Name: Enrolment No:	

UNIVERSITY OF PETROLEUM AND ENERGY STUDIES
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Course: International Marketing — **Semester: V**
Program: BBA (FT) — **Time: 03 hrs.**
Course Code: MKTG3004 — **Marks: 100**

SECTION A
(30 marks)

1. There are SIX MCQs in this section. All are compulsory.
2. Instruction: Choose the correct answer.

Q.No	Question	Marks	CO
1	A company entering a new market with low initial prices is most likely to be influenced in the short term by which type of objectives? a. Social objectives b. Personal objectives c. Market share objectives d. Profit maximization objectives	5	CO-1
2	The understanding of the cultural impact on consumer behaviour is crucial to successful cross-cultural marketing. Which of the following statements is not true? a. The globalization of markets may create the dangerous illusion that consumer behaviour and patterns of consumption in each country of the world are converging b. The assumption that using standardized marketing strategies can target consumers across cultures is preventing the marketer from truly appreciating the differences in consumers of different cultures. c. When the ability to pay is low, consumers may focus more heavily on luxury features in making product evaluations on purchase decisions to ensure value for money. d. Consumers choose particular brands not only for functional or performance benefits but also to express their personality.	5	CO-2

3	For any organization, operating in the international market environment in the 21st century requires types of management competencies. Which of the following is not one of the competencies required? a. Analytic competence in assessing opportunities and selecting markets for entry. b. Leadership competence to enforce regular downsizing and de-layering to maintain a high level of efficiency c. Strategic competence to ensure successful market entry and ongoing marketing management. d. Operational competence to manage and coordinate the global marketing effort	5	CO-3
4	Which of the following is not a benefit of using the new electronic media in international marketing? a. Giving customers and other stakeholders the option on how and when information is available to them. b. New electronic media enable the capturing, storage and analysis of information on customers and their behaviour. c. The increase in electronic communication inevitably creates more wasteful, unwanted and unselective advertising. d. It facilitates the building of long-term satisfying relations with key stakeholders.	5	CO-3
5	Choosing a suitable international brand name is an important, but often difficult, part of the process that creates a strong and distinctive brand. Which of the following statements about choosing a name for a new soft drink is UNTRUE? a. The name should be memorable and easy to pronounce. b. The name must be checked by experts to ensure it doesn't infringe on another company's brand name. c. The name should have positive associations with the benefits and features of the product. d. The brand name must be modern and contemporary.	5	CO-2
6	A modern supply chain should enable the organization to successfully compete in today's International market environment due to several reasons apart from which of the following? a. Predictable but inevitable changes in supply chain relationships. b. The increasing demand for low volume, high quality, customer and specific products. c. Products have very short life cycles and very short development and production lead times. d. Customers want to be treated as individuals.	5	CO-1

SECTION B

(70 Marks)

In this section, there is ONE Case Study. It is compulsory.

Q.No	Discuss the given Case Study by giving the answers to all the questions (a-e)		CO
7.	**(a)** By giving a brief introduction of the case, describe the occurrences taking place in it. Also, recognize the key personnel who are facing the challenges in the operation of the organization.	10 marks	CO-3
	(b) Define the business problems being-faced by the key officials in the case. Also, discuss the short-term and long-term problems.	15 marks	CO-3
	(c) Illustrate the reasons of the problem. Also, explain, in detail, the identified problems as well as apply relevant theories and models, if applicable, from the text and/or readings.	15 marks	CO-4
	(d) Calculate the identified decision criteria against which you evaluate alternative solutions. In addition, compare the possible alternative solutions along with the appropriate pros and cons of each alternative.	15 marks	CO-4
	(e) Apply the solution and implementation for the problems and causes identified in the case. Also, discuss why this recommended plan of action is the best and why it would work. Remember the "who", "what", "when", and "how" in your recommended plan of action.	15 marks	CO-4

<u>**CASE STUDY**</u>

NETCARE'S INTERNATIONAL EXPANSION

As he reviewed the National Health Amendment Bill that had just been introduced in Parliament in June 2008, Dr. Richard Friedland, who had led Netcare Limited ("Netcare" or "Group") since 2005, wondered how pressures at home would affect the company as it strived to become a global player in the health-care industry. The proposed legislation would pave the way for regulated prices and collective bargaining between medical schemes and health service providers such as hospitals and doctors, and could change the entire industry structure in South Africa going forward.

