



Mediclinic International plc

Full Year Results 2017

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James Arnold, Head of Investor Relations

Good morning. Welcome to the Mediclinic 2017 Full Year Results presentation. Welcome to everyone in the room here and all of those on the webcast and on the conference call. Thank you very much.

Before I hand over to Danie and Jurgens who are going to take you through the presentation just a couple of formalities from my side. First of all the disclaimer, forward looking statement, please read that at your leisure. It's there for you to review on your screen and in the presentation pack itself. In terms of Q&A we'll take Q&A both from the room and on the conference call. Those on the conference call please could you register your questions with the operator and we'll take those calls.

I'm James Arnold, Head of Investor Relations. I'm going to now hand over to Danie to open the presentation. Thank you very much.

Danie Meintjes, Chief Executive Officer

Thank you James, morning everybody and thank you for your time and thank you for joining us. James referred to it, it's an honour for us to have our founder and Chairman Dr Edwin Hertzog with us today. He's not normally here but he's in London for the next day or so, so thank you and welcome, Edwin.

I thought of saying something at the end of the presentation but maybe it's more appropriate to say it now. Also a special word of thanks to Jurgens; he became a dad again with his third child whilst he was on the plane here. So Jurgens we really appreciate you sticking it out and presenting here today.

From our side looking at the numbers I think it's fair to say we had an interesting, a challenging and a humbling year behind us. But if I look at the numbers I can start off by saying I am very glad and we are very thankful to report that our two biggest platforms, starting at Switzerland, really performed well. Switzerland in a very low inflation environment saw reasonable growth in the revenue. EBITDA slightly expanded and we will talk more about it later.

In South Africa against the challenging macro environment we saw revenue growth ahead of inflation, stable margins, so very happy with the performance there.

If we go to the Middle East, that we discussed and we reported on in detail over the last year, our Dubai operations steady performance, solid performance at Dubai, but the Abu

Dhabi component was impacted with lower revenue. We talked about the Thiqa impact to a great extent last year and we will talk more about it a little bit later.

And then just a remark on Spire, you saw the results that they announced. For 2016 good growth on an adjusted basis in terms of revenue, EBITDA and earnings per share, and patient numbers grew 2.2%. That is the background.

If we go to the numbers, on a reported basis, underlying reported basis and in pounds, revenue up 31% for the year, but if we do it on a proforma comparison with Al Noor in up 15%. EBITDA up 17%, the margin 18.2% on a group basis. Operating profit underlying 7% up, but with Al Noor acquisitions, more shares and the impact of revenue there down 19% on earnings per share. Good cash conversion on a group basis more than 100%. And then the final dividend proposed 4.25 pence, that is on an annual basis in line with last year.

That summarises the numbers. I will now ask Jurgens to unpack those numbers and then I will give you an update on the operational activity. Thank you.

Jurgens Myburgh, Chief Financial Officer

Thank you very much, Danie. Danie has a nasty habit of breaking the technology so let's see if this works. Thank you. Good morning ladies and gentlemen from my side.

The results for the year are a little bit difficult to present, and so the easiest way for me to do this is to provide a little bit of a framework of the different dimensions in which this can be viewed.

Firstly on a reported bases, on an IFRS reported basis, unfortunately it makes the comparison with last year a little bit difficult and almost meaningless because Al Noor was only in for 46 days in the last year, so that's not a reported basis.

But then to compensate for that on a proforma basis we bring in Al Noor for the full year and to give that comparability, but we only do this at a revenue level; it becomes more difficult to allocate income and costs as you move down the income statement.

And then in constant currency the depreciation of the pound against all three operating platform currencies providing a peculiar tailwind to our results. So I'll provide you with constant currency revenues as well as lower down the income statement to give you a sense of the true performance in the operating environment.

And then finally on an underlying basis, what we do in the interests of providing shareholders with clear and consistent reporting we back out some of the non-recurring items in our income statement.

So these four dimensions, the operating and then proforma constant currency and then underlying, this presentation by and large presents the underlying components of our results.

We're obviously not very good at reporting underlying because underlying is actually lower than our reported. So we'll get better at those adjustments.

Then heading into income statement, revenue as you can see there up 31% on a reported basis. This is up 15% on a proforma basis, so if you add Al Noor in the base, and up 1% on a proforma constant currency basis. This is driven by good revenue growth in Hirslanden

and South Africa and Dubai, offset by the revenue shortfall in Abu Dhabi which we will discuss in more detail.

EBITDA was up 17% on a reported basis, with the margin down to 18%, driven down by the operating results in the Middle East.

The underlying measure at EBITDA level has been adjusted for firstly at a restructuring charge of £5m for the integration in the Middle East. We don't currently anticipate any further material charges in this regard. And, secondly, an adjustment in Hirslanden for past service cost credit of £30m before tax.

Depreciation and amortisation was up by 48% but this is due to the inclusion of Al Noor in the current year. We've backed out of underlying depreciation and amortisation, and accelerated amortisation charge of £7m relating to the Al Noor brand name which, as we announced, we're rebranding to Mediclinic.

Net finance cost reduced by £20m due to the bridge and subsequent refinance of debt in South Africa and the Middle East. The underlying measure here is adjusted for the mark to market of the ineffective hedge in Hirslanden of £13m before tax.

The income of Spire is recorded net of amortisation of intangible assets, recognised in the notional purchase price allocation.

And then underlying earnings per share down 19% as Danie mentioned, and shows the full effect of the acquisition finance in shares and debt, but the subsequent underperformance in Abu Dhabi, which we'll discuss in more detail.

