

NETCARE

Network Healthcare Holdings Limited

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Update on NHRPL and the group's
pricing strategies

Conference Call - Transcript:



You're in safe hands

Operator

Good afternoon and welcome the Netcare management discussion conference call. All participants will be in listen-only mode. There will be an opportunity for you to ask questions at the end of today's presentation. If you need assistance during the conference please signal an operator by oppressing * and then 0. Please note that this conference is being recorded. At this time I'd like to hand the conference over to Marcelle Jankelow. Please go ahead.

Marcelle Jankelow - Citigroup

Good morning ladies and gentlemen. On behalf of Citigroup we'd like to welcome you and thank you for joining us with our call with Netcare today. From Netcare we have Dr Richard Friedland the CEO, Belinda Williams of Investor Relations and Melanie Da Costa the Healthy Policy Director. I think the key purpose of today's call is to discuss some of the topical issues: the surgical rebates, the NHRPL and also touching on the Community Health acquisition. We're going to hand over to Richard Friedland who will take us through these points, and then after we will open up the floor for questions. Richard, thank you very much for taking this.

Richard Friedland – Netcare: Chief Executive Officer

Marcelle thank you and TC very much for arranging it on behalf of Citigroup, and ladies and gentlemen welcome to you from Johannesburg here in South Africa. Thank you for taking time out on this Friday afternoon. There are three topics of conversation this afternoon, although we're happy to take questions on a broad base. Perhaps just to deal with the latest information, with the ruling that came out yesterday afternoon from the competition tribunal put finality on a long process, and I'm delighted to say that we have been allowed to acquire the remaining 56.75% of the Community Hospital Group. As you will know we already own 43.25% of this group. It was disallowed when we filed by the competition commission, even though there were no objectors. The competition commission had gone out to subpoena witnesses. I'm delighted to say that the tribunal ruled that we may acquire the remaining shares with no conditions attached. And so we will be doing that as soon as possible. It effectively adds about 8% more beds to the network country-wide. Two hospitals in Cape Town, UCT Private and Kuils River, and three or four in Gauteng, Montana, Bouganville, N17 and all in all about 600 beds. So we're delighted with that. We think it's a great success from an enterprise development. We assisted Dr. Anna Mokgokong and Mr Joe Madungandaba out of the Macmed debacle, that liquidation. And I'm pleased to say that I think that this has been a very

successful BEE transaction. I'm happy to take questions on that transaction a bit later on when we open the floor to questions.

I think given the hype and controversy around surgical rebates over the last ten or eleven days, emanating from statements made at the Board of Healthcare Funders. It's appropriate for me to address some of the concerns and some of the issues that have been raised over this period and talk to the history of how it's arisen, what the real issues are and how we see resolving those in the coming weeks, and hopefully by the end of August. Surgical rebates are nothing new in this industry. In fact this industry has experienced the cross-subsidisation model for many years. It arose in the 90's when the tariff increases to providers were below medical inflation, and hospital providers were utilising mark-ups as opposed to rebates to cross-subsidize the accommodation and ward theatre and equipment charges. And in 2004 legislation in our country changed, in that single-exit pricing was introduced for the ethical component of drugs, and a baseline price was established. That is approximately 15% of our overall charges, our surgicals and consumables are about 35%, and ward theatres and equipment about 55%. We retained the surgical rebate in 2004 because we felt we had a very good and strong negotiating team, and that we could also leverage a scale in this regard. And I think we were able to achieve better discounts and rebates than our competitors. What many of our competitors did was to remove that rebate structure in 2004, go for something known as the 'net acquisition price', and move that effectively into ward theatre and equipment. And I can tell you for a fact that one of our largest competitors has increased their ward and theatres, specifically their theatre fees, by some 45% to 50% in terms of the differential between Netcare and ourselves.

