Ramsay Investor Day | December 10, 2021

Slide 3 Group Strategy Update

I'd like to acknowledge the Gadigal people of the Eora Nation as the traditional custodians of the country we are meeting on today. We recognise their continuing connection to the land and waters, and thank them for protecting this coastline and its ecosystems since time immemorial. We pay our respects to elders past, present, and emerging and extend that respect to all First Nations people present today.

Slide 4 Agenda Day 1

Today, Martin and I are going to outline the overarching strategic direction for the group. That's been refined in conjunction with the board and leaders across the business over the last 18 months. We'll then hand over to the CEO of our Australian business, Carmel Monaghan. And Carmel will run through how these themes will be taken forward by the Australian business. There'll be plenty of opportunity for questions at the end of today's session, with a range of executives from the business. For those in the room, we hope you can also join us for a bite to eat at the end of the session.

Slide 5 Agenda Day 2

On Monday evening, we'll hear from our European CEO, Pascal Roche, and the CEO of our UK business, Dr. Andy Jones. And that will also be followed by a Q&A session.

Slide 6 Ramsay Health Care - Overview

So as many of you know, Ramsay Health Care was founded in 1964 by Paul Ramsay. We were listed in '97, we've grown rapidly, both organically and via acquisitions since that date. The group now delivers a wide range of acute and primary healthcare services, from over 460 locations across 10 countries. From the groups very early days, Paul's mantra of, "If we look after our people, look after our patients, then the business will look after itself." And that's been led by our purpose of people, caring for people. And this has never been more true in today's environment. And it underpins our vision to be a leading healthcare provider of the future, and our mission, to change what is possible for your health, placing the patient at the center of everything we do.

Slide 7 Strengths of the Global Business

The expansion of the group, has created a global business model with strong positions in the delivery of healthcare services in each of the markets we operate in. This scale delivers a number of strengths in areas, including procurement, operational efficiencies, clinical excellence, and research and development. The refinement of our strategy emphasises a greater focus on the areas where we can achieve benefits from our scale, whilst also ensuring that our regions remain salient to the communities in which we operate. We may have noticed that we're not covering our Asian joint venture, Ramsay Sime Darby today, and that simply reflects the time available, and the relative size of the business, but the joint venture does continue to pursue the elements of the strategy that we'll outline today.

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Slide 8 Key Trends Driving Change

The process of advancing our strategy has involved understanding the likely evolution of healthcare systems. And that's drawing from our experiences across regions, and defining a vision for the organisation, including a set of strategic themes and initiatives to prioritise. During this process, a number of key trends were identified as driving the evolution of healthcare landscapes over the longer term. These include changing patient and doctor expectations, particularly around convenience and support across broader pathways, involve digitisation of care, which is driving convenience, continuous and enhanced care coordination. And with a potentially lower cost of delivery. Also, the emergence of new non-traditional data-driven competitors in some parts of the market. And clinical innovation, which continues to drive trends which support both hospital-based services and non-hospital based services. And then the evolution of reimbursement structures and pay a mix with a greater focus on outcomes and value-based models.

Slide 9 Strategy Overview

We believe that Ramsay is uniquely positioned to take advantage of these key trends, building upon our global platform, our enviable culture, and the strategic relationships we have, to become a leading integrated healthcare provider of the future. While hospital-based care is expected to remain at the core of what we do, our vision is to leverage our physical footprint, strong patient and doctor relationships, and clinical expertise to expand along the patient pathway, delivering a more convenient, integrated, and efficient healthcare services platform, and improved health outcomes for our patients. To realise this ambition, and deliver for all our stakeholders, we'll focus on strategically growing our existing market share through organic growth, brown-field and green-field investment, and strategic acquisitions. And leveraging the existing core business to extend our service offering further along the patient pathway, both in and out of hospitals, with everything centered around the patient, and their experience. And we'll explore new funding models, new payers, and enhance existing relationships that have formed over the course of COVID. And while we continue to offer services across all the therapeutic areas, we'll concentrate investment in key areas, including mental health, cancer, cardiology, and orthopedics, and explore the global potential of these services. And then rather than attempting to do this just on our own, and control everything in house, we'll identify partners and partnership models to accelerate the execution of the strategy.

We'll continue to optimise the business processes to drive cost out of the business, optimising local and potential enterprise resources such as research and development and procurement activity, we'll generate the greatest value as we look at the operating model and patient pathways.

Our strategy will be underpinned by focus on critical elements, including digital and data investment, continuing to ensure global standards of clinical care, developing leaders through our leadership programs, and attracting the best talent to deliver on the strategy. All the while, ensuring our Ramsay care sustainability agenda is strong.

Slide 10 World Class Hospital Network

We will continue to drive organic growth from our hospital network, which is expected to be underpinned by the aging demographics in the markets, in which we operate in, and clinical innovation and investment into new healthcare technologies.

We will continue to invest in the size and scale of our core hospital footprint, by brown-field developments, select green-fields, and bolt on acquisitions. Brown-field investment will include making the more accessible, and improve the amenity for doctors and patients, and ensuring that our facilities are designed to meet the changing markets.

Slide 11 New and Adjacent Services

Our move into new and adjacent services will focus on moving along the patient pathway, retaining that relationship, providing coordinated care using our data and digital capabilities, to improve the experience for our patients and clinicians. Digitising the patient and clinical pathway will be an enabler to our success. Delivering more services across a broader range of healthcare settings, will allow us to lead the way in outcome focus integrated care. We also look at potential of new payer models and will seek to influence reforms in value-based models. Each region is at a different phase along this journey, and we will adapt the strategy to suit the local market structure and our current position in the market.

Slide 12 Operational Excellence

We will invest in additional resources in achieving operational excellence, and we'll work more closely across the regions on areas that support the business where we can leverage our scale, including areas of research and development, clinical excellence, and improving patient outcomes. Strategic sourcing will continue to be one of the key areas of focus. And while the strategy has been evolving for some time, we believe there is more that we can do, and that will be to improve our supply chain, minimise risk, and maximise value.

Slide 13 Strong Organisational Foundations

To underpin our strategy and ensure we leverage our scale, we will continue to invest in our key organisational foundations. This will include investing in creating an ecosystem of intelligence, utilising our data and insight, leveraging our understanding of our patients, and work workflow automation. Remaining a leader in clinical excellence, with integrated research and education, and building a high engagement, strong talent proposition, and an enterprise-wide transformational leadership capability. And continuing to develop our organisational capabilities to improve our market intelligence and execution. And we will invest in supporting the delivery of our vision and plan, and put sustainability at the heart of our plan to ensure we continue to attract talent and investment to build resilience.

Slide 14 Digital and Data

Turning to digital and data, which we see as a critical enabler to deliver on our strategy. Be fair to say that at the current time, we have different levels of digital and data maturity across our regions, driven by varying market dynamics, business models, and service priorities. And I'm going to say legacy systems that we have. Overall, Ramsay Sante, and Ramsay Sime Darby are further ahead in digital maturity, in the markets in which we operate, and within Ramsay. Followed by the UK, we've just executed the implementation of electronic patient record system. That's just happened in the last couple of weeks. And then in Australia, we are continuing to invest in discreet areas, such as patient clinician experiences. While we undertake a full scale review, and design the future digital and data strategy. The investment in digital and data across Ramsay, has to date been relatively siloed within the regions. However, there's an appetite to leverage our experience and understanding across the business. While we do not see value in full digital standardisation across the markets, we are exploring our global data options. Given the current investment and existing platforms across the group, we'll adopt a two-pronged approach to our roadmap. A digital, we'll look to benefit from greater cross regional collaboration and partnering. All regions need to build out the full suite of foundational capabilities, and capture quick wins. The more advanced regions can pave the way for others, and this can be achieved through building scalable solutions with interoperability, where it adds value. The data, we have an opportunity to start the journey by taking an enterprise-lead approach. It sets the global strategy and standards for how Ramsay acquire,

consume, store, manage, use, and protect data. This has the potential to be a differentiator for Ramsay as a global operator. We have recently appointed a chief digital and data officer, who just commence at this on Monday this week, and who will lead the program of work in Australia, and will also be responsible for building our global digital and data roadmap.

Slide 15 Industry Leading Talent

Recruitment and retention remains a challenge across healthcare around the world. Ramsay's people strategy is focused on attracting, developing and retaining industry leading talent, to support our growth and culture. The strategy is broadly built under three pillars, developing the capabilities required to deliver our strategy, evolving our culture to ensure it remains salient and foundational, and establishing contemporary and competitive market frameworks to attract industry leading talent.

Slide 15 Industry Leading Talent

We have a range of initiatives to address our global workforce challenges. In the short term, the regions have in place a number of immediate initiatives that they will outline. From a global perspective, we'll work on initiatives that include developing a world-class global employee value-proposition with regional variations to reflect local market conditions. A global EVP will retain the Ramsay way as our bedrock, and we'll evolve our culture through diversity, inclusion, and flexibility. Secondly, formally defining the characteristics of a Ramsay leader. We want to employ people who align with the Ramsay way, and who will ambitiously drive a transformation agenda. And we will establish a formal Ramsay Alumni program with a view to maintaining the candidate pool for rehiring or referrals.

Our longer term priorities include further developing our leadership academy, combining the expertise and strengths of our regional leadership, and trading programs, which would provide attractive global opportunities for Ramsay recruits, and increasing engagement with a range of multi-national industry and academic partners. And investing in global tech platforms, which will allow us to leverage data, to provide insight and support in multi-generational recruitment and retention programs.

Slide 17 Our Sustainability Journey

A Ramsay strategy for sustainability came together with input from Ramsay people across all of our regions. And the strategy comes to life through three expressions of care. Caring for our people, our planet, and our communities. Our goals and targets cover a wide range of social and environmental issues, such as diversity and inclusivity, mental health and wellbeing, reducing our carbon footprint and waste and responsible sourcing across our medical supply chains. Our commitment to sustainability is also embedded in our debt facilities through sustainability-linked loans.

Our strategy contributes to the UN's Sustainable Development Goals, and we have become a participant of the UN Global Compact. We're also part of the Climate Leaders Coalition in Australia. And we have joined the 40:40 Vision, an investor-led initiative to achieve executive gender balance in Australia's largest listed companies. Our future focus is on attracting and retaining industry leading talent, boosting our employees' mental health and wellbeing, reducing our environmental footprint, developing our climate resilience, enhancing our reporting framework and engaging with our supply chain on social and environmental issues. Our global sustainability committee oversees teams in each region to drive our sustainability initiatives and identify risks and opportunities. And that committee will review goals and target on an annual basis.

Slide 18 Healthier People

In our first pillar, people caring for people. We are proud of the progress we've made in maintaining our focus on high quality care and patient experience, with high NPS scores across the regions. We have achieved gender balance, with women representing 40% of senior leaders. And we have invested in a range of programs to develop our people, including nursing apprenticeships and nursing leader programs. This year, we also welcomed our first cohort in the new Global Corporate Graduate program. And we've just completed a global employment engagement survey of our 80,000-strong workforce. In these challenging times we know, the wellbeing of our people is paramount. And we're focused on practical, local, mental health and wellbeing support, and ensuring we recognise our people for their outstanding work.

Slide 19 Thriving Planet

The second pillar, we know that healthcare sector has a significant environmental footprint, and our people are eager to drive sustainable change. Environmental initiatives introduced already include reducing single-use plastics where it's safe to do so, and increased recycling of waste. We acknowledge the importance for the business to be resilient in a changing climate. We are working to understand the short and medium term risks and opportunities across our existing buildings, future developments and supply chains. As part of this, we have commenced aligning our reporting with the task force for climate-related disclosure recommendations. We have set foundational targets to reduce energy use at facility level and help cut our greenhouse gas emission intensity. As part of this, a major investment in solar energy is being rolled out over the next five years across Australia and the UK. The links between climate and health are clear, and we will monitor the longer term implications for our people and patients. To support our approach, greenhouse gas emissions reduction targets have been included in the FY22 scorecards for our executive management.