The dividend, as Danie mentioned, was maintained year over year, which gives us a final dividend of £4.70 per share.

Over the page, analysing revenue in a little bit more detail, all three platforms showed good growth on a reported basis. Hirslanden grew revenues by 3% in constant currency, with continued growth in the outpatient segment of the business.

Southern African revenue growth was 7% in constant currency driven by good growth across the platform with a few exceptions. And I think just to point out here in both Hirslanden as well as Southern Africa we continue to see the benefit of the broader diversified portfolio where some hospitals might not be doing so well and others pick this up. So it's a key strength inside the platforms as well obviously on a more broader global level in the Mediclinic Group.

In the Middle East constant currency revenues actually declined by 8% on a proforma basis, with stable growth in Dubai offset by significant revenue shortfall in Abu Dhabi.

At the interim stage I provided this revenue bridge, and we do the same here on this slide. We break out the constant currency growth and also provide you with an indication of the impact of the revenue shortfall in Abu Dhabi has had on the Group.

The reason for the shortfall has been discussed throughout the year, but to summarise the implementation on the 1st July by the healthcare authorities of Abu Dhabi, the co-payment of 20% for Thiqa members of Daman, the government owned medical insurance group, visiting private healthcare groups, the impact of this was a reduction in Thiqa patient volumes by

approximately 30% year-on-year. As you know this measure has since been waived, and as Danie will discuss later, we have already seen some improvement in patient volumes.

The Abu Dhabi business has had a number of doctor vacancies during the year which the team has been very active in filling. During the year we successfully recruited 136 doctors in the region, with a further 52 in the process of on boarding. We've also aligned the business and the revenue cycle management practices of Al Noor with that of Mediclinic in Dubai.

And then finally during the year we've seen an increase in the competition facilities across the region and in Abu Dhabi in particular. We're not unused to competition and believe that we have a business model that provides sustainable healthcare to our patients going forward.

Moving on to EBITDA, underlying EBITDA analysis. In constant currency Hirslanden and South Africa grew underlying EBITDA by 5% and 6% respectively, whereas the revenue shortfall in Abu Dhabi contributed directly to reduced EBITDA as well.

And then again at the interim stage I provided you with this slide to give you a sense, from an underlying earnings per share perspective you can see the impact of the underperformance in the Middle East compounded by the finance of the acquisition through debt and the issue of shares.

Underlying earnings per share on a constant currency basis was down 30% year over year.

Turning to the balance sheet you will notice that we continue to invest in our infrastructure, with an increase in property equipment and vehicles. More on this later.

As I mentioned briefly earlier we've accelerated amortisation of the Al Noor brand name which we'll complete in this financial year, FY18. We'll do another £22m in this year. We back that out of underlying.

Our focus on working capital metrics has delivered a tight networking capital position. In the Middle East we've made additional provision for doubtful debts both in the current year as well as pre-acquisition to levels that we're comfortable with.

On cash flow all three divisions delivered over 100% EBITDA to cash conversion, which is an excellent result. Group conversion was 101%.

Capex relates to ongoing investment in the maintenance and upgrade of our facilities, and in particular the purchase of medical equipment to ensure that we stay abreast with technological advances in this space.

Southern Africa increased beds by 78 in the year. In the Middle East expansion capex includes the construction of the Parkview Hospital in Dubai as well as the completion of the North Wing.

On capital expenditure our budgeted capital expenditure for next year is broadly in line with FY17, with the exception of the Middle East, where the ongoing construction of Parkview Hospital increased the investment in that region.

Turning then to platform specific results and starting with Hirslanden, which grew revenues by 3% driven by a 2% increase in admissions and a 9% increase in outpatient revenues. This is a good result considering the high occupancy levels in this business unit.

The underlying EBITDA includes a tariff provision release of about CHF8m. Excluding this release the EBITDA margin would be in line with last year.

Hirslanden continues to carry the cost of the Hirslanden 2020 programme which is aimed at increasing the efficiency of the business through the implementation of consistent systems and processes. Despite the ongoing change in mix towards basically insured patients EBITDA margins were supported by ongoing productivity and efficiency measures in the business.

Turning to South Africa, Southern Africa grew revenues by 7% despite a challenging macro-economic environment and increased competition. Volumes grew by 1% and revenue per bed day by 6%. The EBITDA margin declined slightly due to the pharmacy inflation, the ongoing investment in clinical personnel and the continued change in patient mix.

Depreciation and amortisation increased disproportionately due to investment in medical equipment which has depreciated over a shorter period. And the increase in finance cost relates to the increase in borrowings of ZAR2.7bn due to the refinance of the bridge facility in the first half of the year.

Finally in the Middle East revenues were down on 8% on a proforma basis, Dubai was up 5% year over year and Abu Dhabi down 19% of which more than 50% of the decline was in the Thiqa patient category. EBITDA was impacted by the revenue shortfall, the integration benefits were unfortunately more than offset by this shortfall and also the impact of losses incurred due to the late opening of North Wing in Al Jowhara as well as increased rental costs.

Depreciation and amortisation increased due to the inclusion of Al Noor for a full year and also the amortisation of intangible assets recognised on acquisition. Depreciation increased due to the completion of both North Wing and Al Jowhara.

And then finally before I hand over to Danie, looking at FY18 and our outlook for FY18. In Southern Africa and Switzerland due to the combination of the challenging macro-economic and regulatory environment the effect of competition and cost pressures in the business we see steady revenue growth and stable margins, allowing for the adjustment of the provision release as discussed under Hirslanden, as well as the effect of TARMED in the last quarter of the financial year. You'll also notice that these two platforms have a decline in business days due to two Easter holidays in FY18.

