

Network Healthcare Holdings Limited

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Netcare Investor Day

Web cast - Transcript:



Richard Friedland – Netcare: Chief Executive Officer

Thank you very much. Thank you very much Melanie. Ladies and gentlemen what we're going to do is call upon Jacques du Plessis. He's the Chief Executive of our Primary Care Division. He's been involved with Primary Care for more than twelve years and Jacques if you could join us and give us an insight into our Primary Care Division in South Africa. Thereafter we're going to break for tea because we are running slightly late and we'll hear from our Chief Operating Officer, Ryan Noach, after 2pm. Thanks very, very much.

Jacque du Plessis – Netcare: Chief Executive Primary Care Division

Thank you Richard. Good morning. I'd like to start off to explain the Primary Care Division. The Primary Care Division of Netcare essentially focuses on two core areas, the one core area being medical centres which includes the bricks and mortar of both Primecure and Medicross and then the second focus area, the more strategic focus area being the managed care side which predominantly the IRP sits in the Primary Care Division. I'd like to take you through two parts of the presentation. First of all to show you why we think we're successful in the primary care side in the medical centres and then secondly to shed some light on managed care. I do find that managed care, the terminology is loosely banded around. So if we look at our medical centres I think one needs to start off to stay, what is our competitive advantage?

Undoubtedly it has to be the fact that we're convenient. The convenience factor certainly comes into play whether you see the medical doctor before work or after work three hundred and sixty five days a year. The fact that it's affordable. The fact that all the services are arranged there whether it's pathology or radiology. So the convenience factor for us is certainly one of the highlights and the biggest advantage. With our doctors certainly there won't be a business model. There are doctor [inaudible] as we heard earlier on today but also in terms of the fact that we are doctor-based, both in Primecure and in Medicross. It's not a nurse-based system. I think the fact that we have the footfall, that we have economies of scale that we can benefit on that certainly in this environment this is working for us. The technology side of it, health care certainly needs to focus more on health care if you want to bring the prices down, affordability. I've found that of all the different sectors that still health care doesn't make utilise of the technology to a sufficient level.

But let's look at the scale. I spoke about the scale. We've got a hundred medical centres countrywide now. You'll see there that over the last period, September Primecure's been involved in the last ten months in the 2006 year we have actually closed a further twelve centres in the last ten month period

in September. Over the last eighteen months we've concentrated on focusing the business, making sure that all the centres are profitable. I'm quite happy to state that as we speak at the moment that those twenty five centres are profitable and we will continue now on expanding the brand. We've also added five more of the smaller practises. We like to be conservative in that. We start with smaller practises and then move on to the larger Medicross practises. We do have forty two pharmacies and certainly with the advent of single exit pricing and the following there of the mooted pharmacy professional fees that certainly makes the pharmacy division less, or the retail side of it less profitable. We feel that an integral part of our service delivery, we've restructured and we're comfortable that the pharmacies are paramount to our service offering. Thirteen day theatres, big opportunity there in terms of under-utilisation at the moment. 650 full-time GPs and dentists or consultants represent about seven percent of all the GPs and the dentists in the country and if you see in the next slide we've doubled that when it comes to marketing and patient visits.

Probably the most exciting point on this slide is the fact that we've got capacity of about twenty percent left within those facilities of ours. The average dentist in Medicross currently is three weeks in advance, booked up in advance. The top end dentists you can't get a booking for the rest of the year. Certainly this type of organisation lends itself to centralisation, those repetitive types of works. We've started with that. We've centralised our credit control. There's certainly more scope in terms of that. We now look at the number of patient visits we've seen for the ten month period. There you'll see that over and above the fact that that blue column represents Primecure for a period of eight months last year, we've closed twelve centres but still if you look at the number of visits we've actually managed to encapsulate visits in those twenty five centres and there's good growth as you can see both organically from a Medicross point of view and from a Primecure point of view at two point 7%. An interesting stat there if you'll see that 54% of all the patient visits in Primecure are actually private or self-paying market.

