

Network Healthcare Holdings Limited

(Registration number: 1996/008242/06) (Incorporated in the Republic of South Africa)
(JSE share code: NTC) (ISIN code: ZAE000011953) ("Netcare", "the Company" or "the Group")



Netcare Investor Day

Web cast - Transcript:



Richard Friedland - Netcare: Chief Executive Officer

Good morning ladies and gentlemen and welcome to Netcare operations centre for this investor day. This is a live web cast. All the presentations that are being presented today are available on our website, and we're going to try keeping this reasonably informal. After these presentations there are some one on one's that have been arranged. I know there are some of you that weren't able to get those together, but we are available to arrange those one on one's at a later stage with you. If I can draw your attention to this statement in the introduction, and I'm going to read it out from a governance perspective, it is a note regarding forward-looking statements. The company advises investors that any forward-looking statements and projections made by the company in these presentations are subject to risk and uncertainties that may cause actual results to differ materially from those projected. Factors that may affect the group's operations are described under risk factors on the investor relations website www.netcareinvestor.co.za

Just in terms of the day and the agenda, I will be kicking off with an overview of our operations here in South Africa and the United Kingdom and really looking at some of the strategic factors impacted this year and next year. I'll then be handing over to one of our board directors Dr Victor Litlhakanyane, head of group stakeholder relations who will talk about our relationship with government and our interactions with the department of health. He will then be followed by Melanie da Costa who heads up our health policy unit, to give an overview of some of the challenges and issues around regulations and some of the perceptions around cost utilisation and quality in the South African health market in particular. I'm then going to hand over to Jacques du Plessis who is head of primary care here in South Africa to talk on the growth of Medicross and Primecure, and some of the exciting development there. And then he'll be followed by Dr Ryan Noach, Chief Operating Officer for South Africa, who will give us an overview of our South African operations, primarily the hospital division and Netcare 911. We will break for some tea and then we're going to hear a very interesting insight from our marketing director Thumi Nkosi on some of our issues around our brand, our segmentation and the focus of Netcare marketing going forward. And thereafter followed by Adrian Fawcett who joins us this morning from the United Kingdom who is the CEO of General Healthcare, to give us an overview and progress update on our operations in the United Kingdom. And lastly to round off the day our group chief financial officer Peter Nelson will give you a status update on where we are financially and some of the issues impacting on this year and looking forward.

Just in terms of my presentation, I'm going to give you a very brief business update. You will see that is going to be covered comprehensively in the various presentations that you will hear throughout the morning. Thereafter I want to talk about some of the factors impacting on 2007 and 2008, particularly

some top line issues. Then the issue of Ampath, that's our pathology division, and our planned disposal thereof. Our acquisition of Community Healthcare, some of the issues around the skills shortage that remains unabated here in South Africa and our commitment to black economic empowerment and mobilisation or transformation. And then to share with you what we see as a very exciting growth strategy, both here in South Africa and in the United Kingdom.

In terms of the business update for both South Africa and the UK I think all of our business units are on track. We have gone through a senior management restructure to align our business units. What we have been doing in Netcare is trying to simplify our company here in South Africa in terms of tertiary care, hospital services, primary care and emergency services. And to that end we have structured the business around that. Clearly our top line issues are receiving a lot of focus and I want to talk to that. We are now starting with the integration of the Community Healthcare Group. That transaction will be effective 1st October. And the disposal of Ampath is underway and we hope to be finalising that in the coming weeks. In terms of the United Kingdom we are on track with where we said we would be and where we projected in our results to the market in mid-year. Integration and management restructure is almost complete. There is a significant operational efficiency drive within the business. I think importantly top line issues are receiving a lot of attention. And on our NHS outsourcing division, Netcare UK, there have been some delays and one or two cancellations given the change in the political climate. Adrian will talk to that, and Peter will spend some time talking about the potential of a sale and lease back of our properties in the United Kingdom.

In terms of the top line issues I'd like to give you a brief background. I think we have all heard enough of it, but certainly around the saga relating to rebates and discounts on surgical consumables. Suffice to say we have restructured that funding division. It is now headed up by Mark Bishop. Norman Weltman has retired. We will be beefing up that division quite substantially. Effectively I will be taking you through what we call a three phased approach to this. One is how we intend pricing of that surgical basket going forward. The second issue is the factors impacting on the tariff increases for 2008, and the third issue is our long-term commitment to alternative reimbursement and what we are doing around that. I think you've all seen this pie chart, but this really unpacks our hospital charges. 55% of our charges are really ward theatre and equipment. 15% of the charges are regulated by single exit pricing, there is no mark up or discounting allowed there. And 30% of our charges are surgicals and consumables where we achieved significant discounts and rebates. And it was this that people took umbrage to and did not appreciate the fact that this element was really cross-subsidising our wards theatre and equipment.

