Case study #3

Partnerships driving progress

Ensuring that all citizens have access to affordable, quality healthcare is a momentous challenge facing the sector. It requires commitment, dedication and clear leadership. But critical to achieving this goal is collective action, with **PARTICIPATION** and hard work required from all stakeholders.

Netcare is a strong proponent of the Public Private Partnership (PPP) model, which is proving effective across different countries with different healthcare challenges. In South Africa, an innovative partnership with the Eastern Cape Department of Health has broadened access and unlocked more healthcare services for the local community – meaning they no longer have to travel to larger centres for most medical cases.

The PPP included the building of the Port Alfred Hospital, which opened in March 2009, and the refurbishing of the Settlers Hospital in Grahamstown, reopening in August 2009. Importantly, both hospitals have public and private facilities operating side by side, with the private consortium responsible for managing both the public and private hospital facilities for 15 years.

Netcare CEO Richard Friedland states that: "PPPs endeavour to improve healthcare delivery beyond the bare minimum while leveraging the empowerment opportunities arising from the expenditure. Great emphasis is placed on skills transfer and embedding management and clinical policies that ensure the upkeep of the quality of care delivered."

Picture: Settlers Hospital in Grahamstown.

Operational reviews

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participation

South African review

Executive committee

Richard Friedland (48)

Group Chief Executive Officer

Qualifications: BvSc, MBBCh, Dip Fin Man, MBA

Joined 1997

Vaughan Firman (46)

Group Chief Financial Officer

Qualifications: BAcc, CA(SA), HDip Tax Law

Joined in 2004

Tumi Nkosi (47)

Managing Director – Emergency services

Qualifications: MBA and Chartered Marketer

Joined in 2007

Eileen Brannigan (54)

Group Nursing Director

Qualifications: BSocSc (Nursing), Dip IR, LLB

Joined in 1997

Peter Warrener (48)

Group Human Resources Director

Qualifications: BSocSci, Dip Fin Man

Joined in 2007

Melanie Da Costa (37)

Director – Strategy and Health Policy

Qualifications: MCom, CFA

Joined in 2006

Ingrid Davis (56)

Group Pharmacy and Procurement Director

Qualifications: Dip Pharm (MPS)

Joined in 1994

Victor Litlhakanyane (45)

Group Stakeholder Relations Director

Qualifications: MBChB, M Med (Radiotherapy), MBA

Joined in 2004

Jacques du Plessis (45)

Managing Director – Hospitals

Qualifications: BCompt (Hons) Accounting

Joined Medicross in 1996

Charmaine Pailman (53)

Managing Director – Primary care

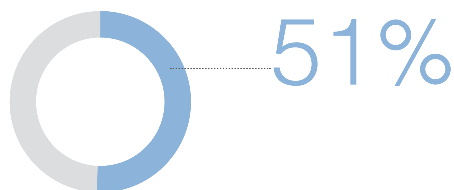
Qualifications: MBChB, MPH

Joined Medicross in 1996

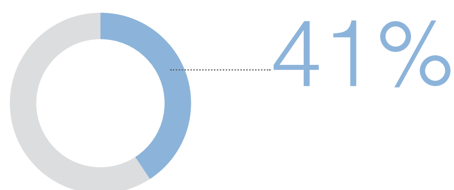
Operational highlights

- 4.9% increase in patient days
- 137 beds added to existing Netcare facilities
- 131 new physicians partnered with Netcare
- 15.1% increase in Netcare 911 lives under management
- 9.0% increase in Primary care managed lives
- More than 6 000 patients screened by National Renal Care
- 3 949 nurses and paramedics trained

Contribution to Group revenue

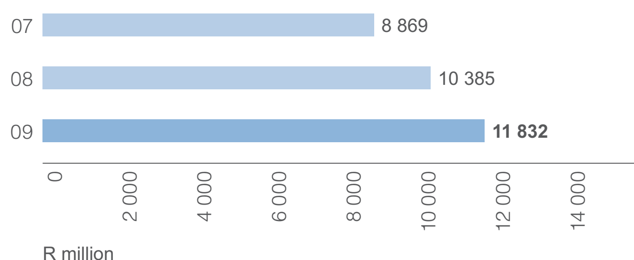


Contribution to Group operating profit

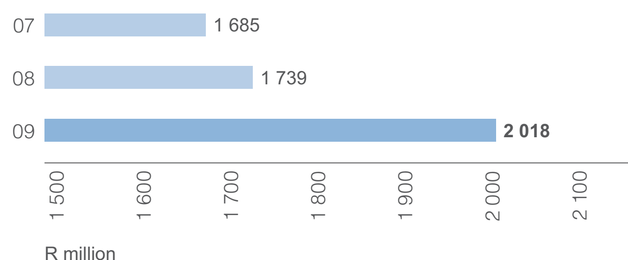


Financial highlights

Revenue



EBITDA



Rm	**2009**	2008	% change
Revenue	**11 832**	10 385	13.9
EBITDA	**2 018**	1 739	16.0
Operating profit	**1 662**	1 401	18.6
EBITDA margin (%)	**17.1**	16.7	
Operating profit margin (%)	**14.0**	13.5	
Capital expenditure	**747**	687	8.7

Health policy and regulation

Health policy

Most nations, rich and poor, are facing the problem of per capita healthcare spending rising faster than per capita GDP. Consequently, expenditure on healthcare is absorbing an increasing share of government, employer and household incomes. This fiscal pressure is forcing nations to confront two fundamental issues: financing growing health burdens and containing the pressures of health expenditure growth.

To formulate appropriate policies to address these issues requires a sound understanding of the factors driving health spend.

Several common factors on the demand and supply sides have caused the rapid rise in healthcare costs globally[1]. On the demand side, people's heightened expectations and demands, as well as the HIV/Aids pandemic, are the principal causes. Widely accessible information about disease and treatments is fuelling greater awareness about health, and expectations are being raised about healthcare's ability to treat and cure.

A recently published study by Newhouse *et al* (2009) expands on previous research into the drivers of healthcare spend between 1940 and 1990. This research concludes that the largest driver of increasing spend is attributed to income/affordability, with up to 43% of growth in real per capita health spending attributed to income growth.

Income is a critical factor in determining how much nations spend on medical care. It consistently accounts for around 90% of variation in real health spending across countries and time[2]. Income growth will continue to drive healthcare's increasing share of GDP in decades to come.

Burden of disease

To determine the extent and severity of a country's burden of disease, the various causes of death are divided into broad categories:

1. Communicable diseases, maternal and perinatal conditions, and nutritional deficiencies;
2. Non-communicable diseases; and
3. Injury.

Most middle income countries are faced with a "double disease" burden. As a nation's economy matures, it develops additional knowledge and resources to address issues such as basic healthcare, clean water, sanitation, malnutrition and communicable diseases. As the incidence of infectious diseases and infant and maternal mortality decrease, middle and higher-income urban households increasingly suffer from chronic illnesses, while lower-income and rural households continue to suffer primarily from infectious diseases.

South Africa (SA), in particular, suffers from a "quadruple burden" of disease, given high levels of trauma due to traffic accidents and violence. Furthermore, the unusually large burden of the HIV/Aids pandemic was recognised by the South African National Burden of Disease study[3] and was assessed separately.

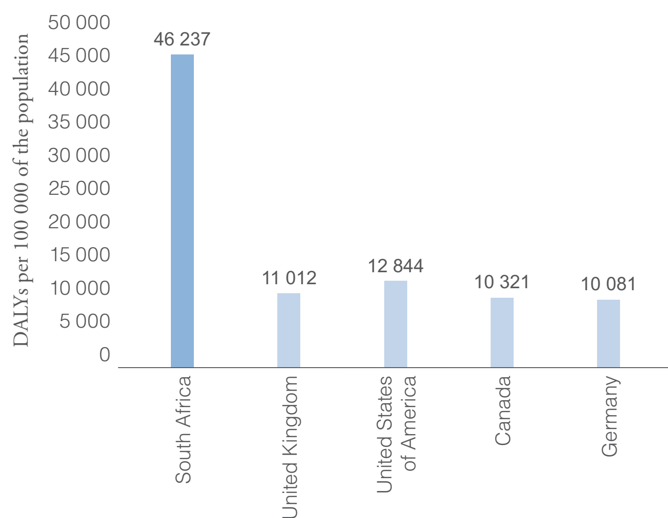
1 *Hsiao W and Heller PS. 2007. What macroeconomists should know about health care policy. International Monetary Fund.*

2 *Smith S, Newhouse JP and Freeland MS. September/October 2009. Income, insurance and technology: why does health spending outpace economic growth? Health Affairs.*

3 *Econex, NHI Note 2, October 2009.*

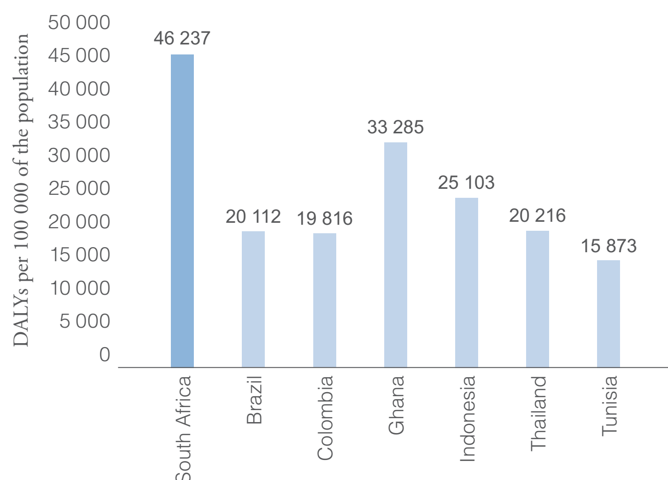
The graphs below reflect the disability adjusted life years (DALYs) per 100 000 of the population. DALYs indicate the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability. At 2.6 times higher than developed countries and 1.8 times higher than the average in developing countries, SA's burden of disease reflects a unique set of circumstances, highlighting complexity not experienced by most healthcare systems.