Those people that are not belonging to a medical scheme or who have fallen off from a medical scheme and on the Medicross side, 20%. We look at the dispensing side with the advent of the pharmacy professional fee round about September 2004, we've estimated if we've lost about 20% of the market share but if you annualise that ten month's results you'll see that we've recaptured a big portion of that market. I'm quite comfortable that with the restructuring and with the disparate pricing system that we have at the moment, once we've sorted that out we'll regain a big chunk of that market share. We pride ourselves on being open extended hours. We pride ourselves to having excellent service. We certainly looked at our staffing models in terms of pharmacists and pharmacists' assistance and definitely have stock available. More importantly, if we look at the actual generic item use, in two double oh three there was mandatory introduction of generics and you'll see that currently

forty seven percent of all the drugs used per item in the Primary Care Division in terms of scripting actually is generic items.

If you compare that with the major pharmaceutical benefit management company, Medicor, you'll see that their average stats for their market share which is about 30% is only 40%. Government quote figures of 42% so it's certainly in terms of the affordability within the Primary Care Centre, its average there. I'm sure you're tired of this slide. I want to reiterate that we are as a group well poised to take care of that LSM six and upwards and specifically as we heard earlier on in terms of the GEM side. We heard about the shifting sands phenomena. So there's more people coming in and I think the Division is poised to take charge of that new seven million market. We spoke earlier on in terms of the private use or the self-pay market and as we saw in earlier presentations that grew from about 17% in the previous year, 47% in the previous year. You'll see that 25% of the managed care patients in Primecure is actually been seen by that twenty five centres.

The other 75% are seen by our network but a little bit more about that later. You'll see a major, certainly a major schemes being Discovery, the Medschemes, MAG Medscheme and Transmed on the other side on Primecure. There has to be a benefit for the patient in order for us to post that continued growth year after year. I think as we indicated earlier on, the convenience side certainly is one of the major reasons. The fact that we're open 365 days a year. Thirdly there are six of the centres that are open twenty four hours strategic to place countrywide. It puts us in a different level to the rest of the competitors. The range of services in terms of emergency capabilities and also the additional facilities certainly helps the patient in terms of satisfaction and I think it's important to make sure that there's adherence to internationally accepted protocols. The fact that each and every visit of each patient is profiled and a practise audit on a monthly basis and peer reviewed I think stands in good stead in terms of international achievement protocols. The fact that your medical records are always available whether you see your normal doctor or you come in for an emergency.

We mentioned earlier on that it's a segmented branded offering. We're well poised to cater from the LSM five right through to the top LSM and certainly the ability to cross-sell with the footfall whether it's for physiotherapy or aesthetic clinics. What is a primary care offering? I think the core offering we all know is the GPs, the dentistry, the pharmacy, the optometry, certainly starts to come in, in terms of the auxiliary services. These additional services as well, it's more in terms of the adds on to the, for the patient. One of our centres in Durban in the Bluff we've got weekly diabetic clinics between seventy to a hundred patients. The doctor gives a lesson. It's free of charge. Certainly that additional add on's that you get at the family medical centre pays off when it comes to growth and the market share. Definitely in terms of the additional services as I've said the cross-selling ability whether it's dieticians

or psychologists or visiting specialists. Before I conclude on the medical centre side if it wasn't for the doctors we would not have a business.

Our relationship is very doctor-centric but why do the doctors come to us? I think the limited and the basis of the administration being taken out for him. The doctor if you think about it studies for seven up to nine years depending on the different university then essentially he comes out as a businessman but lo and behold he hasn't been trained anything about business and we fill that gap and that market. He then sees patients. He does what he does best certainly in terms of patient care. There is a superior remuneration as a result of the kind of [inaudible] scale. Professional autonomy for this individual doctor is very important. Although he's backed up by practise audits and peer reviews and clinical guidelines, he remains professionally autonomous. In terms of the benefits of scale I think I spoke the most about that but the proof of the pudding is in the eating and you'll see over the last ten months up until the end of July we've lost twenty one doctors but not one single one of those doctors actually went back into private solo practise.

