

Network Healthcare Holdings Limited

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Netcare Analyst Day

Web cast - Transcript:



Richard Friedland – Netcare: Chief Executive Officer

I would like to call upon Melanie da Costa who heads up our Health Policy Unit. One of the issues that we've been determined to do is to be pro-active in terms of the development of our health policy as opposed to being purely reactive. It's a new area for us in Netcare. We've been developing it over the last year. It's one that seeks to influence, to collaborate and to partner with government in the development of policy but also to counter some of the issues that pervade around private health care. Over to you Melanie.

Melanie da Costa – Netcare: Health Policy Executive

Thanks Richard. Belinda's already been revving me about time so I'm going to be very quick. Sorry, she's now telling me that I can pace myself. I think the commonality with health policy across different countries is that in delivering and operating any health care system the leaders in health care aim to satisfy three competing requirements and these three competing requirements are that firstly you can ensure that all people have access to the benefit of health care and I guess the second issue would be that the system that's put in place is able to deliver a consistent level of quality and that both of these are able to be achieved at a level of cost that is sustainable. So the issues that we're grappling with in South Africa is certainly not unique to South Africa but what is unique to South Africa is that in the horizon we see a host of regulations aimed to align health care around these three chief tenets of health care. So in my presentation I am going to touch on the various regulations we're dealing with and I guess they are comprehensive but we'll touch on the more specific issues of relevance to the hospital sector and then we'll share with you some of the progress we at Netcare have made over the last few months in understanding where we as a private sector stand on the issues of affordability, access and quality.

On the issue of regulation I guess the most pertinent one would be the National Health Reference Price List, the NHRPL. Now the enabling provision of the NHRPL I've put up for you. Section 91V of the National Health Act. The reason why I've put it up is that a lot of people have asked questions around the background of the NHRPL so we encourage you just to go through and read those enabling provisions. But basically the NHRPL is aimed to increase transparency on the input costs of health care services in this country and if you read that enabling provision it becomes quite clear that the primary purpose of this process is to determine a methodology and it's also quite relieving to find that within the regulations the Department of Health fully appreciates that within the health service value chain there are different delivery models and we do have the capacity to table and model

specific to the private hospital industry. So our main score, the way we're approaching it is we are working via HASA to table this model. We're working with an independent analyst and the first phase of the project is to deliver a hospital delivery model with all of the input costs. Whatever it takes to deliver hospitalisation to a patient. So what that means is that within that model we will cover the pharmaceutical sector including the ethicals as one of the surgical components. Now historically the private sector has struggled with how do we price new technology? So within this model we also want to table an objective manner in dealing with new technology as they come about in the future and at the same time I guess one of the things that can be easily forgotten are the annual escalations so we don't want to find ourselves in future having to fight over annual escalations.

So we think the appropriate manner is to determine some logic around those escalations and build that into the model now that we table and we can hence debate that and have some basis in future. And now the other idiosyncrasies that need to be debated and need to be included in the model, here are some examples. The examples would include geographic cost differences, grades of facilities, levels of specialisation. So there are a host of other idiosyncrasies but these are just an example of what we are debating at the moment. Now we're of the opinion that there probably is a second phase to the NHRPL. It isn't something that has been agreed by the sub-committee of HASA so I'm sharing it with you now but we think it is probably appropriate in future to table a utilisation model and the reason for that is because we've had such change in utilisation over the last few years that it probably is appropriate to start tracking this and in sharing this information and it would probably impact how we deliver health care in future too. So that would be the second phase and we would only envisage that to play out in the next five years. And part and parcel of this, another issue that Netcare is debating is the tabling of a sustainability report. So what is the role of private health care in South Africa? What is the role of private hospitalisations within the national health backbone? And if we want to increase access to more people, what level of investment will that require and what return will our shareholders desire or require in order for us to raise that capital to invest? So those are some of the issues within the sustainability report that we're debating. Once again the sub-committee of HASA hasn't approved this yet but we'll certainly be motivating from our side.