I think the important issue about that is that we have never asked a supplier to increase their prices in order to accommodate a discount by Netcare. And the strongest evidence we have of that is when you look at the increase in price of that surgical basket over the last five years it has been a mere 3.9%. And you may even argue that by moving the rebates out of surgicals into ward and theatre our competitors might have done better, because the increases in that area have been higher. We have some 65 000 line items under the surgical consumables. We only have some 700 suppliers. I think in any industry where a supplier is excluded and not one of those chosen 700 – and here we have some 3000 or 4000 potential suppliers – people feel aggrieved. I don't for one moment think there has been anything unethical or illegal in the practise. None of our internal or external audits have shown that at all. Nonetheless, given the hype over the last ten days, given that our patients and consumers and the public are calling for greater transparency, we have committed to move away from this rebate structure completely. We are in the process of engaging all of the funders in this regard. We hope to have completed this by the end of August. And it may come as a surprise to you, but other than Discovery and one key organisation that has been in contact with us to try and understand this pricing

model, we have not had any push backs from the funders or other administrators in the market, or any concerns being raised by them.

The other issue I want to raise, and one that has been spoken a lot about, is why haven't we moved to this a lot earlier. I can tell you that since early January we have employed an Australian consultant to look at the Australian DRG, and a tariff committee to look at alternative reimbursements. We now have two external consultants working on this. I think we were preparing to come to the market anyway in our fee structure for 2008 with revised alternative reimbursements around fixed fees and a combination of bundled fixed fees or per diems. I don't think we will ever get away from fee for service. There will always be an element of carve-out. Whilst we were doing this we were also evaluating the introduction of a diagnostic related group, or DRG system, here in South Africa. The current one we think is flawed. It was developed by 3M, and is no longer being maintained by them. Our idea was to use the Australian one, which we have just received permission from the Australian government to try and indeed the licence to do so. And we'll be cross-matching our procedures against this. Now, for those of you who are not certain as to what a DRG is, it's a Diagnostic Related Grouper. It gives us the ability to compare a procedure and the diagnosis and include the severity – in other words with or without complications, or with severe complications – and the demographic details in terms of the patient's age, their gender and the chronicity of the illness. What we like about the Australian DRG is the fact that it is embraced by both the public and private sector in Australia, in Germany and in Ireland. We think we will be able to benchmark ourselves against that in a very transparent and effective way.

One of the biggest confusions in this industry is that when we compare prices across providers we can't get to comparing procedures because often the procedure doesn't take into the account of the severity of that procedure or the medical condition, age or gender of the patient – all of which impacts on the overall cost. We think longer-term if this industry were to adopt the Australian DRG, or a modification thereof, we think we would have greater transparency of pricing and comparability across the patch. So at the moment what we've done in terms of this is to start meeting with our funders and looking to what suits them best, either in terms of a fixed fee model on certain procedures (and we think we about 15% of our basket of procedures could be fixed fees) the remainder of this medical per diems and on fee for service. I think we will probably report back to you at the end of August has to the progress in this regard and what the potential impact of this may be. We may well have to look at increasing our theatre and ward or ICU charges. I take great comfort from the fact that when I look at bills from other providers and look at the significant premium on their theatre and ward and ICU's, that clearly they have moved this cross-subsidy into those areas. We will have a similar discussion with some of the funders in this regard. I think that making the charging system a lot simpler will remove any of the confusion in the market and the perception that perhaps we're doing something that is

unethical or illegal or not transparent enough. The South African public deserve to know and we are a public company, and I have certainly committed to doing so. I'll happily take questions on that aspect at the end of this conference.