Absolute burden of disease compared with developed countries 2004



Melanie Da Costa
Director – Strategy and Health Policy

Absolute burden of disease compared with developing countries 2004



Source: Econex calculations from WHO 2009 data.

Regulation

The aim of providing universal healthcare coverage characterises the health reforms in many developed and developing countries, including SA. This is evident in the proposed National Health Insurance (NHI), which aims to expand healthcare coverage to the entire South African population.

Some of the NHI's key features that have been made public include extending cover universally, providing a comprehensive benefit package, utilising a combination of public and private healthcare providers, and the creation of a publicly funded and administered National Health Insurance Authority (NHIA). A Green Paper providing details of the proposed plan has not yet been published.

The first concrete steps to establish the NHI were taken recently through the formation of a National Health Insurance Advisory Committee. The committee's mandate is to "advise the Minister on the development of policy and legislation relating to the introduction of a National Health Insurance System"[4].

Underlying the health reform debate are the issues of:

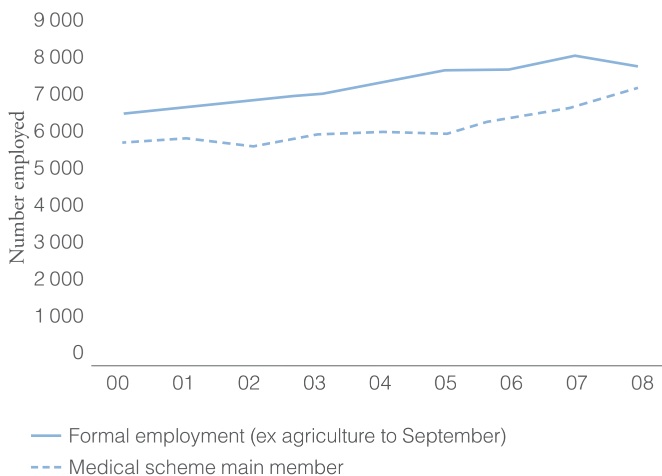
- Affordability;
- Price;
- Demand; and
- Capacity to deliver health services.

Affordability

The affordability constraints in SA are acute; 83% of South Africans (or 39 371 894[5] people) live in households with income of less than R100 000 per annum.

Medical scheme coverage continues to track growth in formal employment; currently 80% of households that earn above R250 000 per annum have at least one person on medical aid. Low income medical schemes have struggled to gain traction with patient affordability constraints exacerbated by structurally low employment.

Formal employment trend versus medical scheme coverage trends



Source: Council for Medical Schemes and Stats SA Labour Force Survey.

Higher levels of cross-subsidies across income groups are required to provide poorer people with health insurance. However, tolerance for higher taxes needs to be determined as the upper quintile (where most medical scheme members reside) currently contributes 82.3% of total health financing[6].

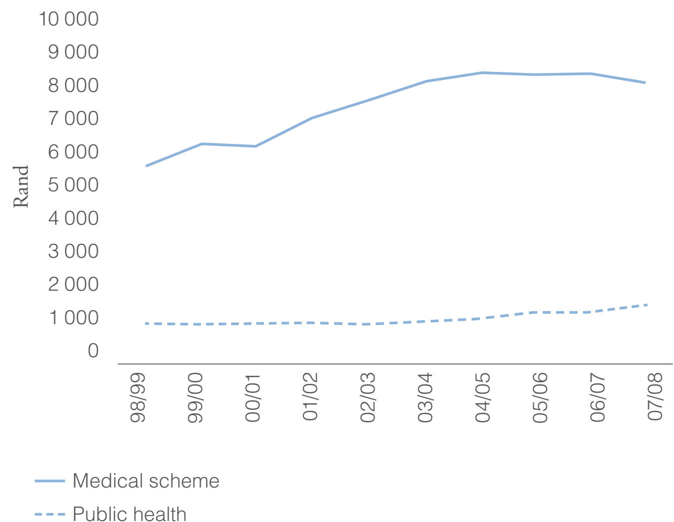
According to Lighthouse Actuarial Consulting, families in the upper quintile paid R1 725 per family per month to the public health budget in 2006, against average medical scheme contributions of R1 655. Under the proposed NHI, an additional health payroll tax is being earmarked. If a payroll tax is effected, affluent South Africans may be paying for healthcare in triplicate in future. This could result in the pool of privately covered members contracting.

Price

Expenditure is a function of price and utilisation. The most effective way to address pricing concerns is through cost benchmarking of both public and private health services. However, the absolute and relative cost of delivery in both sectors remains unclear at this stage. It is imperative for the NHI to establish these costs, which would allow the NHI Authority to objectively assess pricing in the private and public sector.

The Reference Price List process, effected in 2008, provided an opportunity to establish pricing. However, the process has weaknesses. The healthcare sector would benefit from the process being redone and extended to the public sector.

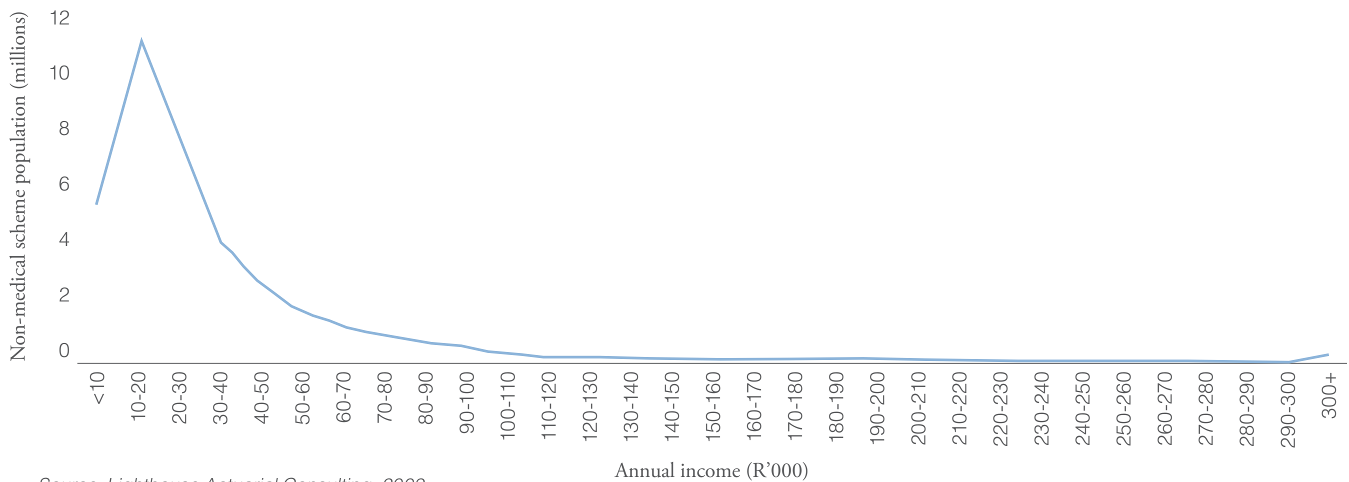
Real per capita expenditure in the private versus public sector



Source: Council for Medical Schemes – National and Provincial Budgets.

4 Government Gazette 32564. 11 September 2009.
5 Stats SA Income & Expenditure Survey. 2006.
6 Theron N. June 2009. Financing and Benefit Incidence Analysis in the South African Health System Econex.

Distribution of South Africans without private medical cover, by household income



Source: Lighthouse Actuarial Consulting, 2009.