In terms of the time line, the only hard time line we have is that the Department would like to publish the NHRPL in September 2008 to be effective January 2009. In order to achieve this and working back on it we know that we'll have four weeks to look at the draft numbers and we know that the Department of Health would like four months to review the data so our intention is to afford them six months. We're going to deliver our deliverables by January, February 2008. Moving over to the Medical Scheme Amendment Bill. This is a very comprehensive amendment and I guess for the purpose of this presentation I've just extracted what's probably most pertinent to us. Starting off with the, it provides for the Risk Equalisation Fund. In our language that means a clearing house. So the

long and short of it is that a prescribed minimum benefit is going to be equalised across the entire industry and in doing that will probably prescribe for the industry to take on more risk and expand access. That would be the end goal. Within the Amendment Bill there are also provisions relating to benefits and how they are structured. I will touch on them in a little while. This specifically relates to issues such as Circular Eight which is Section Twenty Nine of the Act.

Then previously, in terms of how contribution were priced, they were limited in the terms that they could only be priced based on income levels of the individual and the number of dependants but in doing this the schemes were a little bit hamstrung in that they couldn't table network options where they'd negotiated attractive discounts for certain providers for exclusivity. They weren't able to pass those benefits on to the members so one of the amendments is to add another factor to the contribution argument and that is efficiency and this will give rise to all network options. And the last point I guess would be limits. There is flexibility in the regulation so there is an understanding that perhaps in order to address, to expand this market there might have to be a different benefit structure. Perhaps it all falls within this Equalisation Fund, perhaps it doesn't. At this stage the detail behind it is very scant. I'd be reluctant to elaborate but what I can tell you is that the Bill offers a significant amount of flexibility on this issue. In terms of the impact, looking at Circular Eight I think it's appropriate just to look at this graph first. Historically the way medical scheme benefits worked that within any medical scheme there was a host of options but all of those options were quite unique. They were individual with their own, well I think the prescribed minimum benefit was the basic but other than that the supplementaries were pretty stand-alone and in a way you basically had a whole lot of different little medical schemes within a medical scheme as opposed to options and what this provision aims to do is eliminate that where in future if you have a basic benefit for any scheme it has to be common across all the options, absolutely all the options. Anything over and above that will be known as supplementary.

As it stands, most of hospitalisation falls within the prescribed minimum benefits so we would expect that the supplementary would have more of the out of hospitals but the prescribed minimum benefits themselves might change to cater for more primary health care. So just to go back, Circular Eight wants to do away with the silent types of options so there will be common scheme benefits applicable to absolutely everyone and it will be costed at the same but with one exception and that is if you've actually signed on a specific contract and you actually want to create a stand-alone option and pass those benefits on to your members so it will definitely foster the development of selective contracting in the industry. Something of which Netcare is acutely aware of. In terms of the impact of the Medical Scheme Amendment Bill on Netcare itself on the different perspective in terms of our own medical aid, as it stands in terms of the calculations done in 2006, Netcare Medical Scheme will be a net contributor to the RAF. The figure at final core is approximately twelve, R12.6 million. As it stands

though the solvencies in that scheme are very high so that doesn't pose a risk. Sorry, just to go back to this graph.

So effectively what we can expect in future is we can expect options so we can expect within every single medical scheme there is a common basic package. Can we just do P and Bs? If you would like to offer more you've just got to offer it to absolutely everyone. If you would like to add supplementaries you absolutely can. There's just to mention there's a third option here where the benefits are exactly the same as option two. It's just that you've got to throw a discount so you can price it differently. So just a quick look at the positives and the negatives and just by looking at the graph you can see that the positives on the RAF outweigh the negatives. The most important thing is an access growth of this risk form by bringing more people into the system. You'll certainly get more uniformity on benefits and for the man on the street that's very helpful because you'll know exactly what you're getting from the different medical aids. It could foster more price competition by the medical aids. The downside to this as we know that it might discourage innovation because it discourages competition outside of pricing so that will be the downside. In terms of the prescribed minimum benefits I think a lot of the positives have already played out and I will discuss that in a little while. Probably the most important benefit to the private hospital have been the fact that P and Bs have prevented the transfer of patients from private sector to public sector when medical scheme benefits have run out so the dumping on public sector. That's had a significant effect on the business over the last few years and obviously the P and Bs provide a benchmark.

