Ramsay Health Care

26th August 2021

Ramsay Health Care – FY21 Final Results Webcast Q&A transcript

Our first question is from Lyanne Harrison of Bank of America.

Lyanne Harrison: (Bank of America, Analyst) Good morning, Craig. Good morning, Martyn. Thank you to you and your team for all the work you're doing on the frontline for COVID. Can we start with the New South Wales hospital situation? Obviously, lots going on there. Can you give us a sense of for those seven greater Sydney hospitals what you're seeing in terms of surgical activity that's currently being permitted under current restrictions, and then also is there any possibility for some of those restricted elective surgeries or non-essential elective surgeries to be transferred to some of your other hospitals?

Craig McNally: Thanks, Lyanne. Look, it's early days. The restrictions only came in place on Monday of this week and so ostensibly the restrictions are getting back to where we were last year with only the category 1 and category 2 urgent procedures to be undertaken across what is 20-odd hospitals across Sydney are under those restrictions. There's a few exceptions, so you're still allowed to do colonoscopy, so the intent of it is to create capacity that might be required by the broader system and to make staff available.

Now, we've made staff available to New South Wales Health for the past couple of months anyway, so I will say it's a bit frustrating because I'm not sure it's achieving what it needs to achieve. So, it's too early to determine the impact. It's only been three days of activity and so lots of bookwork was still happening anyway. The length of the restrictions are unknown, so I can't give you much more guidance than that, unfortunately.

Lyanne Harrison: (Bank of America, Analyst) Okay. Can you talk us through a little bit about the staff that are supporting or being transferred to support the New South Wales government on this? What proportion of your staff are assisting and at what sort of levels? Are they largely nursing staff that are being transferred?

Craig McNally: Yes, they are largely nursing staff, and as I said in the speech, about 300 staff so far have been seconded to New South Wales Health.

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principally around vaccination, so the Homebush Vaccination Hub, there's quite a number of staff – and they're all nursing staff – quite a number of staff seconded there.

We'll continue to support the vaccination drive in not just New South Wales but across the country where we can, so it's important and it's a clear message that everyone is sending but I'll send it as well: vaccination is critical, and so we'll support that as much as we possibly can.

Lyanne Harrison: (Bank of America, Analyst) Okay. Just one final question from me is with the Victorian cases increasing, what conversations are you having with the Victorian State government I guess in preparation for a New South Wales-like situation?

Craig McNally: Yes, the dialogue with Victoria is – I won't say intense, but it's quite regular at the moment, looking at what the options will be. Victoria's taken the view at the moment that they don't see a need to put surgical restrictions in place, but that's obviously a fluid situation depending on case numbers of COVID patients. But we're in constant communication with the Victorian government.

Lyanne Harrison: (Bank of America, Analyst) Great, thank you very much.

Craig McNally: You're welcome.

Andrew Goodsall: (MST Marquee, Analyst) Thanks very much for taking my questions. I was just interested in the UK and besides the times where you've had those isolation events, I'm wondering whether you've seen any periods in the UK where you've just been able to operate as normal? What I'm trying to do here is I guess just understand if the UK is a vanguard for what Australia or other countries are going to look like post-vax with a bit of COVID still in circulation.

Craig McNally: I think the interesting thing for the UK – so they had Freedom Day a month or so ago but as I pointed out in the speech, what subsequently has happened with the NHS contact app and what was colloquially called the pingdemic with people having to go into isolation if they were pinged, you didn't really get a normal response then in the business through July.

It's gone into holidays and coming out of holidays and so the anticipation is that with the relaxation, particularly around healthcare staff on the 10-day isolation issue, capacity will be there and we'll start to see volumes flowing back into the system again. So, again, it's a longer-term perspective on what the growth in the UK will be but I think as we called out earlier in the year, a bumpy start to the year was anticipated.

Andrew Goodsall: (MST Marquee, Analyst) If you had to – I know it's a bit crystal balling, but if you had to say, well, back from holidays, back to normal, are we talking 90% back to normal, 95%? Obviously, [unclear] …

Craig McNally: I won't crystal ball, Andrew, but I think what we see is a lot of engagement with the NHS and government and the NHS is still looking at how it structures itself to deal with particularly the issue of the long-term reduction in the waiting lists, but the key to that – and look, leading up to the current position we saw faster growth back in private patients and self-pay patients, so [unclear] patients and self-pay patients.

So, the key to the NHS volume increasing and getting back to whatever number that will be is just the mechanisms to get that money flowing because the demand [now we're seeing], no question.

Andrew Goodsall: (MST Marquee, Analyst) I know you called out Victoria 90-day lockdown at a $70 million hit, if you think about where New South Wales is, what proportion of shutdown of surgery are we at relative to that one? Because that was a pretty much – I won't say 100 but it was pretty much just cat 1, wasn't it?

