibility of it. The point you're making is, are you actively going to be pushing it? In Cinven's mandate they said this is why they think it's a good thing to get into. Twelve of our hospitals are active open today and taking ECN bookings on choose and book and are on the same page as the Bupa hospitals. The balance is rolling on in the next weeks. In fact they are live now, but they haven't been certificated. You have to get a certificate to say all the connectivity's work. My intention is that by the end of the year all our hospitals will be available. The department of health has given us low reported number of activity because GP's are not educated yet as to how to use it. They continue with their traditional mechanics of referring to Ryan because they went to college with him. So we're not in a rush. We will be advertising and marketing just the same as Bupa who are changing their name to Spire next month. And in reality we will be on every page identically with them. Now is it going to be out major thrust? I don't think so for about a third of our hospitals. I wouldn't want it to be because it would be cannibalising high-margin work. It may be on the very low to-do activities because you can get those done at theatres at night and therefore extend the usage of theatres in terms of hours. I am enthused by it because it is incremental to the market. I'm not passionate about it, because you have to do three to four times as much work to make the same contribution, and I'd rather be the leader in true private hospitals than liquidate myself to be the Easy Jet.

Audience member

But your utilisation rates are relatively low as far as I understand. If you have 50% utilisation...

Adrian Fawcett – General Healthcare: Chief Executive Officer

That's bed utilisation. In theatre utilisation it would be a lot higher.

Audience member

How much spare capacity do you have then?

Adrian Fawcett – General Healthcare: Chief Operating Officer

It would vary by geography and by hospital. I have been asked this three times now. I feel as if I'm being evasive about it. If I give you a number it would be wrong. For various reasons it might be wards in one hospital, consulting rooms in another, surgeon availability in another. I think if you averaged about 25% across the piece you wouldn't be far wrong, but it would be for different reasons why you are constrained. So I think it is important that we make sure we release the bowtie. So it's an extra theatre that is needed in this one, its extra beds here etc.

Audience member

So how much spare capacity do you have then?

Adrian Fawcett – General Healthcare: Chief Operating Officer

About 25%. I mean I haven't been in the business long enough to give you an articulated mathematical view but that is as close as I can get right now. Therefore we're not capacity restrained on most hospitals.

Audience member

What I don't understand then is if the PMI market is flat, maybe 1% or 2% growth, why are you not enthused about trying to win some more NHS business? Even at a discount it shouldn't impact your margins.

Adrian Fawcett – General Healthcare: Chief Operating Officer

Three very good reasons. One is that the private insured market we can take a lot higher share. We have to believe that because the GP's will divert referrals. And we have not put any energy into that historically as a business. Number two, the private self pay market is in growth. That is where you should target first because it is higher margin, quicker to respond and doesn't liquidate your mix of business. You should then focus on your ECN in terms of making sure you've got a plan in each. We don't want to be behind the game on ECN but what I'm saying is there won't be any competitors ahead of it. By the end of this year we'll be on every screen and we've got the choice what to do then. But I don't think in terms of management time, attention and returns, it would be our best endeavour to throw everything we've got at it. I wouldn't want you to write this up because it's out of point of comparative advantage. I hope Spire put everything they can into ECN, I really do.

Richard Friedland – Netcare: Chief Executive Officer

I think we'll take one more question.

Audience member

Just following on from that discussion. Assuming you can utilise the additional 25% capacity, whether it is across the private market or through ECN, what kind of realistic expectation do you have for margin enhancement over the next three to five years?

Adrian Fawcett – General Healthcare: Chief Executive Officer

Margins this year are growing. I think the half year demonstrated that. We are doing that by a mix of procedures and increasing self pay. The returns improve as your fixed overhead costs recovery. I think I put up a chart for a hospital it's 43% to break even. Incremental business roughly 5% growth on a top line but below a double digit on the bottom, as a combination of the geared effect of the business model and the variable costs that you have to add are a lot lower for the extra business. I would anticipate margins as an industry not to increase at all over the next five years. That is because I think the insurers are going to put pressure on us, and they will want to give us the chance for extra work, but they will want to reduce their total spend with us. And therefore I would anticipate all the positives being offset by insurers on the negatives. Not massive margin expansion after the end of...you're



probably going to have another year of it. All general margin expansion will be done by mixed management. Instead of focussing on lower grossing activities lets aim at the larger one. It won't take long for everyone to clock that. I'm giving you an industry average rather than just our own company.

ENDS

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