Slide 20 Stronger Communities

And the third pillar, caring for our community. Ramsay's long held values, motivate us constantly to improve and find new and better ways of caring. That's why we support a wide range of clinical trials and health research aimed at improving the wellbeing of our patients and society as a whole. To be truly sustainable, we cannot work in isolation. So we are focusing and boosting our focus on responsible sourcing. We're developing a global responsible sourcing framework and have recently appointed a global responsible sourcing manager. Our goal is to ensure suppliers that make up 80% of our spend, have an independent sustainability assessment, and we'll work with other suppliers on improving their performance. A focus on sustainability across our value chain will be key in ensuring business resilience to the challenges ahead.

Slide 21 Regional Communities

Now, people have been paramount in championing initiatives in all of our regions. Ramsay wants to take a leading role in the healthcare sector and drive action to deliver more sustainable and reliable healthcare outcomes. Through this, we know that even small changes can make a big difference, and we look forward to updating you on our progress.

Slide 22 Disciplined Transformation

Finally, reflecting the importance we've placed on our updated strategy, we've established a global transformation office, tasked with aligning our regional business transformation strategies, pursuing new business opportunities across the patient journey, and leveraging Ramsay's strengths and expertise to grow our market share. I'm pleased to announce that Dr. Andy Jones, who many of

you'll know, as the CEO of our Ramsay UK business has been appointed our first group chief growth officer with responsibility for Ramsay's strategic transformation agenda. As part of this role, Andy, will also be working on strategic partnerships to support our business. And Andy will work closely with our global heads of digital and data and clinical excellence, our regional CEOs, and leadership teams to progress our strategy. This role will be report directly to me, and be part of the global executive committee. I'll now hand you to our CFO Martin Roberts. We'll speak around capital allocation across the group. Thank you.

Slide 23 Martyn Roberts Group CFO

Thanks so much, Craig. And good morning, everybody. Great to see so many people in-person here and hello to everybody online.

Slide 25 Leverage and Capital Management

Firstly, I thought we'd run through the leverage and capital parameters of the group. Given the consolidated view, doesn't really give you the whole picture. As you can see on this slide, the consolidated group represented in our statutory accounts includes the consolidation of our majority own subsidiary, Ramsay Sante and an after tax accounted contribution from our joint venture Ramsay, Sime Darby.

As you can see on the diagram, the funding group that supports our borrowing capacity, only includes all the Australian and UK subsidiaries other than our retail pharmacy franchisees and UK day hospital joint ventures. And the recent Fitch credit rating that we received only applies to that funding group.

Ramsay Sante have their own debt funding structure and covenants, which are non-recourse to the Ramsay funding group. Investments made by the European region are in the main funded by its own balance sheet. And return hurdles are approved by the senior management team and the Ramsay Sante board, on which Ramsay holds five seats out of 10, including myself and Craig, who is the chair. Larger investments have in the past required the Ramsay funding group and Credit Agricole to inject equity into the Ramsay Sante balance sheet. For example, the Capio acquisition was partly funded by equity injections from ourselves, and Credit Agricole.

Slide 25 Ramsay Consolidated Group Leverage

At the 30th of June this year, our leverage and return metrics were artificially impacted by the money held on Escrow to fund the proposed Spire healthcare transaction. Given the transaction did not proceed, the $1.96 billion in funds held on Escrow have now being repaid back to us. Leverage at the consolidated level on a proforma basis, assuming the Spire transaction was not on foot at the 30th of June, basically was 3.7% compared to 4.4 times in the PCP. There are no restrictions as such on the leverage at the consolidated group level. The ceiling is in effect determined by the covenants that sit within the funding group facilities and within Ramsay Sante's debt facilities.

Slide 26 Ramsay Funding Group Leverage

The funding group leveraged on a proforma basis at 30th of June was 0.7 times below historical levels. FFO adjusted leverage on a proforma basis at 30th of June was 2.39 times below the FFO leverage target of four times that is consistent with the investment grade rating granted earlier this year. The proforma headroom at 30th of June to this ceiling, was $1.4 billion. At the 30th of June, on a proforma basis, the undrawn capacity under the funding group's debt facilities was $2.4 billion. Over the last 12 months, the funding group and Ramsay Sante have commenced the process of

extending the duration, and diversifying the sources of our debt. Over the next 12 months, we expect to take advantage of our investment grade credit rating to go over the public debt markets, refinancing the debt due in FY24 and FY25.

Slide 27 Capital Allocation

Regarding capital allocation. This slide shows our post-tax ROIC earned over the last 10 years at the consolidated group level, based on both a historic core net profit and statutory net profit. These metrics are calculated on a AASB 117 basis for consistency, and the outcome on a AASB 16 basis in FY20 and FY21 footnoted on the slide. The calculation is the same formulas that used in the calculation of the ROIC gateway, and the LTI Awards introduced in FY21. ROIC fell below Ramsay's cost of capital FY20 due to the financial impact of the first wave of COVID, and was impacted again in FY21 due to COVID. We do acknowledge that at the current level, we have significant level of capital available on our balance sheet, and we continue to look at acquisition opportunities across our regions, with the aim of increasing our scale, and returns, and moving into adjacencies to complement the existing footprint of the business consistent with our strategy. We will also continue to assess opportunities for the recycling assets, where this provides shareholder value.

Slide 28 Investment Parameters

Following the introduction of the new leasing standard, AASP 16, we've changed our internal investment parameters for new investments, including brown-fields. We've changed it to a cashflow-based post-tax ROIC metric, which replaces the pre-tax return on capital employed metric used in the past. We also have investment hurdles of an IRR above 10% and EPS accretion. I would note that at the discretion of the Ramsay board, where investments are considered to be strategically important, new investment can have IRR and cashflow less than 10%, but they do need to be above our WACC.

Slide 29 Capital Allocation Capital Expenditure

As we announce that the FY21 four-year results, we expect capital expenditure for the next few years to be elevated above historic levels. Principally, as a result of investment in brown-field developments, particularly in Australia, and other elements of our strategy, including the digital and data strategy that Craig talked about before. The timing of CapEx in particular, brown-field investment may change depending on development approval processes and building schedules. So with that, I'd like to thank you. And now, I hand over to the CEO of our Australian business, Carmel Monaghan, to run through how our strategy translates the Australian business, before we'll then have a break and move on to Q&A, Carmel.

Slide 30 Ramsay Health Care Australia

Thanks Martin. Going to put my timer on because I'll talk too long. Right, thank you. And great to be here with you today to talk about the Ramsay Australian business. And I'm joined here by Doug Meagher, our chief financial officer, who will be on stage later also to answer any of the difficult questions. For those of you who I haven't met, I've been with the company for 23 years. I've been 28 years in healthcare, and this is my first year coming up, just past my anniversary of one year as CEO. And it has been a very interesting time in healthcare. So obviously, interesting time to take over. We've had some significant challenges managing COVID, weekly meetings with our medical advisory committees around the country, fit testing, PPE testing, infection control, as you would imagine, huge amount of regulations coming from state and federal governments, managing COVID patients. Lots of our staff, and I know Craig's talked about it in the past, but about 700 Ramsay staff assisted in New South Wales alone with vaccination hubs. And then we persisted in other states, we went to

Queensland and, tell us how many nurses you need. We will supply them to help vaccinate because we didn't want to see the same elective surgery restrictions we've had in New South Wales and Victoria happen in Queensland. So we've been really at the forefront of assisting in the COVID crisis and that's been a wonderful thing to be able to help. It obviously impacted as you've seen, but it was important for us to do. And as with all adversity, it often makes you discover who you really are. And what we discovered was, what we confirmed was that Ramsay is a really indeed a strong healthcare company. We were sustainable right through. We kept all of our staff employed. We didn't draw down much on the package that was offered, in fact, only $11 million last year. We did a marvelous thing to help the community and we came out stronger for it. In the end, we're a stronger company. We spent the year looking at our strategy as well, and so we didn't lose sight of where we need to go. So we'd spent the year looking at that and that's been a really positive year.

I'm going to go through some of that strategy today. This is a deep dive on the strategy. I'm not going to get too much detail about what's passed because I know you had that update in October. And I'll talk about the current private healthcare dynamics in the country. I've got a lot to get through, so I'm going to talk fast and I'm going to skip some slides and you can come back and ask me questions if there're specific things that I missed for you.

Slide 31 Ramsay Australia

I don't really need to remind you that Ramsay is the largest private hospital operator, obviously in the country. And we've got strong and growing market share in all of our major states. Thanks to good geographic location and constant investment in those facilities through the Brownfield and Greenfield development programs. And we're increasingly operating businesses outside of hospitals as well, so you're aware of our [inaudible 00:30:24] into pharmacy, which has been successful. We've had 60 pharmacies today, community pharmacies and growing, and we have 40 pharmacies within our hospitals dispensing medications. But we also have a big allied health business delivering allied health and psychology services through 32 sites which I'll go through later, and 40 of our sites are now referring to our hospital in the home program through our joint venture with AU.

Slide 32 Strong tract record in earnings growth

Ramsay has a strong record in delivering growth for shareholders. And we've been proud of that, but I'm not going to update you much on quarter one. As I said, you've gone through that suffice to say that in quarter one, we obviously experienced significant financial impacts from COVID. And that continued into October as forecast by Craig and Martin at the quarter one results update. Elective surgery restrictions were lifted in November, so mid-November in Sydney and Victoria's lifted restrictions from 29th of November to the capped rate of 75%, which we think will probably continue through December. So we don't see that coming up.

I know you'd be interested and you're going to ask me later, so I'll preempt that, for December we are seeing increased return obviously to surgery rates and our theater utilisation is up in the 90% mark for New South Wales. So that's good, but it is really too soon to draw any conclusions from that. It's not a trend, it's not a consistent picture across the country. Certainly it's good. We know there's a backlog of surgery. We know surgeons want to operate a lot and we're trying to help that and smooth that way through, but we also expect the situation to remain volatile. And we do have staff fatigue, doctors wanting to take leave. Like all of you, everyone's tired, so we do expect that there'll be some leave taken over December, January. And so the picture is going to remain a bit uncertain for some time to come. On the nonsurgical side, growth spin subdued obviously with the lack of elective surgery as well, which you're aware of.

Slide 33 Industry Trends in Australia

In terms of industry trends in Australia, despite the COVID impacts, the underlying industry fundamentals, aging population, increased chronic disease, obviously are still good. And that's driving the hospitalisations and we'll continue some time to come and you'll see later we're focusing much more in cancer and those areas which are very much growth areas.

We've been pleased that private health insurance has turned around. We've had those five quarters of growth now in private health insurance numbers after 15 quarters of decline. And so that's been a positive trend in all age groups in private health insurance. So that's good. Obviously the pressure on the public sector remains, and we expect that to remain for some time, percentage of elective surgery waiting lists, admitted within clinically appropriate times has dropped over the last few years and that will continue, and that's in all states. Probably the last graph here in the corner at the bottom is a concern for us and we've had negative net migration for a couple of years, and that is going to impact workforce and create a competitive live market and I'll talk to some of the workforce challenges a little later.

Slide 34 Insights from Latest APRA Data

I'm going to skip over this slide and you can ask me questions later, just suffice to say that, as always, Ramsay continues to have favorable market share growth, according to the APRA data in terms of admissions, and that was for the last 12 months to the end of September and in the first quarter with the exception of New South Wales, which was to be expected because we had seven hospitals closed. So obviously we had some unfavorable growth in New South Wales. But generally speaking, very favorable growth and that's ongoing.

Slide 35 Industry Risks and Opportunities

In terms of regulations, we do have, obviously healthcare is a market where there's lots of regulation and that's consistent. There's been no change over 20 years. There's always something happening in healthcare that's new legislation and new areas. I'm not going to go through all of this slide. You can see, read through yourselves as to how we are quite adept at being responsive and we work together with all stakeholders to get the right outcome. A lot of this is covered on other slides, but I will call out the prosthesis reforms, because I know you are interested in that. And we have been working with the government on this for a few months. Everyone wants reduced prosthesis pricing. There's no argument there. So doctors, hospitals, patients, private health insurers, all want to see public pricing in prosthesis. And that's what we've been advocating for. Generally, there's a large prosthesis reforms that Hunts trying to get through. And that's a good thing. And hopefully that leads to premium reduction from private health insurers. And actually a lot of things that Hunts done over the last couple of years have reduced that premium index growth, which you saw on the last slide. So that's been positive. What we were concerned about from private hospital perspective was the general miscellaneous prosthesis reforms, and the idea that the department was pushing to get rid of the general miscellaneous list. We've been advocating to both minister's office and the department and we think the outcome will be positive in that regard, that there will be a pricing mechanism that will look at public reference pricing and we'll work towards a bundle model, which will help with our volume control for the health insurers. So that's the outcome and that's a positive outcome if that's what happens across the prosthesis issue. On everything else, I'll cover those items in future slides.