Craig McNally: Yes, well, it was a bit more cat 1 and urgent cat 2. Remembering that – without getting into semantics about this – the private hospital system doesn't use the categorisation system that the public hospital – so it's effectively urgent work, work that patients will deteriorate if they're not treated within 30 days, et cetera, so there's a few definitions that sit around those criteria, obviously.

Victoria in that period, in the 90-day lockdown, it was a similar situation to the original restrictions that we saw generally across the country in the first half of calendar '20, so I don't have in my mind clearly what that percentage of surgical

work was. But if it's consistent, it would be in the range of – you're getting 30% to 40% of your surgical activity through that cat 1 and urgent cat 2 category.

Andrew Goodsall: (MST Marquee, Analyst) I'll try and [back stop] but I know we're talking all big picture at the moment. Then the final one from me is how you're thinking about '23? '22's clearly another transition and we've just got to get through it, but are you feeling just generally there's potential of more clear air by '23, just the way things are tracking? I know it's a big picture one but…

Craig McNally: It's important to try and understand and I think as I've called out a few times that vaccination rates will be important to getting back to some sort of sense of normality, just not for our business but for the country in general, but it applies equally to our business.

So, on the assumption that vaccination rates in all of our countries – and Australia's lagging a bit behind where we are in our European markets, for example – then we're certainly optimistic about what '23 and beyond holds. You see that reflected in the investments we're making in Australia, for example.

Clearly, we've upped the level of investment that we're making into the Australian business from what it has been historically over the last decade, and we see that level – as again, I've pointed out in the presentation that we see that increased level of investment being sustained for a number of years. So, that's just an indication of our optimism for what we see post the COVID consequences.

Andrew Goodsall: (MST Marquee, Analyst) That's great, thank you very much. Appreciate it.

Operator: Your next question is from Gretel Janu of Credit Suisse. Please go ahead.

Gretel Janu: (Credit Suisse, Analyst) Thanks. Good morning, everyone. So, firstly just on Australia, it's clear that Victoria took a long time to catch up to the other states post its extended lockdown last year. I guess as we look towards what's happening at the moment in New South Wales and Victoria, should we be expecting a very slow [start to] recovery as well? Just trying to understand what happened in Victoria last year and whether it potentially would be applied here.

Craig McNally: Yes, look, my view as you're probably all aware has always been that that recovery is slower and longer than maybe people would have anticipated, that it'd all come back quickly. I mean, what we saw last time when we go back to July '20, really, you see a peak once restrictions are lifted, so a quick peak, and that was for a month in that period, and then it settled back down to a premium level of activity but at a lower level than the peak, obviously.

So, I think that's the same, that's the trend we'll see as we come out of the lockdowns and restrictions that we're in.

Gretel Janu: (Credit Suisse, Analyst) Understood. Then just moving on to the UK. So, with the Spire acquisition, you wanted to gain greater mix towards the private business, so now that you've moved out on that, what is the strategy here to try to improve that mix towards more private? Is that part of the reason for the increased CapEx in the UK, is to grow more organically into that private payer mix?

Craig McNally: Irrespective of Spire – and certainly we were disappointed when the shareholder vote from a couple of the shareholders didn't go for us, but irrespective of that, the strategy in the UK has been growing the private insurance and self-pay business itself.

So, we've got things in place and we saw accelerated growth in the private over the last year anyway, so even without the capacity that a Spire portfolio would have brought to us, we'll continue to grow the private part of our business in the business that we currently have.

Gretel Janu: (Credit Suisse, Analyst) Understood. Then at the time the Spire acquisition as well was announced, you mentioned that you were doing a strategic review, potentially looking at sale and leaseback, sale of some joint venture assets. Is this still on the cards and should we be expecting any further announcements on this?

Martyn Roberts: Yes, I can answer that, Gretel. So, we obviously did do that review and continue to look at all of our investments wherever they are, but clearly the urgency is probably not there given the Spire transaction hasn't happened but we're continually reviewing where we're invested. We've been

reviewing our property portfolio to see what opportunities there are there. There's nothing imminent but it's continually under review.

Gretel Janu: (Credit Suisse, Analyst) Understood, thanks very much.

Operator: Your next question is from Sean Laaman of Morgan Stanley. Please go ahead.

Sean Laaman: (Morgan Stanley, Analyst) Thank you. Good morning, Craig. Good morning, Martyn. Hope you're both well. First thing to say, just thanks for the increased disclosures. It really helps us a lot. With respect to the leverage within the business overall, I was just wondering, since the Spire deal didn't proceed, is that what has reshaped your thinking or has it reshaped your thinking on spending on brownfields in Australia, just to square that one away?