For a company with a market share in South Africa in excess of 28 per cent, growth at home by acquisition was always going to be limited and subject to stringent scrutiny from competition regulators. Potentially strong organic growth options at home, however, were on the horizon. At the same time, Netcare was itching to demonstrate its skills and abilities on a wider international platform.

One of Netcare's key long-term goals was to deliver innovative, quality health-care solutions to patients in every continent of the world. The recent acquisition of the General Healthcare Group (GHG) in the United Kingdom had propelled Netcare from a predominately South African operation into one of the largest private hospital groups in the world. Political pressures in South Africa, however, could only further complicate the difficult decisions to come in defining how to execute the group's strategy. What lessons, Friedland pondered, could be learned from the GHG acquisition, how could he leverage the group for further growth internationally, and which continent was best suited for expansion?

NETCARE OVERVIEW

Netcare, founded in 1994, was listed on the Johannesburg Stock Exchange in December 1996 with six hospitals. Several small and independent hospital groups in South Africa were acquired soon thereafter, including Clinic Holdings Limited and Excel Medical Holdings Limited. In 2001, Netcare acquired Medicross, a managed health-care provider network of 75 medical and dental centers across South Africa. In 2006, Medicross then acquired Prime Cure Holdings, a provider of primary care services for the emerging market with a further 25 centers and 130,000 managed care customers.

By 2007, with 18,877 employees, Netcare was demonstrating strong growth (see Exhibit 1 for Netcare's financial statements). Netcare was providing the following key services in South Africa (see Exhibit 2 for a map of locations):

- Private hospital and trauma services through equity interests in 56 hospitals with more than 9,546 beds, 358 operating theatres and 86 retail and hospital pharmacies;
- Netcare 911, the largest private emergency service with more than 7.5 million members and a fleet of 246 response vehicles and ambulances, three helicopters and two fixed-wing air ambulances; and,
- Ancillary health-care services including primary care services through Medicross and Prime Cure, and diagnostic services through an interest in a nationwide administration and logistical services infrastructure servicing 290 high-tech pathology laboratories and depots.

THE SOUTH AFRICAN HEALTH CARE INDUSTRY

South Africa is often characterized as two countries living side by side, with a largely black, poor population with limited access to health care and a low standard of living, on the one hand, and a wealthy, predominantly white population utilizing a world-class private health care system, on the other. The poor rely on a public health-care system that is focused on primary health care and the management of HIV/AIDS, tuberculosis, malaria and other diseases afflicting the poor such as malnourishment. In contrast, the private health-care sector resembles that of a developed country and patients are typically older and require tertiary-level care.

Health-care spending in South Africa in 2004 was 8.6 per cent of GDP, which equated to a *per capita* spend of roughly US$390 per annum[1] of which about 60 per cent went towards private health care. Approximately 14 per cent of the population had private medical insurance, while 40 per cent used private sector health services, as outpatients or otherwise.[2] Compared to other countries, the private health care system in South Africa ranked near the top in terms of access and quality, while the public sector ranked near the bottom (see Exhibit 3).

In South Africa, the hospital groups generally did not employ physicians or medical specialists but rather competed on the basis of attracting doctors to practice in one of their hospitals. Private patients saw their local doctor or specialist, who then referred them to the hospital of their choice to perform operations and the like. The private hospital then billed a medical insurance scheme directly. In a sense, the traditional business model was doctor-driven, with the hospital "renting" facilities and nursing hours to doctors. To attract the busiest doctors to practice in their hospitals, the organizations competed to have the latest and best medical technology, the best nursing staff and world-class facilities.

The overwhelming majority of private patients in South Africa were covered by medical insurance schemes, which had tended to increase tariffs above inflation rates. This was leading to increased spending on private health, but at the same time encountering resistance from consumers. Meanwhile, the growth of traditional private sector medical schemes had been slow. In response to these circumstances, the South African government had explored options for broadening social health insurance to the general population. Its first two initiatives were the introduction of a broad-based medical scheme for the 1.1 million public servants in the country, and making health insurance compulsory for all formally employed South Africans. These initiatives would increase the pool of insured people by between seven and 10 million and free up public resources to concentrate more on expanding primary health care and on HIV/AIDS

[1] *World Health Organization, 2006.*

[2] *Statistics South Africa, General Household Survey, 2005.*

management and prevention. For service providers, such as Netcare, the major implication was a shift from traditional low-volume, high-margin operations to high-volume, low-cost, low-margin ones. The structure of the health-care market in South Africa is depicted in Exhibit 4.