I show that to you in this graph over here where you can see some of our competitors had taken away rebates and discounts from the surgical consumables and had increased their wards and theatres. One of our major competitors has a theatre rate that is 50% higher than ours at the moment and has ward rates somewhere between 8% and 30% higher than ours. Clearly the market prefers not to see that cross-subsidisation and so we're moving to remove that and during the month of September we will be in discussions with funders. The most important element on this is our inflation on that basket over the last five years has been some 3.9%. The inflation on wards, theatre and equipment has been substantially higher. So this really is the three-phased approach. We will be removing any form of discount or rebate from those surgical consumables for normal commercial terms in terms of settlement discounts, based on the time value of money. I can say to you that most of our funders have accepted this in principle and we are considering what type of pricing structure we will use. For those of you not familiar with these acronyms, net acquisition pricing and single exit pricing. In our meeting with the South African medical device manufacturers and providers they were certainly opposed to a single exit price for the entire industry and preferred to go to the net acquisition price. We are contemplating that with different funders at the moment. Although from an operational point of view the timing appears to be 1st January we will obviously have financial implementation of that a lot sooner with each of our funders.

I think the major issues for us really are the tariff increases for 2008. We have been developing a sophisticated model around this, primarily because of the significant wage increases that we are expecting in the labour market. A lot of this has been predicated by the department of health's increases recently following the public sector strike of nurse's salaries. We see that actually as incredibly positive. Nurses have traditionally been underpaid or poorly paid, and this will have a knock-on effect within the private sector. We intend to remain competitive and it will certainly have an impact in terms of the tariff negotiation. And then again training, and I'll talk to this later, is placing a significant burden on healthcare provision in South Africa. We are the largest training institution of nurses in the country in the private sector, and we are still committed to that. I will talk to that later, but it does come at a significant cost. And then we are developing models around alternative reimbursement. We started with that in January of this year. If we look at it, we have been engaging with some foreign and local consultants since the beginning of the year. We are looking to put some fixed fees to the market. We will be complete on that modelling at the end of October. And medical per diems, in other words charges per day, are also at the end of October.

We have been evaluating a diagnostic related grouper known as the DRG system. This is an Australian model that we have been looking at. It allows us to assess the clinical data related to an episode of care in terms of the diagnosis, the procedure and in terms of the demographic factors that

impact on price and length of stay, namely the patient's age, their gender and the chronicity of their illness. We are busy trialling the system. We got permission from the Australian government to do so. And we will know close towards the end of November whether that has merit within the South African market. The reason we chose this is that this system, this DRG system, has been embraced by the public and private sector in Australia, in Germany and also in Ireland. And we think that this certainly has merit within our own circumstances here in South Africa for the industry. Currently we are doing about 20% alternative reimbursement. We are targeting about 50% of that within the next 24 months.

In terms of the disposal of Ampath, as you know we own 50% of the Ampath holding trust. It's a company which manages the pathology practises and services that are rendered. The health professional council of South Africa really doesn't want to see corporate ownership of pathology services and I think we've been in negotiations for over a year with the pathologists to dispose of our stake. We are advanced in that and will be aiming for 1st October. We are going to be treated that in our results as a discontinued operation. I think Peter will be showing a slide on that later in the presentation. We are very excited about the acquisition of Community Healthcare. It is a true black empowerment success story. We acquired the remaining 56.7% of Community Hospital Group. As you know the competition tribunal, after a lengthy deliberation ruled in our favour without any conditions, and we will make that effective on the 1st October. It brings some 682 beds into our network. That is an increase of some 9% of our coverage nationwide. And if you look at the cost of that, that was settled for R40 million in cash and 14.2 million shares at an EBITDAR of about six times, and certainly at a replacement cost per bed of about R561 000. We have been working very closely with Community Healthcare and we are absolutely delighted with that acquisition.

I'll put this slide up just to explain the complexity of the issues we face around the skills shortage in South Africa. To show you in actual fact this is a pipeline issue where we bring in enrolled nurses here right at the start and it takes four years to get them to qualify as a registered nurse. You can see that we are training some 3400 nurses at the moment in various different courses. You can see the kinds of numbers that we're going to have to be training over this four year period to 2011 and what we are committed to do. I think it is significant that since 1996 government have cut the number of training colleges and number of nurses trained, and the private sector has been training and graduated more nurses. On a very positive note, government is actually doubling the number of nurses trained, but we're still seeing a loss of nurses, particular to the Middle East and the United Arab Emirates. And also some to other countries. Less to the United Kingdom and Europe. You can see what our vacancy rate is at the moment it is about 24%. We would like to get that vacancy rate down to 15%. That allows us to flex our wards and flex our hospitals to cope with the various occupancy changes.