Craig McNally: The investment profile for Australia didn't come about as a result of the Spire transaction not happening. It's been worked through for the last nine or 12 months in great detail, so we intended to do that regardless of the Spire acquisition.

Sean Laaman: (Morgan Stanley, Analyst) Right, thanks, Craig. Then just on some of non-surgical pieces like psych, rehab and the like, is there a view that some of those might remain more permanently depressed as a result of COVID? Has there been a change of business practices associated with some of those services taking a little longer to spring back, or do you just think it's a matter of time?

Craig McNally: Look, I could say I'm depressed, but I'm not. There has been some changes in some of the clinical models. Not materially at the end of the day, but there's certainly no question that some of the models of care have been tweaked, particularly when we're looking at day patients. We talked about – rehab's always called out, that mobile, generally healthy, orthopaedic rehab cohort of patients has been declining for a number of years and it's probably accelerated through COVID.

But I think most of it – and when we look at our non-surgical profile of activity, most of it's come back and come back strongly. The exceptions would be the inpatient medical cohort and that's directly a result of people being isolated and social distancing where respiratory infections haven't been strong, no flu season,

as an example. So, that inpatient medical cohort's been slow and day psych has been slower to recover as well and that's a partly social distancing issue.

But other than that, whilst the rate of recovery is certainly slower than surgical work, it has recovered and so leading up to the end of the year when we look at the last quarter and look at that non-surgical activity, we were pretty positive about where it was getting to.

Sean Laaman: (Morgan Stanley, Analyst) Cool, thanks, Craig. If I could just get a comment – we know that – if you're able to – we know that Medibank's promoting this – promoting might be the wrong word – this short stay no gap joint replacement surgery and they talked yesterday how they've signed a bunch of contracts with hospitals, they're developing a short stay facility in Kew.

We understand some of the insurers are thinking down the same lines. I'm wondering if I could just get your very high-level thoughts on that as an opportunity.

Craig McNally: Look, I think [you've got to] put it in context. So, on day surgery, you'll cut through the APRA numbers and you saw the growth in day surgery activity over the last 12 months. We've got about 27% market share in day surgery in Australia. The aggregate of all the standalone day surgery in Australia have 21% and so there's that relativity.

Our day surgical work has grown – oh, it's about 13.5% to 14% in that period where the standalone day surgeries have grown at about – I think they were about 10.7% or 10.9%. So, in terms of any material issue, it's not going to be significant on us. I think the bigger issue in that vertical integration model is really about where it heads in terms of a managed care issue and that's a whole different issue.

Not a great direct impact on us. We're big enough and ugly enough to look after ourselves in that respect, but I think where you see doctors who are interested in that model – and I'll come back and circle around the out-of-pocket piece – they tend to be doctors who are relatively young and who are trying to establish their practices, or they're at the end of their career and looking at some sort of equity bonus at the end of that in participating in those models.

The vast majority – I'm going to say it's 100-fold more than the people that are interested – the vast majority have a real concern about the model and that it's just the thin end of the wedge in terms of clinical decisions being made for financial reasons rather than clinical reasons. So, when I look at the big picture of it I'm certainly not concerned from a Ramsay perspective as I said, but there'll be a lot to play out, particularly from the doctor community, not so much in the hospitals, in the way that will be effective.

But again, back in context, we currently have 27% of the day surgery market in Australia, a really strong position. Day surgery is about 62%, 63% of our procedural activity. That hasn't changed much over the last five years or more, so I just don't see it as material.

Sean Laaman: (Morgan Stanley, Analyst) Great, I appreciate your answer, Craig. Take care. Thanks.

Operator: Your next question is from David Bailey of Macquarie. Please go ahead.

David Bailey: (Macquarie, Analyst) Yes, thanks very much. Morning, everyone. Just firstly on Capio, I was just wondering if you can quantify where those synergies ended up and any details as to where the additional benefits came from. I saw the commentary from Santé saying there was a bit of [a beat] in their result this morning.

Craig McNally: Yes, we're pretty pleased the whole integration of Capio into the business. The synergy benefits that came through have been much better than we thought. They were a bit delayed as we said last year because of the impact of COVID on volumes and some of those synergy benefits are obviously [unclear] related when you particularly look at procurement.

But they're across the board, to be honest. Procurement benefits are certainly part of that. More efficiencies and some alignment of practice has enabled us to get additional benefits. Without breaking it down into its great detail, it is across the board.

David Bailey: (Macquarie, Analyst) In terms of the magnitude of the euro amount?

Craig McNally: Can't tell you that.

David Bailey: (Macquarie, Analyst) All right.

Craig McNally: But it is certainly much better than the €20 million we forecast.