I think want to come out to the NHRPL regulations that were promulgated earlier this week and explain our stance on it and perhaps highlight some key elements. And then in terms of the methodology that is being proposed here, I will probably hand over to Melanie Da Costa to give some greater cover on this issue. NHRPL is nothing new. We have been quite surprised by the hype around it because it has actually been around since 2003. It was based on the Board of Healthcare schedule. The data was never really collated or analysed from the hospital groups, but it's always been out there serving as a reference for tariffs in the industry. What has happened now is that government has published a regulation that outlines the process and methodology for determining the base costs to achieve a new NHRPL. I think we welcome this. There is no question, and this recent furore has raised this issue, that clearly there is a crisis of affordability in our healthcare market. Government is seeking that we should be providing healthcare to far more South Africans. We embrace that concept. This is a country of have's and have not's, and traditionally the private hospital market has looked after the affluent South Africans. We have a social and a moral obligation to extend that care, and we want to do that to the lower income market. And I think NHRPL regulations are part and parcel of that process. We intend to share our data in a very transparent way in order to achieve that. I think for those of you who know our UK operations, we have been working on a similar NHRPL level with the HRG system in the United Kingdom, where all the procedures we do for the NHS are based on a HRG system, and we've been able to make margin on that. And indeed there is a market forces factor which allows you to increase or decrease the price depending on the geography. So from where we are at the moment we have been studying these regulations and we've been looking at the methodology of that. And perhaps at this point it will be worthwhile to hand over to Melanie. Maybe you could shed some light on the methodology that we have been asked to comment on the kind of methodology being employed.

Melanie Da Costa - Netcare: Health Policy Director

Good afternoon everyone. I'm very certain that everyone has gone through the regulations. In terms of the NHRPL it will be determined for relatively homogenous service provider groups. So the hospital industry believes that it needs to table one hospital costing methodology. And we're very focussed on the fact that the model needs to ensure sustainability for the industry and all of its participants, more specifically the smaller groups and the independent hospitals that don't have the benefit of the laws of large numbers. We support a joint initiative on building the proposed NHRPL hospital model, and this



is a model that will need to be tabled to the department of health for approval before we use it in the determination of the price. Now HASA has been pro-active in employing a consultant. The consultant we have selected has much experience in building pricing methodologies for regulated industries, and specifically specialises in sustainability pricing. So our submission is going to reflect the cost building blocks and the drivers thereof. And we are going to focus attention on the required rate of return for the private investment industry. We fully understand the importance of earning a positive spread on cost of capital, and we will communicate this to the department of health. At this stage in terms of the methodology, any further comment would be premature. Now that we know the regulations and we understand the scope of it we will start commencing the building blocks of the methodology and table it for approval.

Richard Friedland – Netcare: Chief Executive Officer

Great. I think probably at this stage we can open up the conference call to any questions, and we welcome any questions you may have.

QUESTIONS AND ANSWERS

Operator

Thank you. At this time if you'd like to ask a question please press star and then 1. If you decide to withdraw your question you can press star and then 2 to remove yourself from the queue. A reminder, if you'd like to ask a question please press star and then 1. Our first question is from Marcelle Jankelow of Citigroup. Please go ahead ma'am.

Marcelle Jankelow - Citigroup

Thank you. Richard, could you please expand on the issue of medical gasses? There has been a lot of it in the press and the public are saying they are not receiving the benefits and the potential R300 million in the system which has not been passed on to them. Could you just give us your view on that?

Richard Friedland – Netcare: Chief Executive Officer

Yes. I must say that we were somewhat surprised by the allegations made at the BHF conference. We were first alerted to this issue in late June. We made an appointment and saw the department of health in this regard on the 12th July. Somehow in all of the furore that has come out that has never been recognised. We want to work with the Board of Healthcare funders in this regard, and I've spoken to Rajesh Patel and I think we're seeing him next week. But effectively the issue that private hospitals have – and I'll speak generally and then speak specifically about Netcare – is that it's extremely difficult to measure per millilitre the use of these volatile gasses. Now it's not to say that it's not possible if you have the right machinery and you have the right monitoring. We have many machines within our group, and we have some 316 anaesthetic machines, some 14 in Medicross and some 302 in the Netcare hospitals. And this excludes obviously the community hospitals. We have many different types of machines, but we do have some machines which allow you to get a digital reading on the screen. What we need to do is put monitors on top of that which can give you an