Slide 36 Infrastructure Overview

Just from an infrastructure point of view, we've had a strong track record in fixing up our facilities. We obviously invest heavily in our facilities. We have 64 hospitals, as you can see on this slide and seven standalone day surgery units and one infusion center. And we continue to invest in those facilities and improving for the experience for private health patients. One of the areas that we've really concentrated on is single room accommodations. That is a really, really important obviously for our customers, and you'll see we've grown up to 81% now, and that includes public hospitals. So if you remove the public hospitals from that, they'd be much higher in the private sector. So we have done really well at doing that.

In terms of regional areas, I've been really pleased that we've invested a lot in regional areas over the last few years, about 30% of our Brownfield spend since 2018 has been in regional areas. And just in the last year, that's jumped quite dramatically. And that reflects the demand in regional Australia. As I travel around to those regional hospitals, we are seeing growth, growth in population. It's one of the differentiators for Ramsay. We started in regional Australia in medical surgical business, and we have a differentiated portfolio in that regional mix and that's a really positive thing. And as we see population growth and doctors wanting to move to regional locations, we'll continue to see investor in those facilities. So from the ground up, we are seeing a lot of investment there.

Slide 37 Admitted Activity: Overview

In terms of activity and what we're seeing in activity, obviously COVID made things more volatile as I've said, and it's difficult to predict going forward, but there's a few things on this slide that are important to call out. We've certainly seen growth in day admission more than overnight, and that's obvious, not unexpected given nonsurgical activity, overnight activity in psych and rehab were really heavily affected through COVID, through visitor restrictions, elective surgery restrictions. So there was no joint replacements going to rehab. And hospitals like our rehab facilities in Illawarra were taken over for the COVID response, Mount Wilga, et cetera. So we fully expected that growth has been less. It's something that is reflected on that slide. Births surged during COVID. And you can see we were up quite a bit in the first quarter, however, forward bookings look like that will normalise in time. So we think births will go back to normal.

On a public admission front, we did experience a 68% increase in public admissions during FY21 on FY19. And we saw increases in mostly our non-traditional markets of New South Wales and Victoria, obviously off a low base, but that's continued into October as well. The public activity under the COVID agreement was done at cost recovery, but the relationships were built. We have built really significant relationships with the public sector, and I think that will continue into the future. We will see more pockets of less public resistance. The public sector actually realised that the private sector exists, and that was a good thing through COVID. We've won a few contracts with up to 50 cardiac surgery cases at Wollongong Private for the public sector. And that's in a very short time and we've had two big mental health contracts that we've won recently as well.

I see that there will be some ongoing discussions with the public sector. We've had positive discussions with Liz Cof and Nick Steel in Queensland, and there is a desire to use the private sector more in small areas. We have to make sure that we continue to differentiate the offering. It's absolutely vital. Private healthcare will still be the main area where we get our business from, but there is the opportunity to look to more public work. And I think that'll be in pockets as I said.

The bottom right graph is interesting and shows that our investment in emergency departments over the last seven years has been the right strategy. You can see that inpatient admissions from our ED delivered about 20% of our admissions. And that has really grown at a nine and a half percent almost CAGR over the last seven years. And that's through new EDs. So we've had new EDs opened. Lake Macquarie was new, St. Andrews was new, Hollywood is new and Peninsula. All of those new

EDs have delivered what we thought they would, and Hollywood only just opened and already meeting its business case. So very effective in delivering our patients. We've expanded our emergency centers in Queensland. What we saw through COVID, and you may know this from some of your discussions with other hospitals, it's crazy. Emergency presentations and admissions have really leaped up. And we're not sure why, I can't get to the bottom of why. I think maybe GP is still closed, not seeing patients, certainly not seeing COVID patients or anyone with a respiratory illness. So that's been challenging, so we are seeing this more presentations to ED public and private sector alike. So that's interesting.

We've just recently expanded our Joondalup emergency center as well, and we've got on the radar, a number of other emergency departments three, one that's been approved. So Warringal is underway and you'll see that in a future slide. And we are also looking at Wollongong and Westmead as future emergency departments, along with expansions of some of these existing ones. So that will be an ongoing strategy for the future.

Slide 38 Admitted Activity: Rehabilitation

I'm going to talk about rehab, because I know you are all very keen to understand the impact of rehab at home. And I don't subscribe to the view that rehab at home will replace inpatient rehab. The only thing happening here is health funds inappropriately trying to interfere with clinical admissions to rehab. And the reason why I think that is that we have an aging population. We've predicted for some time that orthopedics, neurology and rehab would grow. It's been on the radar for a long time. And we are seeing that. We have seen a shift to greater acuity in our rehab facility, so that certainly has happened. And you can see on the bottom graph on this slide, the low functioning people, people with low functioning motor scores have increased in terms of our admissions into Ramsay facilities and people with high functioning scores have decreased. We have seen that change. And so we've got the higher acuity patients coming through our rehab facilities.

We do have increasing demand for reconditioning given the beneficial evidence of that shows for cancer, neurological conditions, Parkinson's, cardiac disease, persistent pain. So we are seeing a slight change from joint replacement into those other areas, but certainly the low functioning joint replacement services are still predominant. And the outcomes that you can achieve with low functioning people through rehab speak for themselves. It's very important after surgery that you get on the road to recovery quickly and your rehab is good. And we have potentially now the most comprehensive database of rehab outcomes, data based in Australia with about 275,000 clinical data points, 20,000 patients.

An example of the outcomes that we look at are the six minute walk test. And the smallest improvement considered clinically worthwhile for a rehab patient is to be able to walk 50 meters in six minutes. And all of our patients leaving rehab are achieving double that. Really important that you don't go home and you can't walk that 50 meters in six minutes, and you haven't had the care to do that because you are not going to be able to keep up with your rehab program and you'll fall behind. You'll be walking half the distance of your husband if you're going to go for a walk in the morning. So it's a really important test that's clinically relevant and very important that you do get back on the road to recovery fast.

We have 32 facilities currently offering rehab. And the average age of our patients is in their 70s. We've recently expanded our inpatient beds in three sites and our day patient services in three other sites. And we also have a number of additional rehab services in the pipeline. I don't see the demand for this decreasing on the basis of rehabilitation at home, what rehabilitation at home is actually seeing is probably more of the patients that used to go to community physio. And we have those patients coming into our Ramsay connect service. So we are certainly seeing an increase in those patients, about 5% increase in patients coming out of hospital into those high functioning,

motor people going to Ramsay connect, but it hasn't seen a corresponding decline in our inpatient rehab program.

Slide 39 Admitted Activity: Mental Health

Similarly, with mental health, I thought just do a deep dive in mental health. Mental health was also impacted through COVID, particularly visitor restrictions, social distancing. So not having so many people in a group class, you have to have eight people instead of 12. So all of those things were compromised. And so that was difficult through COVID. And concern of psychiatrists. Psychiatrists are probably the most scared through COVID of any of the groups of specialists. That was an issue, so we've had to deal with those things. However, for the long term, as we're hearing, there will be increase mental health burden, and there's an ongoing demand. There's huge demand in mental health. The only issue that holds us back from assisting more is the workforce. So psychiatrists and psychologists and mental health nursing is an area that we really have to concentrate on and grow. So that's something that we're doing.

Ramsay is a leader in mental health delivery, acute to health private delivery, and will remain so. We've renamed all of our facilities in recent times to Ramsay Clinics, so there'll be Ramsey Clinic New Farm, Ramsay Clinic Northside, as opposed to the individual names and that's to assist the digital front door strategy, to assist people to find and services they need. We've approved some major developments, including a new Greenfield mental health side at Ipswich, which will be a 40 bed development on a slide later. And we're expanding our Northside Wentworthville facilities from 68 beds to 125.

We are seeing a huge need for adolescent mental health. And we opened the first adolescent mental health unit in a private hospital in Sydney at Northside Clinic, and it was full in the first few days, and that remains the case. So big demand. Again, finding psychiatrists that want to do adolescent medicine is an area that we have to focus on, but we do have plans to open further adolescent units both in Northside, Wentworthville in this new expansion, but also in Melbourne and Brisbane. So that will be an area. And I'm going to talk later about our psychology services.

Slide 40 Outcomes, Quality, Experience

In terms of outcomes, Ramsay is really a leading brand in the marketplace. I have no doubt of that and it increased through COVID. As I went around to hospitals and talked to doctors and nurses, they all said, "Thank God I worked for Ramsay through this period," we really did keep them safe. We supplied them with all the information they needed. The information flow daily has been incredible and that made them feel very safe and secure in their employment and their work with Ramsay.

Our hospitals deliver exceptional services to patients. You can see here, our NPS, which is a measure of whether you would refer a patient to Ramsay Hospital is 73, that's world class. That that is a world class score. And when we talk to hospital groups in the states and overseas, they're quite amazed at that score. And this is a score that we get back from 30,000 patients that we measure quarterly. So 30,000 patients are telling us, yeah, I would refer someone here and this is a good facility, and that's a great score. So we're very proud of that. We also joined the Commissions Survey this year, and that's a new national survey, which measures a whole range of 12 questions and a whole range of other factors. And we score 96.2 on very good or good in that survey. So it's a further validation of just how good our facilities are. Any business would love those figures. And I think that's been a good thing.

Our team, this has been enhanced by a chief nurse and chief medical officer. I often say to the team, we have the best nurse and the best doctor working for us. They've come out of the public sector, so it's surprising that they're that good, but they are good and they are brilliant. So they have great ties with the public sector, but they also are just delivering extraordinary outcomes in terms of clinical

governance, patient care, safety, outcomes, research. And so, we are really lucky to have those people in our team.

We have 15 clinical trials delivering amazing clinical trials. Clinical trials are absolutely imperative. Patients with cancer want to be on a clinical trial. And so we've really driven hard on this area over the last few years and we have 250 active clinical trials. We've already finished a whole heap of them, but there's a lot of clinical trials. So if you've got melanoma and you want to be treated with the best drug, you will go to Greenslopes Hospital and you will get the best newest clinical trial treatments. And so, it's imperative that we keep going and keep investing in that area. And now there're clinical trials in mental health. You might have seen Albert Road Clinic launched a new depression drug or nasal spray or something. So lots of new treatments for patients through clinical trials and that's a good thing. And we've got a whole range of other research.

One of the things that I'm really passionate about is registries and participation in registries. Australia has some of the best registries in the world. Monash University has great record of keeping registries. Through registries, we scientifically validate whether we are good and we are good. So we have lots of cardiac surgery registries and neurosurgery stroke, infection control, ICU, lots of different registries where we can measure against everyone that participates in those. And so we do really well in all those areas.

Slide 41 Outcomes, Quality, Experience

I'll skip through this slide. I don't know how long I've gone.

I've got plenty of time? Oh, good. Okay. So we're concentrating in some of the major areas, cancer, orthopedics, cardiology, mental health. We are really leaders in these areas in the country. In cancer, we've appointed 14 cancer care navigators. One of the things about the private sector is we've been a bit behind in cancer in terms of some of the extras that you may get through the public sector. And so we've really launched ourselves into this space and increased our services. And so having cancer care navigators that can help you through the journey and help you into some of our programs for after that journey is something that we've really concentrated on. Also, looking at multidisciplinary teams, clinical information systems, really investing in this area around cancer and how we can deliver a better experience for cancer patients so they really feel managed through a journey that's quite complex and quite harrowing.

In orthopedics, we're a leading supply of joint replacing surgery. Public, private alike. We're doing about 20% of all orthopedic joint replacements in this country. And so we are a leading provider of that service. We've invested in 23 robots this year. So lots of new robots, new toys for doctors coming out. We've got 29 robots now across all of our facilities and this is a good thing. This keeps doctors sticky. This is not what you'll get in a little day surgery. These robots are really important for doctors and this is what they want to do now and it's increasingly improving outcomes for patients.