In terms of the negatives the most obvious negative for any policy maker is that the P and Bs are focused on tertiary care not a preventative care. Now this has been highlighted, the Minister of Health made reference to it at the recent Board of Health Care conference. They clearly have to review these P and Bs and ensure that there's more out of hospital care catered within the P and Bs. Just quickly looking at international benchmarking, I think enough has been published on this. The long and short of it is that the benchmark is relative to the country stated on the Board and the reason why they chose these countries is the argument that there was a similar geographic structure specifically around Australia and Canada and by that they mean the disparities between the urban and the rural and some of the issues that go with that but what is common across all of these countries is that there is a presence of a single buyer. Can we read anything into that? The Department of Health says not at this stage so the intention is not to move to a single buyer in South Africa at this stage but what it does do to the impact to the private hospital cost is it obviously lowers our input cost. Now to give you an example of that our pharmacy division pulled out an example of volatile gasses very recently. This was in the last week. But we're looking at what are we as Netcare paying in South Africa for volatile gasses and what are we as GHG paying for these same gasses in the UK so it's quite obvious that there will be benefits had in the international benchmarking. In terms of the timeline, the Pricing

Committee still hope to conclude this within the course of this year and actually have it published within the course of this year.

The last issue to touch on is the quality argument. Now the little work that's been on quality measurement was done by the Monitor Health Care Group, I mean the Monitor Group in the late two thousand and three. I think we've shared that information with you many times so we're not going to repeat it and in that survey we rank very well but other than that I guess the belief of quality health care is really a perception because we aren't objectively measuring. We're not publishing any information and it's our belief that we have to increasingly do that to have an objective measure and the Minister in her speech at the Board of Health Care Forum has also referred to this saying so we understand that it's quality but you know what it's just perception so let's put some structures in place, approve it and within the National Health Act there is capacity to launch certain quality measures. The one is the Inspectorate of Health Establishments and the other is the Office of Standards and Compliance and I guess it's the Office of Standards and Compliance which might be the organ to collate quality information so this is going to be at a national level and effectively this Office of Standards and Compliance is going to advise the Minister on the norms and standards in order to advise proper use of objective information so we can expect something eventually to come out from that sphere but Netcare's aim is to be a little bit more proactive on that so hopefully we'll table something on quality outcomes sooner. In terms of cost there's been a lot of discussion about the rising costs of private health care in this country so I just want to specifically look at hospitalisation quickly.

Now there has been an escalation in expenditure on hospitalisation by medical scheme members but it has been more acute over the last decade and we need to understand why so let's just analyse this and I am going to do this in a sec but the first thing I want to highlight to you is just refer to nineteen ninety eight where you see this I guess break in trend. In nineteen ninety eight we had the publication of a Medical Scheme Act and there were two fundamental changes in the Act that were very beneficial to private hospitals. One was the introduction of prescribed minimum benefits which was pretty inclusive of most hospitalisation and it also ensured that you couldn't take these prescribed minimum benefits and take it to State. It had to reside within the private sector, primarily within the private sector. The second thing is that the scheme introduced community rating and what that meant is that risk rating was removed so as an example of what that means is in January two thousand to June two thousand was an open period. Absolutely anyone could join a medical aid irrespective of age, and there were no late joiner penalties and I remember I got my gran and all of her buddies on at that time, so we'll show you in a while what the impact was to us in terms of the ageing profile within hospitals.