David Bailey: (Macquarie, Analyst) Yes, okay. Some comments in the presentation as well, just about moving into JVs and new services and also adjacent services. Are there any specific areas of focus or any regions you might be able to highlight or expand upon there?

Craig McNally: It's a longer-term strategy for us and across all regions, the regions are looking at how they can supplement the hospital business with out-of-hospital services. That applies in every region, I'm going to say. We've talked previously about the Scandinavian model being a lot more out-of-hospital than hospital based, but when we look at France, France have got some initiatives around primary care. Australia's got initiatives around outpatient rehab, home rehab, home care generally integration, more integration of the pharmacy business. So they're all important parts of the total integrated service, but as yet they're not material compared to the hospital business itself except for Scandinavia.

David Bailey: (Macquarie, Analyst) Okay and then one just quick - one quick final one; you mentioned once restrictions get eased you a bit of a surge of activity, then growth at the premium rate. I mean, is there any loss to volumes in these sorts of lockdowns that we see in Australia? Do you think people don't come into the system that they would have otherwise, or do you think the majority of the volumes do come back?

Craig McNally: I don't see it any differently than I saw it last year really. That a lot of the non-surgical volume doesn't come back but the vast majority of the surgical volume comes back and it's still unclear about where that level is. Is it 80% or 90%? No one is really sure because we've still got people avoiding accessing the system in the first place. So that premium volume that we've seen in surgical activity outside of lockdowns and restrictions is a combination of the backlog.

But also, we're not really sure what component of the normal activity hasn't entered the system yet either. So it's a hard one to predict, but again, I

emphasise our view is that we just [unclear] that premium activity to deal with the backlog of work in the system coming at a Lowr premium and over a longer period of time.

David Bailey: (Macquarie, Analyst) That’s great. Thanks very much, Craig.

Operator: Your next question is from Saul Hadassin of Barrenjoey Capital. Please go ahead.

Saul Hadassin: (Barrenjoey Capital Partners, Analyst) Thanks. Good morning, Craig, good morning, Martyn. Craig, can I just ask you if I think about the key takeaway from this results for me, it's actually the guidance you've given on that significant uplift in CapEx and as you said over the medium to long term and your, I guess, confidence in the service delivery outlook.

Can you just talk to - can I just push you on, for example, if you look at the growth component off-spend into FY22, can you just give us some sense or better sense strategically of what you are planning to invest that circa $150 million in across those regions?

I know you were asked before, but in terms of specific service delivery types of models, what are you targeting with that spend?

Craig McNally: It's the same trend as we’ve had previously Saul just at a higher level. So again, the proportion shifts from that inpatient capacity to throughput, particularly around operating theatres, day surgery capacity. The investment in day surgery has continued - in our day surgery capacity has continued to climb over the last five years. It will continue to accelerate that way.

More investment in digital capabilities as I mentioned and that's one to - there's many lenses you could have put on a digital strategy, but one of those is operational efficiency. And so we expect to get some benefits out of that investment in the medium term.

So I'm going to say nothing is materially different in terms of the direction that we were pursuing before. So there's not one particular thing we're saying, okay, well let’s stick all our money there now.

Saul Hadassin: (Barrenjoey Capital Partners, Analyst) Sure and Craig, just on the brownfield side then and particularly in Australia, I guess, has anything changed in terms of why the step-up is so material into '22 and beyond by site? Is it just a timing thing that a lot of facilities are reaching capacity at the same time and that's driving it or how have you discovered some new opportunities by site in Australia?

Craig McNally: So timing, Saul. And I think part of that is a sLowr last couple of years in the quantum that's a little bit of catch up on that. But it's also looking at what the broader strategy needs in terms of investment to be able to execute on that strategy and deliver that strategy. And so there's an acceleration of some things that we might have thought were a bit further down the track and maybe that acceleration has been driven by COVID influences to a certain extent.

But it's really saying, okay, well, this is what we saw heading into the future and so let's bring as much of that forward as is reasonable to do. And when I said there was no specific other things, I mean the digital - investment in digital is more than the trend that was occurring before now. So day surgery capacity theatres still dominate the level of that investment.

Saul Hadassin: (Barrenjoey Capital Partners, Analyst) Thanks Craig. And just last one for Martyn on the same CapEx side of the business. Martyn, Ramsay historically had targeted 15% EBIT return on invested capital specifically for brownfields. Does that metric still hold and if not, what do you estimate could be that medium term return on both the brownfield and I guess considering the growth CapEx step-up as well?

Martyn Roberts: Yes, I mean, as Craig said in his speech, our expectation of return on that CapEx is for us to get similar returns than what we've had in the past. So that 15% EBIT return on capital still applies. Now some projects might be year 4 rather than year 3, depending on the strategic nature of them or the ramp up, but that is pretty much the right rule of thumb.