It's not just about training nurses. We've got a multi-pronged approach, and this is demonstrated here. We are part of the wozakaya campaign. We have brought back 42 nurses and we are interviewing another 100 in London in October. We are very excited about that prospect. We also now have permission from the department of health to acquire a corporate licence to import nurses. We are looking to import nurses from the United Kingdom and from central Europe. People who no longer qualify for work permits in the UK. We certainly want to offer them short-term contracts in South Africa. We think that this can bridge the gap until 2011 when we have reached our requisite number of trained nurses. We are very keen on training non-nurse categories to take over the functions that nurses are currently doing. For instance in ICU in terms of technologists. We can train people to look after machinery, that we don't need a registered nurse to do. We can use caregivers and clinical engineers to do all that. And that is before the South African nursing council for approval. We have been delayed given some of the issues pertaining to the nursing council.

I've put this slide up to demonstrate our absolute commitment to normalisation in South Africa. Given the ravages of Apartheid and particular the inequity we see within the healthcare sector in a country that really is one of have's and have not's. And these DTI codes, black based economic empowerment codes came out in February. We finished our own internal scoring in April, and I'm delighted to tell you that we have already been accredited at a level 5. Just to point it out to you that's at 80%, a BBB rating. And Primecure has already got to level 4. That's an A rating. We are targeting to be at an A rating in 2008 and we think we can achieve that. If you have a look at it over here we score very well on socio-economic development. Full marks on enterprise development. Very poorly on preferential procurement, primarily due to the fact that most of our suppliers are not accredited yet. So we have gone out to them in a very robust manner to say that we expect them to get accreditation. And we believe that we can achieve certainly at least 10 to 12 of those points within the next year. Obviously on skills development in terms of what we're doing we score high, and we are addressing very aggressively the employment equity and management control issues. And I'm confident we will achieve an A grade rating within the next six to eight months into the new year.

I want to talk to you about some of the growth strategies for South Africa and the United Kingdom. Some of them are common to both geographies, some more particular to South Africa and others to the United Kingdom. There is no doubt that we are seeing organic growth in both markets, and in our view the base is growing, particularly in South Africa. But importantly, both here in the United Kingdom and indeed worldwide we are seeing demand-driven utilisation driving increased occupancies in our hospitals. And I'm going to unpack some of those issues for you, because it translates into a very exciting organic growth story, both here and in the United Kingdom. There is no doubt that acquisition-driven growth here in South Africa is limited. It is less limited in the United Kingdom and there are

some opportunities there for us. Certainly on the South African geography it is very limited, but the growth of primary care for us is one of the most exciting growth stories. I would argue that we are well poised and positioned here in South Africa. It's not a market we have begun to unpack in any manner or form in the United Kingdom.

Let's have a look at these increased utilisations which I think are common to both geographies. We're seeing an ageing population demanding more healthcare and using more healthcare. And I'll show you what the admissions look like in our population here in South Africa. There is an increased utilisation. They are staying longer in our hospitals. Technology is driving more healthcare usage and early diagnosis. We are treating diseases that were previously inoperable and people are surviving them. And certainly lifestyle diseases are playing a significant role, from obesity to age onset diabetes to cardiovascular disease. We are seeing a massive increase throughout our hospitals. Have a look at this, because I have shown this before. This demonstrates how growth in admissions in Netcare South Africa amongst this population of 60 years and older, 50% of our new admissions are coming from this demographic age profile. And have a look at what they do in hospital. They tend to stay longer in hospital. This is a graph of average length of stay. Obviously neonates and babies tend to have a longer stay. You can see that patients over the age of 60 upwards stay substantially longer. Our average length of stay in South Africa is three days. This is data coming out of the United Kingdom. It is in pounds, but you can see that the expenditure per capita by age is substantially higher in the elderly age group.