Another issue I'd like to highlight which is extra in terms of external factors is in nineteen ninety eight through to two thousand and two we had a currency crush so if you recall that fifty percent of our input basket is made up of drugs and surgicals and that most of this is imported. A thumb suck is that about 70% of the drugs and surgicals would be imported either in a direct fashion or indirectly to the active ingredient so it goes without saying that we would have been impacted but I will show you the upper line costs. So in that period if I recall the Rands depreciation relative to the currency was about 57% but let's go into the detail. In order to explore why total costs are increasing we need to look at two dynamics. It's price and it's utilisation. Okay, the girls get this, the boys struggle with it. Okay, the price issues apart are two spheres. It really is tariff which is ward and theatre and it's your non-tariff which is your drugs and surgicals equally with utilisation but the utilisation can be summarized like this. Do you have more people stepping into your facilities? Its more bellybuttons in bed. Are they perhaps staying longer? For what reason? What about the change in cases? Why are they stepping in? Is it for ear, nose and throat or is it trauma? There's a very big difference in that. Do we have more chronic diseases? What is new technology doing? So there's a host of different drivers around utilisation and I think that up until now in terms of the debate around policy this utilisation argument has not been given enough attention.

We think there's been a turning point over the last while especially in light of what was tabled at the Competition Commission as it's quite clear that there's some utilisation dynamics here that we do need to explore. Let's quickly look at price. So notwithstanding that we had a currency crunch what I've pressed on the sly here is Netcare's total increase across absolutely all the spheres of the hospital business and notwithstanding the fact that medical inflation exceeds CPIX by a considerable amount in this time period of 1999 through to 2006 Netcare's total average increase per year across the total business is 7.7. That's a CPIX of 6.2 so in looking at this it's not obvious to me that the driver of overall expenditure is price so perhaps we need to explore certain other angles. But just looking at it at a broader angle because that was just Netcare's prices but let's see if we can understand this from a different perspective. So if we just take the Council for Medical Schemes' figures in 1998. I'm specifically looking at ward and theatre but I have done this exercise across the entire industry. It has been published before and I think we have shared some of the detail with you before but if we just wanted to look at the impact of price and isolate it from utilisation, let's look at what we would project expenditure to be just based on price.

So if R3.7 billion is what is spent in 1998 and the price escalation that carried is 8% you would expect in 1999 R4 billion to be spent on ward and theatre. Similarly in 2000 you'd expect a 7.5% increase. Sorry, it's not expected, that was actual and you would expect R4 billion being spent on ward and theatre and similarly you go down to 2005 and what you find there is you actually expect the projected expenditure on ward and theatre based only on price to be R6.3 billion but in reality it was R10.4

billion so what accounts for the difference? That is utilisation and every way you analyse this, be it by expenditure by the Board of Medical Scheme Environment or expenditure by a beneficiary or if you look at it by Netcare revenue or Netcare revenue per admission, I always get back to the same figures and that is the fact that about 60% of the change we're seeing is price and 40% is actually utilisation. I'm not sure if you can extrapolate that but that certainly has been the history and low and behold America's the same and I promise you I only saw this after I did my own research but the American's actually publish, when they publish expenditure on hospitalisation they break up what was the price impact and what was the utilisation and in America from 2000, from 1998 through to 2005 approximately 44% of the change was utilisation and 50% was price so we can't ignore this argument of utilisation in policy.