accurate printout. Unfortunately that's not all our machines. We estimate throughout the hospital industry probably only 50% of machines are so-called low flow. And I'm not sure what percentage throughout the industry would allow that measurement to occur. But we're taking a very rational approach to this. If we're able to measure it, we'd be delighted to do so. There is a cost potentially involved. I think we would have to replace a whole range of machines. And on those ones that we can do it I think there's got to be a physical measuring device as opposed to purely digital. I don't think any funder is going to take one's word that the reading happened to be X without any proof of that on a printout or anything else. So we welcome that debate on that and we think it's far less opaque than it's being made out to be. We'll be engaging with the Board of Healthcare Funders next week on this issue.

Operator

Miss Jankelow do you have any further questions? There are no participants in the queue at this moment.

Marcelle Jankelow – Citigroup

Ok if I can continue, just in terms of the NHRPL is it possible at this stage to give an indication of how your prices compare relative to what is proposed?

Richard Friedland – Netcare: Chief Executive Officer

You know I'm happy for you to answer that Melanie. Why don't you answer it?

Melanie Da Costa – Netcare: Health Policy Director

I just want to contextualise the existing NHRPL. As Richard mentioned it was tabled a few years ago and emanated from the BHS scale of benefits. So what happened at the time was that the hospital group didn't submit data to re-assess the base NHRPL. And then over the years what happened was

that the escalations granted on the NHRPL approximated CPIX rather than medical inflation. So that caused a bit of a differential. And then over and above that we also had annual technology changes that one would need to account for in terms of setting tariffs, which wouldn't have been accounted for. This explains why the private hospital industry tariffs are approximately 20% to 25% above the NHRPL as it currently stands.

Operator

This is the operator. We have a question from Nick Krige from BlueBay. Please go ahead.

Nick Krige – BlueBay

Hi. I want to ask a question about getting a positive yield as to the cost of capital. Can you just work through that calculation that you currently do? I think there was a 2% spread in one of the adverts. And then if one wants to maximise that spread one can use the op co prop co type of structure to maybe create that spread and widen that spread. What is management's feeling about that, both here and in the UK?

Richard Friedland – Netcare: Chief Executive Officer

Do you want to answer the spend and I'll answer the op co prop co issue?

Melanie Da Costa – Netcare: Health Policy Director

Just in terms of the reference to the spread on cost of capital, the methodology used in that is the Holt CFROI. The cash flow return on invested capital. And basically we're looking at the cash flow return on invested capital versus our weighted average cost of capital. And as you know the cost of capital is the derived cost of capital for the country based on market shares. And then you obviously have to add back inflation. That's based on the published health figures. Sorry the second part of your question related to expansion of that...?

Richard Friedland – Netcare: Chief Executive Officer

Well let me come back to the issue of op co prop co here in the United Kingdom. I think it's well known to our investor community and our stakeholders that we have been evaluating the op co prop co opportunity, particularly the sale and lease back issue in the United Kingdom where in effect yields have contracted quite substantially since the acquisition on the 12th May last year, to the extent where we may take advantage of that. We may decide to get involved in a sale and lease back, retire the debts in prop co and perhaps de-lever some of op co and de-gear some of the debts here in South Africa. That is very much an option that we are considering at the moment and is very live and active with us. We are looking at it as we speak, equally so in South Africa. As you'll know we own most of our properties, bar three, and we are also looking at the op co prop co structure. We feel that yields have not contracted sufficiently, but we are certainly going to be running our business internally next year, in our new financial year on 1st October, on the basis of an op co prop co. And we have put our business structures into two different entities in order to accommodate that so that we can see the ultimate benefit. We feel that this market has some way to go though before we decide to do that, but we're certainly considering that very seriously.

Operator

Our next question is from Mark Ingham. Please go ahead.