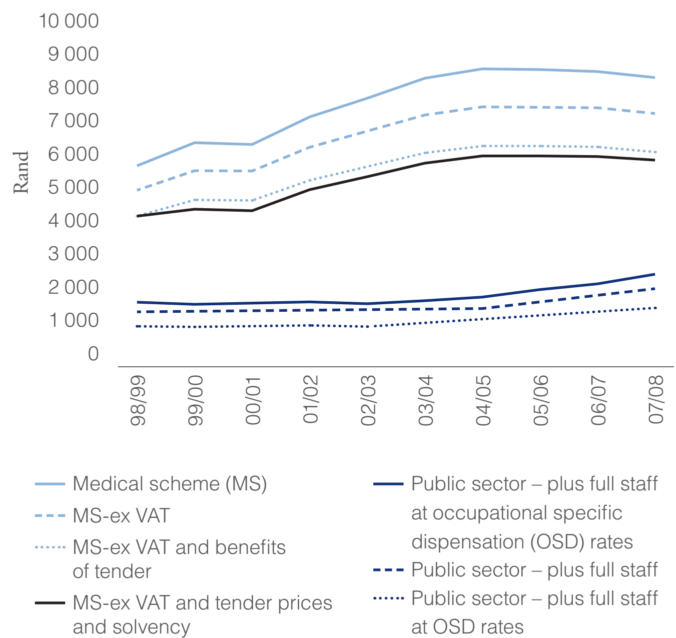
The disparity between healthcare expenditure in the private and public sector is often proposed as a driver of health reform, in pursuing the goal of social solidarity. On the face of it, the real per capita expenditure on health in the private sector is between five to seven times more than in the public sector.

However, different commercial imperatives exist between the private and public sector that, when adjusted, dramatically reduce the health funding differential between the private and public sector. These include:

1. Levying VAT on private health products and services;
2. Medical scheme solvency requirements;
3. Public purchases of drugs and medical devices are based on tender and are cross-subsidised by prices paid by the private sector. This is further entrenched in the single exit price regulation that is only applicable to the private sector;
4. Higher vacancy rates and ongoing difficulties in filling posts reduce the cost of delivery in the public sector; and
5. Cost of capital and private investor return requirements.

Once the numbers are adjusted to ensure a like-for-like comparison, the private sector expenditure differential falls dramatically closer to two times that of public sector expenditure.

Real per capita health expenditure adjusted for VAT, medical scheme solvency, tender prices versus private sector input costs and differential vacancy rates



Source: Actuarial Lighthouse Consulting.

Demand

The South African NHI proposal proffers the concept of zero (no) co-payments, with all services covered under the benefit package of the NHI. This feature implies that access to healthcare will be free to all South Africans at the point of service. This can be compared to universal general insurance with no 'excess' payable on claims[7]. Taking current healthcare provision in SA as a starting point, a newly introduced comprehensive benefit package with zero co-payments is bound to result in a dramatic increase in the demand for the whole range of medical services.

Understanding the impact of market-wide changes in health insurance is crucial for analysing the optimal design of health systems. Market-wide changes in health insurance can fundamentally alter the nature and character of demand and medical practice.

Finkelstein (2005)[8] examined the impact of market-wide changes in health insurance on the healthcare sector by studying the single largest change in health insurance coverage in the United States: the introduction of Medicare in 1965. He found robust evidence that Medicare's introduction is associated with an increase in hospital utilisation, hospital spending and the adoption of hospital technology. Based on Finkelstein's estimates, the overall spread of health insurance between 1950 and 1990 may explain at least 40% of the five-fold increase in real per capita health spending, and potentially far more.

This leads to the question of whether this research explains why most other Organisation for Economic Cooperation and Development (OECD) countries have also experienced sustained growth in the healthcare sector over the last half century (OECD 2004). It is interesting to note that, like the United States, many of these countries established their national health insurance systems in the 1960s and 1970s[9].

Capacity to deliver health services

The potential exists for a substantial near-term stimulus for healthcare demand if coverage is expanded to the currently uninsured population. It is unlikely that the healthcare sector has the existing capacity to meet the country's current and future healthcare needs.

Health professionals

With public sector health professional vacancy rates at 36%[10] and private sector vacancy rates around 25%, it is unlikely that significant increases in access to health services will be achieved without a concomitant redesign of the delivery model, as opposed to only changing the funding model.

Too much focus is being placed on the distribution of health professionals between public and private sectors at the expense of the real issue – SA has a shortage of health professionals.

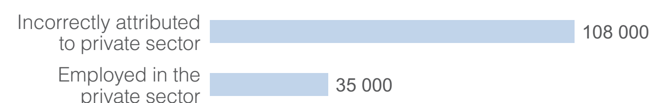
Nursing and midwifery per 10 000 population

Country	Number of nurses and midwives
United Kingdom	128
Australia	97
Russia	85
France	80
SA Private	39
SA Public	30

Source: WHO, Persal and HASA.

In the NHI debate, the number of health professionals has only been based on the number of people with professional registrations, including the Health Professional Council of SA (HPCSA) and the Nursing Council. Using the number of professionals employed by the state, authors have assumed that the balance of health professionals work in the private sector. This assumption is inaccurate as many people with valid health registrations no longer work as health professionals or have emigrated. According to Persal, there were 105 000 nurses employed in the public sector in 2008, compared to the Nursing Council figure of 213 000. The difference of 108 000 nurses was incorrectly attributed to be working in the private sector, yet the correct number is closer to 35 000. The total for active nurses would therefore be closer to 140 000, not 213 000.

Number of nurses employed in the private sector



Inconsistencies in the number of doctors recorded on the databases of the HPCSA, All Media and Products Survey (AMPS)[11] and the Labour Force Survey are equally severe. According to Persal, there were 10 650 doctors employed in the public sector in 2008, compared to the HPCSA figure of 35 000. The difference of 24 350 doctors was incorrectly attributed to them working in the private sector, yet the correct number is closer to 12 475. The total number of active doctors is therefore closer to 20 000, as opposed to 35 000.

7 *Econex. September 2009. NHI Note 1: Key Features of the Current NHI Proposal.*

8 *Finkelstein A. 2005. The aggregate effect of health insurance: Evidence from the introduction of Medicare. National Bureau of Economic Research.*

9 *Cutler. 2002.*

10 *Source: ANC NEC NHI Document. 22 June 2009.*

11 *AMPS is a survey of households and adults (16+) covering product and media usage.*

Number of doctors operating in the private sector

Hospital

The public sector manages approximately 82% of hospital beds in SA, with the remaining 18% privately owned. An expectation is being created that private hospital access for all South Africans can significantly alleviate the problems of access in our country. Recent analysis completed by Lighthouse Actuarial Consulting[12] concluded that the private sector has spare capacity to cater for an additional two to four million lives, considering the shortage of hospital beds and healthcare professionals. This remains a far cry from what is required to alleviate bottlenecks to access.

Conclusion

Notwithstanding the private sector's ranking among the best health systems in the world[13], SA ranks 175 out of 191 countries in the World Health Organisation's performance report. There is significant capacity for improvement, and areas of excellence in both the public and private sector can be leveraged.

In a resource constrained environment, the private sector is an essential partner in finding solutions to the healthcare maladies affecting our nation. Netcare stands ready to partner with government and the Department of Health to meet the critical challenges we face in broadening access to quality healthcare, and ensuring better outcomes. Through our substantial training of nurses and paramedics, our active involvement in Public Private Partnerships, servicing indigent patients through Netcare 911 and extending private healthcare to lower income groups through Prime Cure, Netcare is already demonstrating this commitment.

12 *Private Hospital Review. 2009.*

13 *Monitor Group: 2004 and 2008 survey.*

Hospital operating review

Our business

Netcare's Hospital division owns and manages 54 private hospitals across South Africa (SA). Four of these hospitals are Public Private Partnerships (PPPs), with two PPP hospitals opening during the year in Port Alfred and Grahamstown in the Eastern Cape.

The Hospital division comprises a mix of full-service, high-tech hospitals and same-day surgical units. The division has 8 766 registered beds representing approximately 29% of the private healthcare market and some 7% of total registered beds in SA, including state facilities.

The division's service offering is tailored towards providing specialised care, which is reflected in 16% of our total beds being intensive care (ICU) and high care (HC). The division has 22 catheterisation laboratories, three electrophysiology (EP) laboratories, 40 accident and emergency units, 35 hospitals offering maternity services, 47 retail and 52 institutional pharmacies, seven transplant units, 35 specialised rape crisis centres and four breast milk reserve centres.

The year in review

The Hospital division posted excellent results, recording a 4,9% increase in patient days with an average weekday occupancy of 72%. Our two new hospitals, Blaauwberg and Alberlito, increased occupancy to over 60%. Length of stay has increased by 1.2% while a balance between surgical and medical admissions has been maintained.