During the Apartheid era, the private hospital sector served the minority white population almost exclusively, while the majority black population had to use public hospitals. To address social and economic inequities, the South African government developed a regulatory environment to drive national and sectoral transformation. The Broad-Based Black Economic Empowerment Act, promulgated in 2004, allowed the government to issue Codes of Good Practice for private sector firms.

The Codes provided a core set of indicators and criteria to define and measure Black Economic Empowerment (BEE) and guidelines on how to establish sector transformation charters and targets to achieve meaningful, effective and broad-based BEE. Central to the Codes was a balanced scorecard approach, which measured an enterprise's BEE contribution across a range of indicators, as follows:

	Weighting
Equity ownership (by historically disadvantaged individuals)	20%
Management control (by historically disadvantaged individuals)	10%
Employment equity (achievement of affirmative action targets)	15%
Skills development (of historically disadvantaged individuals)	15%
Preferential procurement (from firms owned by historically disadvantaged individuals)	20%
Enterprise development (of firms owned by historically disadvantaged individuals)	15%
Socio-economic development	5%

The BEE Charter for the Healthcare Sector (the Health Charter) sought to manage a myriad of health-care challenges effectively and ensure a healthy workforce that could participate productively in the economy. While the Health Charter had not yet been finalized, the development process had entailed information sharing and open discussion between the public and private sectors and had fostered partnerships in a previously fragmented industry.

What differentiated the draft Health Charter from other sectoral charters was that improved access was considered equally as important as broad-based black economic empowerment.

PROPOSED LEGISLATION

In her 2008 budget speech in the National Assembly, the Minister of Health, Dr. Manto Tshabalala-Msimang, noted that:

> Of the R118 billion[3] that was spent in the health sector in 2007/08, R66.4 billion (or 56.3%) was private sector expenditure, which serves about 7 million people, while R51.6 billion (43.7%) was utilised in the public health sector, which provides services to about 40 million people. Over the past years, the private health sector has been unable to increase access and also appears to be unable to contain cost escalations. ... The National Health Amendment Bill has been submitted to this House for consideration. The Bill provides for the appointment of a facilitator to work with funders and providers to seek agreement on tariffs for healthcare services provided by the private health sector. This process should bring some transparency into the process of tariff setting in the private healthcare sector and assist us to contain costs" (June 5, 2008).[4]

Industry representatives regarded the Bill as a price-setting mechanism, while the Department viewed the Bill as creating a regulatory framework through which prices were negotiated, as happened in many developed countries. The country's third-largest private hospital group said the minister should rather work with the industry to find alternative mechanisms to price controls to make health-care services available to more people: "Medi-Clinic maintains the opinion that the draft bill objectives are already covered by extensive legislation. It is undesirable that the Health Act be amended to introduce additional regulatory controls."[5]

South Africa's private health-care industry warned that the proposed changes could hasten the emigration of doctors and nurses and undermine investment in the country. Private hospitals were highly capital-intensive and if returns were not sufficiently appealing, the capital would be routed elsewhere.[6] Indeed, Med-Clinic noted that it and Netcare had already made significant investments offshore. Medi-Clinic had recently completed the acquisition of a Swiss hospital group (Hirslanden Finanz) at a price of $2.36 billion. Concern from investors was also cited as causing downward pressures on company share prices, and Netcare shares were trading at around R8.00, down from a peak of more than R13.00 some six months earlier.

NETCARE'S STRATEGY

Netcare's philosophy and approach to its health-care business was characterized by a strong performance-driven culture with a fanatical attention to detail. With a reputation in the South African health-care industry for innovation and an obsession with measurement, Netcare maintained world-class standards in patient care, staff competence and relationships with medical practitioners.