Technology is driving increased usage. This comes from the February edition of the Harvard Business Review but talks to the impact of how technology is driving both procedures and utilisation within our hospitals. And a frightening statistic in South Africa: this is the number of diabetes admissions and days in our hospitals that has grown from 2002 from some 18% to 23%. You can see the impact of lifestyle changes, the impact of increasing affluence on adult onset diabetes within our own group here in South Africa. Let's look at some of our growth strategies within the South African market. If we look at the base, what you can see here is that the base in South Africa for the last ten years in terms of the traditionally covered or medical aid market has been absolutely static. But we saw a small inflection point of some 2.3% in 2005, and lo and behold that continued in 2006. We obviously haven't seen for 2007 but that was for nine months, and if we extrapolate that it is 4% growth. We think that is due to continue. There are a number of factors driving that growth within the South African market. You can see the enormous opportunity that exists for the private healthcare sector to partner government in providing healthcare. If you look at this we are only looking after 15% of the population. I say that with a huge caveat, because we are only looking after 15% of the population that are

traditionally insured. I will actually show you later that that figure is actually closer to 40%. I think Melanie will talk to it in her slide in terms of the spread of private healthcare in South Africa.

These are some of the factors, and I'm going to unpack each of these eight factors for you, that are driving growth in the medical aid population. Firstly we have seen a growth in employment. There has been a 14% growth in employment since 2001. We have seen the lowest medical aid inflation in South Africa in 27 years. I will show you a graph that we couldn't see anywhere else in the world. I don't know if it is going to remain like that given the wage inflation we're expecting in the next year or two. There has been no doubt that there has been a growth in disposable income. We are seeing a sifting sands phenomenon as the South African population become wealthier and move up the living standards medium curve. And I think what we are seeing for the first time is what we always speak about, this late cycle beneficiary. Healthcare and insurance is at the end of a consumer boom. People buy mobile phones, they will buy clothing, they will buy motor cars and housing. And at the very end of that they will turn to insurance and medical aid. We are seeing the first signs of that, and I'll show you some evidence of that. There is no doubt that the HIV burden in our country is enormous and placing an enormous burden on our department of health and state facilities. The tax legislation introduced last year in 2006 has certainly made health insurance more affordable. What we see is the real tipping point in this market. Probably the most significant development is the introduction of the government employer medical schemes. Government has put its money where its mouth is and given a R6 billion subsidy to bring on its civil servants that are employed. This could increase the market by some 15%. All indications to date indicate that it is well on track to achieve that. And we believe that proposed legislation coming out will further stimulate this market in the coming years.

That is the growth and employment in South Africa. I'm not going to get involved in controversies as to how we define employment, but in our view there has been a 14% increase. This is a graph one couldn't show anywhere in the world, where in fact medical inflation is now less than CPI. The phenomenon we are seeing for the first time in 27 years, obviously recognising that fuel and food costs in South Africa are driving inflation very high. This is this increase in prosperity, the so-called shirting sands. In our living standards medium market you can see there has actually been a 19% increase in our target market over the last 5 years. Yet we have only seen a 4% growth in health insurance. It's that late cycle beneficiary that is finally beginning to kick through and stimulate this market. This is the emergence of black diamonds. I urge you to read this survey; it was produced by Professor John Simpson at Cape Town University's Unilever Strategic Studies Institute. It is a survey done very recently of this emerging middle class. It has grown by some 30% in the last fifteen months. It now sits at some 2.6 million people. They're defined as people within the NSM 9 and 10 earning above R7000 a month, plus those with a tertiary education and working professional. 12% of

black South Africans are classified as black diamonds. They have 54% of black purchasing power in South Africa versus 43% in 2005. There are some of the demographics. But the most important issue for us is that 87% of those people surveyed within the survey said they believe it is necessary to have a medical aid. But the coverage was only 26%.

We're seeing an increased utilisation of private facilities. We think it's a result of increased disposable income. We think it is a result of where state facilities are at the moment, also the fact that it is a late cycle beneficiary. We have seen a 19% growth in out of pocket spend. Ryan will show you later where this spend has occurred in our group and where some of the opportunities exist for us as we package product for a market that is becoming more discerning. It's not necessarily on medical aid, but it is choosing selectively to utilise our facilities for specific products. We have seen a growth in maternity and significant growth in casualty admissions. In fact all of the studies worldwide demonstrate that as a new market comes into healthcare it begins to access primary healthcare, casualties, pharmacies and outpatients' first before the conversion to tertiary care occurs. This is Stats SA October general household survey. And you can see the percentage of the population using state facilities has dropped from some 67.8% down to 59% over this period. And the use of private facilities, and I'm not just talking hospitals, has now increased from 32% up to 40%. We believe with the burden of HIV that trend is set to continue. Have a look at the HIV prevalence in South Africa. It still continues to rise. We are dealing with a significant pandemic in our country. This is taken from the monthly Fast Facts from the South African Institute of Race Relations. It demonstrates the impact of HIV in the various industries and sectors within South Africa.