Lifestyle diseases, longevity and the positive impact of medical technology continue to drive growth in healthcare spending. It is evident that the demand for private healthcare remains strong, fuelled by an increase in the medically insured population.

Total admissions increased by 4.3%. In particular, deliveries in our maternity units increased and more cases were completed in our catherisation laboratories. Retail scripts dispensed from our hospital pharmacies increased by 5.8%. Over the year we also grew our Netcare retail pharmacies in Woolworths stores to three.

Netcare has 85% of its business under fee for service (FFS) contracts and 15% under alternative reimbursement models (ARM). We continue to develop protocols and guidelines to ensure quality outcomes at the lowest possible cost. On average, generic medication comprises 63% (2008: 56%) of substitutable medicines dispensed in our hospitals, and this increased to 67% at year-end. The use of generics helps us maintain quality healthcare at lower cost. Standardisation of surgical products also continued to yield good results.

A significant cost driver remains the shortage of skilled nursing and pharmacy staff, a risk we mitigate by operating our own training colleges. During 2009, we had more than 3 300 learners at our five campuses, studying various basic, post-basic and short nursing programmes. 1 295 nurses graduated during the year. We also trained 44 interns and more than 60 pharmacist assistants, at basic and post-basic level. In addition, 334 of our management staff completed Management Development Programmes. Surgical Technology and Clinical Engineering Technical Assistant learners were also trained. We aim to take in over 3 500 learners during the 2010 financial year.

Working capital was well managed with debtors' days at record levels. Stock was kept at minimum levels throughout the year. The centralisation of the creditors function also contributed to the improved working capital management.

We continued to invest in our existing infrastructure to meet increasing demand. During the period under review 137 beds and facilities were added at the following hospitals:

- Akasia Hospital – 16 ICU beds and a 30-bed medical ward;
- Sunninghill Hospital – a six-bed trauma ICU which is still under construction;
- Port Alfred Hospital – a five-bed ICU and 26 general ward beds;
- Settlers Hospital – eight ICU beds and 24 general ward beds;
- Kuils River Hospital – 10 HC beds, which required forfeiting seven general ward beds;
- Pelonomi Hospital – six ICU beds and 13 general ward beds;
- Blaauwberg Hospital – equipped two new theatres;
- Linksfield Hospital – a catherisation laboratory;
- Greenacres Hospital – a trauma unit and a major upgrade in the ICU, HC and pharmacy;
- Kingsway Hospital – an oncology and a day ward; and
- N1 City Hospital – a neuro interventional theatre with MRI and CT scan capabilities.

Jacques du Plessis
Managing Director – Hospitals

Construction on the new 125-bed private hospital in Waterfall, Midrand, together with our empowerment partners, commenced in September 2009.

An additional R282 million was spent on new and replacement medical equipment, including a new EP lab at Milpark Hospital, and R99 million was spent on plant and equipment. Our ability to avoid utility interruptions was strengthened further with emergency generator plants upgraded to dual redundancy at The Bay, Umhlanga and Greenacres hospitals. We also significantly increased water storage capacity in the division to cope with extended water interruptions.

At Netcare we are passionate about people and value our staff's perceptions about their work environment. Our annual independent staff survey showed that 74,1% of staff are proud to work for Netcare, further evident in lower staff turnover and absenteeism, and in Netcare being awarded fifth place in the Large Companies category of the 2009 Deloitte Best Company to Work For Survey.

We are also passionate about ensuring that each patient is satisfied with their experience at a Netcare facility. As a result, we have introduced a new patient satisfaction scorecard in our hospitals and emergency units, with more than 25 000 questionnaires completed by our patients on a monthly basis. All aspects of our service are rated, from admission to nursing care. Our most recent patient satisfaction score was at 88%.

Netcare's Caregiver of the Month programme culminates in our Night of the Stars award ceremony, where staff members that have shown exceptional care to their patients are honoured. The event highlights the commitment of Netcare's staff to our core values. This year the three regional winners each received a Mazda 2 car.

We continued to support our network of expert doctors who have selected a Netcare facility as their treatment centre of choice. This year we welcomed 131 new physicians, of which 68% are from surgical disciplines. In living our value of participation all specialists with privileges are requested to complete an extensive independent questionnaire, and this year our services were rated 75.3% satisfactory.

Netcare continues to maintain the highest standards of patient care and safety. A further six hospitals received international ISO 9001:2000 accreditation through the United Kingdom-based CHKS Healthcare Accreditation and Quality Unit. This brings the total number of accredited hospitals to 16.

Each hospital has an established Physician Advisory Board comprising specialists from each discipline. They are responsible for ensuring that doctors adhere to the Professional Code of Conduct and uphold the high standards of clinical governance that Netcare subscribes to.

We have made significant strides in managing our environmental impact. Various solar powered technologies have been implemented at our facilities. We are also tracking and managing utility consumption in terms of volume, based on carbon footprint parameters and revenue. Our focus on environmental reporting was recognised by the UK-based Carbon Disclosure Project (CDP) with a ranking of 14th place on the South African CDP Carbon Leadership Index.

Prospects

A number of hospitals continue to experience pressure on available capacity, specifically in the KwaZulu-Natal region. As a result, applications to expand capacity have been submitted to the relevant Provincial Departments of Health.

Approval has been received for the following facilities:

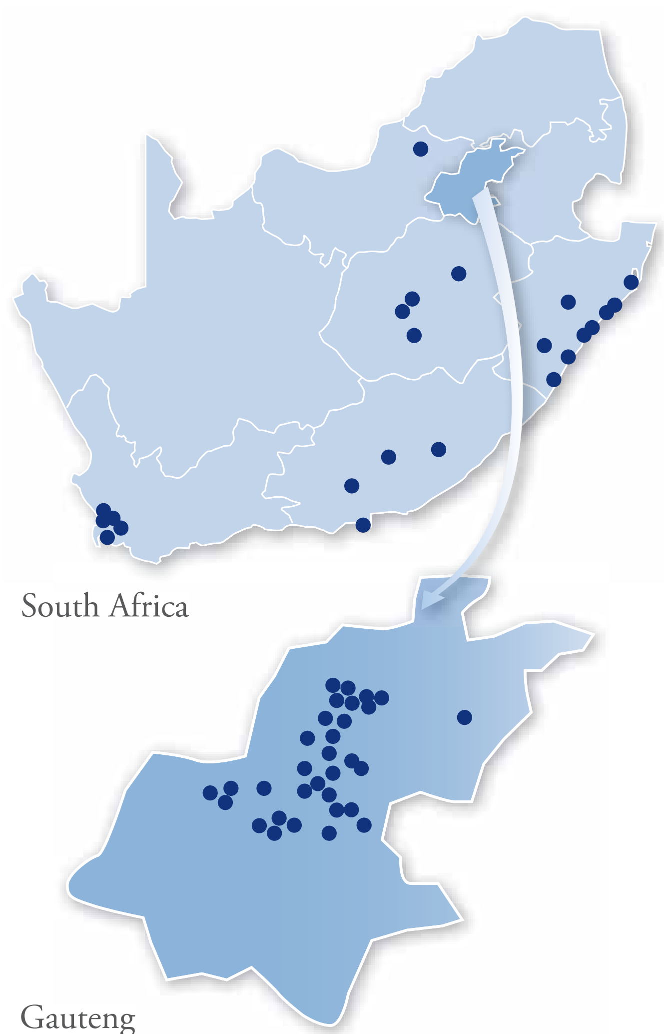
- 31 beds at Linmed – five paediatric, 11 adult surgical and 15 day ward beds;
- Seven beds at Sunninghill – all HC beds;
- 35 beds at Kingsway – 23 medical and 12 surgical beds;
- 12 beds at Kuils River – five paediatric, three maternity and four HC beds;
- 12 beds at N1 City – four paediatric and eight ICU beds;
- 14 beds at Parklands – all general ward beds;
- Six beds at St Anne's – all HC beds;
- 20 beds at The Bay – all medical beds;
- Ten beds at Linkwood – all maternity beds; and
- 57 beds at Mulbarton – eight neo-natal, 20 maternity and 29 adult beds.

The SAP Enterprise Resource Planning pilot at Sunninghill Hospital is nearing completion and we plan to roll out SAP to more hospitals during 2010. The SAP software platform provides centralised functionality and standardisation resulting in efficiencies.