In cardiology, we've got eight hospitals now undertaking TAVI and probably Wollongong will be next, so we'll have nine. And that's a new heart valve replacement service. And there'll be plenty of more of those come down the road. We'll have MitraClips, TriClips, there's so many more new cardiac procedures coming down the line that prevent you from having have that major bypass surgery. So that's really important. And as I said, we opened the first new private mental health facility for adolescents in Sydney.

Slide 42 Strategy Update

Onto strategy, I'm going to run through some big items.

Slide 43 Ramsay Australia Organisational Structure

But first, just to let you know, from an organisational structure point of view, we did put in a new organisational structure when I started last year and we've only just filled the last role. So it took a year to find the chief digital officer, but she's brilliant. So I'm glad we took the time and we interviewed everyone in the world for that job, so I'm glad we found Rachna. Now we have the full team on board.

As I said, chief medical officer, chief nurse, brilliant. Their strategies are to drive medical recruitment, doctor recruitment, nurse recruitment, as well as a whole range of other things and doing a great job. Look after our clinical governance, make sure the patients are safe. They're doing that. The chief nurse was a really important factor. You will ask me no doubt about workforce later, and I'm going to talk to it. One of the areas that we are concerned about is the future workforce and how we keep our nurses sticky. Colleen does a great job on the HR side from looking at expanding our programs and how we deliver our management programs. But equally we have to get these nurses in, and there's not nurses there. We have to grow our own. And so, we haven't got this migrating workforce that we've always had and Sydney and Perth particularly have relied on that migrating workforce. So they're not there at the moment and we're going to have a bit of a time over the next few years, we're going to have to grow our own. So we've really invested hard in those workforce programs, which I'll talk on a little later.

Chief operating officer for out of hospital is a new role. This is the area that will concentrate on all of those areas outside of hospitals, pharmacy, allied health, all the ambulatory care centers that we might do, any doctor ventures, blah, blah, blah, psychology. Andrew Smith has come over from CBHS. He was the CEO of CBHS Insurance, so private health insurance. He's been a CEO in the past and he's running that strategy and doing a good job in that area. We've got a new chief people officer and our payer relations functions, obviously very important and something that we've really built a lot this year is our relationships with the health insurers and how we work with them on innovative programs around the hospital.

Slide 44 Key Growth Areas

So strategy wise, these are the key growth areas that we see as important. Hospitals hasn't changed, but we've probably ramped it up a bit. I'm going to go through day surgeries, any of the outer hospital stuff, mental health, and further adjacencies down the line.

Slide 45 Organic Growth

In terms of organic growth, as I said, we're a world class hospital network. We have strategically located hospitals delivering the best services in our regions. Our focus is on doctor recruitment and doctor engagement, capacity expansion, planning, developing relationships with local government. All of those things won't change. And we are consistent in driving that organic growth in our local hospital network and will remain so.

Slide 46 Capacity Expansion

From a capacity expansion point of view, our successful brown pill program will continue and probably is ramping up. And I know Craig told you at the end of year results release that this is something that we are ramping up and we will see a lot more and we've got a lot in the pipeline. We have got a lot of expansions going on. So in FY21, we spent about 324 Million approved, 325 million on hospitals expansions. And we expect that level investment to continue. Our FY22 approvals so far are tracking at 129 million, including 132 beds and seven theaters. And we've got a lot more to come to Craig, and Martin, over the next little while. And subsequently the board.

Slide 47 Currently Approved Developments

Currently we have about 700 million of projects already approved and underway. So these are projects that are underway. We've opened blue, red, green slopes in Hollywood just, not all of Hollywood. I think two thirds of the beds, but the emergency center as I said is open. And so those projects were completed in the first half. Into the second half we'll be opening Westmead, further theaters at Greenslopes and North Shore and a major development at Pindara. So that will be the second half features and obviously a pipeline of significant projects. With Warringal being our biggest brownfield we've ever approved. So in terms of quantum of dollars spent that won't open to FY24. And along with the Northern Hospital on here that Northern Corridor of Melbourne will be significantly Ramsay by FY24 and Warringal's a great, no regret investment hospital.

Slide 48 Selected Projects

Greenslopes, just some pictures and a bit more detail, opened 64 beds and three more operating theaters, ICU expansion, et cetera. Greenslopes is a massive hospital. It's where I started, I love Greenslopes. It's good site, ongoing doctor interest in being in that campus really changed in the last five to 10 years from veteran hospital to private hospital. These hospitals, Hollywood and Greenslopes 700 bed plus hospitals. And they are big significant hospital that deliver some of the best work in the country.

Hollywood is the leading orthopedic hospital in the country. No other hospital is close to it in terms of the orthopedic procedures that delivers and Greenslopes will get there, they are the best in cardiology, but their orthopedic services are growing significantly well managed facilities.

Warringal has been a bit of a dog's breakfast in terms of what it looks like. It's a fantastic hospital, lots of great services offered out of it. We've expanded it over the years, but it needs some more work. And so this significant expansion as I said, the largest we've ever approved will deliver a fantastic hospital across the road from the Austin in a huge medical precinct. So these are no regret facilities.

Slide 49 Selected Projects

As I said, Greenfield projects currently under development, the Northern Private Hospital in Epping, in Melbourne and Ramsay clinic in Ipswich, which will be a site clinic across the road from our very good San Andrew's private hospital. And now we've interviewed every psychiatrist in Ipswich and they all want a private hospital, they are a huge demand and so that I've got no doubt will be a good facility as well.

Slide 50 Major Developments in the Pipeline

Major developments in the pipeline. These are developments that we have got on the agenda for the second half of this year for approval to the board, again, major developments. So it's just a select few. Lake Macquarie in Newcastle is an amazing hospital. Hasn't missed a beat through COVID and has an excellent ICU, great cardiac services, great orthopedic services. And so an investment in this hospital is necessary. It's old, tired, again, another rabbit Warren, we have to invest in it, and we also want to stick a day surgery here. So the picture of that on the slide is the day services center that we will build in that facility. Joondalup Private, you all aware we have Joondalup Health Campus in Perth. We have a private hospital on the campus, but it doesn't have theaters of its own accord. It shares as theaters with the public. We are looking to expand Joondalup Private. And this is, I don't know, who's been to Perth recently then gone up to Northern corridor Perth, but it's huge and growing, and one of the fastest growing corridors in the country and an amazing area. We will put a big private hospital on this campus, expand what we've got, stick in some theaters, day services, et

cetera. And I've got no doubt that this will be successful. We've talked to all the doctors and there's high demand, and it's a great growing area. So this will be one that we bring to the board early next year, and in Wollongong Private, going great guns. This was our last Greenfield site that we opened in 2016. And it's been a great hospital, great development. And we are looking to put an emergency department there and expand that side as well.

Slide 51 Comprehensive and Integrated Health Care

I'll move on to the new and adjacent services. So obviously we are growing our services outside of hospital. And this just gives you a map of all of the areas that we will touch the patient in on that journey. And I think we'll talk through all of the different components of this as we go through.

Slide 52 Stand-alone Day Surgeries

First though on day surgery, this is another focus area. I know you are all interested in this space and I am happy to answer questions on all of that, but just to let you know, first thing we deliver day services, day surgery through 52 of our sites, including seven stand-alone surgery with 62% of all procedures being day surgery. That hasn't changed. We are a significant day surgery, have a significant day surgery offering, and that's reflected in the APRA data as well. And it's been growing. We are investigating additional community day surgeries and short stay facilities, and they will be different. They will be low cost construction, low cost operating models, highly scalable. So we will look at how we deliver those effectively. They do have a lower return. So we will be looking at how we do that in an effective way. And we will use digital systems to enrich the customer experience, the doctor experience, et cetera. So, we are investigating how we look at these purpose built surgical centers in some locations. But as I said, we have a strong record in day surgery. I'll preempt your questions about Medibank day surgery strategy. And I've seen that conjecture, that Medibank Strategy is going to negatively impact on private hospitals. And I don't concur. So doctors need facilities where you can do both high complex and low complex work. And they like that ability to be able to go between those cases. And so we haven't seen many of our doctors significantly interested in those ventures, the ones that are maybe interested are those that are maybe looking to retire, invest money and get out, but good luck to them because not lot of money to be made in day surgery. So it'll be an interesting model. We already provide day surgeries, as I say, in our existing facilities and short stay surgery and priority access will be given to the doctors that work with us and that we will provide ongoing support, ongoing equipment and all the nurses, et cetera, that they require. So we consider that we will continue to be a leader in this market, despite what happens in that space.

Slide 53 Integrated Care for Mental Health

On mental health as I said, we're a leader in acute private provision and mental services, but we'll be leveraging our out of hospital services and community based services in this space. So we're looking to grow a model right across the journey for mental health. We have a great acute provision, but there're opportunities to grow outside of that as well. One of the areas that we are concentrating on is establishing psychology services out in the community, and we have a number at the moment and we'll have quite a number over the next three years and we will corporatise, look to corporatise those psychology services. And that's been quite popular at the moment. As I said, we recently were successful in getting two public contracts for mental health, one in New South Wales and one in Victoria. And they are early signs and early stages of what we see possible in mental health. There is an alarming shortage of psychiatry beds in the public sector and psychiatry services. So in eating disorders and all those areas, it's an area that the private sector can help with. And so we've won two big contracts to do just that in Macarthur in Sydney and Albert Road in Melbourne. And the

Melbourne one came out of the Royal commissions recommendations that the public sector needs to use the private sector more. And this is the first stage. So, that's been a good thing. Obviously we've got hospital growth. I talked about adolescents. We are looking at new models of engagement with our psychiatrists to assist them grow the business with us. And we're actively exploring lots of academic partnerships. So there's a lot going on in mental health. And I think in time to offer a broader mental health offering where you can offer community outpatient, inpatient, day patient services will be a really exciting thing for Ramsay. And that's what we're driving.

Slide 54 Outpatient and Community Care

On our outpatient and community care strategy, these are the main areas of concentration. Obviously you're aware that we started the Ramsay Connect business with AU on March 20. It's pretty hard time to start, right at the beginning of COVID, but we now have 40 Ramsay facilities referring to those at home services. So we've delivered services to about two and a half thousand patients. And we've secured as we've grown with that service, we've secured new funding partnerships with funders, and we're expanding that across the state. So that's an ongoing discussion with those health funds as we come up for negotiation. And it's really forming part of our comprehensive cancer pathway as well. So all of those activate services and special rehab services for cancer, both prehab and post cancer provision are really launching well. So they're good. We are opening with Ramsay Connect a virtual hospital in virtual care capabilities in Joondalup, in Perth. So we've got a trial going on with that. And that started last month. Ramsay Health Plus has 28 clinics and they delivered 40,000 services in FY21. We have a lot, we have 1400 allied health staff working across our facilities as they work, they can work in and out of hospital and we're expanding how they work outside the hospital, in the community, offering programs, et cetera, lots of programs offered through that service. Our pharmacy service is growing. They're really concentrating now on healthcare, we are not a discount pharmacist. We're not in toilet paper and fragrances. We are a proper healthcare providing pharmacy service. And we will concentrate on hospitals, on aged care, on provision of services. They've delivered 20,000 COVID vaccines. So, that's the area pharmacy we are in. We're not a Priceline. That's a little bit different.

So, that's home medication reviews. All of those areas of pharmacy will be where we concentrate. In terms of psychology, as I said, we are expanding our psychology services. We have four psychology centers now in New South Wales, we'll have 11 by the end of the year. And we have over the next three years, I see 300 psychologists working for us. We already have psychologists in our facilities, our hospital facilities, these will be community based psychology services. And as they open, of course, as you would expect, huge demand for these services, all of these businesses are low margin services. They're low margin areas, but they are essential to helping us grow outside of the hospital. And that's something that we will continue to do.

Slide 55 Adjacencies

In terms of adjacencies such as radiology, pathology, radiation, oncology. These providers have traditionally engaged with us at a local level. So hospitals have engaged with the local pathology company and the local radiology company, et cetera. We've taken this year to get to the bottom of all of our leases and service level agreements within our hospitals. And to look at how we can leverage our scale to achieve better outcomes from these services and for our patients. Historical arrangements will not be the way we move forward and particularly given the consolidation of the industry and some potential channel conflict. I see this as a moving space. And so as lease renewal dates ensue, we'll make sure that the offerings are in line with our strategy. And so we think there's a range of options that remain open to Ramsay in regards to integration of the adjacent services in time.