Netcare's strategy was based on six major themes:

Organizational Growth

Netcare saw its presence in South Africa and the United Kingdom as an opportunity to combine the expertise and experience of senior teams from both countries to drive sustainable growth across two major private and public health-care markets. In South Africa, organizational growth had come from expansion of existing hospitals and the building of new hospitals, with four being completed in 2006. Additionally, it had secured large contracts for its Netcare 911 emergency and ambulance service. Netcare was expanding

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[3] *US$1=R7.80.*

[4] *Minister of health budget speech 2008 at www.info.gov.za/speeches/2008/08060515451001.htm*

[5] *Medi-Clinic CEO Koert Pretorius, Business Day, June 4, 2008.*

[6] *Sunday Times, May 25, 2008.*

into new emerging markets by providing a low cost, high volume service to private patients who previously could not afford the traditional private hospital offering. In the United Kingdom, Netcare's operations were reorganized into regional structures and three new National Health Service (NHS) contracts were awarded in 2007.

Operational Excellence

An ongoing focus on building and sustaining a culture of excellence at every level of operations characterized the Group. It was committed to driving efficiencies and containing costs in ways that did not compromise quality. In South Africa this had led, for example, to the implementation of a Systems, Applications and Products (SAP) system, the accreditation of all hospitals and a drive to implement shared-services centers. In the United Kingdom, 28 hospitals were IT-enabled for the NHS Extended Choice Network and back-office functions were integrated.

Physician Partnerships

General practice physicians and specialists were the most critical part of the private hospital business model and Netcare focused on providing them with state-of-the-art facilities, skilled nurses and the latest technology. Netcare had invested heavily in facilities and technology and nursing and doctor training. These initiatives led to Netcare attracting an additional 162 medical specialists to its facilities in 2007. In the United Kingdom, Netcare had launched partnership schemes with doctors and expanded to more than 60 Practice Development Groups across their hospitals.

Best and Safest Patient Care

Netcare introduced a clinical governance program to define clinical pathways, which in turn lead to reduced variability in service and thereby safer patient care. Netcare also formed a Medical Advisory Ethics Committee and had its own clinical governance guidelines for trauma, ICU and infection control. The Group boasted of having the lowest hospital infection rate in South African recorded history. Netcare experienced a 5.9 per cent increase in admissions in 2007 over 2006 (to one million), and a 9.4 per cent increase in primary care visits (to 3.6 million in 2007). Netcare also enjoyed a 1.7 per cent increase in total cases handled in the United Kingdom to 1.1 million.

Passionate People

Netcare's HR strategy was a critical component of its overall business. South Africa was suffering a critical shortage of skills, including nurses. Aggravating the skills shortage was a brain-drain of nursing skills from South Africa to countries such as Saudi Arabia, the United Kingdom, Canada and Australia. Netcare believed that it needed to be an employer of choice to attract and retain nurses and related skilled workers, as well as to increase the training of nursing students to overcome these problems. Netcare participated in initiatives by South African companies to recruit expatriates back to South Africa. Netcare also trained 3,700 nurses and paramedics in 2007, at a cost of R100 million.

Transformation

Under the leadership of founder Dr. Jack Shevel, Netcare had adopted a largely confrontational approach to the government and regulators in the industry.[7] Netcare left the Hospital Association of South Africa (HASA) when HASA wanted to follow a consultative lobbying approach with the health minister over new pricing regulations. Netcare broke ranks and launched a controversial court challenge. Ultimately, the court challenge was successful but relations with the government were considerably soured.[8]

When Richard Friedland took over as CEO in 2005, he immediately ordered a strategic review and Netcare's approach to government changed significantly. Friedland recognized that government was an important stakeholder in the health industry and that regulations had a strong impact on a health operator's ability to make a profit. Netcare's current approach was to engage early and regularly with the government so that it was seen as a partner in health care.

Friedland embraced the Health Charter and Netcare currently had 17.3 per cent black equity ownership and seven per cent women ownership. The majority (61.4 per cent) of the company's workforce was from previously disadvantaged groups and Netcare had spent R37 million on corporate social investment, including R18 million covering indigent patients. On a well-respected scale of BEE commitment, Netcare was rated at the highest level.