We recently commissioned a study by TSN old research surveys and to have a survey done within our doctor groupings of six hundred and fifty doctors and seven out of ten doctors said they're extremely comfortable with the Medicross scenario. To me that is a vote of confidence. Certainly we can see that emigration is still a big portion of the reason why we are losing practitioners. That concludes my one focus area. Now we need to move on to the managed care side and again I want to say what is the competitive advantages? Certainly we would like to believe that we've got the intellectual capital, intellectual property and to match that with essential care. When one talks managed care I want to use the words essential managed care that's coupled with evidence-based medicine. Please let's dispel this issue about under-servicing. Probably the biggest competitive advantages for us, if one compares us with a managed care or the word managed care and we heard it earlier on in Melanie's presentation what the administrators do, if we take risk and from an analyst point of view I'll satisfy you later how we manage that risk. But certainly we can take risk.

We actually take that medical loss ratio and it's transferred from the scheme to the MCO, the Managed Care Organisation, Primecure, and we manage that risk. Whether its primary care ie GP or dentistry or whether it's out of hospital specialists or whether it's with tertiary side on the hospital side. It's easy to put a network of doctors or a network of hospitals together. Our network is contractually bound. Each and every one of those three thousand doctors, I'll show you know, in our network has got a contract where it's exactly stipulated what that doctor needs to do. How he's remunerated. How we want him to treat the patients. On which guidelines and what protocols. The fact that there's a proven track record – we've been taking risks for the last five years. Again we're the only managed care organisation that have got contracts with the public hospitals whether, and there's two contracts

mainly in the Western Cape and in Gauteng. I spoke about the fact that we're one of the few if not the only managed care organisation that's accredited by the Council for Medical Schemes as a managed care organisation taking risk.

I mentioned earlier on that there's confusion about this managed care. Administrators apply the managed care principle and admittedly they utilise certain tools but they don't take risk. They will charge a fixed fee per month to do certain managed care principles regardless of the outcome. I don't want to sleight the part of the funders here but I certainly do believe it's a way to up the administration fee which is supposed to be limited at 10% from Council's medical schemes point of view if you look at the health care pie it's 15%. Our market in terms of the, and I need to say this, is our estimates. The market is still small. We estimated it at 450 000 lives. You'll see that we have the lion's share there. Why is it not moving? Again earlier on we heard from Melanie in terms of the prescribed minimum benefits. There needs to be a prescribed minimum benefit for this organisation that specifically caters for that low income market segment. I'm not always so sure that the market understands the needs of that market. With a household survey that Discovery was sponsoring in terms of limbs it found that the participants were looking for three main things. They were looking for GP services privately, they were looking for dentist servicing privately and believe it or not they wanted optometry services.

Now if I show you our next slide you'll see that we cater for that. We've got three thousand three hundred contracted, contractually bound practitioners. It includes optometrists by the way. As I said earlier on running a network has got some additional benefits to it. We have relationship managers that contract the doctors on a regular basis making sure that he's got the right material, that he's got the data to actually manage the patients, our managed care patients and these doctors here; they see seventy five percent of the managed care patients. Two large schemes have recently contacted us to actually manage their network for them. They decided that they're not in the network, they haven't got that track record and the likelihood of us at least getting one tender awarded is great. This is actually just the process of a chocolate factory. I just wanted to make it a bit more impressive. On a serious note though the data and then intellectual property that one has to manage in managed care at the end of the day is the be all and end all. We're fortunate in the fact that we have the IT technology sorted in terms of MIP for our claims management.