Slide 56 Procurement Optimisation

I won't talk too much to this slide. So on procurement, an environment where we've been supply constrained and supply costs increases during COVID, we've been really fortunate to have a global procurement strategy and a global procurement relationship. So, that's held us in good stead. We aren't seeing any particular supply constraints at this time. So we're pretty confident at the moment. And we really have strong relationships with suppliers. In fact across one of the things that I've really tried to drive across the Australian business is to develop those relationships much stronger. And that's what we are doing. We think there's more we can do. There's certainly always more you can do in procurement. And we've driven historically our procurement focus has been on medical. We've expanded the procurement team to cover everything from IT and all the other areas, professional services. So there'll be an expansion of this team into that space. And we will always seek more value out of our procurement team, obviously driving the sourcing and sustainability agenda as well.

Slide 57 Workforce Initiatives

Workforce, as I said in the beginning, it's an area that we see will be increasingly competitive and it's important that we do as much as possible to grow our workforce. So we have a great organisation, great staff culture. And so we have been able to retain, we do have an excellent retention of graduates that start with us and so that's an area of concentration.

Slide 58 Workforce Initiatives

At the start of this year we launched four new programs and I'll just go to those, four new nursing programs have been launched. We've always had a graduate nurse program, but we've changed it, expanded it, made it better. We will increase our number of graduates by 25% in February. And we will continue to increase the number of graduates we take in. We've made it a two year program. We've put post certification opportunities in there for mental health, et cetera. So people can specialise so far more attractive and working really hard on retaining those people both before they start and then after they commence. So, been a lot of work on re-engineering our nurse fellowship program. Also investing in our leaders, our nurse leaders are critical to retaining the staff. And so we have directors of clinical services are imperative to running the hospital well. We're investing in programs for that group of leaders, but also our nurse unit managers of all the people in a hospital that make it successful. It's the nurse unit manager on the ward. And so they are the most important workforce of all. And so we've started Nurse Leaders of Tomorrow Program to really help that level of nurses through management, leadership onto DCS, et cetera, but by keeping them and making them better nurse unit managers. We see that attracts other nurses and makes it more of an aspirational career. And in the back to the bedside program the biggest feedback we get is nurses are increasingly administration. There's increased amount of administration, increased amount of work, paperwork, et cetera. So how do we get them back to the bedside? We've started a robotic process automation program through our financial services last year, and have saved about 4000 hours in one year across by putting bots out and doing invoicing and all the things that they do. And we see the opportunity in nursing that we can do this as well. We're working with a company they've identified 300 pilots. We will drive out these bots across our nursing profession to see if that can't help get nurses back to the bedside. And so that'll be an area of focus for us.

Just further on the workforce side, we've locked away three EBAs for in the first quarter of this year, and we've got one to go. So we hope that that goes some way to making it, we know what our budget is in, in that regard. We're rolling out a whole range of employee value propositions via Colleen and the team. And so there's a lot of areas of focus. We are excellent at workplace health

and safety. And some of you might know that we joined CompCare from 1st of December last year, and we're on track and on budget through that program. We've outperformed the scheme as I thought we would because we have an excellent team in this area. And so we're really leaders in this space and CompCare is delighted with how that's going. And so are our staff. So it's been a really win-win.

Slide 59 Ramsay Cares

Lastly on Ramsay Cares, Craig talked about this. I won't go into a lot of details suffice to say, we've some of the areas of focus we've launched a mental health first aid training program, we've had 132 staff go through that program. They love it. It's about making sure that you identify mental health issues in the workplace. And that's been a great program we'll continue. And I think we've got a thousand staff to train over three years. And in terms of the planet initiatives, we are rolling out our solar panel installation. We've had about five hospitals now install solar, a little bit delayed because of some COVID issues and construction and all those things, but we're on track. And we've had a really big emphasis on removing single use plastic items. Hospitals are big waste producers. And so we recognise that. So we've reduced 24 million pieces of single use plastics. We've also taken out water bottles, so there's no water bottles in our hospitals anymore. We went through six million a year, so we've taken out six million water bottles across the country. And hopefully that also helps to drive down the number of plastics going into the environment. So there've been things that we're proud to have done. And the staff have really been behind that. A lot of the clearing for the planet stuff is imperative from a staff perspective. That's what they want to see you doing. And that's what we are doing. So, that's been great. We have a great committee working through those projects. That's it. Did I get in the time? Oh, all right. So they scared me so much. So we've got 10 minutes break, which you can get water toilets are out to the right and then we'll see you back for questions. Thank you.

Question and Answer Session

Before I hand it to Craig, just a few housekeeping issues around asking questions. If you are joining us virtually, please press the raise hand button to ask a verbal question. The raise hand button can be found at the bottom of the Zoom interface. Once selected to ask a question, your name will be called and you'll be asked to unmute yourself. If you prefer to submit a written question, please press the Q and A button at the bottom of the Zoom interface to type your written question. We'll take questions from the floor first and then go to verbal questions and then written questions. Craig.

Craig McNally:

Thanks, Kelly. It's my pleasure to introduce the team, they're up on the stage. I'll start on my right, professor sir Edward Byrne is our global chief medical officer and Ed joined us earlier this year in February. Had an illustrious career across Australia in the UK in all facets of healthcare. So we're really fortunate to have Ed on the team. Colleen Harris is our group chief people officer, and also responsible for our ESG program. And Colleen's doing a magnificent job across workforce. Martin you all know Martyn Roberts, our CFO. Carmel, you've just seen and met. And Carmel's doing it from a long career in Ramsay, stepping up to be the CEO of Australia, she's doing a fantastic job. And then we've got Doug Meagher. Doug is the CFO for Ramsay Australia. And in a period where we are doing lots, particularly around systems and structures Doug and his team are doing a fantastic job. And Henrietta Rowe. Henrietta is our group general council and company secretary, and is a Wiz at corporate governance. So thank you all. Happy to take the questions.

Andrew Goodsall – MST Marquee

Thanks very much. Andrew Goodsall from MST Marquee. Just following up on presentation. Just the expansion into non-hospital services. Just trying to understand how you're thinking about adequacy of reimbursement and what the margin effect is in terms of perhaps the Australian margin in terms of the blended effect.

Carmel Monaghan:Thanks Andrew. I'll get Doug in answer the margin question, basically we've been expanding into these areas for some time and there they will be low margin businesses, but the idea is that you can start to offer more larger contract work. And so when you go to a health fund to negotiate a contract for next contract level, you can start to offer some different programs that are attractive to them and attractive to patients beyond just the hospital programs. That's something that they're all looking for. And we've had some success in that in recent times with health fund negotiations. So they are looking for these programs that go beyond what the offering is today. Some of that's to get patients out of hospital quicker or to keep them more well for longer. Less readmission, all those sort of things. So from the DVA to all the other health funds, they're looking at these programs. And so it will be bundled into some of that health fund contracting process. Of course, there's lots of payment for these programs, whether it's extras, cover or Medicare funded, psychology will be largely Medicare funded. But what I hope to see in the future is that we can start to look at much larger contracts with different payers. So whether its public payers or other insurers, there's the opportunity to say we have a program that where we can decide right care, right time, right place. And some of that will be in the community. Some of it will be in hospitals. Some of it might be day programs, but it's a different offering rather than just the traditional model we've had. So it's not so much about building these services to create a revenue streamer on its own right, on its own siloed out here. It's a bigger offering together with our hospitals that I see as being the best outcome in a few years time. But it's a matter of growing that service. I think definitely with public, with psych and public, there's a big opportunity. And we just have to look at what that might look like. If you can look at a whole population funding like we do in south Australia where we are funded differently there on a population health fund program, similar to what we do in Sweden. That's different, you start to say, we can look after this population's mental health and we'll decide where they go and we have to fit into those buckets.

Doug Meagher:

So just picking up then on the margin again. Can I be heard? I think I can be heard now. Thanks. So yeah, just picking up on the margin. So yeah, as Carmel says, looking at them in isolation as a silo, the margin is a little lower than the other businesses, but we apply the same investment hurdles to these considerations as we do everything else. And when you look at their macro effect, it's around the opportunity for growth and a better integrated care pathway that we look at with them, how they compliment the existing service offering.

David Lowe from JP Morgan:

David Lowe from JP Morgan. Maybe we can continue on, on that theme. I mean, can I get you Carmel perhaps to talk to the competitive landscape and yeah. Does Ramsay have a differentiated offering from some of the big charitable competitors as yet? Or is that something that we should expect some five years into the future?

Carmel Monaghan:

I think the biggest issue in this space is workforce like everything else. And so if you can attract and retain the workforce, you will have a differentiated offering. And that's the bit that we're concentrating on. So at the moment we're concentrating on the workforce and what it looks like and

the right management structures, the right systems, right tech to make sure that people want to work with us. So if you get that, then you will be successful. We already have, like I said 1400 allied health staff, we're a big provider. And as we build up our psychologists and we keep building that team out and we will do it slowly but surely. In lots of regions, we will see that we'll be successful. And we are growing that and being successful so far in terms of our own program. So Ramsay Connect is looking after Ramsay hospital patients, but eventually there's a market to look at other payers and other providers. So yes, we will. But we're just being specific in what areas we're looking at, but like the NDIS is, they are there's no supply, there's just not the workforce. So it's number one, getting the workforce right. And that's what we're concentrating on.

David Lowe from JP Morgan:

Funny, you should mention that on workforce was the other question I did want to touch. I mean, we are hearing about our global basis around the nursing workforce and healthcare workforce generally. You've signed the EBAs, and I'm not expecting you to disclose the detail, but does this workforce issue manifest itself through the financial outcomes? I mean, it seems to me that cost of providing health services is going to go up. You've obviously got payers that you need to bring along in that discussion as well. So just perhaps near-term, like the next year or two, and longer-term, how you think we'll see that come through in the financial results.

Carmel Monaghan:

Yeah. Look, we've had good health fund rate increases recently in the three health fund negotiations that we've done, and I'm very mindful of making sure that they stay above our EBA increases. So that's... I'm very mindful of that, and we will, and we have, but it's... They're... No doubt cost of doing business going up. You know, and Craig's talked to you about, the cost of doing business during COVID. We haven't finished that yet. We're still trying to normalise, and that's an issue. At the moment, workforce is okay, but I foresee some challenges. I don't think we're going to escape that. All industries are going to go through some workforce pressures and inflation and all those things. We are working hard to lock in the EBAs now, in light of that.

David Lowe from JP Morgan:

Well, one last question on this topic. Agency... If we go back, I've followed Ramsay for too long, I remember the days when agency costs were one of the first questions we asked, and they were going up, and then they came under control. I mean, do you see much risk that that's going to happen? I mean, it seems to be happening in the US.

Carmel Monaghan:

Yeah. There's no agency out there to get, so cost isn't going up at the moment, but we haven't been increasing agency costs just yet.

Doug Meagher:

Not a significant change.

Carmel Monaghan:

Not a significant change.

Dave Stanton from Jefferies:

Thanks, Dave. Stan from Jefferies. Just to follow up on David's question there, if you can't get agency, and you've got challenges with nursing staff, then does that sort of put a damper, again, from a financial point of view, in terms of your volume growth going forward [inaudible 01:29:33]?

Carmel Monaghan:

Yeah, look, we're not seeing much service disruption now. So as of today, no. And so, at this point in time, we're able to deliver all the services we need to, with the workforce that we have, and I see that continuing. We will have some staff fatigue, like I said, and equally, doctors will go and leave, and so over the course of these next couple of months, I see that playing out, and then we'll have to relook at where we stand. But no, I don't see it being an issue. We've got 600 nurses starting in February under the graduate nurse program, and we've got an active EN program that we are looking to ramp up as well. So we'll just have to continue to invest in those programs and make sure that we don't hit those hurdles, but yeah, not yet.

Dave Stanton from Jefferies:

Understood. Thank you. And then my question. COVID costs, I see in the presentation, you talked of thinking that will decline and just [inaudible 01:30:40]. Can you talk to [inaudible 01:30:43] how you see that rolling out over the next 12 months of work?

Carmel Monaghan:

Might let Doug answer.