Friedland's vision for Netcare's vision in South Africa was to be able to provide a tiered system that could provide access to all South Africans:

> The top tier is already well-serviced and there is a high degree of competitive rivalry between the private hospital groups to service this market. Netcare is the leading hospital group in this highly competitive sector of the market and intends for this to remain so. For future growth, however, Netcare has to take risks and develop new models to service the rest of South African society. This is not only the only alternative for organic growth in South Africa, but is also a social imperative. Netcare is well-placed to offer a holistic solution to the formally and informally employed who can not currently afford private healthcare. The future lies in a new funding model and efficiencies in service provision. Netcare is well-positioned to serve this market with its primary healthcare offerings of Medicross and Primecure — 51% of patients using Primecure in 2007 paid for services out of their own pockets. The reason for this was primarily a lack of trust in the public service healthcare, or the desire for a more efficient experience. This will also remove a substantial burden from the South African public healthcare.

INTERNATIONAL EXPANSION

Netcare began to expand outside South Africa in 1997. The United Kingdom was chosen as one destination, based on its low penetration of private sector operators and its attractive demographics in terms of an aging population. (See Exhibit 5 for an overview of the relationship between demographics and health-care spending.)

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[7] *"Cool operator Shevel looks back on R10bn adventure," Business Day, May 13, 2005.*

[8] *"Rivals speak on Netcare's move," Business Day, August 11, 2004.*

The U.K. Health System

In 1997, when the Labour Party came to power, the National Health Service (NHS) was in disarray as a result of severe under-funding and lack of modernization. There were waiting lists of more than one million patients, with five per cent waiting for more than 12 months to see a doctor. Increases in health expenditure fluctuated between zero per cent in some years to six per cent in others and, since the 1960s, real spending per annum averaged 3.6 per cent of GDP, while the average for OECD countries was 5.5 per cent.[9] Compared to other developed countries, the United Kingdom had fewer doctors and health-care professionals per capita, and investment in health care technologies and facilities was low. Many buildings predated the formation of the NHS in 1948. The problems were exacerbated by poor morale amongst staff and severe staff shortages.

In response to these challenges, the U.K. government set a series of ambitious targets for the NHS in 2000,[10] including:

- Maximum wait for inpatient treatment of six months by 2005;
- three-month maximum wait for outpatient treatment;
- Primary care access to a general practitioner within 48 hours by 2004;
- A wait of no more than 18 weeks from general practitioner consultation to hospital treatment; and,
- Patients to have a choice of four to five practitioners by 2006, and open choice of health care providers by the end of 2008.

The Labour government hoped that the initiatives would result in more choice to patients, more value for money by the introduction of market forces, the creation of a sustainable independent health sector market, increased capacity in difficult areas and innovation in the NHS. In doing so, it also intended to change the balance between public and private funding (see Exhibit 6), and thereby open the way for public/private partnerships.

Netcare's Entry into the United Kingdom

Netcare entered the U.K. market in 2002 to provide specialized health-care services on contract to the NHS. Netcare had seen an opportunity to use the skills that it had developed in South Africa to win tenders with the NHS in the United Kingdom. According to Friedland:

> Initially Netcare's hope was to take advantage of the NHS waiting lists and fly UK patients into South Africa for treatment, but this was not feasible due to the nature of the UK market. In rural England many people had not even traveled to London and it was unlikely that they would want to travel to South Africa. Instead Netcare decided to send South African medical professionals to the UK to test whether they could operate efficiently within these boundaries. Netcare introduced systems that were regarded as novel and groundbreaking by patients such as the patient making one visit and having a complete diagnosis with all services such as x-rays and other assessments available on the spot.

Netcare's first tender was a five-year contract with the NHS (worth GBP 42 million[11]) to perform 44,737 cataract procedures. Netcare enjoyed almost immediate success, as it was able to adapt its home-grown

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[9] NHS Plan 2000, Department of Health, United Kingdom.

[10] www.dh.gov.uk.

efficient methods to the U.K. environment. Realizing that it could not perform all of the procedures from a single location, Netcare developed mobile ophthalmic units that rotated between different locations, offering pre-operative assessments, surgery and post-operative care. Each unit had a staff complement of 30.