In the Middle East the Dubai performance is expected to remain stable, despite the competitive landscape, and in Abu Dhabi we'll see improvement over the next couple of years. The combination revealed only a modest improvement in Middle East revenues for the full year and a gradual improvement in underlying EBITDA margins over time, including the impact associated with the expansion of Airport Road in FY19 and Parkview Hospital in FY20.

We think we've reached an inflection point in the Middle East, but due to this, the first half of FY18 Middle East revenue and margins are expected to be sequentially lower, largely due to the high patient volumes and revenues in Abu Dhabi prior to the regulatory changes, asset sales and business and operational alignment initiatives during FY17. As I said, we expect a modest increase in revenues for the full year and to make progress on margins. With that I'll hand over to Dani. Thank you very much.

Danie Meintjes

Thank you, Jurgens. A high-level overview on the operational activity, and I'll start off with Hirslanden, the biggest platform in terms of revenue and EBITDA as you've seen in the slides; around 50% of the contribution coming from there. And looking at the results we must see it against a background of strong competition in that environment where we compete directly with the Cantonal hospitals. It is a mature healthcare environment, and taking that into account, I really feel very pleased with the results achieved there.

It needed a focused approach in terms of cost management, specifically on productivity, leave management and obviously productivity or efficiency gains in the procurement energy or the procurement focus that we have in that platform.

It is also worth mentioning, if you look at the numbers we've done less bed days, but we've seen a 1.7% increase in the number of patients, meaning the efficiency that the patients go through your productive system increased, and you must read that against a fixed fee environment for a great component of the patients.

We've mentioned it in the past, there's an ongoing focus on further investment on outpatients, that is part of the 2020 strategy, and that outpatient strategy will also be supported looking at the out-migration of care, the focus in that part of the world, in line with the rest of the international business, where less complicated cases will flow out of hospitals and we will follow a strategy similar to South Africa where we can actually treat those patients in the outpatient and surgical centre that we create.

We always have an eye on the insurance mix. You will recall for those of you knowing the business well, when we had the major regulatory change in 2012 it was also the time when we added 80 beds to the Hirslanden Hospital and we saw quite a big uptick in our general insurance, a basic insurance, that stabilised. If you look at the occupancy figures, fairly high occupancy, but in total the basic insurance is growing slightly faster than the supplementary insurance.

We've covered the regulatory environment quite extensively during the year, specifically the introduction of the VVG tariff or tax that they voted down in the parliament that we are thankful for; but Jurgens alluded already that TARMED is under the revision, and for those not knowing TARMED it's the price catalogue for all activities in the outpatient environment. But overall, good performance. I'm very happy with what they achieved there.

If we then go to South Africa, by far the largest operation in terms of activity, 52 hospitals, more than 8,000 beds, but only contributing much less, the business model is different. It is also the exchange rate. But we still see a continued growth in patient numbers in our market. We've referred to a stable insurance market but we must recall or remember that even a stable, stagnant market consumes more, driven by ageing population and also technology.

In terms of the regulatory environment we covered the health market enquiry, suffice to say, not a lot of new news coming out of it, but to say that it is further postponed, it is officially postponed until the end of this year. We expected some of the initial reports that would have come out already, that is on hold at the moment. We actively participate, we've got our senior management engaged in the process, we use very strong legal and other advisers, but nothing dramatic to report at this stage, but we obviously cannot ignore it.

In terms of the national health insurance, it's a hot topic in the political circles and we will hear more about it. Keep in mind that it's a 14 year project, that we haven't seen any significant positive moves even on the focus on the primary healthcare that they wanted to improve, and the key debate will be about the affordability of what they propose. So we will watch this space but nothing at this stage that we can report on.

We are very selective in terms of our growth and investing the capacity, we've updated the market in the past on that, but we are very positive about the day clinic strategy that we are following. And just to remind you, for those hospitals where we are under pressure with capacity the strategy is to build low capital intensive day surgery centres in close proximity to the hospital, offer our own surgeons the opportunity to do the lower complex work in those facilities and then backfill the hospitals with the more complex work. We've got two of those units, we're very happy with the performance, five more that we are busy with and we like the strategy. Occupancy's still high, you can see in the table at the right there, the graphs, stable performance.

Turning to the Middle East that Jurgens' covered in detail, I will start by saying we are very positive about the long term prospects of our investment in the Middle East. Our M&A strategy to have doubled our footprint in the Middle East by buying in Abu Dhabi, we are positive about it. Yes, things didn't work out according to plan, but as Jurgens said, we are comfortable that we've laid the new foundation, we did all the hard lifting, heavy lifting, management worked extremely hard to clean out a line, we had the Thiqa co-payment that came as well that we didn't foresee at this stage, that is removed. So overall I'm very positive about the prospects going forward.

Doctors are the key driver of the business and we alluded to that, Jurgens referred to it, we made good progress but you don't bring a doctor from abroad into a system and then they have a full practice tomorrow morning. It takes time and we are also very selective at who do we recruit in terms of our strategy, the market we serve, etc.

But growth in that part of the market, we are busy with the Parkview Hospital, it is out of the ground, they are above the ground. I have a webcam that is live, I can see the progress almost every day, it's quite good to see. And the location of that hospital with a selective clinical spread of what we offer between Welcare City Hospital and the new hospital, I believe that hospital is well positioned for those of you knowing Dubai, inland and there's a huge community developing around that area. So I'm very positive about it.