Doug Meagher:

So I think you'll recall, I think when we first mentioned those, we were running at 8 million a month, and that's then come down to around to 4 to 5 million a month. We're still experiencing that at the moment. We're certainly hoping that that will take us through the second half, but we're not a really significant change in that for a little while yet.

Lyanne Harrison from Bank of America:

Hi. Thank you. It's Lyanne Harrison here from Bank of America. I might move away from nursing for a little bit and talk about your transformational digital and data programs. Can you give us an indication of timeframe, what sort of costs and benefits you're taking into account, and what we could expect from that over the next three years?

Craig McNally:

I'll take that to start with. So, the costs aren't finalised yet, but... And as I said in my presentation, where we are in terms of the rollout of the evolution of the digital and data strategy varies by region. And so there's been some reasonable costs that occurred over the last few years to get to where we've got to. With the chief digital and data officer coming on board this week, focus over the next three months is to nail down the priorities in that digital and data roadmap, and then we'll put some costs against it.

But everything... We've always been a cautious investor in that business technology, we've always been on the front foot in terms of clinical technology, and so I think we are always going to take a conservative position. But in saying that, we know where we need to get to, we're prepared to invest in that, and we'll look at a three to five year horizon rather than what we do next year. Just make sure that we make small steps, and I think in all industries, you're now seeing that the

advancements in technology have made them more accessible and cheaper, and so being a laggard in the industry and being a laggard across industries... We're probably in good place to sort of leap ahead with not a massive capital investment, but we'll come into the new year and we'll be clear on what that looks like.

Lyanne Harrison from Bank of America:

Okay. And just to summarise that. So what you're seeing is that you're still in investment program probably over the next three years, and we're unlikely to see any sort of margin expansion until the latter?

Craig McNally:

Oh, no, you'll see bits of it. Carmel talked about the creditor automation, so there's benefits that will come through, but they'll be project-specific, and geographically specific. We'll see... In the UK, now that the BPR rollout, which we've just deployed in the last couple of weeks, we're confident in the next 12 months, we'll start to see benefits that will flow to the bottom line on that. So it's not as though everything waits until the end of the program, because it won't be one, one massive initiative. It will be a series of smaller initiatives that will rule it.

Lyanne Harrison:

Thank you.

Speaker 3:

You talked about the ability to get PHI outcomes above EBA. Is there any sort of realistic scenario where that doesn't happen in the future?

Carmel Monaghan:

No.

Craig McNally:

Look, I think we just.

Carmel Monaghan:

No, I don't know. No, I think that's something that we... Inflation in workforce salaries is already happening, we're seeing it in all industries. There will be some challenges, but I think health funds are in a good place, and the negotiations have been smoother. And so we'll... And we're in a good position to demand a quality price. So it's all [inaudible 01:34:53].

Craig McNally:

It's about where the environment is at the time of the negotiation. And so we think Carmel has said our recent experience has been a lot more positive than it probably has been for five years the health funds are in much better financial position than we've been. And so that does make the negotiation easier, and... Yep. We have a view about what cost escalation looks like, and we take that into the negotiation, which very much depends on when the timing of that negotiation is.

John Deakin-Bell from Citigroup:

John Deakin-Bell here, from Citigroup. I was just interested in that margin question again, and around the addition of theaters, I think. We said that there were 30... In that 700 million of Capex 30

theaters, I think you'd come up 410 or something. So 6% or 7% theaters over three years doesn't sound like a lot. What percent of that theater increase per annum is likely over the next five years? And is the increment of return on that higher than the overall margin in the Australian business?

Carmel Monaghan:

Just to clarify that those are approvals that are currently in the system. So... But there are a stack of other things coming down the line that could be other theaters that come on in that next three years as well. So just to clarify that they're approved, right. But there's a whole lot that will be approved over next year that could come on in the next two years, or one year, or whatever. As you add theaters, it's pretty simple to open those up. So in that way I expect there'll be higher than 30-odd.

Craig McNally:

As a general rule of thumb, that incremental volume should drop down at a higher margin than the existing business, but it's not linear. It goes in steps, depending on what the fixed cost space you need to put in for the extra capacity that you put on board. But when we look at the makeup of the brownfield spent, which isn't just about theaters, and certainly not just about beds. It's about throughput and there's a range of things that we spend it on, consulting suites get a lot more proportion of the brownfield spend at the moment. So... But simple rule, more volume, you should drop that down at the height.

John Deakin-Bell from Citigroup:

So all things being equal, if you've got higher margin, but some elevated costs, at the worst, your margins should be stable going forward. Is that how you [crosstalk 01:37:38].

Craig McNally:

I mean, for us, I think we've been pretty transparent about that's our objective, stable margin. We don't get too aggressive on margin growth, even though over the years, we've had some solid margin growth, but the objective is, maintain margin. And whilst the non-hospital based businesses are small, they are structurally diluted to margin.

John Deakin-Bell from Citigroup:

And Sir Ed, perhaps I can ask a question of you. In your capacity, the elevated PPE and the use for the pandemic. How long do you think it's going to go on for, and how much extra cost do we need to wait in for that? Is it going to be there forever, or is it going to disappear?

Sir Edward Byrne:

Look, I mean, this pandemic has surprised us at each step of the journey, and we have Omicron coming through now, but in general, I've been very involved in this in the UK before coming back, so I know quite a bit about it. I'm pretty sure the worst of it is well and truly past us. We're now in the endemic phase, which will go on for quite a while, and it will equilibrate across different countries, and we'll have to live with it. But we know where that's going to be. I mean, in healthcare, basically, it's going to increase the overall healthcare load a bit, because there'll be a load of COVID in the background in hospital, and elsewhere in the system with long COVID. But the hospital rates won't be anything like we've experienced in the worst parts of the world. Long COVID will put a little bit of extra stress on, but the system has expanded a bit to allow for this. And this gives a lot more opportunity for private provision. One thing that's been clear in every country, including Australia, is that public provision, acting in isolation, can't cope that well with this type of crisis situation, but when the private sector steps up alongside, and the two sectors work together in synchrony, which

we've really seen here, you manage. So going ahead, there'll be more and more possibilities for the private sector to engage in different areas, both in terms of its share of non-COVID work, and certainly, in an outpatient setting, perhaps helping with some of the long COVID management. Thank you.

Carmel Monaghan:

Just as an example on a small item, like gloves, we were hearing from our procurement manager yesterday that they were 3 cents to buy before COVID. They went up to 18 cents through last COVID, and that's a lot of dollars when you use a lot of gloves. And they've come back down to 7. We've just been out of negotiations. So yeah, we're going to see some price reduction, as well as the supply increases. And so that's... I think we'll see some retraction of those costs in time.

Doug Meagher:

Just add to that, we were very cautious as we went through COVID, and so we stocked up on PPE substantially. So we're still working through some of the stuff that we've acquired at the [inaudible 01:41:03] take a while to get through the system.

Gretel Janu from Credit Suisse:

Thanks. It's Gretel Janu from Credit Suisse here. Just wanted to go back to the margin topic, and day hospitals in particular. So, are your standalone day hospitals able to earn a greater margin, as opposed to when it's combined with your overnight hospitals?

Craig McNally:

I'll answer at a higher level. Short answer is no. Depending on the case mix of them... And so standalone day hospitals tend to have a lower acuity. And with that lower acuity, you have a lower cost base, and so, theoretically you should... And given the way that the reimbursement mechanisms work, you should be able to operate on the same margin regardless of the budget, but overall, what we see is lower margins in those, and lower returns of their capital investment, particularly around compliance with those facilities has always made the economics difficult.

Gretel Janu from Credit Suisse:

Understood. And then, in terms of the adjacencies looking into radiology, pathology, radiation, is the ultimate aim just to acquire a provider and then roll it out to all your hospital network? What are the other range of options that you talk about in the slides?

Craig McNally:

OK, well, I'll answer that one. We won't be specific about that, but we do have a range of options. We have a lot of diagnostic service providers based on our campuses, and I've said for a number of years that, over time, I think they should be more integrated into the hospital service. There's good providers and not-so-good providers, and so we don't want to take the risk on that whole patient experience and the integration. So there'll be a range of models that will come through, and we'll have different partnership models with different providers, and we may own some ourselves, but too early to say exactly what it's going to look like.

Saul Hadassin from Barrenjoey:

Saul Haddassin from Barrenjoey, a couple of questions, just on returns. Maybe Martyn, question for you, but rather margin-focused than ROIC-focused of... To give those adjacencies in maybe the out-

of-hospital care. I'm assuming it's low-capital intensive, albeit low-margin. Do you sit as accretive to the group ROIC building up that offer?

Martyn:

Well, if it wasn't, we probably wouldn't do it. So as we said, I mean, we've moved to cash ROIC to get away from all the rubbish with double AFP 16 in accounting, and just focus on cash returns. It's a pretty similar... Yeah. When we used to say that investments needed to be 15% return on capital employed after year three, the 10% cash ROIC it's kind of the same number, but in a cash number. We're working through the business models now, and the pay surgeries. That's why Carmel said that they will have to be very low-cost build, efficient processes, digitised so that, from a workforce perspective, it's lower-cost to be able to get those kind of returns. And so we're going through that now, but those business cases, we'll have to meet the hurdles that I talked about earlier.

Saul Hadassin from Barrenjoey:

And the health... The Ramsay connect, and the health plus again, are they higher-returning opportunities?

Martyn:

Doug, talk about that.

Doug Meagher:

Ramsay connects a joint venture with AU, as Carmel said, so obviously our investment of that is relatively small, but it's a very good offer we can do together. In terms of the Ramsay Health Plus, it's a very low investment. So the return on that [inaudible 01:44:39], but again, it's a very small part of the business.

Saul Hadassin from Barrenjoey:

Thanks. So just one on day surgery, and particularly standalones. Just, your decision to pour dollar into community-based standalone facilities as opposed to building out and offering on your own campus, is it more just your geographic footprint, where you might have lack of exposure that drives that decision? And what specialties are you particularly interested in? What makes sense economically in that [inaudible 01:45:03]?

Carmel Monaghan:

So just to confirm something, doesn't mean that we're not investing in our day surgeries on our campus. That's number one priority. So a lot of that brownfield spend is in improving the day surgery experience on our campuses, whether that's day of surgery, admission, et cetera, et cetera. So it's 10 hospitals at the moment that are broadening their offer, expanding their day surgery offer. Within the Joondalup development, there'll be a big day surgery provision. So that's not changing. We are investing in those services. On the community standalone sites where we think there's a place to be, will be in, yes, you're right, new geographic locations also. Western Sydney, Western Melbourne, lots of pockets in Queensland. So we've got mostly to look at where we can look at holes and what we can do extra in those holes. And doctors are looking at new markets. So doctors that work with us today in our bigger hospitals also want to look at new market places. Largely, day surgeries are gastroenterology, plastic surgery, dermatology, those sort of areas, with a smattering of urology, et cetera. It doesn't mean in the future that they won't be cardiology, more orthopedics. They could be, but largely, I still see those services being offered at our big campuses, because they want the backup of the ICUs and services that back them up. But there will be a tendency to have some

services done in those smaller day surgery units, and so we are future-proofing, or we're planning for those day surgery units. They'll be future-proofed to plan for what might come down the line.

Craig McNally:

I'll just add to that. When we look at growth opportunities, so growth corridors, developing markets, we'll just look at what model gives it, what footprint we should have in that, and whether it's starting with something small so that we can scale it. We took a decision on the northern corridor of Melbourne, because [inaudible 01:47:10] for the northern hospital, because the opportunity really was for a more co-located facility, that putting something more substantial into that corridor was the way we'd go. So we just look at the markets, what the growth profile was, where the doctors are, all the things that would go to make [inaudible 01:47:30] what we should do.

Kelly:

Are there any other questions from the floor before we move to the further questions online? Okay, we'll move to verbal questions online.

David Bailey from Macquarie:

Yeah. Thanks. Morning, everyone. Just following on from some of Saul's questions, actually. Talking to, today, in short, say, hospitals on the move by insurers into this space, I'm just wondering, the... Any interesting observations on the challenges you see in scaling up this model? And then just some more detail or commentary in relation to the factors that drive the economics, or return to these businesses, would be interesting as well.