Saul Hadassin: (Barrenjoey Capital Partners, Analyst) Great, okay. Thank you very much guys.

Craig McNally: Thanks.

Steven Wheen: [Jarden, Analyst) Yes, good morning, Craig and Martyn. Can I just ask with regards to the Australian arrangements, in particular in New South Wales what does the viability for capacity guarantee look like today? Is that being addressed more specifically around some of these hospitals that have been identified by the government to take over the capacity?

Craig McNally: I'm not sure I got the gist of that Steve. Can you say that again?

Steven Wheen: (Jarden, Analyst) Yes, the viability capacity guarantee that you've had operating previously, how does that work when they've separately identified only seven hospitals? And do you get some sort of payment or guarantee of costs for those hospitals where they've taken over your capacity?

Craig McNally: Martyn can answer this, but no, the reconciliation of the viability payment, if we indeed need to step into it is in New South Wales by facility. So when you're taking pieces out of the network, it's hard to have the same arrangements we've done previously. So that's the current understanding with New South Wales Health.

Martyn Roberts: Yes, I'll also add as well is obviously the end date, we don't know, but also, we haven't had clarity of the start date either. So whether it starts on 23 August or whether they're going to backdate it, so there's quite a bit of uncertainty there. So it's a little fluid, I'd say.

Steven Wheen: (Jarden, Analyst) But your expectation would be that they would be covering the costs of those individual facilities at that point is that correct?

Martyn Roberts: Correct. Yes, but if you remember last time that the reconciliation worked on a quarterly basis and so that kicked in at the end of March 2020. And we'd made losses in April. But to a large extent, they are offset by profits we made in May and June, and we ended up not claiming very much money from the State Government in the end at all. In fact, in Queensland, we didn't claim any monies. So really, a lot of this does depend on the duration of the program as well.

Steven Wheen: (Jarden, Analyst) Yes, understood. Okay and just with regards to the UK, what's your - the negotiations that you're having with the

government and the NHS, do you have any - when will they be finalising the allocation of funding to that clearing of the backlog?

And do you have any sense as to how it will look, whether it will be spot contracts or an expansion of the Choose and Book program.

Craig McNally: I'm not being evasive, Steve, but I don't know when those arrangements will be concluded but I do anticipate what they'll look like. And they'll be a combination of expansion of Choose and Book and Spot contracting.

But in terms of when they actually formalise the arrangements around the move from the consultation process - I've got to say I'm not being cynical. The consultation process has upped the ante a bit in terms of detail. But they still back the intention with the funding and so that still needs to flow.

Steven Wheen: (Jarden Australia, Analyst) Okay great. And then just lastly, Martyn, you mentioned I guess the momentum around your strategic review has obviously sLowd since Spire fell over. But as part of that process and considering the appetite for REITs to own healthcare assets in particular hospitals, why wouldn't you take advantage of, say, cap rates, which have just come down to extraordinary low levels than they have been historically? Is that an option across some of your more mature assets?

Martyn Roberts: It is an option for sure and it's also an option to fund some of the step-up in cap rates [unclear] as well, which we're reviewing. But I'd say two things on it though, is as you'd imagine with our portfolio, we've got a very low tax base in our portfolio. So we are mindful of the capital gains tax. So that's one issue. And you've also got quite high levels of stamp duty in Queensland, for example. So all those things come into our thinking. Clearly, we've got very low levels of gearing at the moment.

So yes, cap rates are low, but still more expensive than our debt. So all those things come into consideration, but as I said, yes we're still reviewing it. We're still assessing it as an opportunity but there's nothing imminent.

Steven Wheen: (Jarden Australia, Analyst) Right, okay, but I mean, would you - I mean, the cap rates that were previously applied to say Healthscope's assets, which was 5%, I mean, taking advantage of cap rates now at 3.75%,

that has to be an extraordinary recognition of the value that sits or that is currently unrecognised on your balance sheet, around your assets right?

Martyn Roberts: We're certainly aware of the attractiveness of our assets put it that way.

Steven Wheen: (Jarden Australia, Analyst) Yes, okay. Great. Look forward to it.

David Low: (JP Morgan, Analyst) Thanks very much. I'm aware of the time so I'll try to keep it fairly brief. Martyn, could you talk a little bit to working capital and the French situation, if there's anything worth saying there as to how we should think it's likely to play out this year, please?

Martyn Roberts: Yes, no good question. So in the Sante release actually they've highlighted. So the amount that's sitting there on the balance sheet payable to the French governments and it is governments across the various regions is €121 million.

So that's essentially the amount that probably would have to normalise over time. We thought that that would all be pretty much squared away by the time we came to this reporting period, but with the extension of revenue guarantee scheme and continuation of cash advances, that hasn't really happened.