Mark Ingham – Independent Analyst

Thank you, and hello Netcare team and thank you for being so frank. Three related questions. Firstly, with the new pricing there is a chance that we may see volume throughput stimulated through your premises. Is it possible to quantify what that could be over time? Secondly, the price inflator of 4.9%, I don't quite understand the economic rationale behind that. Perhaps you do. And then thirdly, the move away from the rebate structure. Is it possible to quantify what impact that could potentially have on you? Would it be net - net square for you or would it potentially result in fewer profits for the group?

Richard Friedland - Netcare: Chief Executive Officer

Mark thank you very much for your questions. Could you just repeat? I understand the first one around volume and I understand the third one around the impact of moving away from these rebates. Could you please just repeat your second question? We just didn't get that.

Mark Ingham – *Independent Analyst*

Certainly. The inflator which stands at 4.9%, I don't quite understand how that number has been arrived at.

Richard Friedland - *Netcare: Chief Executive Officer*

It was 3.9%. That was our surgical basket.

Mark Ingham – *Independent Analyst*

Right.

Richard Friedland - *Netcare: Chief Executive Officer*

In fact if you look at our tariff increase as a total over the last five years inclusive of that it is 6.1%. Do you want to explain the methodology of the 3.9%? It's just that surgical basket.

Melanie Da Costa - *Netcare: Health Policy Director*

We have a surgical basket that remains about 80% constant year in and year out. So there might be some technology change which might affect that basket but by and large that basket stays constant. Just looking at the price change, the literal inflation rate on that basket on average since 2003 has been 3.9% increase. I just want to elaborate on that. Obviously we have seen stable currency and that's the main driver of it. A large portion of the suppliers in South Africa are multinationals of European descent. The result of that is that the currency benchmark would be closer to the Euro than to the US dollar. And hence we haven't seen deflation in that basket, but we have seen a pretty stable basket.

Mark Ingham – Independent Analyst

Ok thank you.

Richard Friedland - Netcare: Chief Executive Officer

Mark your issue of volume coming through as business is that we think there is a very exciting organic growth story unfolding in South Africa. We have put out this growth strategy slide, and the market has had sight of them, in terms of building our case around that. But we have seen some real growth in the medical aid market. In 2005 of 2.3%, this past year some 3-4% and we think its due to take off. We've seen huge growth in the self-pay market. I think currently in our business it is running close to 25% growth. Mid-year we said it was at 19%. We have seen growth coming through in primary care and obviously with GEMS. And you saw the announcement by Eugene Watson yesterday that their scheme has grown exponentially. I think they've now got 160 000 lives of which half are new lives. And we think that is set to come off if there were principle members, and there were limit legislation that would further stimulate it. So when we look at our five year forecast, and we built a five year model on this, we see this market potentially rising to 11.1 million lives from the 7 million that we have here. It sounds a fantastic number but we have looked at that very carefully in terms of an incremental growth both on the existing medical aid market as well as the lower income market, and potentially on the GEMS market. Remember that GEMS alone if it was successful would add 15% to the existing base. So I hope that answers on volume for you. On the question of rebates and the impact of it, obviously our desired position is not to have any loss of margin and be able to maintain our current position. I think a large part of that will be determined by our negotiations with funders in the coming weeks. And I think we'll be able to report to you thereafter what the net net position will be.

Mark Ingham – Independent Analyst

Super. Thank you kindly.

Operator

Our next question is from Jonathan Larkin of Old Mutual. Please go ahead.

Jonathan Larkin – *Old Mutual*

Hi Richard. Just a question on the tariff negotiation. You mentioned you would be looking to get an increase there. Maybe just in light of the NHRPL and understanding that it is a guideline, would that not make that challenge a bit more difficult in terms of negotiating with the medical schemes, who would then look to the NHRPL to try and negotiate against you on that?