Jurgens also referred to it, our, let's call it flagship hospital in Abu Dhabi, the Airport Road, we're going to replicate a cancer unit similar to what we've done in Dubai there, we are busy with a landlord, we approved it at Board level so we will start with that as soon as possible to augment the clinical level of services that we offer there.

For interest's sake we just added the tables to the right, you can go through it, outpatients and inpatients in terms of volumes, and if I can just highlight some of the number: year-on-year our outpatient volumes dropped 16% but the Thiqa category dropped 31%. Inpatients, we saw a 12% drop, but the Thiqa patients a 33% drop, just to augment and to support what Jurgens was saying.

I'm not going to elaborate on Spire, they reported their numbers, you are fully aware and they performed well, management focused. They also reported extensively on the latest acquisition at that stage, St Anthony's, there's a very specific plan to bring that hospital up to levels of performance that they would like to see, both new hospitals open so they're on track.

In summary, maybe just to frame the business environment that we operate in. In our industry the most positive for me is that we see a constant growth in the demand for quality healthcare. That is going up, that is not the challenge. It's underpinned by the ageing population, disease burden in certain communities, new technology, including medicine that drives that demand. But in two specific areas where we operate we must acknowledge there's a lower economic growth environment. In South Africa the economy didn't grow at all

over the last year, forecast going forward, very conservative, under 1%. We can't ignore that. And in the Middle East the lower oil price definitely softened the economy there.

We also saw new competition, we gave you the numbers and the names previously, specifically in the Dubai region, in Abu Dhabi and Dubai. And then in South Africa we noticed competition hospitals literally opening at our doorstep and we gave you the names, from Windhoek to Polokwane, Constantiaberg, Kimberley etc. So those are realities that we must factor in.

And the last most important is the overall challenge worldwide in terms of affordability of healthcare. And for that reason we, as healthcare providers, must be prudent, wide awake, in terms of evaluating the delivery models. And we talked about it in the one on ones. We need to look at better integration of care, less wastage, making sure that the total delivery system, including the doctors and other service providers are properly aligned to ensure the best outcome at the lowest cost at the end of the day. We are focused on that, we invest in those initiatives, and for that reason our key core focus is on high quality care and given optimal patient experience.

Without going into the detail we started to engage Press Ganey for our patient experience measurement, American based company, benchmarking to international standards, rolled out in South Africa and in Dubai, busy rolling out in Abu Dhabi, pilot project done in Switzerland and Brazil rolled out in Switzerland.

The participation rate or the number of people that participate in the survey, quite high, and year-on-year we see an improvement. But what you must understand, these are just the numbers, what is behind these numbers are a specified, detailed focused approach on what do the patients tell us. Are they worried about how we manage their medication, the handover of the nurses etc, so there's a dedicated per hospital, per item, focused approach to drive up. But if you look at the results up sitting in the 82% overall score, and if you look at the component of will patients recommend the hospital definitely or probably, the combined total around 93%.

Also it might be worth mentioning, Koert Pretorius took a very bold step in South Africa during the market health enquiry, in a discussion with the chairman at a stage they asked about transparency and why didn't the hospitals give more information to the patients. Koert told him about it and then the judge said but why don't you share it with the patients. So about a couple of weeks ago we published the results on our website, per hospital, whether it's about cleanliness of the room, nurses sort of response to requests etc, in the public, any person can see it, so we took quite a bold step and they took the lead on that.

Next, to deliver on our strategy we need our staff, 33,000 of them, to be aligned with what we want to achieve. You can't do it from a corporate office. We engaged world leaders, Gallup, to start with a survey of engagement, it's a little bit more complex than just looking at the numbers, participation rates good, it's the second year we've done it. We see an increase and similar to the patient experience a detailed process per group of supervisors and their subordinates in terms of communicating more, sharing with them, give them the tools to do the work, encourage feedback where we can improve, to make sure we create this atmosphere and a delivery environment to support our patients, first initiative.

I'm not going to elaborate but obviously in clinical quality high focus, the first area was to get reliable numbers, comparable numbers. Ronnie van der Merwe and the team worked really hard, he coordinated on an international basis and you can see the numbers, they're coming down, going in the right direction, and there is really a strong focus and we invested in more clinical people to drive these initiatives, we're very happy with the progress there.

To summarise and conclude on the strategy, patients first unashamedly, that is what we focus on. Making sure that we offer them a safe environment, we improve the experience and we work very hard, specifically in South Africa, to get the doctors in the process to have an integrated process of service delivery.

In terms of efficiency, you are used to these numbers or what we say here, we try to use our scale to coordinate, to make sure that we use collaborative approaches to share knowledge, to share resources, to lift standards and to lower our costs.

One of the key areas is procurement where we've got one central procurement coordinator, and where we're focused on the high ticket items first and now the high volume items. Starting to import our own products, we're going to brand it ourselves with our own in-house brand, and that is for all the platforms. And we saw good return for our efforts in terms of that.

Yes we want to grow, but we don't want to grow at an irresponsible rate. I refer to our day and outpatient strategy of growing capacity there. Our first priority is to increase capacity at the existing platforms for the obvious reasons. If we think of South Africa, we are going to build five more day clinics. We're waiting the approval of the Klerksdorp cluster of three hospitals. We believe it might go the tribunal for approval. If we think of Dubai, that is where the biggest growth will be, a new hospital, plus some more clinics, plus the cancer unit. And in Switzerland, most definitely on the outpatient facilities including surgical capacity. We will also look at new territories, but we will do it in a responsible way.