Just to elaborate, a lot of people think that utilisation is just an increase in number of patient days. I think it does account for a large portion of it and what you've seen is that every single year we've had a 5% growth in patient days. Now this becomes a bit confusing in light of the fact that the medical aid populations stay constant so it tells you that either people were using more government hospitalisation than we thought or more people outside of the medical scheme population are actually using private hospitals but there are other dynamics that drive utilisation other than just growth in patient days. Ageing, just one example and one of the unintended consequences or perhaps intended consequences of the Medical Scheme Act but here we specifically highlight Discovery Health only because they did have the lowest age profile at the time that the Act was enacted and since then this is just the admissions into Netcare Hospitals. We've seen this dramatic ageing in the Discovery population and we can actually go back into our books and quantify the impact that ageing has had on Netcare because there's close on a perfect relationship between age and the average cost per admission so as you know the older people get the more chronic diseases they have, perhaps a compromised immune system, they stay longer, or they come in for more complicated procedures and there is a near perfect relationship between the cost and the age and based on this you can calculate that for every year of ageing it costs an additional R228 in hospital bill so when you consider the fact that you've got 500 000 in-patient hospital admissions you can actually calculate the impact of ageing so for Netcare from a period of 2001 to 2006 Netcare's added an additional R230 million onto the top line that it wouldn't have had failing ageing.

We also have to look at the change in the nature of admissions so it's not just a function of the fact that there was a five percent change in patient days but are people coming in for different reasons? What we have over here is the 25 major disease categories. Now within the 25 major disease categories I reflect risk factors and these risk factors really tell you the risk of the pricing on one category versus another category so it goes without saying that the broad categories, these bigger categories over here actually show a lot of risk in the prices so you can have a lot of cost blow out so I

specifically highlight to you newborn and neonate because I think you are aware of the rates of growth in the maternity section and obviously that also leads to neonate business and in terms of trauma we've got one point two million additional cars on the road. That's had a huge impact on trauma so when you look at this case mix change you want to understand what has changed and obviously if we run out of admissions then we'd ride over people's feet like Belinda but she's very loyal to the team so she was willing to take one for the team but I hope that gives you a scope that the utilisation argument is just not simple.

I think all we're trying to table is that it is real and it is complex. And just to prove to you that it isn't a free-for-all. It's not a function of just entering a hospital because your specialist has asked you to. There's a process that you have to follow. R3 billion is spent in managed health care in South Africa every single year and managed health care is effectively the police. They'll tell you whether it is appropriate to go into hospital and when you're within hospital you've still got a case management process you've got to abide by so Mister Jones, why is Mister Jones still in ICU? So there's communication between the case managers within the hospital and the case managers at the funders nearly every single day so it isn't just a function of utilising for the sake of it and in terms of new technology it's also not just a function of utilising because the schemes have benefit limits so you've got to abide by those issues so just so that you understand there is a framework in which we have to participate. Then in terms of the population accessing the private sector. In terms of the broader population, the general household survey has done a significant amount of work and they're saying that anywhere up to forty percent of the population could be accessing health care value chain within the private sector. Our estimate indicates that anything between ten to fifteen million people using private health care is probably a conservative and a realistic figure but as we know, hospitalisation is a more intense resource so it isn't easy to pay out of pocket for hospitalisation so how many people are actually using hospitals, private hospitals in South Africa? So what I indicate here in 2005 is that according to hearts and numbers R21 billion was spent in private hospitals. Of that 75% of that was spent within the medical aid market so where do we attribute the further R5 billion?

So we know that an element of this could be out of pocket funding but the way that P and Bs have been structured there isn't a lot of P and B out of pocket but there could be an element. We know that [inaudible] which is your workers' compensation adds another R1.2 billion but those are new lives, those are additional lives to the market so because we can't segment the R5 billion into very specific detail yet, all I can tell you is that the number of people using private health care or private hospitals in 2005 is anywhere between the R6.8 million which were the medical aid lives in that year and R9.1 million which is if you would extract the lateness at the same cost it would mean 2.2 million additional people are making use of private hospitals in this country. In terms of public versus private expenditure there is much discussion had about the disparities and the inequalities which are

absolutely valid. We wanted to look at this research to see how do we compare to peer countries at similar GDP levels. Firstly we just look here at the government expenditure per capita and we compare it to countries that have very similar GDPs to South Africa and we see that the government spent about a \$158 US per capita. This is according to World Health Organisation and that means they're spending about forty percent of the entire budget.