Richard Friedland - *Netcare: Chief Executive Officer*

I think that the NHRPL is a completely separate debate because we're building that on up from cost. I think there are significant pressures outside of this rebate issue on tariffs going forward for all providers. If you look at this year, given the public sector strike and the fact that government has come out with quite significant increases for nurses, and particular categories of nurses. I think that we're going to see a significant wage inflation which must translate and must be borne in mind when negotiating the tariff increases. So certainly the tariff increases for 2008 are not dependant on NHRPL, and in fact the document does not envisage that NHRPL will be effective in 2008 anyway. But I do think there are going to be tough tariff negotiations for 2008, no question about it. I think there are three elements in that mix besides the rebate issue. I think we have nursing salary increases, we have retention issues around a shortage of skills and we also have training costs. I'm delighted to tell you that we are progressing very well with the potential importation of nurses from England and from central Europe who are not longer able to have working permits renewed in the United Kingdom. There are a lot of people from central Europe and elsewhere who have expressed interest through various agencies, and we are currently looking at that model. I know Mediclinic has looked to bring in some Indian nurses. We've worked very closely with nurses from central Europe and our director of nursing Eileen Brannigan has just returned from England this week and had discussions in that regard. So we are trying to address the skills issue so that we can take some of the pressure off the supply side of this equation.

Jonathan Larkin – *Old Mutual*

Thank you.

Melanie Da Costa – Netcare: Health Policy Director

Jonathan I just want to elaborate on one point that Richard made with respect to whether there will be an NHRPL in 2008 or not. According to regulations there will be a referenced price list, but it will be based on the previously determined NHRPL as opposed to the new structure.

Jonathan Larkin – Old Mutual

Ok. Thank you.

Operator

At this time if you'd like to ask a question please press star and then 1. Our next question is from Frances Cloud of Nomura. Please go ahead.

Frances Cloud - Nomura

Hi Richard. I am afraid I'm going to have to ask you a very basic question because I don't totally understand the background to all of this. As far as I understand it, at the moment this NHRPL is simply a guideline and not something that actually determines the figures that you're paid. Is the government's idea that when they've established this new NHRPL that will then be applied to all hospitals?

Richard Friedland - Netcare: Chief Executive Officer

I don't think that we're absolutely sure on that issue. We have been given a reassurance by the department of health that it's purely going to be used as a reference price, but I think we'll get greater clarity on that in the current months as this evolves and we debate the methodology and other issues around that. But the indication that we have had in our meetings with government is that it's simply being used as a reference price.

Frances Cloud - Nomura

And what does that actually mean? I mean, what is the good of having it as a reference price?

Richard Friedland - Netcare: Chief Executive Officer

I think they're trying to see greater transparency and to give people the opportunity to see what they consider to be a reasonable price to pay, so that there can be some kind of market forces of negotiation introduced with the supplier of those services.

Melanie Da Costa - Netcare: Health Policy Director

Frances I think it's also important to note that the way in which the NHRPL regulation is drafted is that it does allow operators or specialists to mark up the return on investment which they propose and buy an appropriate risk premium. I think that ties in with the Minister's statement that she issued this week. I think they recognise the importance that private healthcare has to play in this country going forward, and therefore there is this acknowledgement that we can make an adequate return. And the regulation specifically caters for it. So earlier we said the old NHRPL was at a 20% to 25% discount to the current prices out there. We have run the equation with reasonable numbers, using their bank rates and applying a relatively conservative marked risk premium, and we come out in a pretty similar position to where we are today. So I think that regulation is structured to allow us to make a return.

Frances Cloud - Nomura

Alright. And then just a second question on the potential expansion of the insured population. As you model going forward and you look at the big increase in the number of lives under cover, what does it mean for your own profitability? As I understand it these GEMS type policies are quite limited in terms of the benefits that they offer, and therefore presumably the remuneration to you. I was wondering if what the outcome may be is a big increase in volume through your hospital but a rather less large increase in actual fee income.