I spoke earlier about GEMS, and you can see the phenomenal sigmoidal growth here in this market. They have brought on 155 000 principle members, some 400 000 lives, within this past nine months or a year. They're well on track to bring on the million lives. They'll probably be the largest funder in South Africa. They have five schemes. It is a key strategic imperative of ours to partner with GEMS and to become a credible partner. Already we are contracted to provide all the emergency services across the full five schemes. Netcare has a network option in the Beryl scheme. We have put another option on the Sapphire scheme where the state is the designated service provider, and on default of the state we will provide those services. And Primecure runs the full risk management services for the two lower schemes. Jacques will talk to that later. GEMS is a key driver of growth in the South African market.

If you look at the South African market, these are our five year projections in Netcare. We look at projections on a regular basis, and we think there is some phenomenal growth expected out of South Africa. These are our projections to December 2012. We project an 8% compound annual growth in

beneficiaries from the 7 million that we see today to some 11.2 million. This would be the traditional market, but significant growth in this LSM below LSM 8 through GEMS. And you can see that coming through. It's probably best to explain our growth strategies when you look at this triangle of living standards medium. Traditionally the private hospital sector and private medicine in South Africa has looked after the affluent. We believe that market is growing. We saw 4% last year and we think this market will grow for the reasons we've spoken about. But significantly it is this market here that has never been penetrated. It is now being penetrated by GEMS and by other products such as Keycare. Government civil servants have 171 000 members who earn less than R500 a month. That is R60 000 a year. They fall squarely into this bracket. They will be brought into the GEMS market. The Keycare products and other low income medical products target this and we have strategies around that. We think self-pay will penetrate this entire market and our primary care division is clearly aiming both at this market for Medicross and also this market for Primecure.

As we will talk about it later, we think that the disintermediation of the GP will be reversed going forward. A lot of the chronic illnesses that have been treated within hospitals will revert to primary care, and we think having a compliant primary care network will allow us to capture that stream of activity. And so these are some of our strategies and I'm not going to go into them in detail because they will be separately unpacked by each of the speakers you're going to be hearing this morning. In terms of the traditional market obviously it's around our footprint. It is about our occupancies. It is about our work with consultants and doctors, and it is about differentiation and alternative reimbursement models. Certainly in terms of LSM's below 8, these are some of the initiatives we are targeting there. In terms of the LIMBS model we are looking at different hospital models. The question of employment of doctors or contracting on a different basis such as we do in Netcare UK where we are working with the NHS at national tariff is a key issue that we want to tackle. Clearly we want to be a preferred partner to government. We are absolutely committed to public/private partnerships. Clearly we believe that preferred provider networks are probably the way to go. The self pay market represents an enormous opportunity for us to tailor-make products and in primary care we think that we have a unique competitive advantage here in South Africa of having a compliant, contractually bound network that spreads across the country. And we have significant IP here. All of us talk about the emerging market and penetrating this market. We certainly didn't have the technology to do that until we acquired Primecure.

I'll talk briefly on the United Kingdom, but Adrian is going to cover this in substantial detail. I'm sure you'd rather want to hear this from him. Clearly the factors driving growth there are an underdeveloped private sector, low penetration of beds and PMI in Europe. The market has been a robust PMI market. There is no doubt that NHS services are going to be rationed going forward. The end of this five year

boom in NHS funding is coming to an end in 2008. It will then rise by a CPI factor and we think that will not be able to sustain the provision of NHS services. And we think there still remains partnering opportunities with the NHS, perhaps not at a central level, but certainly at a local level. You can see here in the United Kingdom is the lowest in this graph as a percentage of GDP spend. You can see the private sector in the UK, penetration of that entire market is some 5%. There is no doubt that wealth and employment is increasing in the UK and this graph demonstrates that. This is the PMI market which has been robust and stable for many years. This demonstrates the rationing that is going to occur post 2008 when it is estimated to increase by some 3-4% as opposed to the 8-10% that we have seen over the last five years.

These are some of the strategies. Again I'm not going to go into significant detail. Our commitment to partnering with our consultants, finding out what they want and...when I talk about consultants I'm talking about specialists. That is the term used in the United Kingdom....having a doctor-centric approach to that, understanding the kinds of services we have and broadening them in the market, improving the patient experience, partnering with the NHS through a variety of initiatives and delivering on our existing contracts and aiming to close those outstanding. Ladies and gentlemen I'm going to stop there. I am happy to take any questions if there are. I'm happy to take questions through the rest of the day as well. If there are no questions I'm going to call on Dr Victor Litlhakanyane to present to us next.

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