What we have found as you can see over here so this would be the contribution by government. This would obviously be the contribution then by the private sector. Once again relative to companies with, countries sorry, with similar GDP levels. And we were surprised to find that South Africa didn't stand out as we would have expected it to. What appears to be the case is it's not uncommon to have a high level of private health care funding in developing countries that have small economic pies and high populations. But as you well know not everyone has access to private health care to let's be frank with this and just narrow this down. Now unfortunately we don't have that depth of knowledge in these other countries but we can certainly narrow this a little bit further down in the private sector so what you know is that the GDP in the private sector, especially the medical aid market, is significantly different to the average across the country. Let's just look at what our expenditure would be if we take the seven million lives as a given as the only ones accessing private care and what you find in that situation is South Africa spends about \$1500 if seven million is the only number of people that access private health care. If the figure is the ten million or the fifteen million as we believe it is the case there you can see how we do compare so it's not a perfect system by any means but I think it does give us comfort that there's an element of relative efficiency. And just in terms of my, this is my last slide.

We understand that we need to do more work on the quality outcomes to see how we compare but it just adds a broad brush in terms of our hospital capacity, you know do we have excess capacity in our market? What we've done is we've just explored the acute care beds per one thousand population. The South African figures are 2006. It is possible that there has been a change in the other categories. What you find here is that South African private sector has three beds per one thousand lives. Netcare compares pretty well and then the public sector's just behind us at 2.6. In terms of lengths of stay, sorry that's hidden over there, but South African private hospitals come in lowest at an average length of stay of three. So I hope that that gives you just a broad overview on some of the topics. I mean each topic is a presentation on its own that hopefully we can flesh out in months to come but for now if there are any questions I'd be happy to take them.

QUESTIONS AND ANSWERS

Richard Friedland – Netcare: Chief Executive Officer

Melanie, thank you very, very much for that very comprehensive overview but obviously...ladies and gentlemen are there any questions? There is a question over here, ma'am?

Audience member

You, in those slides you mentioned that the government was saying there won't be a single payer until social health insurance comes in and with RAF terms that's all supposed to be a precursor to SHI. Have you and what are you guys doing in terms of that? Have you heard anything?

Melanie da Costa – Netcare: Health Policy Executive

Well what we heard is we basically give you a direct quote just so you understand it, so what they're saying is it could be a possibility in future. At this stage it's not very clear so, you know it lands up being anyone's guess as to how it will play out but the intention, the intention might be there but it seems to be too far out into the future to put any probabilities to it. Yes?

Richard Friedland – Netcare: Chief Executive Officer

Question at the back.

Audience member

Thanks. Hi Melanie. Just a question on, you made reference to the Medical Scheme Amendments Bill. It sounds like the result of that would be increased competition amongst the medical aids. Now if they, would that not result in them putting pressure on you down the line on the tariffs or does the NHRPL prevent them from doing that?

Melanie da Costa – Netcare: Health Policy Executive

Firstly on the first question or the first assumption is that there'll be more competition. Now this will be different competition because previously there's been a lot of competition across different spheres from an innovation and the benefits and I guess their vitalities and other issues and now they'll be very constrained. The competition is going to be around pricing so it goes without saying that there'll be a more robust competitive environment for all players. I think that is fair.

Audience member

[Inaudible question]

Richard Friedland – Netcare: Chief Executive Officer

Sorry could you repeat that question into the mic?

Audience member

When the NHRPL does come in, I realise that's some time away, but that essentially gives you guidelines in terms of what the pricing on a procedure is. Can the medical aid ask you to give them a reduction on that because it is a guideline after all?

Melanie da Costa – Netcare: Health Policy Executive

Yes, just so that you are aware there is currently an NHRPL in process so in our negotiations today is robust as casting around appropriateness of price and even using that benchmark so I don't think it will be anything new. You know as it stands today there is robust negotiation.

ENDS



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