Craig McNally:

Look, I'll start with the last part of that question. The economics are difficult [inaudible 01:48:28] that we need to invest to... Australia is an expensive market in terms of healthcare building standards, and so you haven't seen a massive proliferation of standalone day surgeries over the last decade, because the economics are very difficult. And so then when we look at, what are people, pointed out previously, we are the largest provider of day surgery in the country, and we provide more day surgery than all the standalone day surgery doing in aggregate. And so that gives us great insight into where that day surgery market is. And the scale of the initiatives that people are talking about, sort of insignificant, if you like in terms of the way we look at it. I think Carmel's point earlier about doctor engagement and how doctors want to participate... I think one of the subtle comments she made about our preference will be for doctors who want to work around our campuses. That is a big magnet for doctors to stay with us rather than look at some of those other models. There will be people that do that, as Carmel said, but it's not something that we are at all concerned about. It's dono;t Don;tthink its significant. [inaudible 01:49:54].

David Bailey from Macquarie:

Yep. Got it. Maybe one for Martyn, sale on leaseback, and there's obviously plenty of appetite for the hospital-type healthcare assets at the moment. The examples from the peers, where there is minimal tax leakage by various ownership proportions. I mean, if you could run a scenario whereby you sell part of your property portfolio, buy back some stock, maybe find some acquisitions [inaudible 01:50:26], multiple uplifts on the operating business. Is this something that you're looking at a bit more closely in the near-term, or considering the near to medium term?

Martyn:

Yeah, David, we've done a lot of work in this area, and really sort of run the ruler over it to quite a deep extent with a whole bunch of advisors. Those models you're talking about, the kind of 51-49 structure such as Telstra just did with their towers, et cetera, to avoid tax leak leakage, you need to have a tax base that's above the 49%. We just don't have that. So given the historic nature of the buildup of our hospital network, the tax base for our network on average is way lower than that. And so we don't think it would be a good use of shareholders' funds to pay hundreds of millions of dollars of capital gains tax. So that's a big challenge for us. Would we consider a smaller portfolio where there's a few hospitals with a higher tax cost base and maybe sell a smaller percentage? Possibly. And they might be ones where we've got, some of the more significant brownfielding investment going forward, where we could get an investor to co-invest with us. That might be something we might consider, but there's certainly not anything active in the short term. But yeah, and the other thing I would say, some others have managed to avoid capital gains tax by virtue of the fact that they've had significant capital losses carried forward, that they've been out offset these against [inaudible 01:51:46] of capital losses to do sell leasebacks. To Craig and the team's credit, there aren't any capital losses for me to use. They haven't stuffed that anything up over the years. So there's nothing to be done there. So, look, we keep looking at it. We keep investing in time and effort, considering lots of different options. We haven't found one yet. That would be satisfactory to do that. And right now, as of today, we don't need the money, obviously, but it could be a good way of diversifying our borrowings in the future, we understand that, but it's a bit of a barrier right now.

David Bailey from Macquarie:

Yep. Understood. And just my final question, there was a slide in there today on procurement. Just wondering if there's any update on either timing or quantum of benefits from the JV with Ascension, New Source Global. I haven't heard much on that one for a while.

Martyn:

Hey there, David. So I think, as we've said for a while, both of our organisations have been focusing on COVID. We did prove out the model with a couple of smaller categories, but we've got to do some homework ourselves now to be able to access that properly. Carmel or talked about category-based buying. That's exactly where we need to move to, and going back to more national-based contracts with our suppliers. There's quite a lot of work to go through to do that, and we'll come back and revisit that sometime in the future, but there's no update there, really. But what I would emphasise, again, is what Carmel said. We're focusing on other parts of the P&L, so not just medical supplies, and we're seeing some good benefits from that. So it doesn't stop the work and the focus and the increase in the team that we've got on procurement.

David Bailey from Macquarie:

Okay, thanks. I'll jump back in queue.

Speaker 6:

We have the next question from Steve Wheen at Jarden Group.

Speaker 6:

Hi, Steve. Please unmute yourself and ask the question.

Steve Wheen from Jarden

Can you hear me now?

Speaker 6:

Yes. Thank you.

Steve Wheen from Jarden

Okay. Sorry about that. This is a question for Martyn, just on the investment parameters that you've put up. Are you saying that there's no change, essentially, with the old parameter to the new perimeter, based on using a cash ROIC?

Martyn:

It's kind of the same outcome. I mean, there will be subtle differences, but you think about a 15% pre-tax return on capital employed is going to end up being, depending on tax deductibility, et cetera, 10% post-tax ROIC.

Steve Wheen from Jarden

Yeah, okay, but there... I mean, you do have-

Martyn:

The EPS hurdle were there already.

Steve Wheen from Jarden

Sorry, start that again?

Martyn:

IRR hurdle and the EPS hurdles were already there.

Steve Wheen from Jarden

Yes. But there would appear to be some more wiggle room, I guess, within those hurdles, with the extension to acquisitions being achieving those hurdles in five years, because it was previously three, and now there's, I guess... That comment about the strategic investments where you can go below 10%. So that would be the major changes [crosstalk 01:55:05].

Craig McNally:

I think that's the way we've always looked at it, anyway. In acquisitions, I think we've said over the last few years that the environment for acquisitions on the global scale has become more competitive, certainly in this low-interest rate environment. And so for us to be competitive in those, we needed to revisit that, and that's been the case for a few years, so... And I just think, on the strategic side, we've always taken a view that if something was really strategic important, then we would be flexible on what that return criteria are. So that's not new for us.

Steve Wheen from Jarden

So it's not in response to missing out on some transactions more recently, just because there's perhaps some more patient capital out there that have lower wax than perhaps yourselves?

Craig McNally:

Yeah I mean that’s the reality and so I think the Spire opportunity was a good example of it. We maintain the discipline on what we thought value was, and what the return profile should be, and

we just didn't chase it by putting more money on the table. But certainly when you've got InfraFunds coming in to healthcare assets with the lower cost of capital it's a more competitive environment, but we still have to maintain the discipline that we have to look at it on a longer term basis.

Steve Wheen from Jarden

So, with these changes, would you be able to bid more aggressively for Spire?

Craig McNally:

No, because we're working on this anywhere anyway in that opportunity. The answer's 'no'.

Steve Wheen from Jarden

Cool. That's good. Just with regards to the negotiations... Sorry, just with regards to investing, you've got a slide there about adjacencies and integrating various adjacencies within your business. What does that entail with regards to the commentary around the leases? Is that taking imaging in-house to run it yourselves? Is that the intention to be able to do that? And do you have the capability to do that without making an acquisition on that front?

Craig McNally:

Following on from the answer I gave earlier, we'll be flexible about those models and where we have partnerships. Now, Carmel alluded to it, the historical structure for third party providers to provide, particularly diagnostic services, imaging and radiotherapy; nuclear medicine particularly. They're old structures, they were things that were legacy from 20, 30 years ago. And because they're long term agreements, now the quality of service agreements that were put in place 10 years ago aren't what they should be today. So, Carmel and the team have gone through and looked at what all those arrangements are across the portfolio and have developed the framework for a strategy going forward about how we can integrate those services more. We'll be much more critical on the arrangements with providers, there are some providers who, I said, there are some providers who are better than others. There are some providers who see themselves competing in some of our markets, and so where those relationships are going down the track we'll be much more critical about. And so they won't be just what they've been in the past and the models will be different. There will be a mix of JVs, us owning things, and the key on some of those things is the clinical capability that sits with the doctors that are associated with those businesses. That generally comes across. You can't put an imaging service next to Greenslopes and have the complexity of a Greenslopes imaging service. So, people are attracted to that, but it will be, I won't say horses for courses so much, we'll have some particular strategic direction and particular relationships that we want to continue to build on going forward. And some relationships will fall away because they might have misread what we were after.

Steve Wheen from Jarden

Okay. And then just lastly from me, and perhaps for Carmel-

David Low from JP Morgan:

Sorry, David Low from JP Morgan again. Can I just touch on this strategic investments? Can you tell us what strategic investments you've made in the past and what you'd consider in the future? And what I was trying to interject with is Spire considered strategic?

Craig McNally:

Oh, it was absolutely considered strategic, but it doesn't-

David Low from JP Morgan:

So you could go outside the criteria?

Craig McNally:

Yeah, but it doesn't mean it's an open checkbook either. Looking at what a strategic investment is for us, and we're looking at five or 10 years down the track, what we can build, how we can add value to something. A great example would be, it's a bit old now, but North Shore Private. That was a really difficult business case at the time. It would be even more difficult today, but we'd always do it. We'd always take the view that that's the sort of business that you want to see into the future, even if you're going to take a hit in the short term.

David Low from JP Morgan:

So, your expectations would be that in a longer time period you'd hit the hurdles, you just wouldn't get them in the timeframe?

Craig McNally:

Oh, absolutely. There's no point doing something strategically if it's not going to add value.

David Low from JP Morgan:

If I could just go back to one of the other topics as well. I mean, what we see from the Medibank offering is a particular offering on out-of-pocket costs, which has been a very hot topic, perhaps less so in the current environment with private health insurance memberships going up, but have you seeing much pressure from those out of pocket cost arguments on your business at all?

Craig McNally:

I'll take it first and I'll hand it on to Carmel. Whoever takes some initiatives, whatever they may be, that has an influence on controlling out-of-pocket costs I think is a good thing. I think the whole industry benefits from that. Specifically, are we seeing some impacts? We've got some programs that we've looked at about trying to have, not zero out-of-pockets, but known out-of-pockets, so to understand what those limits are. Some more successful than others. I think what we're seeing is in our role that we've taken is one about education, about where the market's going, and not trying to dictate to doctors what they should charge. But I think what we're seeing is a lot more questioning at the start of a patient journey. And so before referrals are taking effect, people want to understand what the financial implications are a lot more than they used to.

Carmel Monaghan:

Yeah. Yeah, no, we're not seeing too much impact on us from those particular models, so there's limited number of doctors still that are undertaking those models, so one, two, three doctors. And then where they have been put in place, like in some obstetric cases, some has been payment on both sides by the health insurer and the hospital or whatever; they've failed. So, there hasn't been a degree of success yet that we've seen from some of those out-of-pocket models, and the doctors that are in them they've come back to us and want a lot more money. So, that's the trouble they're going to have a little bit. So, doctors might start here, but eventually... they're happy with this, but eventually they want more. So, it's going to be an interesting challenge that anyone that works with doctors, and we've worked with doctors for 60 years, it's a challenging prospect to go into business with them as well, and to try and do those arrangements. So, good luck, but that's going to be challenging. But as Craig said, absolutely. We're supportive of bringing those costs down, and in cases like Western Sydney we've worked really closely with obstetricians, and the pediatricians need

us to give more transparency of price, and that has worked. But what we find is here's the offering at this price and here's the normal offering, and still people choose this offering. So, it's interesting when you put it in front of them, it's actually just the transparency that's more valuable. And when you put it say, 'Well, you get this here and you get this here, we'll choose this one.' It's still playing out that way at this point.

David Low from JP Morgan:

And if I could just one more; the prosthesis, I wasn't completely sure, Carmel that I completely followed what you were saying. I mean, I think we've probably all heard bits and pieces-

Carmel Monaghan:

Yeah, it's a complicated area.

David Low from JP Morgan:

The general and miscellaneous part was a bit that I wasn't quite sure what your expectations are of this.

Carmel Monaghan:

Yeah. So, the idea from the department was that they would actually get rid of the General Miscellaneous list altogether. So, those sutures, staplers, all those little bits and pieces that get covered at the moment by the health insurer, the glues are in general miscellaneous bucket. And so that's currently a pass-through to the health insurer. That's been upsetting the health insurers along with the rest of the prosthesis pricing on it. Some of those items have been overpriced compared to what they were before they were listed, so there's been some challenges. On the general... On the big, broader prosthesis reforms, that's going down the path of public reference pricing. The General Miscellaneous list was being removed altogether, and so that would've required us to negotiate a price with the health insurers and the suppliers, and would've left hospitals post-COVID lots of challenges, lots of other things on our minds to go and do all that negotiation. Now, I can back Ramsay to do that, but there's lots of hospitals out there that have not got the wherewithal to do that. And so as a representative on the APHA and with the CHA, we've worked together with Hunt to say, 'That's not causable. That's not fair on hospitals.'. We've come to all of these challenges, and the list is worth about 300 million, so it's tiny in the whole scheme of things of the whole big list, but it's still a significant challenge to hospitals to have covered that. So, what we've argued to Hunt is that you need to keep list and just public reference price like everything else you're doing in prosthesis. And that's what he's accepted as a better option, but we are still waiting to see the fine print and the department still would like to get rid of the list. So, there's some challenges still to come, but I think that's where we're hopeful that's where it will land. Yeah.