We invest in our people. We've almost doubled our capacity of nurse training in South Africa year-on-year. We changed the funding model. So training our own people, retrain people, getting the right doctors, sharpen them up. Carry on with continued professional education is high on our agenda. It costs money, but we believe that is the right way and the only way to create long-term shareholder value.

So in total I am positive. We had a hard year behind us, but I think we've done all the work that we could have done to set a new base, and going forward there's no reason to believe that we are climbing up from where we turned last year.

That concludes that, and I will hand over for Q&A.

Q&A session

Question 1

James Vane-Tempest, Jefferies

I just have a few on the Middle East business if I can. In Dubai you talk about stable performance. I was just wondering with the ramp up of the North Wing project, what are some of the competitive pressures you may be seeing? I think with the mandatory health insurance in Dubai was more benefiting the sort of lower end of the market, and with your focus on the upper end, what kind of competitive threats are you seeing?

Danie Meintjes

Starting off with the general health insurance, the lower end of the market. We've never built our business in Dubai on that, and we don't see it at this stage, at those price points, as part of our market growing model. Just to mention linking to that, we've got quite a big

component in our Abu Dhabi business of the Basic insurance, and one of the strategies that we actively follow is to change the mix from the Basic insurance to the more Enhanced Thiqa and others, and we do it in various ways. But of course that is one way to give yourself a price increase for the same volume of work.

The North Wing is a unique offer. It's a high-end facility. We've told you that we used our Swiss colleagues to set up the standards; and as Jurgens mentioned, the numbers that we see at this stage we're very satisfied with. That unit is performing well. It's not running at capacity yet, but that will make a big contribution to the region. I'm positive. And we don't build it on the Basic insurance component. Does that answer your question?

Jamie Vane-Tempest

Thank you. So if the North Wing is positive and you're seeing that develop, where are seeing the competitive pressures in Dubai?

Danie Meintjes

A number of hospitals have been built over the last number of years around our hospitals. You drive from the airport, on the way to Welcare Hospital you will see a Lifepath or a Life whatever hospital right on our doorstep. If you drive down Sheikh Zayed Road, you will see two new hospitals that opened, on the left hand side there's a cardiology unit that opened. There is another announcement of a hospital to be built in the Jumeirah area. So there is competition coming. Competition keeps you sharp, you must just make sure that you define your market properly and be better than the competition, then you can survive. But competition can't be ignored in that part of the world.

Jamie Vane-Tempest

Thank you. I have one question on Abu Dhabi if I can. You talk about a modest increase given the Thiqa co-payment coming in July, and now sort of being removed. I just wonder why you're not more bullish on the rate of recovery in Abu Dhabi?

Jurgens Myburgh

It's a fair question. We've only had three weeks of trading since the waiver of the co-payment, and so what we'd like to do is provide you with an update potentially as we go through the year. Where we are currently is we are saying we are seeing some improvement, but we're not in a position yet to give you an accurate read through on that for the full year.

Danie Meintjes

Just to confirm what Jurgens was saying, we're checking, and I asked the guys, before the co-payment waive off the co-payment waive per unit, and there are definitely a mixed uptick of Thiqa patients, I think that is a given. How it translates into revenue at this stage, we haven't got those numbers accurate enough to make a forecast. It's early days, so I can't give you a more positive view on that at this stage, we will have to give it some more time. Once we have traction on it, then we will update the market if need be.

Question 2

Jamie Clark, Bank of America Merrill Lynch

I have a couple of questions on Hirslanden please. Firstly, you said that you saw an increase in patients but a reduction in bed days, and that resulted from efficiencies. How efficient can you be within DRG system? I think there are limits or there are laws on the number of days patients have to stay in hospital per procedure.

Then secondly on the outpatient migration, can you give us some colour on that? I think quantifying the TARMED changes were a £30m annualised impact. Do you have the capacity to service additional outpatients if your inpatients have to become outpatients? Does the outpatient system in Switzerland as a whole have the capacity to take those patients on if it happens?

Danie Meintjes

I'll respond and I'll try to cover all the questions. In terms of efficiency, in a DRG environment, and I'm not an expert, but there is a so-called sweet spot of discharge. So if you paid a fix fee, within a certain timeframe you can't discharge too early because then there is inherently a clinical risk of a patient leaving too early. If you wait too long then obviously you use capacity for the same fixed income and you lose basically doing that.

If you compare the private sector, our average length of stay to the typical Cantonal government hospitals, we are much more efficient on average length of stay, and we compare it in certain categories. If you ask what is the optimal how much more, the only thing that I say is we are focused on to get that efficiency on the radar, and I think you can see some of it. Less better - 0:40:15.2 is 1.7% more patients. Quite a revenue uptick, using your facility as good as you can. So I can't give you a hard number of how much further you can go in terms of the market.

To my best knowledge there has not been an established day surgery offering in the Swiss market as you would have in South Africa, for instance, it's not there, but there's gradual pressure. One of the cantons, the canton of Lausanne, is focusing on that. There are a list of day procedures that are seen that can be done in a less complex environment safely. The normal process you can expect is that they will lower the price of those procedures, whether you do it in-house or outside. But if you have capacity constraints it's better to have a co-located day surgery, we firmly believe in that. In Lausanne at our one hospital, not for this reason, we just de-bottlenecked the whole hospital in terms of patient flow, to have a separate entrance, a dedicated day surgery area for it, and we saw a great improvement in efficiency and throughput in that hospital.

So you will have various options. You will have to evaluate it in terms of the usage, what is available. But the strategy is to get our outpatient facilities that is currently not surgically orientated, to get them surgically orientated as well. But the team is working on that strategy and I can't give you numbers, but we can't ignore this trend, it's a worldwide trend.