So that's the amount there at the end of June. Will that reduce by [unclear 62:47] December? Hard to say, to be honest, because each of the jurisdictions is treating it slightly differently.

Whether they've been offsetting their normal billings against the receivable or not. But that's the amount that's sitting there on balance sheet at the moment.

David Low: (JP Morgan, Analyst) Okay, thanks and then just I think back to Saul's question, I mean I think as Saul said, their step-up in CapEx is probably the news in this result.

And two questions from me on that. One, you talked about digitisation. Are we talking electronic health records given how expensive they can be? And secondly, can get you to talk a little bit to what's happening in Europe because I think we understand the brownfields reasonably well, but I see the spending in

Europe is going to be matching up with the Aussie spending, according to that slide 15.

Craig McNally: Okay, I'll let Martyn talk about the amounts of money. In terms of the way we [unclear] and just to add to the answer to Saul's question, I guess as well. The opportunities in all the markets are there.

We probably haven't been as transparent in some of the European, Ramsay Sante investments in the past as we're becoming now. But the ability for us to grow what we currently have - and that's along the lines I was talking about - but also we're a dominant provider of some key services where growth will be going forward; mental health, building out - I sort of flagged in the presentation - building out the mental health service profile is important to us in a number of markets. We're the largest provider of oncology services. We've seen significant growth, particularly in France and in Australia around cancer services and we'll continue to invest or increase the investment in that.

And so whilst the brownfield program in Australia is probably the one we've spoken about more than others, there's a brownfield program in the UK. Principally - we're going to say, the majority of that has been focused on increasing day surgery capacity.

In France, it's not dissimilar to Australia in terms of making sure we're better in end to end cancer services, cardiovascular services. We've got some of the best facilities in the world in cardiology and cardiac surgery in France, particularly in Paris. Making sure we build that out.

We're a massive provider of orthopaedic services. So that whole musculoskeletal service line we continue to add to that. And it's building out what we do, but also adding other services that are related to that that make it important.

And so yes, Martyn, you might want to add to that?

Martyn Roberts: No, I think you've covered it, Craig.

David Low: (JP Morgan, Analyst) Sorry, just two last bits. I mean so the CapEx spend in Santé that's going to be funded equally by the partners? I mean it's coming out of their debt.

Craig McNally: Yes, it comes out of Santé as it should.

David Low: (JP Morgan, Analyst) And sorry, you talked about digitisation, I'm a bit wary of how much has been spent on electronic healthcare towards hospitals. I'm just wanting some sense of…

Craig McNally: I didn't mean to avoid answering the question.

Craig McNally: We're not an advocate of those big box EMR solutions. I don't want to name any of the organisations that provide it but we think they're expensive. They're high capital costs. They're really restrictive in terms of the way you can operate. They dictate the way you operate rather than vice versa. So we're looking in a digital strategy, the sort of digitisation of clinical data is important going forward. And so the way we will tackle that is not necessarily a big bang solution.

For the UK we've been rolling out an EMR system there, which is not a big bang solution. And we'll finish that rollout in November this year. So we've got lots of lessons to learn from that and positives.

France has got some digital medical record or clinical data in particular areas. Australia, we don't have the intention to rollout a full scale EMR, but we'll look at the opportunity for those Lowr cost, more agile solutions to that. But it is important that we digitise a lot of our data.

We sit on an enormous amount of data. And so there's a long-term opportunity for us to be able to leverage that data in terms of developing new clinical models, research activities and we're uniquely placed in the global sense, in terms of the diversification of markets we have and diversification and access to patients and digitising or having a digital strategy address that as part of the rationale.

David Low: (JP Morgan, Analyst) Great, thanks very much.

David Stanton: (Jefferies, Analyst) Good morning team and thanks very much for taking my questions. Just a couple of more shorter-term questions and then one longer term question. Look, just put simplistically, you called out the cost, the 90-day lockdown cost in Victoria, or EBIT impact in Victoria was about $70 million. If the lockdown in Sydney continues for three months, and you said Sydney is double Victoria, should we just think $140 million potential impact?

And what are the puts and takes on doubling the EBIT number seen in Victoria please?

Craig McNally: Martyn?

Martyn Roberts: Yes, I can ask that. Look, I mean we're not giving a forecast, that's clear. We're just trying to be helpful to reference people back to what it costs. I mean, the variables of puts and takes on it, as I said earlier are what's the start date and what is the end date?

And then also does it actually end up being just on a facility-by-facility basis. That's what we think it's going to be at this stage, but clearly the risk if the New South Wales Government were to move to take over more hospitals, or it was progressed across the state, then that would be bigger obviously. I mean, those seven hospitals are bigger than Victoria just in themselves. And the whole state is double. So we're just trying to give a few reference points, but I'm afraid you're going to have to draw your own conclusions on that.