Netcare innovated in the development of "factory services," where economies of scale were achieved by scheduling a large number of similar operations together. The resulting efficiencies allowed Netcare to perform 22 cataract surgeries per day per surgeon, while the best practice in the United Kingdom was 12 per day.

A South African entrant into the U.K. health-care market did not go unnoticed and elicited some concern from the general public, but this quickly dissipated with direct experience. The 10,000th patient had the following to say about the service:

> I was a bit apprehensive before the cataract procedure with Netcare, but I was delighted with how it went. The staff were fantastic. I liked the cleanliness of the unit. There was no pain. I hope the NHS continues using partnerships like this.

Success with the cataract contract led to other opportunities, such as running a surgical centre in the Greater Manchester area. This facility had 48 beds, three laminar flow theatres, a rehab department, clinical support services and 120 staff. The period of the contract for the surgical centre was for five years, from 2005 to 2010, and would lead to 44,863 procedures for which the NHS paid Netcare GBP 85 million. The quality of the service provided is reflected in the comment by a patient of the centre:

> Everyone was so lovely and understanding at the centre, I know that they have operated on hundreds of knees but I felt very special and certainly not just an operation number. Since I have returned home I have been able to take up bowling again and although I still feel the odd ache and pain I can just ring up my surgeon and have a consultation.

Netcare subsequently won a tender to run primary health care facilities in Leeds. All services were provided through Netcare UK, an established independent service provider to the NHS.

In focusing on publicly funded health-care services, Netcare realized that it could apply its knowledge and modern processes in additional areas such as renal, dental, diagnostics and others. Netcare UK's stated strategy was to become the provider of choice amongst patients, general practitioners and commissioners for an increasing range of health-care services. In charge of U.K. operations at the time, Friedland felt that by working together with Primary Care Trusts, Acute Trusts and Strategic Health Authorities, Netcare could provide additional capacity and capability, and contribute to a quality public health service, delivered at or below NHS tariffs.

Growth through Acquisition

In May 2006, Netcare acquired a controlling interest (52.6 per cent) in GHG. GHG's business unit, BMI Healthcare, was the largest private acute care hospital provider in the United Kingdom, operating 48 acute care private patient hospitals with more than 2,606 beds, 152 operating theatres and 37 pharmacies, and was supported by 4,200 medical specialists.[12] These various facilities functioned autonomously, and

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[11] *GBP1=US$2.*

[12] *"General Health Care," BC Partners, 2007, www.bcpartners.com/bcp/cases/generalhealthcare.*

Netcare saw an opportunity to enhance their efficiency through implementation of the Group's standardized systems. In the financial year ending September 2007, Netcare UK/GHG admitted 230,000 patients and served 892,500 outpatients. (See Exhibit 7 for a map of BMI's geographical coverage.)

In explaining the reasons for the GHG acquisition, Friedland commented:

> We're confident of achieving strong organic growth in South Africa, but given our size it had become difficult to make significant acquisitions. We've built a good base in the UK, learnt about that market and have also been involved in several unsuccessful acquisition attempts there before.[13]
>
> Having served the needs of the UK healthcare market, we have gained invaluable insight into the challenges and opportunities that exist in this market. We have targeted the UK healthcare market for expansion, as the long-term demographic trends and prospects for development of the private acute care market as well as partnership with the NHS, offer significant future growth potential.[14]

The GHG acquisition provided Netcare with infrastructure, property and facilities, a strong group management team, local connections, purchasing power and an opportunity to build the Netcare brand outside South Africa on a quality platform. Additional benefits included:

- Leveraging the combination of best practices from both organizations;
- Providing opportunities to grow the U.K. private market and take advantage of further NHS partnerships;
- Providing a natural hedge within a changing market;
- Providing Netcare with the capability of transforming health-care delivery in the United Kingdom and South Africa through combining skills; and,
- Positioning Netcare as a leading international health-care solutions company.