Our Medcap technology in terms of the hospital risk and case management whether it is between the different switches. Whether it's pathology. Whether it's between the providers. But it's electronic and the date is electronic. The call centre, it's twenty four hours on duty and let me give you an example. In our call centre level and we've also always heard this for the worst stories from America in terms of managed care, if a doctor would phone in for a authorisation and that authorisation or the procedure he wants to conduct differs from our guidelines and our protocols, immediately he's transferred by that

missing sister case management just one of the six medical advisors. There's a relationship. In other words it's always peer on peer that has the discussion. Its possibility one of the biggest success factors of our call centre. Again we speak a lot about managed care. I'm trying to show you a bit about the risk as I mentioned earlier on and the involvement we have. We started off here with a fee for service which is still the most common method of our funder and provider payment. We're moving a bit to managed fee for service but you'd notice in the first three points there there's no transfer of risk yet. Preferred provider organisations, IPAs that were involved in terms of these fees and then came the word capitation when we capitated transferring risk to one portion and that's where we had the balloon effect so what we simply did there we squeezed it. We squeezed the GP.

By the way it only takes seven percent of that Council for Medical Schemes Health Care pie and that didn't work. The GP just transferred the risk whether it's to the specialist or to the hospital. We moved into the group HMO model, health maintenance organisation, a bit of alternative arrangements there and there's still some of that happening. We like to think that as the managed care division we're sitting here and the big difference is we've transferred the risk to the MCO, the Managed Care Organisation. How do we manage risk? On various ways. As I mentioned earlier on, data. Data actuarial studies are the most important. Whether it's before the contract, during the contract or after the contract we manage that data and we've got the five years data. Generally we've got insurance stop losses, we've got off-ramps in the contracts and at the end of the day if that doesn't work we've got three months notice period so we feel that we're well covered. Touch wood so far in the last five years we haven't burnt any option. In fact there's other methods as well where you share risk, not only yourself but you share risk with a scheme.

GEMS, both Beryl and the Sapphire options that we manage. It's a good example for that. I can tell you that Gems gets money back in terms of the risk sharing arrangement so there is risk sharing but we also partner with the scheme. But how exactly do we do that? If you look at this example and I'm very conservative. I've taken an LSM five to seven member. If you take him and his family, divide his contribution by three, maybe R600 per member per month is being paid. We come in and we, then obviously administration conservatively at about 10.5%, managed care fee, that is that theoretical managed care fee that I spoke about earlier on, not ours, that health care management, mandatory commissions and obviously reserve building. That percentage won't work out to 25% because the option has to have 25%. We will come into a scheme and say to him because of our managed care tools we're prepared to take risk and say we will be able to drop that health care benefits. That's where the GPs, dentistry, hospital, specialists are being paid out. We're prepared to take that and we'll give you a 30% saving just with our managed care tools to start off. Brings that down to R328. Now the administration has to be less and one can say that's where the conflict of interest lies.

Remember here you're talking to the scheme so once we've got that fiduciary responsibility of the scheme versus the administrative split that problem will also be disappearing if you look at accounts for medical schemes, what they want to do, what they believe managed care needs to do. Thank you. Go back one. Sorry about that. It's getting too excited. So let's move across to what we offer. We then say that the administrator needs to manage what he's supposed to do. In other words collect funds, pay out funds, and manage call centres. We then would manage, and our growth margins come out of that risk but you'll see here that we've lobbed off 36%. You've heard what Melanie said in terms of Circular Eight, in terms of that basic benefit. Every scheme will have to have it and if you don't believe me, as Victor said, look at the ANC green paper, look at the white paper. It's coming. We are successful in doing that. In terms of our admissions per thousand, and we don't under-service. We've got essential medical care based on internationally accepted protocols. We've lobbed off forty five percent there in terms of admissions per thousand. Our length of stay is twenty two percent less.

I can go on. In terms of our cost of admissions, in terms of the average medicine costs. Remember that all that medicine cost is generic. But let's have a look in terms of the admissions. 38% of those admissions went to Netcare. Netcare market share 36%. I'll leave you with that. This is my favourite slide. When we took over Primecure in 2006 February we had ninety thousand lives. We've got a 180 000 lives. We've grown that phenomenally albeit that thirty percent or sixty percent at least of growth comes from the Gem's lives. When I spoke to Eugene Watson, the Principle Officer, earlier in the week he indicated to me that gems now is in excess of 160 000 principle lives or four hundred and 30 000 or a 160 000 principles and 430 000 lives which makes them the largest restricted scheme and we haven't even started with them in terms of the other departments whether it's defence or foreign government. You'll also see there these two options that we manage in terms of full risk. For the first time now the Sapphire option which is the fully subsidised option has surpassed the growth in Beryl.