Jamie Clark

Just a quick question on the UAE business please. You said you were looking at reducing your exposure to Daman Basic patients and the lower income patients. I think outpatients were down 8% in the year, and inpatients down 1%. Is it affair to assume that that decline accelerates in FY18; or are you postponing that switch just until you see what happens to Thiqa volumes?

Danie Meintjes

The strategy will be different in Al Ein than the Airport Road versus Khalifa Street, because it's different offerings that you offer to the market. I'll just give you a typical example. If you have a surgeon or a specialist that is fairly fully booked, at our booking system we need to make sure that we give preference to the higher category of patients to be seen by the specialist, because by doing that at the same productivity you will see an uptick in your income because there's a high price point.

The other dilemma is, if you have outpatient facilities where there are normally quite a number of people sitting in the waiting areas, segregating and separating your client profiles is a priority for us. Let's say the high income Emirati compared to a construction worker, it's a very different profile to treat all those patients in the same environment. We will have dedicated clinics to try and separate those categories of patients and just give them a better environment to treat those.

Our strategy is definitely to increase the enhanced components of the insurance at the cost of Basic insurance. But you will not move away from Basic if you can't substitute it with others that will not make sense.

Question 3

Hans Boström, Credit Suisse

On this point looking at your numbers you disclose very helpfully on page 22 in the presentation about the patient mix and peer mix, you clearly see that Basic insured patients in Abu Dhabi have actually declined the least. So I suppose we can infer from this that the issue you have suffered in the past has very much been driven by absence or lack of doctors as opposed to the Thiqa issues. Is that a correct conclusion to draw? And how do you see this mixed change change in the next one or two years? Should we assume that the Enhanced and Thiqa patients are vastly outgrowing the Basic patients?

Danie Meintjes

I think it's fair to say that the drop in patient numbers was not only Thiqa, you can see it in the other categories as well. So our alignment of business strategy and operational processes, getting rid of certain doctors, certain doctors leaving for their own reason that definitely impacted the numbers. But your point is?

Hans Boström

Well I suppose the point is that how should we expect your volumes to improve? You obviously give guidance that there will be a gradual improvement in the year. And how the mix will change over the next one or two years? Because that's obviously clearly very important to your margin improvement profile as well.

Danie Meintjes

I can't give you hard numbers otherwise it would be an easy business. But the strategy would be exactly as I explained, to grow the more Enhanced Thiqa and others at the expense of Basic and get your activity in the hospitals running at full capacity. So to give you a practical example, if you're in an environment where the Thiqa and Enhanced are lower, so the areas in Al Ein for instance, you will have to gradually do that shift because you can't just do away with the Basic insurance and have capacity in your system and having overheads to cover. So it'll be a gradual process, but that is a strategy we will follow. To give

you the numbers, you could expect the Enhanced is we will be focused to grow it faster than the Basic side.

Hans Boström

While we're on the UAE, two technical points. What impact do you expect introduction DRG system in Dubai to have? You've mentioned April 2018.

And secondly, could you give us an update on the imposition of VAT, presumably beginning of next year?

Jurgens Myburgh

The impact on DRG, we're not factoring any material impact at the moment for the introduction of DRGs. On VAT, our understanding is that it will come in in the beginning of the calendar year. Medical services would be zero rated, and so the impact on us would be neutral.

Danie Meintjes

But DRG is a difficult one. As sure as I can give you is that we do have experience of DRGs in Abu Dhabi in a very different format than Switzerland. But in our company we do have knowledge about DRGs, and it's managing your cost, and depending on how that price point of DRGs will be determined in Abu Dhabi different to what it is in Switzerland. Switzerland's a cost base working up, that is your base rate. In Abu Dhabi it is a price, so they determine and then you negotiate a multiplier on top of that. So depending on how they will approach it in terms of the price point, which is not known at this stage yet.

Hans Boström

And finally, I just had a question on South Africa. Your peers in South Africa have reported quite cautious guidance for their current or the rest of their financial year, and you seem to strike a slightly more upbeat tone talking about revenues growing in line with inflation. Is that because of acquisitions you are making, are currently pending or coming in, or why would you expect not necessarily to see a drop in patient volumes in your facilities?

Danie Meintjes

I can't judge the tone, I wasn't there when they spoke.

I will try and summarise. We saw a decline in patient numbers in the latter half of our financial year and I think the other two groups saw the same.

We are optimistic that nothing will drop over the cliff from a macro environment but that is the uncertainty at this stage. What we need in South Africa is stability in terms of leadership, stability to create confidence for people to invest and we repeat by saying we will gradually invest in new capacity, specifically the day clinics but we have got no major hospital under construction at the moment.

For our existing hospitals we have reasonably good occupancies and the starting point is to be the right address, using the chairman's words, for the doctors, where they feel safe, where the patients are looked after, where the patients feel safe. That if you have one doctor coming out of the academic world then you must get an opener practice that he would have

a choice and hopefully he will choose us for whatever reason. So we're not over-optimistic but we are not totally negative about going forward. We will just watch this space before we invest capital.

Question 4

Kane Slutzkin UBS

Just a couple of questions please, just on the regulation that was obviously implemented last year, July, what sort of actions did you take to mitigate that impact, specifically referring to the cost-base? To what extent were you able to adjust the cost-base post that regulation? And now with the reversal how much of that effect, if we can it that, comes back into the system as you anticipate increased volumes? That's the first question.