SA hospitals

Hospital	Location	Registered beds
Gauteng		5 289
Akasia Hospital	Pretoria	162
Bell Street Hospital	Krugersdorp	50
Bougainville Hospital	Pretoria	60
Bronkhorstspruit Hospital	Bronkhorstspruit	43
Clinton Hospital	Alberton	165
Constantia Day Clinic[1]	Roodepoort	24
Femina Hospital	Pretoria	134
Garden City Hospital	Johannesburg	363
Jakaranda Hospital	Pretoria	130
Krugersdorp Hospital	Krugersdorp	310
Linksfield Hospital	Johannesburg	283
Linkwood Hospital[2]	Johannesburg	33
Linmed Hospital	Benoni	172
Milpark Hospital	Johannesburg	342
Montana Private Hospital	Pretoria	162
Moot Hospital	Pretoria	92
Mulbarton Hospital	Alberton	155
N17 Hospital	Springs	170
Netcare Rehabilitation Hospital	Johannesburg	110
Olivedale Hospital[2]	Johannesburg	265
Optiklin Eye Hospital	Benoni	14
Optimed Clinic[3]	Alberton	12
Park Lane Hospital	Johannesburg	204
Pretoria East Hospital	Pretoria	358
Protea Day Hospital	Krugersdorp	10
Rand Hospital	Johannesburg	151
Rosebank Hospital	Johannesburg	135
Sunninghill Hospital	Johannesburg	258
Sunward Park Hospital	Boksburg	214
Union Hospital	Alberton	222
Unitas Hospital	Centurion	469
Wierda Park Hospital[4]	Centurion	17
North West		163
Ferncrest Hospital[2]	Rustenburg	163
Free State		362
Kroon Hospital	Kroonstad	80
Pelonomi Private Hospital[3,5]	Bloemfontein	87
Universitas Private Hospital[3,5]	Bloemfontein	127
Vaalpark Hospital	Sasolburg	68
KwaZulu-Natal		1 618
Alberlito Hospital	Ballito	119
Kingsway Hospital	Amanzimtoti	145
Kokstad Private Hospital[3,5]	Kokstad	36
Margate Hospital	Margate	85
Parklands Hospital	Durban	193
St Anne's Hospital	Pietermaritzburg	200
St Augustine's Hospital	Durban	418
The Bay Hospital	Richards Bay	198
Umhlanga Hospital	Umhlanga	224
Eastern Cape		487
Cuyler Hospital	Uitenhage	124
Greenacres Hospital	Port Elizabeth	300
Port Alfred Hospital[3,5]	Port Alfred	31
Settlers Hospital[3,5]	Grahamstown	32
Western Cape		847
Blaauwberg Hospital	Blaauwberg	100
Christiaan Barnard Memorial Hospital	Cape Town	244
Kuils River Hospital	Kuils River	154
N1 City Hospital[2]	Cape Town	225
UCT Private Academic Hospital	Cape Town	124
Total		8 766

1 Interest in joint venture.
2 Leased property.
3 Investment in associate.
4 Hospital closed.
5 Managed hospital.



Emergency services operating review

Our business

Netcare 911 is the leading provider of emergency medical services (EMS) in Africa, and is proud to offer fully integrated and efficient solutions to patients in crisis situations. Our core competencies are world-class emergency medical assistance, evacuation by road or air transportation and telephonic medical advisory services. We also offer a range of innovative products such as specialised travel advice, trauma support, Health-on-Line, capitation arrangements with medical schemes, and fund management for medical schemes and corporate clients.

Our emergency management meets international standards, and our network of 169 emergency vehicles and 70 rapid response vehicles, crewed by advanced life support paramedics, is well equipped to handle any medical emergency.

Netcare 911 employs state-of-the-art technology to manage emergency calls and dispatching of emergency resources in South Africa (SA). Our 24-hour Emergency Operations Centre, operating in Midrand, Johannesburg, is the hub of our network and is staffed with trained emergency call agents and resource coordinators able to manage pre-hospital emergencies and inter-facility transfers.

Our Aeromedical division consists of a dedicated fleet of fixed wing and helicopter air ambulances, managing and providing aeromedical evacuations for a large number of insured and private clients locally and internationally.

Netcare 911 International Assistance provides a 24-hour contact centre for outbound and inbound travellers, supporting them in times of medical need. As partners of the International Assistance Group, a global alliance of independent assistance companies, and using our global referral system, we manage medical emergencies for insured South Africans across the world.

Our Special Projects division has built a core competency in providing mining, industrial and commercial clients with turn-key emergency medical solutions for all on-site and remote medical requirements.

In conjunction with Netcare Education, Netcare 911 operates the largest private EMS training centre in Africa. The School of Emergency and Critical Care is led by a dynamic team of experienced instructors and academics in the EMS field and is accredited by the Health Professional Council of SA.

The year in review

Netcare 911's revenue growth has been driven primarily by an increase in membership in schemes with which we have capitation arrangements. The division recorded a 15.1% growth in total lives under management to 7.5 million lives. Over the year we focused on retaining clients and developing a solid business platform to support growth in the coming years.

We have achieved significant efficiencies across Netcare 911's divisions, especially in finance, the call centre and operations, through our "Back to Basics" programme. It was launched in June this year to extract efficiencies and develop robust measuring and reporting tools for the business. We believe that the programme's success has placed Netcare 911 in a highly competitive position.

Further cost-saving initiatives were implemented with emphasis on reducing overtime and exiting non-core services. These have yielded positive results for the business.

During the year, Netcare 911 assisted more than 2 800 indigent patients at a cost of R13 million.

We have maintained close and productive working relationships with our medical scheme and corporate clients. This has been achieved through a concerted effort to engage with them and ensure service delivery by all our divisions.

The market continues to be attractive to small, regional EMS providers, the majority of whom are located in remote areas in SA. Management has moved swiftly to maintain and win market share by re-allocating and introducing new resources in strategic areas. We have increased our SA footprint by introducing new branches in the Rustenburg, East London and Mpumalanga areas.

A critical shortage of skilled paramedics and doctors with training and experience in emergency medicine remains a challenge to the business, with the pool of doctors and paramedics constantly decreasing. As a result, the demand for our experienced and specialised staff remains high. We continue to maintain competitive remuneration and people management policies in our efforts to maintain our position as the employer of choice.

We welcome the introduction of the new training programme for Emergency Care Technicians by the Department of Health. However, we are concerned that the new two-year course, which replaces a number of shorter courses, might have the unintended consequence of contributing to skills shortages in the industry by delaying the entry of new technicians into the market. We hope the programme is implemented in a proactive and coordinated manner to prevent this.

Establishing an approved Reference Price List (RPL) to ensure a sustainable EMS sector is ongoing.

Prospects

Our focus for the year ahead will remain on building and harnessing relationships with our clients and providing a service that adds value to their businesses. We are evaluating a number of strategic growth opportunities outside of SA through our International Assistance and Special Projects divisions. These opportunities are being carefully investigated to ensure they will provide sustainable value for Netcare 911.

Tumi Nkosi
Managing Director – Emergency services

Primary care operating review

Our business

Our well established brands include a national footprint of 107 Medicross and Prime Cure Medical and Dental Health Centres. These offer comprehensive primary healthcare services delivered by 677 independent general practitioners and dentists.

Our centres also provide pathology and radiology services, day theatres and emergency services, and include 41 Pharmacross retail pharmacies. A range of ancillary health services are provided by dieticians, physiotherapists and optometrists. In addition, the division provides travel advisory and travel medicine services from 12 Netcare Travel Clinics.

Over the past twelve years the Prime Cure business has grown into a leading managed care organisation. Our contracted provider network has enabled medical schemes to offer benefit options to the previously uninsured lives, from primary to full risk cover. This has been vital in extending access to affordable quality healthcare to lower income groups.

Our contracted designated service provider network includes 5 099 doctors, dentists and optometrists, 1 266 pharmacies, 24 Prime Cure clinics, various provincial hospitals, and 270 private hospitals. Prime Cure is well positioned to leverage off our risk management competencies and provider relationships to extend our market leadership.

The Prime Cure Wellness brand provides occupational health, employee wellness, travel advisory and HIV services to 35 corporate clients nationwide. We are also providing these services to an international organisation with projects in ten African countries.

The year in review

Revenue increased by 10.8% to R1 513 million (2008: R1 365 million) aided mainly by a 10.7% increase in the Reference Price List (RPL), additional Medicross clinics and the expansion of the managed care and risk management services.

EBITDA for the division decreased to a loss of R24 million (2008: R4 million profit). Results were adversely impacted by underwriting and debt provisions from the prior year and changes to the division's organisational structure. As previously communicated, the remedial programme to address the underperformance of the business continues.

Medicross and Prime Cure Medicentres

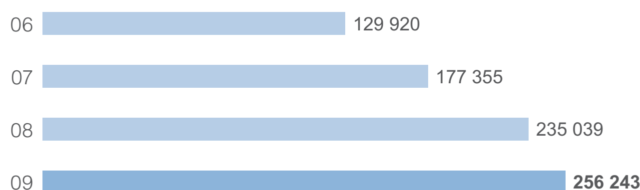
The swine flu epidemic resulted in higher patient volumes in all centres across the country and prolonged the increased seasonal activity associated with the winter months.