David Stanton: (Jefferies, Analyst) No, understood. Sorry, I've missed this, but the whole state is double New South Wales?

Martyn Roberts: Yes.

David Stanton: (Jefferies, Analyst) And Greater Sydney is around the same size of Victoria?

Martyn Roberts: Those seven hospitals by themselves are a little bit bigger than Victoria I think [unclear].

David Stanton: (Jefferies, Analyst) Understood. Thank you. That's clear. And then just if we talk to France and UK again, very quickly, because I'm conscious of time. But it sounds like in France you've got the revenue guarantee and ongoing Nordic - well, in terms of Capio the ongoing Nordic growth, they sound reasonably positive for 2022.

What are the potential negatives we should be thinking about?

Martyn Roberts: Well, I think the risk in France is - assuming we do get the revenue guarantee to December. That's our expectation. But there's been no decree issued yet. But if you recall, the last one didn't get issued until April for

the January to June period. Assuming that happens, the biggest unknown for us then is what does any transition agreement out of that look like?

So if you recall in the UK, there was actually quite a good transitional agreement that ran from January to March that saw us through the period of getting off those government contracts onto normal trading.

We don't know what that's going to look like in France. So that will be a near term risk I would say. And the Nordics, look, they've been trading very well.

One thing I would highlight is in our segment reporting, the provision that we took against the German sale is in the Nordic segment. So the result is actually given the fact we don't have non-core items anymore is a bit misleading when you look at that. So you have to back that out, but the Nordics has been trading very well. The governments have given us, I would say more ad hoc support over there for what's happened.

So it's very hard to say what that looks like going forward, but if things continue to go the way they are, then we're quite confident with our business in the Nordics now going forward.

David Stanton: (Jefferies, Analyst) Okay and would it be fair to say that in the UK the negatives for '22, ongoing COVID impact and no compensation from the NHS. The positives might be gross in privately insured patients coming in?

Martyn Roberts: And also self-pay. We already saw quite a big increase in self-paid customers as well on top of private so yes.

David Stanton: (Jefferies, Analyst) Okay and then finally we noticed your step-up in my favourite topic, brownfield operating theatres going forward. Can you talk to the competitive dynamic here in terms of other Australian operators opening, potentially opening over the near to medium term brownfield operating theatres as well.

I'd just like to understand whether you guys think you'll pick up market share in operating theatres going forward please.

Craig McNally: We're certainly probably better placed than competitors in terms of our financial capacity. So that could certainly indicate that. We're not doing it to capitalise on that necessarily, David. We think as we look at our

portfolio and continue to strengthen the key hospitals in the portfolio, those magnet hospitals where doctors and patients and staff want to be keep generating demand. So we've got to put that capacity in place. Now we always argue that our portfolio of hospitals is the superior portfolio in the country and that provides opportunity.

David Stanton: (Jefferies, Analyst) Understood, thank you.

John Deakin-Bell: (Citi, Analyst) Thanks Craig. Again, conscious of the time. I have two very quick questions. One is just around the rebound in the UK, for example and obviously there's plenty of demand, but how do you get the doctors or the surgeons to work materially more hours to clear that? I mean I'm just trying to understand what do you think a realistic increase over a one or two year period might be in terms of procedures.

Craig McNally: Look, [unclear] I mean part of the reason I've always espoused the theory that the premium levels will be lower and longer. And I don't think the UK is a one- or two-year recovery. I think, we're three, four, five years of that. And so you can only work within the capacity, the workforce capacity that you have putting aside the physical capacity. And you don't want to burn them out too quickly.

So it's not dissimilar in the UK than it is in Australia. I think a difference is the private sector where it's a fee for service arrangement rather than the work they do in the public sector, where their salary drives more efficiency and more volume. So there is a financial incentive for doctors to work in the private sector if the volume is there. But I think it is a longer-term recovery rather than a short, sharp, get it all done.

John Deakin-Bell: (Citi, Analyst) Yes, thank you. And then just secondly, back on Australia and the question of sale and leaseback. I mean it’s obvious that interest rates where they are, that there's no problem with getting someone to buy the assets. But can you just explain to us your view on the strategic imperative of owning your key assets and then having the ability like you're doing now stepping up brownfields when you want to, rather than having to deal with a land [unclear].

Craig McNally: Yes, I'll start on the philosophical perspective I guess, as much as anything else. I mean, we have a mix of leasehold and freehold businesses. Australia is predominantly freehold. Europe is predominantly leasehold. And it all depends on the lease document about how much flexibility you've got, but hospitals are dynamic buildings. They're not office blocks. So the bigger and more complex the campus, the more flexibility, ideally you want.