And then just on SA I'm just following on from the last question that was asked, we spoke about the funding constraint and you were referring to the South African environment more from an economic growth perspective, could you just give us a little bit of colour on how you see the whole admissions story in South Africa as a period of being negatively impacted by that? Are you comfortable or confident enough in your clinical and doctor quality to remain relatively unaffected by some of the issues we see from the medical aids, the actions that they're taken?

Danie Meintjes

Unfortunately we had a serious disturbance, interference on the line, I picked up that you asked about regulatory changes and how can we influence that and managing it going forward. Is that the first question because I couldn't follow?

Kane Slutzkin

Okay so now let me quickly rephrase, the question was once the regulation was implemented were there any actions you took to try and mitigate the impact? And if so with the reversal of that regulation, specifically with respect to the cost-base, is there any fat that comes back into the system now, now that you anticipate increased volumes.

Danie Meintjes

Are you talking specifically Switzerland Thiqa?

Kane Slutzkin

No I'm talking about Abu Dhabi so I'm saying you had the regulation imposed last year, July, did you do anything to the cost base post that regulation and now with the reversal does anything come back into the base because you've now got to cater or gear up for higher volume?

Danie Meintjes

The short answer is no. We took cost out of the system in terms of staff that we thought was over and above the staff we needed. And I think we made it very clear that we didn't dip into the clinical staff because we were busy building up a business and those people are very difficult to replace and it takes a long time. So where there's more support staff combining two corporate offices etc., so there is no immediate additional cost that I can see that we will

bring in unless you scale up to a level where you need more staff to service the patients that you see, specifically when you open new facilities. Is that the question?

Kane Slutzkin

Year exactly. And just a second one, I don't know if you heard that one on SA?

Danie Meintjes

Is that base management in South Africa?

Caines Lutken

I was just trying to find out what's your take on that and whether you're comfortable enough with your clinical quality to remain unaffected to some extent?

Danie Meintjes

It's fair to say that the insurance companies do have a focus on volume management and a number of those were public to say the challenge in South Africa is not price, it's volume, it's consumption. They also coined the phrase of supply-induced demand in certain provinces. So we are used to the fact that this oversight and admission management and people in hospitals that do feedback evaluation of patients and whether they still need to be in ICU and if a neonatal is in a neonatal unit are they still ventilated, do you charge the right tariff? I'm very comfortable with that.

We have put a high effort into coding for a long time already. It spilled over from Switzerland, we knew it was the right thing to do and I would like to think that we are a little bit ahead maybe of some of our competitors on the clinical focus, collecting data, because we want to do what is right and what is sustainable and that is that. But we want to keep our hospitals busy. So there might be a further focus on it but I'm not uncomfortable with where we stand at the moment. I don't know whether you referred to networks as well or only case management?

Kane Slutzkin

That's fine thanks a lot.

Question 5

Sean Ungerer – Arqaam Capital

Good morning everyone, just three questions please. Just following on, on the Hirslanden revenue story in terms of cash admissions, just to confirm, and so sorry for harping on this point, but is your outlook for volumes to be flat or you are modelling or expecting some growth there? It's just tying that back to your outlook for SA continued revenue growth in line with inflation and I'm just trying to touch on that point?

Danie Meintjes

Shaun, thanks let's answer the revenue forecast in South Africa, our guidance is in line with inflation. This year we've beaten inflation with about 1% but our guidance, taking into

account cost pressures, competition and all the factors we mentioned, inflation is our guidance that we feel comfortable with. Jurgens you want to add?

Jurgens Myburgh

Yeah we don't break that down. The contribution to revenue growth is your tariff, then your volume growth and then your increased facility utilisation. So we don't break that down but what we're saying is we see the combination of that to be in line with inflation.

Sean Ungerer

Okay got you. And then just in terms of the capex ramp up for Parkview are you able to chat around that and how much you're sort of seeing in FR17?

Danie Meintjes

Jurgens will give you the exact numbers. Keep in mind that will be the second hospital that we own the land, so at this stage in the Middle East we only own the buildings of the City Hospital as well as the North Wing and a separate plot of land and this land we will also own, we bought it. And the capex projects will be phased in – total cost 650.

Jurgens Myburgh

Total cost is 680m dirhams of which we'll spend 75% in the next two years and approximately 18m has already been spent.

Sean Ungerer

Okay great thanks very much. And then just in terms of the expected impact from total reverse of the 30m francs I mean obviously you're not going to see much in FY18, bulk of it in FY19, that's just quotes at the moment. You've obviously got mitigating actions in place that you're thinking of, I mean is that still the guidance 30m before mitigating actions, is there any colour you can provide on that?

Jurgens Myburgh

Yes so that's 100% right and Shaun it is 30m before mitigating actions. There are some mitigating actions but because this is happening at a tariff level you can do volume increases, you can look at how you build through and your interaction with other healthcare providers, but the key mitigating action will be around volume and utilisation but this being a tariff adjustment it's difficult to mitigate materially against it. And so the guidance is 30m on an annualised basis but it only comes in in Q4 or this financial year.

Question 6

Charles Weston, Berenberg

Just to follow up on the points about the UAE doctors can you give us a bit more granularity in terms of the employment of new doctors, maybe the change in doctors on a net basis over the year in the UAE, and maybe on a gross basis as well to be able to give us a sense of how many have left and how many have arrived?

And then also how expensive that is, can you give us a sense of like-for-like, essentially wage increases by the doctors or the clinical staff overall? Thanks.