Richard Friedland - Netcare: Chief Executive Officer

Frances I want to answer that in two parts. Firstly the GEMS schemes are mirrored on current existing medical aid schemes and those subsidies have increased just recently. So I don't think there is a limitation on four out of five of them. The most basic one, the Sapphire Scheme, is the one where the state is the designated service provider and that might be somewhat slightly more limited. But essentially the GEMS schemes are not limited in terms of that. The top three are open and only one scheme, the Beryl Scheme, has been negotiated at a significant discount. It's a network option. Our view is that this is a marginal income. A lot of this is coming out of the lower income work. We are already at occupancies of 64% and it does make a significant difference to us, this marginal income, in terms of the volume. Frankly we think we can offset those discounts through that flow-through of that marginal income. Now obviously our models have taken into account a number of suppositions, and it depends which of these markets are growing. Our view is that the traditional market is growing quite aggressively. We're seeing 3% or 4% growth in a market that for ten years have not grown, and that's quite significant. South Africans are becoming wealthier. People are shifting up what we call the 'wealth triangle' and it is having a significant impact.

Frances Cloud - Nomura

Right thanks.

Operator

Our next question is from Alex Corner of JP Morgan. Please go ahead.

Alex Corner – JP Morgan

I'd just like to ask a question on this NHRPL. I think you may have answered it when answering Frances' question, but could you just explain to me when we look at the new system is this entirely new in terms of the way it's being calculated which it appears to me? And if you look at this acceptance of positive return on invested capital above your cost of capital, if the previous NHRPL was at a 25% discount, what is this one going to come out to roughly with regard to what you're charging? That's my first question. And also within this NHRPL there seems to be a clause whereby

they wanted to benchmark medical care professionals' remuneration to the state system. I just wanted to know what sort of impact that could have on doctors who currently are doing the majority of their work in the private sector? Do you think there would be a further exodus if that happened?

Melanie Da Costa - Netcare: Health Policy Director

Hi Alex its Melanie here. I'll try and tackle your questions. With respect to whether the methodology has been tabled different to the historic one, I actually can't shed light because I don't know the methodology used historically. If I specifically look at the methodology included in these regulations, the more we feel that we would table one that is specific to hospital groups. I specifically refer you to the exclusion or exemption opportunity we do have. There might be a situation in which the methodology that has been tabled is not appropriate to all service providers. And specifically they ring fence three players, being emergency services, hospitals and I forget the third one. So with regards to the methodology I can't answer that. But even the one that it is in this document, I can tell you that we will certainly engage the department of health with the external independent consultant that we have to see if we can table something more reflective of our own business model. In terms of how it would improve the current gap between our tariffs and the existing NHRPL, I have to believe that the sharing of information will add more clarity to the department of health in terms of our business model and our input costs. So it is with great faith that I believe it will close that divide. The extent of which could be anyone's guess, so I wouldn't want to be drawn on that. And then the last point you raised, they specifically do mention public health professionals' salaries. We honestly don't have an opinion on it at this stage. The truth is that we are only able to employ private sector rates. In terms of the nursing salaries perhaps Richard can elaborate on how that does currently compare to public sector, because in terms of our own business model that will be the bulk of the impact.

Richard Friedland - Netcare: Chief Executive Officer

Well we're currently dissecting at the moment the increases that have been offered by the Minister, and they are significant. We're busy doing that calculation throughout our business and I think we can report back to you probably in a couple of weeks as to what that impact would be. One of the things we are doing this year which is very different to what we have done in previous years is that we've already started engaging with the unions. We want to clear the wage increase for next year before we begin what the tariff increases should be for 2007. Previously we have done it the other way around and always passed on our tariff increase to nurses. We think this year there might be a slight step

change in that regard, because we have to firm up on wages before we firm up on negotiations for 2008.