Our partnership with Edcon continued to provide an effective means to extend access to healthcare, with Edgars' cardholders able to use their card facilities at Medicross Medicentres for their healthcare needs.

Prime Cure Managed Care Services

Prime Cure continued to expand its managed care and risk management services into the previously uninsured segment of the South African healthcare market, recording growth of 9.0% to 256 243 capitated lives.

Growth in managed care lives



Prime Cure matches the footprint of our providers to the footprint of our members on a regular basis, to ensure that our resource distribution is optimised and our network can provide comprehensive access, even in the most remote areas of the country.

The Clinical Advisory Board provides clinical governance oversight in the development of clinical protocols and pathways, including the 26 Chronic Disease List conditions published by the Council for Medical Schemes.

Prime Cure Wellness

Prime Cure Wellness services are delivered through on-site Occupational Health Clinics in a number of sectors. We have extended this to the construction sector with off-site services through our clinic network. The services provided to our international client have been extended to include Mozambique.

More than 5 000 employees across 10 African countries are provided with material on health education in English, French and Portuguese, annual health screenings and health risk assessments, as well as disease management of HIV/Aids, Malaria and Tuberculosis. These services are provided through locally contracted medical practitioners or referrals to appropriate public health services, depending upon the country.

Prime Cure Wellness provided HIV disease management to 19 medical schemes through an independent call centre facility and a network of 1 300 doctors, as part of the main Prime Cure network. HIV care and treatment was also provided to 4 500 patients in the Free State through a provincial treatment programme that was donor funded. We were also involved in an extensive voluntary counselling and testing (VCT) programme which has been conducted in a number of organisations, with more than 25 000 VCT consultations performed.

Prospects

Primary care has reviewed its businesses to ensure sustainability and growth in 2010. We have started upgrading clinic infrastructure which will continue in phases. Our initiative to improve access to travel advisory services will be strengthened by training ten professional nurses in travel medicine in 2010.

In our managed care business, extending benefits to low income earners in sectors such as mining are presenting new growth opportunities. These should support schemes in growing their membership base and support Prime Cure in extending healthcare delivery.

Charmaine Pailman
Managing Director – Primary care

Prime Cure has extensive experience in both clinical risk management and primary care service delivery. This positions us well as a strong partner in primary healthcare delivery as envisioned in the government's programme of action for health reform. The scarcity of critical skills in nursing, pharmacy and dentistry, and the challenge presented by the increasing age profile of general practitioners, remains the focus of Netcare's human resources development plans. We will continue to mitigate these risks with ongoing investments in training and development.

Medicross and Prime Cure Medicentres, as the largest national network of private primary care clinics, deliver high volume quality primary healthcare in urban and peri-urban settings. We plan to optimise growth to ensure our business continues to deliver quality while expanding to accommodate higher volumes.

Other businesses

Associate company investments

Netcare has several interests in associate companies. In South Africa (SA), the attributable earnings of associates showed a strong turnaround, from a loss of R8 million in 2008 to R17 million profit in the year under review. This reflects the success of our continuing efforts to exit loss-making, non-core investments and to focus on our investment strategy in Public Private Partnerships (PPPs).

Public Private Partnerships

Netcare's PPPs provide the platform for our commitment to broaden quality healthcare services in the countries in which we operate. We have seven PPPs under management, now all profitable after interest and taxation. The PPPs include:

- Universitas and Pelonomi hospitals (Community Hospital Management);
- Port Alfred and Grahamstown hospitals (Nalithemba);
- Lesotho Hospital (Tsepong);
- UCT Private Academic Hospital (UCTPAH); and
- Bronkhorstspruit Hospital.

Netcare has garnered strong experience in PPPs, starting with the use of public healthcare sector beds in Bronkhorstspruit in 1997, which continues to date. In 2002, we joined a consortium of partners in acquiring the UCTPAH, a private facility and training hospital in Cape Town. We established a co-location PPP agreement with the Free State Department of Health in 2003, the first PPP of its kind in SA, which allows Community Hospital Management to utilise spare capacity in Bloemfontein's Universitas and Pelonomi hospitals.

Our participation in robust and delivery-orientated partnerships is proving its worth with two PPPs becoming operational during the year. In SA, the Port Alfred and Settlers hospitals PPP with the Eastern Cape Department of Health commenced operations, with both hospitals featuring public and private facilities.

The Port Alfred Hospital, completed in March 2009, was rebuilt from the ground up and offers the local community state-of-the-art medical facilities. The refurbishment of the Settlers Hospital in Grahamstown was completed in August 2009, and included the construction of a new private wing. The public and private wings share a number of upgraded facilities. At both hospitals we will continue providing facility management and soft services.

The private vehicle for the partnership is Nalithemba hospitals, which will be responsible for managing both the public and private hospital facilities for 15 years.

Outside South Africa, Netcare is leading a consortium of partners in building a new public hospital for the Government of Lesotho, the largest healthcare PPP in Africa to date. This landmark project includes the refurbishment of three filter clinics in addition to the new hospital in Maseru, with the entire project scheduled for completion in mid 2011.

Other associates

Other associate investments include KOPM Investment Holdings (the holding company for Lesedi Hospital in Soweto), Kokstad Private Hospital and Optimed.

Joint venture investments

National Renal Care

National Renal Care (NRC) is the largest private dialysis provider in SA with a network of 54 dialysis units, seven dedicated peritoneal dialysis units and seven specialised acute therapy teams. NRC is a 50% joint venture between Netcare and Adcock Ingram.

NRC has adopted a total disease management philosophy. It offers chronic haemodialysis, peritoneal dialysis, acute haemodialysis, continuous renal replacement therapy and plasma exchange therapy. NRC supports this range of therapies with the Healthy Start Programme (HSP), a kidney disease prevention and management programme for patients at risk of kidney failure, patients with kidney disease and patients at risk of developing kidney failure. The programme includes testing blood glucose, measuring blood pressure and screening for kidney function; dietary and lifestyle modification; education; patient and family counselling; and the monitoring of blood results.

NRC recorded a 23.5% increase in chronic dialysis sessions and a 27.4% increase in acute sessions. More than 6 000 patients were screened and nocturnal dialysis commenced at the N1 City facility, a first for SA.

Patient education and support remains one of our key areas of focus. NRC hosted several support groups and patient forums nationally. Patient workshops were also held in Cape Town and Johannesburg, with patients attending from the public and private sector.

NRC is committed to improving access to dialysis in SA. During the year, a number of Public Private Initiatives were successfully negotiated. Government hospital dialysis patients are treated at NRC facilities in George, Paarl, Rustenburg, Ladysmith and Port Elizabeth. NRC also provides acute dialysis services at various public facilities countrywide.

NRC expects the number of dialysis patients to grow, considering SA's high levels of HIV, diabetes, hypertension and obesity, all precursors to kidney disease.

Executive committee

Adrian Fawcett (41)

Chief Executive Officer

Qualifications: MBA, BSc Economics

Joined in 2007

Phil Wieland (36)

Chief Financial Officer

Qualifications: BSc (Hons) Mathematics, ACA

Joined in 2006

Belinda Moore (47)

Group Marketing Director

Qualifications: BA Soviet and European Studies

Joined in 2007

Phil Pegler (41)

Group Director Hospital Development

Qualifications: BSc (Hons) Business Studies, MBA

Joined in 2007

Catherine Ward (51)

Human Resources Director

Qualifications: MSc Organisation Behaviour, BSc Biology, Postgraduate Diploma in Personnel Management/CIPD

Joined in 2006

Guy Blomfield (42)

Group Strategy and Commercial Director

Qualifications: BA (Hons) Accounting and Finance, MSc Corporate Finance

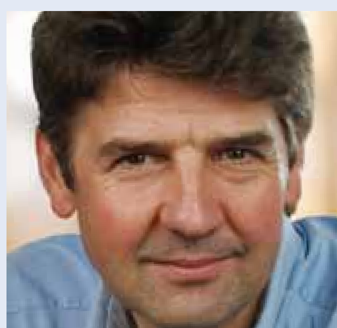
Joined in 2007

John Von Klemperer (61)

Managing Director Hospital Operations

Qualifications: EDP (Wits)

Joined in 2006



Stephen Collier (52)

General Counsel

Qualifications: Barrister; LLB (Hons), LLM, Dip AL

Joined in 1982

Duncan Empey (63)

Group Medical Director

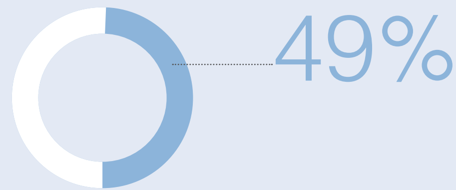
Qualifications: MB, BS, LRCP, MRCS, MRCP, FRCP