When you've got a smaller - let's say it's a one or two theatre standalone day surgery facility, it's probably not going to add a lot of change over a medium period of time. So you're probably not as concerned about what the ownership structure of the real estate is there as you would be on a green slopes, for example, where you know you're going to continue to invest.

You're not precluded from it being a leasehold business, but you get more flexibility when you own the freehold obviously. So that's the philosophical position.

And so where you want to have that balance - I mean, we have leasehold assets in Australia and we continue to invest in those. And sometimes the arrangements are we're footing, the bill or others, the landlord is footing the bill and it's [rentalised].

That's the way it is in Europe as well. So we don't have an aversion to it because we have a lot of our hospitals around the world that are in that structure. It's just (1) whether you need to do it and (2) what you're giving up to do it. And what you're giving up, not just short term, but it's really long-term. And you've seen different organisations getting into difficulties about that if they haven't got it structured properly.

John Deakin-Bell: (Citi, Analyst) Great, thanks very much Craig.

Operator: Your next question is from Chris Cooper of Goldman Sachs. Please go ahead.

Chris Cooper: (Goldman Sachs, Analyst) Thanks, Craig and Martyn. Three clarification questions, which hopefully should be quite quick. So Craig, on the resilience of the backlog, you said today you're not seeing any change to your prior expectations. I just wanted to confirm that means you're still seeing north

of 80% of procedures ultimately coming back at some point. I mean, obviously not tomorrow but maybe in the next sort of two or three years.

Sorry to come down on your number but obviously [unclear] rangy point to it in the past and I appreciate you've probably got a lot more data points through the year so far.

Craig McNally: Look, just as a principal I see no change to that going forward. That's…

Craig McNally: Well, we're not really sure about what that number is but…

Chris Cooper: (Goldman Sachs, Analyst) And day patients, I mean it's good that this discussion is moving forward a lot more. You pointed to a 63%, I believe you said of activity in Australia, is done in day patients for your operations here. Presumably less in value terms but as you say, it also grows quicker. So I'm just curious to hear how you're thinking about CapEx in the context of some big investment plans over the coming years here. Are you spending more or less than 63%, your day patient mix on incremental capital expenditure in Australia?

Craig McNally: I'm going to say it's less because that 62% is the proportion of procedural volume. So it's not 62% of our activity of our total activity is day case work. And so when we invest in mental health capacity and services that's not related to day surgery. So I wouldn't line it up that way.

Chris Cooper: (Goldman Sachs, Analyst) Okay, if I was to roughly assume 50/50 between day and more traditional settings, would that be rough ballpark?

Craig McNally: Not necessarily and I'm just thinking about how to give you an answer, that gives you some guidance. No, look, in any single component of the investment, day surgery capacity and theatre capacity are the largest components.

But it's broad now. There's consulting suite developments and that to lock doctors in. There's investment in digital technology, et cetera. So I just wouldn't proportionate it that way.

Chris Cooper: (Citi, Analyst) Okay and the monthly - I believe they're termed COVID related costs are $4 million to $5 million now. So you talked a lot about I

guess the importance of vaccine rollout today. Can I just ask whether that $4 million to $5 million is sensitive to vaccines in any way, or would you advise that we just assume that run rate continues through to the start of fiscal ’23?

Craig McNally: I think the latter is the best assumption, Chris. It does fluctuate from month to month. I mean, when we are not in lockdown situations, we can - we don't need to have the screen at the front of the hospitals taking temperatures, et cetera. But then as soon as there is any kind of activity around, we have to put those people back on again. So it does jump around a bit, but I think that's the kind of the run rate that we anticipate, certainly for the foreseeable future.

Chris Cooper: (Citi, Analyst) Understood. Thanks very much.

David Bailey: (Macquarie, Analyst) Sorry, just one quick follow up; payout ratio is nearly 80% in the fiscal ‘21 result. How should we think about the dividend and dividend payout ratio going forward?

Martyn Roberts: Not necessarily that amount. So as Craig said in his speech, this was really a particular dividend where we wanted to recognise our loyal shareholders that have been with us over the pandemic and it's a pandemic impacted result, so we wanted to pay a dividend back to FY19 levels. It will all depend on what the activity and what our profit looks like in FY22. So the Board will make those deliberations as normal, but you shouldn't necessarily just extrapolate the 79% payout ratio going forward.

Craig McNally: Yes, absolutely not.

David Bailey: (Macquarie Group, Analyst) Thanks guys.

Operator: There are no further questions at this time. I'll now hand the call back to Mr McNally for closing remarks.

Craig McNally: Okay, thanks everybody for taking the time to listen. So have a good day. Bye.

End of Transcript