Alex Corner – JP Morgan

Can I just ask one further sort of question? You're saying you think in five years there will be 11 million lives under coverage and you're at 7 million now. You're in the low mid 60% in terms of your capacity utilisation. It strikes me that in order to get those people in, that extra 4 million people, there is going to have to be a major expansion in terms of capacity. Has government got a joined up policy here whereby...obviously you're not going to increase your capacity if you're not going to make a decent return on that. Are they fully aware of the economics of what they're ultimately trying to achieve here and what needs to be done? Or is their head in the sand type stuff?

Richard Friedland - Netcare: Chief Executive Officer

I think you ask a very valid and important question, and I can't answer that fully. But I would hope that we would be in a position to be able to explain that very well and that we're going to have some rational and good commercial debate around that. In our mode, which looks at this potential market, we're looking to increase our occupancies to - again I don't want you to take this as a definitive number - but close to 69% to 71% overall. Remember 75% is kind of close to maximum because it implies that we're operating 100% during the week and we're pretty empty on weekends. That does not take into account a different model where we could use our weekends as spare capacity for lower income products and more of a waiting list type of initiative. Having said that our model builds in about 100 new beds a year over the next five years to pick up that capacity as well. But to answer your question about having the rational debate, we certainly intend to get involved with that. Its early days. I mean these regulations have just come out, and we're obviously going to put a lot of time and energy and analysis behind it to ensure that we can get the most equitable result at the end of the day.

Operator

Thank you Mr. Corner. We have a follow-up question from Mark Ingham. Please go ahead.

Mark Ingham – Independent Analyst

Thank you. I'm just looking at the more recent reference price list, and maybe just trying to get a practical example here. If I take surgical cases per day, they have a figure here of 950 240. How are these numbers arrived at? What is the economic basis of it? How does it compare with what you would typically be charging for that similar example in your hospitals? And then secondly, the adjustor of about 5% that is used, in your opinion how has that been arrived at?

Richard Friedland - Netcare: Chief Executive Officer

Mark I just can't go into that kind of detail because I would have to look at that specific answer. We're happy to put it on the website. We'll look at it, dissect it out, see what is included and what is excluded and give you greater colour on that if that is ok.

Mark Ingham – Independent Analyst

Ok.

Operator

We have a follow-up question from Nick Krige. Please go ahead.

Nick Krige - BlueBay

Richard just a follow-up on the expansion question. You've obviously done a lot of modelling and looking ahead. What kind of return do you think is a fair return on any further cap ex that you will have in South Africa?



Richard Friedland - Netcare: Chief Executive Officer

We're going to come back to you on that question based on our forecasting model if you don't mind. I don't want to put a number out there. I'll come back to you on that and we're happy to put that on our website as an answer to you.

Nick Krige - BlueBay

I'm just trying to work out the yield on your asset. It seems to be substantially above the yields that I can get on hospital investments around the world. And I thought well is the government intending to manage down that return that I can get on these investments? Surely this was a key metric in your models looking forward?

Richard Friedland - Netcare: Chief Executive Officer

We can come back to it specifically. I don't want to give you guidance here that is incorrect. And I'll come back to you with those specifics.

Nick Krige - BlueBay

Ok thanks.

Operator

Ladies and gentlemen there are no further questions. Would you like to make any concluding remarks?



Marcelle Jankelow - Citigroup

I think from our side Richard thank you very much. We appreciate your time and this gives us a lot more clarity in terms of what we are expecting. We thank you for your time. I think there will be a replay of this on the Netcare website. The details will be on there. I don't know if you want to make any concluding remarks Richard.

Richard Friedland – Netcare: Chief Executive Officer

Yes. I think there is a lot happening in the industry at the moment. I hope we have been as transparent as we can. There are specifically two issues that we will come back to you on and put that on our website in the investor relations section. I hope that by the end of August we may come back to you with a greater clarity on some of the issues that we have raised today. So thank you very much for your time and attention.

Operator

Thank you for joining us. You may now disconnect your lines.

ENDS

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