Joined in 2008

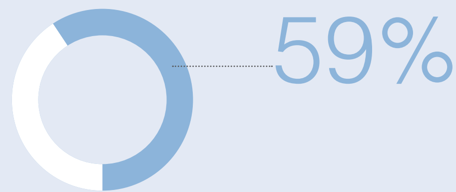
Operational highlights

- 7.8% growth in overall caseload
- Increased NHS volumes
- Four sites added – two hospitals, a radiosurgery centre and a primary care centre
- Primary care team established in BMI to build strong relationships with GPs
- "GP hotline" launched for easy referral of patients to a BMI hospital
- Delivered over 2 000 days of management leadership and commercial development programmes for middle management

Contribution to Group revenue

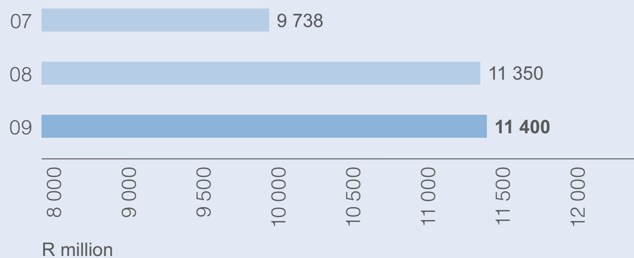


Contribution to Group operating profit

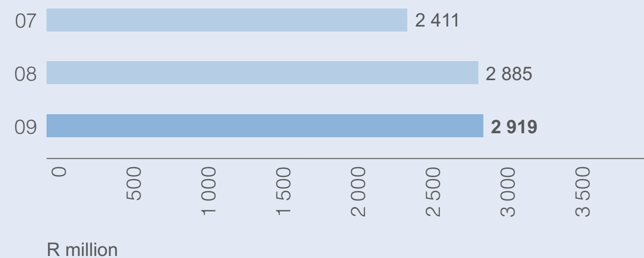


Financial highlights

Revenue



EBITDA



Rm	**2009**	2008	% change
Revenue	**11 400**	11 350	0.4
EBITDA	**2 919**	2 885	1.2
Operating profit	**2 048**	1 979	3.5
EBITDA margin (%)	**25.6**	25.4	
Operating profit margin (%)	**18.0**	17.4	
Capital expenditure	**525**	553	(5.1)

Healthcare sector and regulatory overview

Healthcare sector overview

The independent private sector continues to play an important role in the delivery of healthcare in the United Kingdom (UK). The National Health Service (NHS) provides both primary and secondary care, including accident and emergency services, and general practitioners (GPs) act as the gateway to both the NHS and independent hospitals for outpatient services, diagnostic testing and elective procedures. NHS expenditure in the year to April 2009 was approximately £120 billion, and expenditure in the private acute sector (including NHS spend) has been estimated at about £6.5 billion[1]. Compared to many European countries the independent sector in the UK is relatively small and there is considerable opportunity for growth, particularly as NHS spending is constrained due to government financial pressures.

Consolidation in the independent sector continued in 2008/2009, with General Healthcare Group (GHG) acquiring two more hospitals, thereby extending its position as the leading private operator in the UK under the BMI Healthcare (BMI) brand.

Details[2] for the four major providers in the UK at mid 2009 are:

	Number of hospitals	Number of beds
BMI Healthcare	60[3]	2 706
Spire Healthcare	36	1 633
Nuffield hospitals	32	1 319
Ramsay Health Care	34[3]	988

In the UK, most private medical services are procured through private medical insurance (PMI) or self-funded "Trust" schemes[4], with an estimated 12.3%[5] of the population covered. Despite significant increases in real terms in NHS expenditure since 2002 and material reductions in NHS waiting times for elective treatments, the PMI market has proven to be reasonably robust and has maintained coverage of above 12% of the population.

Direct patient payment (self-pay) and the NHS make up the balance of procured healthcare services in the independent sector. The NHS is progressing in its reforms to provide patients with a choice of hospital when they are referred for acute care by their GP. This is being achieved through the Choose and Book (C&B) programme, which is based on a standard tariff and includes any participating independent and NHS provider under the "Any Willing Provider" programme. While still in its infancy, C&B is viewed as the key to delivering efficiency and enhancing value for money in public healthcare provision.

Private medical insurance

The PMI market in the UK is dominated by Bupa and Axa PPP healthcare; together they cover over 65%[6] of the market with a combination of insurance and self-insured corporate medical expense schemes. New entrants, such as Pru Health (part owned by Discovery Holdings) and Simply Health, are seen to be driving innovation in the sector. Pru Health has grown rapidly and now represents 2.5% of the market, demonstrating that new entrants are capable both of winning market share and growing the total market size.

1 *Laing & Buisson, Laing's Healthcare Market Review, 2009-2010, Table 2.1.*
2 *Laing & Buisson, Laing's Healthcare Market Review, 2009-2010, Table 2.8.*
3 *Including Independent Sector Treatment Centres.*
4 *Similar to medical aids in South Africa.*
5 *Laing & Buisson, Laing's Healthcare Market Review, 2009-2010, Figure 3.7, and narrative.*
6 *Laing and Buisson, Laing's Healthcare Market Review, 2009-2010, Table 3.12 and narrative.*

Despite annual NHS expenditure increasing by £26.3 billion over the last four years, the wider PMI market has grown to cover approximately 7.5 million lives. In 2008, PMI revenues grew above the rate of inflation, rising by 7% to £3.6 billion, above the growth rates for the previous two years at 4.9% (2006) and 4.1% (2007).

Year	Lives covered at 31 December (000)	PMI revenues[7] £m
2004	6 518	3 019
2005	6 474	3 109
2006	6 406	3 239
2007	6 468	3 392
2008	6 366	3 640

NHS budget growth has significantly slowed over the last four years, from an average of 7% per annum in real terms to 4% in 2008. This decline provides the independent sector with an opportunity to fill the funding gap and despite macroeconomic uncertainties, the fundamentals of the healthcare sector remain positive for the PMI market. The demands of an ageing population and a declining NHS budget in real terms should counteract the impact of a slowing UK economy.

Self-pay

Although dwarfed by PMI expenditure, the self-pay market is important for the independent sector, which continues to differentiate its patient proposition from the NHS.

Increasingly, the NHS policy is to refer patients to a department as opposed to an individual consultant. The independent sector typically excels at providing paying patients with a choice of consultant and quicker, more convenient appointment times. While there has been significant improvement in NHS waiting times, a choice of consultant remains an important private sector differentiator.

The NHS has also experienced setbacks in service standards, for example in controlling hospital acquired infections (notably MRSA and Clostridium difficile), whereas the independent sector's standards remain impressive, further differentiating our offering.

The self-pay market also has access to treatments that are not traditionally covered by medical insurance or adequately covered by the NHS, including cosmetic surgery, weight loss surgery and fertility treatment (IVF). Over half of IVF treatments in the UK are provided by the independent sector. Within this field, BMI is the market leader with these services offered in certain BMI hospitals and through a joint venture that offers dedicated IVF units.

NHS

A cornerstone of NHS reform is for GPs to provide patients with a choice of hospitals for elective treatments. This is facilitated by a national IT infrastructure and a standard procedure fee. The independent sector has been encouraged to join the C&B programme, and all BMI hospitals in England are now registered to participate. BMI is being selective in the work it is taking on from the NHS; we believe that active management will provide a real opportunity for further growth. However, BMI will continue to focus primarily on private PMI and self-pay patients.

7 The figures have been recalculated back to 1992 by Laing and Buisson. Data does not include employer self-insured Trust schemes.

Regulatory overview

The principal regulator for BMI hospitals in England is the newly formed Care Quality Commission (CQC). In April 2009, the CQC took over the regulation of all health and social care across both the independent and state sectors in England. There are parallel arrangements in place for GHG's three hospitals in Scotland, through the Scottish Care Commission, and one hospital in Wales, through the Health Inspectorate for Wales.

In England, where most of BMI's hospitals are located, the CQC has taken over the functions of the Healthcare Commission and the Commission for Social Care Inspection, and both commissions have now been dissolved. Formal regulation of the NHS by the CQC will commence in April 2010, and so currently, while the form of inspection visits and reporting is similar across both private and NHS hospitals, the standards against which compliance is measured are different. The CQC is working hard to develop a consistent approach across its inspectorate, but the regulatory regimes will only be converged in 2011.

Good working relations have already been established with the new regulator, and it seems that the constructive approach followed by CQC's predecessor is being continued. A number of GHG staff are working on sector-wide initiatives with the CQC to help set performance standards, which will form the basis for the new regulatory regime to be applied from 2011. There is a shift to a regime based on self-regulation with a lower frequency of on-site inspections by the CQC.