Our growth is not only from the number of lives but certainly in terms of the risk, I think I've highlighted that point and lastly in terms of the managed care you'll see this is a typical type of portfolio that we have. The basic package without hospital cover will cost you just over a R130 and we still make a decent margin out of that. I just want to highlight five points that will impact our results for the twelve months ending. As we indicated earlier on the first slide Primecure will be consolidated for twelve months versus the eight month period in the past. Certainly the closure costs of the twelve sites had an impact in terms of the terminating expenses and also the extraordinary lease costs that we needed to take account for countered by a healthy growth of two point seven percent in terms of patient visits but negated by sub-optimal tariff increase in terms of NHRPL going forward in two double oh nine I'm comfortable that will be to our benefit. And then as we say we've made some centralisation savings

but the full benefit will only be seen in 2008. If you look at some of the outlook for the Primary Care Division I mentioned earlier on that our expansion opportunity is a big focus area.

We have got the capacity. We certainly are in the next three years will add about twenty sites, nineteen sites to our footprint. Those sites aren't pie in the sky. Some of them are opening just in before the end of the year. Bloemfontein South, Gatemax in Umhlanga and Primary Care in Alexandria and Soweto to the latter part of two double oh eight. We're certainly looking at broadening of our services. Specific in terms of that cross-selling, aesthetic clinics you would know is very much in the highlight of the moment. We believe we are a bit different. Ours is doctor-based. I'm talking about the skin lasers, some fillers, some botox and so forth. [inaudible] capacity utilisation needs some attention. There's at least a 40% capacity utilisation there and interaction with schemes would hopefully help that capacity utilisation. Clearly the managed care allows them to grow that. As our setup is currently in terms of overheads we can manage 250 000 lives. With that infrastructure before we had to add more people but it's not capital intensive, we've got a robust IT system, a robust call centre and we talk about more medical directors, a couple of call centre agents.

I'm excited about the Woolworths and the Edcon project. I believe Ingrid Davis has been running and charging with that. We've got a pilot site down in Cape Town, in Kloof and we're waiting for our licence in Athol Square just behind us and then the Edcon project. From the twenty sixth of next month if you're an Edcon card holder whether it's Edgars or Jet 4.4 million of those card holders you can use your card for any medical services within the Primary Care Division and then clearly the SAP implementation I think will bring more benefits to us, more centralisation to us. We've been testing the information system health portion which is the big portion; it's the actual billing side of it. That's one of our primary care centres in Randburg and we're going live there on the first of October. In terms of the specialist practise management I'm happy to say we're starting a pilot project. We've finalised our IT and essentially what we're going in terms of practise management for general practitioners, we're going to roll that out to our specialists.

Then I'd like to leave you with our strategic outlook. Richard mentioned something earlier on of the decade of the GP coming and if you look at those top ten diseases which 70% really should be managed by the general practitioner. Prescribed minimum benefits are being revised to be more GP friendly. In other words the GP can manage more of those cases within its own facilities. If we take an example of hypertension, the GP will diagnose the hypertension and the patient is off to the specialist. The big difference, he never comes. And that's what we want to try and start there, the reversal of the GP discontinuation, having the GP as the true gate-keeping. I mentioned that we need enabling legislation for this to come. Do yourself a favour, go and read the ANC green paper and you'll see that it's on its way. Thank you for your time.

Richard Friedland – Netcare: Chief Executive Officer

Jacque, thank you very, very much. Ladies and gentlemen do you have any questions? Thank you for that outstanding presentation and that insight into primary care, Jacques. What we'll do now ladies and gentlemen is break for a quick cup of tea or coffee, a comfort break. It's quarter past eleven. We'll reconvene here at half past eleven. Thanks very much.

ENDS

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