John Deakin-Bell from Citigroup:

Thank you. It's John again. Just a lot of questions around the return on capital on that slide 27 is great detail, thanks, and you're very clear on the criteria. How does the decision making process work for existing assets that make a lot less than that hurdle rate? So for example, RGDS I think's 4% return; well less than the 10. Should we assume that those assets are considered to sale? Because obviously selling them would be returns enhancing for the rest of the business. Or if you don't sell them, should we just assume that at some point they will hit that hurdle rate and they'll make 10% that's due?

Martyn Roberts:

What you should assume is that any incremental dollar we invest in those businesses has those hurdles. And so it's not a hurdle for historical activity. Ramsay Santé sits very strategically within our business. We get a lot of those global benefits that we talked about earlier in Craig's slides, it is a substantial part of our business. If you recall when that business was acquired, a lot of the procurement benefits actually are in the Australian business now, you don't necessarily see it in the Santé business. But it's not a criteria for divestments, but you should be reassured that Ramsay Santé has the same investment hurdles for every incremental dollar they invest in their business.

Speaker 8:

Andrew.

Andrew:

Andrew here.

Martyn Roberts:

Did you turn it off?

Andrew Goodsall from MST Marquee:

Sorry. That's a bit better. Just thinking about the public sector, I know they've been engaged with you through COVID, the extent to which they're starting to contemplate how they do their wait list catch-up next year and the role that you might play there.

Carmel Monaghan:

Sorry, was that in wages catch-up?

Andrew Goodsall from MST Marquee:

No wait list.

Carmel Monaghan:

Oh, wait list. I wasn't going to help them with wages catch-up. Yes, look, I think like Ed said, there's going to be some time to come before the public sector can return to normal and I think there'll always be challenges around the respiratory illnesses, and long COVID effects, and all those things. Particularly in our overseas markets, probably more so than in Australia, but here I see us... we are very open to assisting public sector. At the moment that's challenging because we've got a lot of backlog of private work, and so the doctor's got to do that. So, the big challenge is around time, the theater, and doctors availability, and staff. So, that will be a challenge. But in the long term, I think there's going to be a lot more we can do. And they'll be in specific areas like looking at significant, longer term public contracts. And what we say to each of the DGs in the states is don't just give us this little bit and say, 'We want you to do this for three months.' Let's look at a longer-term contract that's five years or a couple of years. And then at least if we know, and we can budget to do a whole lot of gastro cases over a year, then we can plan it and we're not trying to fit it in three months alongside our private work. So, it's more of I think that's what we'll see more of. Surgery Connect, obviously in Queensland's very successful. You don't have in New South Wales and Victoria as easy, but with the amount of work we've done down here, I think there's an appetite now and to look at some of those things. So, how do we do it in a better way?

Kelly:

We'll go to the verbal question online.

Speaker 7:

We have the next question from Steve Wheen at Jarden Group.

Steve Wheen from Jarden Group:

Thank you. Just following on from that question, I was just wanting to get an update. I think Craig, when we last got a trading update, you were talking about some good progress with the state governments in Queensland and New South Wales, but the pricing in Victoria was somewhat problematic, or open to renegotiation, or you were certainly attempting to renegotiate. Any updates as to how much they may have come to the party to allow the private sector to help them with some of their backlog?

Craig McNally:

So I'll [inaudible 02:10:48] detail. I think what we were trying to say was there was the immediate COVID issues that had to be dealt with, and so they were priced at a certain price point. When we look at longer-term arrangements to deal with longer-term issues and impact on the system, then our view is they need to be, and will be, for us on a much more commercial basis. And so the bigger the scale and the longer the term, the more likely it is that they'll be on a commercial basis. The shorter, more crisis management stuff, you just do what you got to do.

Carmel Monaghan:

Yeah. On that.... Sorry, I'm getting a bit backlog. Yeah, nothing more much to say on that. I think we did public work at cost recovery through COVID, so coming out of that we've now got other contracts going on and we'll... And those contracts are all handled at a local health district level within their budgets. And so there's a lot of different differences within those. And there's starting to be more discussion at an AMA level about doctor arrangements and how that works, and so we'll start to see a little bit more standardisation across some of those health contracts. And we've just engaged a public health contract person to assist us through some of that, because we're very adept at the private side, but we need to increase our skills on the other.

Steve Wheen from Jarden Group:

Thanks Carmel. And can I just ask you to clarify one thing you mentioned earlier just with regards to your ability for the PHI pricing to be above EBA rates. Is that from this point on, or is the existing arrangements with PHI, like the multiyear agreements with Medibank, are you seeing that those rates are above EBA as well?

Craig McNally:

Well, we'd never talk about that. But yeah, everything is going forward. So, when we go to the table next time, we'll look at, as I said, what our view on cost escalation is, and you wrap that into the negotiation. You can't fix grant mechanisms in the existing agreements to change them. So, you live through that and whatever they may be. So, that's probably all I'll say.

Steve Wheen:

Yeah. Okay. And just timing of the next [crosstalk 02:13:29].

Lyanne Harrison from Bank of America:

Hi, it's Lyanne Harrison from Bank of America again. Just to follow up on back logs in the wait list, and if we think about the private backlog at Ramsay, how long do you think it'll takes to work through that? Obviously, given the challenges you spoke about fatigue and needing take leave over Christmas and January, and also, fingers crossed, that there's no more restrictions and elective surgeries.

Carmel Monaghan:

Yeah. I'm not sure we can give you an answer exactly, because we don't have a waiting list in the private sector. The doctor knows what they've got coming down the line, or we can go by his anecdote, and what they're booking now, and what they're telling us is that they're busy and they've got three, six month waiting lists for patients. And it's very site specific as well. So, Sydney we did have... There's probably not as big a backlog as there is in Victoria for us, because some of the other hospitals were able to continue surgery whilst our seven hospitals were shut, so that was challenging. But in Victoria, there's more significant backlogs. But we can't tell you what that is.

Craig McNally:

And I think what we're going to see in terms of profile is what we saw last year. Small spike of increased volume to start with, then just settles down to a lower level but still at a premium to where it was historically. Now how long that lasts for? Not sure.

Kelly:

Okay. We just might take a couple of the written questions.

Kelly:

A couple from **Sean Laaman from Morgan Stanley:** Without investment in brown-fields, how much runway for growth do you see in our existing Australian network within the limits of current physical headroom?

Craig McNally:

Oh, look, we're keep getting better at using our facilities efficiently and the investment. Brown-field not exactly excluding brown-fields, but it's all about getting that throughput capacity increased and in getting a better process in place to move people through faster. Length of stay fluctuates. Length of stay for, surgical length of stay particularly, has been decreasing for some time. But as the patient cohort gets older, we've got more comorbidities, we're going to see inflection in that, so there's a bit more art and science in the way we look at capacity.

Kelly:
Sean Laaman from Morgan Stanley:

And secondly, how much will ground boots be on an ongoing key feature of sustaining historical pre-pandemic growth rates?

Craig McNally:

It's whilst we, I mean... If we just get out of the pandemic for a moment, the drivers of demand for healthcare are still there. And so if we are managing our portfolio properly, and we're not putting too much capacity in too soon, then we're going to have a continual stream of ground field development to keep up with what is that growth and demand.

Craig McNally:

And the style of the ground fields will continue to evolve. But whilst there's growth of demand, there'll be opportunity for ground field.

Kelly:
Sean Laaman from Morgan Stanley:

And thirdly, on the four and a half percent admission growth from '21 versus '19, what portion of that growth is from public admissions?

Craig McNally:

It's very small.

Speaker 8:

Not much.

Carmel Monaghan:

Small. Yeah, tiny.

Craig McNally:

Just insignificant.

Kelly:

Okay. And a couple of questions from Troy Cairns

Kelly:
Troy Cairns from Quest AP

There is not a lot of money to be made in day hospitals, Carmel, but at the same time you recognise that the industry volumes will continue to move that way. What can you do to expand in day surgery and not see negative impact on Australian hospital margins?

Carmel Monaghan:

Yeah. So, as I said, we'll continue to expand day surgeries on our campuses, which is where we will concentrate and we are continuing to concentrate. So, a lot of those investments are in day surgeries on hospital campuses today. And in terms of community day surgeries, we've already got a portfolio and where it makes sense we'll continue to look at and investigate other locations for... and when I say day surgeries, I'm talking about short stay surgical facilities as well. So, there could be opportunities and there are opportunities to look at those, so we will continue to look at those. And they give us a greater geographic portfolio that's I think, like we said, Ramsay's a leading hospital operator, we have good market share, important that we continue to grow that market share, and we will through looking at new locations.

Craig McNally:

But just to emphasiSe that point again, the proportion of investment in to day surgical capacity will be biased towards our campuses. And so the standalone piece is going to be the smaller piece of that.

Troy Cairns from Quest AP

Okay. And another question from Troy: can we see in Ramsay be more likely to employ doctors directly in the future, given the various strategic areas of expansion? It is not something you've done in the past, so why now, what are the risks in moving down this path?

Craig McNally:

Yeah, look, it is a challenge and I have a personal view that when we get 10 years down the track, there will be a variety of doctor engagement models. It won't be completely in an employed model, but I think as young doctors are coming through, they're not necessarily looking at their careers from a perspective of operating their own business independently. There'll be a mix of people who want to be employees, who want somebody else to manage their business so they can concentrate on the clinical piece, and there'll be people who want to do it the way that historically it's been done and operating their businesses as a small business. We just need to make sure that we're adaptable. I think there's a real challenge in the transition of the way that that model will emerge. But it's a longer-term issue, we're not going to see it the next three or five years. It's 10 years plus as the next generation are going through.

Kelly:

Great. So, if there's no other questions...

Anja Samardzic from Alliance Bernstein

Thank you. Anja Samardzic from Alliance Bernstein I just have a little bit of a question around... You're talking a little bit about there being a back in elective surgery, what I guess is the biggest rate limiting factor in clearing that backlog? Is it the willingness of doctors to put on extra lists, work weekends? Is it not nursing or is it facilities?

Carmel Monaghan:

Different in every area. But certainly theater time, nurses, workforce availability would be the key area. Doctors being able to manage it and get through it, so they're the key things.

Craig McNally:

Yeah, the physical constraint is not the most significant one. And then depending on where you're talking about public patient backlog or private patient backlog, the limiting factor on public is money, and how much government's prepared to put towards addressing wait lists.

Anja Samardzic from Alliance Bernstein

I guess following up on that, is there anything you can do in the short term to address any of those limitations?

Carmel Monaghan:

We can work weekends and that's what we're doing. So, we're doing a lot. As much as we can within those workforce constraints obviously, and patient safety, and making sure we've got everything right. So, it's largely a workforce issue.

Craig McNally:

It's fair to say we're not knocking back any volume as it comes through [crosstalk 02:21:20].

Carmel Monaghan:

Yeah. Just to add to the question before about doctor engagement models, I think one of the things that we do really focus on is making sure that we protect the system that we have in Australia. Australia has a really excellent balanced healthcare system. And so I talk a lot to doctors and this... for their money that we spend in Australia, which is around 9.5% of GDP on healthcare, we get a really good outcome. We get excellent outcomes in this country for what we do. So, we don't want to move down a UK model, we certainly don't want to move down a US model. And maintaining the excellent outcomes that we get here, we have the best cancer survival, five year cancer survival rates in this country are best in the world. This health system is considered by the Commonwealth Fund and others to be in the top three health systems in the world. And so for what we spend, we get great outcomes. So, there's a lot of talk about doctor out-of-pockets and all of those things. At the end of the day we also have to recognise that we get excellent outcomes for what is spent on healthcare. So, it's something that I'm very passionate about; making sure we maintain that we don't move down a model of managed care, or money talks and money directs those patient outcomes. So, we have to make sure that's still top of mind that what we have is good, and we need to recognise that.

ENDS

Yours faithfully

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