The CQC will use a broad range of criteria to determine whether inspections are required. Risk assessments and scoring will be based on self-assessment submissions, self-inspection reports and quarterly submissions of clinical indicator data provided by the hospitals. Inspection reports by other regulators and any serious incidents or complaints received will also be considered. GHG requires that a programme of self-inspection is performed every six months; internal reviews are generated by a dedicated Quality and Risk team that report directly to the corporate office, and these are submitted to the CQC. The move to a more self-regulated environment plays to one of GHG hospitals' key strengths – the high standards of quality and safety that we consistently achieve.

GHG has just published its first set of Quality Accounts. These will be mandatory from 2010, but management felt it important to move early on this initiative to demonstrate to the market the quality standards we have achieved. The Quality Accounts summarise BMI's activities and successes against three quality domains: safety, effectiveness and patient experience.

At the same time, the healthcare sector is working closely with representatives from the NHS to develop standards for a range of measures of clinical performance, including clinical outcomes. Over the last year, agreement has been reached on a number of these indicators, a reporting structure has been negotiated and put in place, and data collection and transmission systems are being created. This is a long-term project, with initial reporting expected to begin in 2010.

United Kingdom operating review

Our business

Netcare owns a 50.1% stake in General Healthcare Group (GHG), the largest provider of private acute care in the United Kingdom (UK). Under the BMI hospitals brand, GHG operates a national network of 57 hospitals across the UK, comprising 2 894 registered beds, 152 theatres and 37 pharmacies. During the 2009 financial year, BMI hospitals admitted more than 260 000 patients and attended to over 1.1 million outpatients. Through Netcare UK, GHG is also an established independent service provider to the NHS, operating two surgical centres and a Commuter Walk-in Centre.

GHG has strengthened its position as the leading private healthcare provider in the UK by broadening its geographical coverage and improving its performance through various acquisitions. In October 2008, GHG acquired the Thornbury Radiosurgery Centre in Sheffield, City Medical in Central London and Woodlands Hospital in Darlington. Fitzroy Square Hospital (previously St Luke's Hospital) in Central London was acquired in April 2009.

The Thornbury Radiosurgery Centre is a joint venture between GHG and the Centre's consultants. It provides cutting edge non-invasive brain surgery for a range of conditions. City Medical is a consultation and general surgery centre serving as a satellite unit to GHG's London hospitals. Woodlands Hospital is a 38-bed acute hospital and services a key geographical area within our hospital network. Fitzroy Square has 38 beds and eight consulting rooms as well as a major and minor operating centre. It will improve accessibility for consultants and patients who spend most of their time in London.

Almost 90% of the UK population now lives less than an hour from a BMI facility and we are beginning to see the real benefits of our national coverage and scale.

Review of the year

GHG has delivered strong results reflecting continued healthcare demand despite the economic uncertainty brought about by the global economic downturn.

Overall caseload grew 7.8% year-on-year, reflecting both organic growth and the acquisitions noted above. There was a shift in the case mix with good growth in NHS patients, offsetting some declines in the self-pay market. Private Medical Insurance (PMI) patients remained stable on a same-site basis. The NHS is expected to remain a key partner now that the national Choose and Book (C&B) programme has been introduced. This programme lets the public select private facilities for their NHS treatments, assisted by their general practitioners (GPs).

Netcare UK continues to successfully service existing Independent Sector Treatment Centre (ISTC) contracts. These include the Greater Manchester Surgical Centre (GMSC), the Commuter Walk-in Centre in Leeds (which treated over 30 000 patients during the year) and the surgical initiative with the Scottish NHS in Stracathro. The five-year ophthalmic contract to provide 44 000 cataract operations was successfully completed in April 2009. The surgical initiative with the Scottish NHS and the GMSC contact will end in January 2010 and May 2010 respectively.

Revenue increased 7.6% to £831.5 million (2008: £772.6 million). Due to the lower average ZAR:GPB exchange rate in the period, rand denominated revenue increased marginally to R11 400 million (2008: R11 350 million).

The EBITDA margin increased from 25.3% to 25.6%, translating into an 8.9% increase in EBITDA to £213.1 million (2008: £195.7 million). However, rand denominated EBITDA increased by 1.2% to R2 919 million (R2 885 million) due to exchange rate fluctuations. Ongoing efficiency initiatives during the year ensured that the shift in case mix did not adversely affect the EBITDA margin. The integration of the seven hospitals acquired from Nuffield in February 2008 and the contributions from the 2009 acquisitions allowed the business to achieve further cost efficiencies. Profit after tax was £16.0 million (R237 million), an increase of 44.1% year-on-year.

The change in case mix from self-pay (payment upfront) to NHS (payment over 100 days) required an additional investment in working capital, which negatively affected GHG's closing cash position. During the year, working capital was further affected by catching up on payments to creditors to address the backlog built up during the introduction of the shared service centre in 2008.

GHG continued to improve the infrastructure of the business, with capital expenditure (including intangible assets) amounting to £46.5 million (R653 million) for the year. This included a major refurbishment of 25 hospital reception areas and 30 wards, the acquisition of industry-leading scanning and imaging equipment, and the implementation of business-enabling IT systems.

BMI is proud to be able to claim that we are "The Consultants Choice", with more consultants choosing to work in BMI hospitals than any other independent provider. A primary care team has been established in BMI to build strong relationships with GPs who are pivotal in referring patients to BMI consultants. The team will focus on promoting BMI's consultants and hospital services, and will engage with GPs and practice managers to actively increase patient referrals to BMI hospitals. The primary care team will also support consultants in networking with local GPs.

12 BMI hospitals were listed in the Nursing Times Top 100 and individual staff received a number of employment, leadership and management awards. The business has doubled its spend on staff training over the last three years and will continue to increase its investment in this critical area in the coming year.

During the year, GHG was one of the first independent operators to publish Quality Accounts to communicate publicly our excellent patient satisfaction levels, clinical outcomes and rigorous management of infection control in our facilities.

Prospects

Our focus for 2010 and beyond remains investment in our asset base and service provision, and on maintaining and further improving facilities.

In the short-term we anticipate that recessionary pressures will subdue the growth of PMI and self-pay spending on private healthcare, but this is likely to be largely offset by growth in NHS activity. However, the underlying fundamentals of the UK private healthcare sector remain intact, with NHS budgetary pressures likely to increase demand for private facilities. GHG is well positioned to make progress in the current market and increasingly well positioned to benefit from an economic upturn.

Adrian Fawcett

Chief Executive Officer

Hospital	Registered beds
Scotland Region	**203**
Albyn Hospital	44
Fernbrae Hospital	20
Ross Hall Hospital	101
Woodlands	38
North West Region	**368**
The Alexandra Hospital	170
The Beardwood Hospital	31
The Beaumont Hospital	34
The Highfield Hospital	57
The Lancaster Hospital	27
The South Cheshire Private Hospital	32
Victoria Park Hospital	17
North Central Region	**273**
Chatsworth Suite[1]	16
The Duchy Hospital	27
The Huddersfield Hospital	29
The Lincoln Hospital	32
The Park Hospital	92
Thornbury Hospital	77
West Midlands Region	**362**
The Edgbaston Hospital	55
St Edmunds Hospital	40
The Droitwich Private Hospital[2]	46
The Foscote Hospital[1]	16
Meriden Hospital[3]	52
The Priory Hospital[2]	118
The Sandringham Hospital[3]	35
South Midlands Region	**236**
The Chiltern Hospital	66
The Manor Hospital	23
The Saxon Clinic	40
Three Shires Hospital[1]	54
Oxford Clinic	22
The Shelburne Hospital[3]	31
London Region	**491**
Bishops Wood Hospital[3]	42
Fitzroy Square Hospital	16
The Blackheath Hospital	69
The Clementine Churchill Hospital	141
The Garden Hospital	30
The London Independent Hospital	80
The Kings Oak Hospital[3]	52
The Cavell Hospital	45
The Sloane Hospital	32
South Central Region	**287**
The Hampshire Clinic	65
The Mount Alvernia Hospital	90
The Princess Margaret Hospital	80
The Runnymede Hospital[3]	52

Hospital	Registered beds
South East Region	**379**
The Chaucer Hospital	60
Fawkham Manor Hospital	39
Chelsfield Park Hospital	50
The Esperance Private Hospital	50
Goring Hall Hospital	52
Mcindoe Surgical Centre[1]	30
Shirley Oaks Hospital	50
The Somerfield Hospital	48
South West Region	**279**
The Bath Clinic	75
The Harbour Hospital	40
The Ridgeway Hospital	50
Sarum Road Hospital	48
Werndale Private Hospital	28
The Winterbourne Hospital[2]	38
Total	**2 878**

1 Hospital operated under management contract.
2 Core hospitals held under long-term lease.
3 NHS Partnership hospitals.

UK hospitals