Danie Meintjes

I will start with the latter and Jurgens remembers numbers better than me. If you think of a cost basis and comparing cost, just to give you full granularity, so if we recruit doctors obviously you must decide are you looking for a neurosurgeon, ortho, female gynae whatever there is a starting point, there is a price arranged for those people. Our remuneration approach in Dubai that I happened to institute there and that has now rolled out to Abu Dhabi, is to pay doctors a reasonably good base guaranteed salary. We will then add a little bit to it and guarantee it for a certain time, normally six months, I think that is still what they do. We then obviously phase the doctors in, market them, on board them, market them to the colleagues if they are in a specific speciality. And then they ramp up patients, outpatients, inpatients etc. and we look at the underlying professional fee that we charge on behalf of the doctor because we sell provisional fees. That we stack up against the salary. Once the salary is covered we start to share with them on the top side.

So our increased cost of the doctors are always overshadowed with the higher income. The key point I want to make is what we don't do is we don't align doctors to bring us more income for radiology, pathology, medication, keep patients longer in the bed etc., nothing perverse. But the good doctor who's sought after, with long waiting lists and working hard will earn more money in line with whether he works for himself at the end of the day. So that is the cost ratio that you must work out.

There are certain disciplines that you need, that you need sometimes to pay a premium and the volume income is not there but you need that. Think of cardiac surgery, the volume of cardiac surgery is not high in that region but if you have a cardiac unit you need to have it. You need to have the right guy and sometimes he will just run on a guaranteed salary. So the cost is backed up with the volume and the income that he's generating at the end of the day.

Obviously staff turnover costs you money and if you have a doctor that left, if he had a good following, some of the patients might fizzle over to the other doctors but they might go to opposition as well. So we don't want doctors to leave. But our track record of doctors staying with us in the Middle East is very good. If I go to the Middle East now there are still doctors, quite a wide number of them, that we appointed when I was there almost ten years ago. So traction of doctors is good because they earn good money. It's a fair, nice environment. And the one thing that I must emphasise our ability to manage the doctors in terms of clinical quality etc., is much easier in that part of the world because they're employed. It's a much easier environment to do that.

Does that answer your question on the cost?

Charles Weston

It does a bit. I was just wondering if you could put a few numbers on it if you have that in terms of perhaps the net change and the gross change in doctors?

Jurgens Myburgh

Yeah it would be in the 12 months before we took over the business there was a gross exit of 157 doctors in the business, gross. And as I said in the financial year we recruited 136 with a further 52 that's in the process of on boarding. So it's clear that throughout the year,

and this is on a total complement of let's say 600 in Abu Dhabi and the numbers I'm quoting the 157 is in Abu Dhabi, the 136 and the 52 is in the region. But it's fair to say that a) you will always have an element of vacancies. It's also fair to say that we had a disproportionate increase in vacancies in the Abu Dhabi business during the year. We've been in recruitment overdrive and I think we're now back at a level where we're beginning to feel more comfortable. We will have vacancies, but as Danie mentioned as part of the presentation it's very important that the ramp up of these doctors and their practices it takes six to 12 months for this doctor to then establish their practice and get up to a full operating level, if I can call it that.

Danie Meintjes

One comment I spent time with the recruiting team when I was in Dubai a couple of weeks ago. I'm very comfortable that we've got a very competent team and that there are not obstacles to recruit doctors. It does take long and there will always be a churn of doctors. And the 50 that is on boarding at the moment is over the whole region, Dubai and Abu Dhabi and Al Ain. So the concern to me is not whether we can find doctors, we do find good doctors, what is the focus now are for those people that are new in the system to get the word of mouth talk in town about their availability, the clinical skills etc., and for that reason we made the bold decision to rebrand all our hospitals and the clinics there and the process to be phased out so that we have some hook to hook the new story on and to talk on the radio shows and get out in the newspapers and promote new doctors. So building the practices is the key hard work that needs to be done now, not finding the doctors.

Maybe a last question then we must conclude.

Question 7

Cora

Thank you just following up from Charles' question; of the 157 doctors that left in Abu Dhabi how many of them were surplus to requirements? So are you trying to get back to that number or were there some that were redundant in the system anyway?

Danie Meintjes

Try and get back to what number, sorry I missed that?

Cora

Do you need to recruit all 157 back or is there an element of being more efficient with fewer doctors?

Danie Meintjes

You know it sounds funny I don't know the details of doctors because I'm not concerned about it. If you open the Al-Jawhara hospital you phase it in, you will get constantly new doctors that you need to recruit. If you have the north wing coming on stream just by that you will have new doctors to recruit. So I can't give you a hard number. At the moment we've filled the big negative gap that was left in Abu Dhabi but they're there, they're on board. But if you bring a doctor X from somewhere patients are not streaming to him, I mean they don't know him from a bar or soap, or her. So driving that process, getting colleagues to refer in

for that speciality and making an awareness in the community is one of the key elements that we focus on at the moment.

Cora

And the like-for-like wage inflation, taking say a neurosurgeon versus a neurosurgeon what's that?

Danie Meintjes

For salary increases?

Cora

Yeah.

Danie Meintjes

Salary increases in Dubai is cut according to our tariff increases. The salary increase in the Middle East this year was very close to zero.

We had a small component that we had to allocate and it was not a general salary increase because in Al Ain, nor not Al Ain in the Abu Dhabi Al Noor businesses there were serious discrepancies in the system that caused problems to manage your staff complement. So we used some money to do some balancing there but we didn't give a salary increase for the Middle East this year. Neither did we for Switzerland.

Closing Comments: Danie Meintjes

Does that conclude it? Right from my side thank you all for dialling in. Apologies for the technology that dropped us and wishing you well. Thank you.