The acquisition was a creatively structured transaction where Netcare, in consortium with three partners, successfully bid GBP 2.2 billion for GHG. This price was equivalent to 13.4 times GHG's EBITDA (earnings before interest, tax, depreciation and amortization) of GBP 164 million in fiscal 2005. The consortium included Apax Partners Worldwide (one the world's largest private equity partners, with a particular interest in health care), London & Regional Properties (one of the largest private property companies in Europe, with investments in the United Kingdom, Sweden, Finland, Germany, Denmark and Lithuania) and Brockton Capital LLP (a U.K.-only opportunity fund, with significant experience in real estate and private equity).[15]

Netcare received 52.6 per cent of GHG in return for a payment of GBP 219 million and the injection of its U.K. operation into the transaction. The consortium partners received 47.4 per cent in exchange for their contribution of GBP 303 million. The balance of the purchase price was debt-financed, and secured by the property that was acquired. GHG management received a performance-based equity interest which may

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[13] *"Netcare Bids 2.2 Bln Pounds for General Healthcare (Update6)," Bloomberg, 2006, www.bloomberg.com/apps/news?pid=10000087&sid=aIeXsX_VriY4&refer=top_world_news.*

[14] *"Network Healthcare Holdings Limited acquires leading private hospital group in UK," Apax, April 25, 2006, www.apax.com/en/news/story_general-healthcare-group-limited.html.*

[15] *Ibid.*

equate to approximately seven per cent of the equity over a period, but Netcare's share may not dilute to less than 50.1 per cent as a result of the participation.[16]

In explaining the transaction to South African investors, Netcare addressed concerns about exposure of the South African operation to foreign debt. Netcare noted that its share of the purchase price was funded using new debt facilities provided by Dresdner Bank, which were raised for the purposes of the acquisition. GHG was restructured to form an operating company and property company, OPCO and PROPCO, respectively. OPCO had a ring-fenced debt of GBP 265 million of secured and unsecured mezzanine debt with no recourse to Netcare South Africa. (This was a condition for the deal from the South African Reserve Bank due to exchange controls). PROPCO had GBP 1.650 million debt secured over land and buildings.[17]

Questions Raised

The GHG acquisition raised questions at home about Netcare's commitment to its South African base. Friedland, however, argued that the deal in no way detracted from Netcare's operations in South Africa, which contributed 47.7 per cent and 46.1 per cent to revenue and operating profit, respectively, and employed approximately 18,900 employees:

> Netcare remains fully committed to providing affordable, quality healthcare to more South Africans. We fully embrace the Department of Health's drive to achieve equity and access in healthcare. As one of the largest hospital and managed healthcare operators in South Africa, there are [simply] limited acquisition-based expansion opportunities on offer to Netcare domestically.

Further, Friedland noted that GHG had a strong management team to partner with Netcare to drive the development of the U.K. business forward. As a result, the acquisition of GHG would not denude Netcare South Africa of resources or management capability.[18] It was not at all clear, however, that the South African government saw things the same way.

OTHER INTERNATIONAL EXPANSION

The United Kingdom was not Netcare's only foray into international markets, and other initiatives had less favorable results. For example, Netcare began its international expansion with an entry into Rwanda in 1997, following that country's genocidal civil war. When the Rwandan government privatized a polyclinic, Netcare invested R60 million into converting it into a hospital that was able to provide world- class specialized services. The King Faizel Hospital had previously been used as a refugee camp.

The venture enjoyed a high profile at the time, being officially opened by the president of Rwanda, and the hospital was world class. The project, however, was a disaster for three main reasons. First, the project was dependent on doctors who had fled Rwanda and the African lake region, returning once stability had returned. These doctors, however, were seen as highly skilled and experienced and consequently were in great demand almost everywhere. To fill the gap, Netcare had to employ and fly in South African doctors.

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[16] *Friedland presentation to MBA students, GIBS, June 7, 2007.*

[17] *Ibid.*

[18] *"Network Healthcare Holdings Limited acquires leading private hospital group in UK," Apax, April 25, 2006, www.apax.com/en/news/story_general-healthcare-group-limited.html.*

The second problem was a lack of understanding and appreciation for the enormity of the social and cultural trauma that Rwanda had recently gone through. Netcare came from a South African experience that was fundamentally different to the Rwandan one. Rwanda at the time was a country recovering, as opposed to a recovered country. The differences and animosity between Hutus and Tutsis were still very much in evidence. For example, when Netcare put a Hutu in charge of eight Tutsi receptionists, the hatred and distrust was so evident that it was almost impossible to run the operation. Netcare failed to appreciate the diversity in the situation. According to Friedland, "We came out of South Africa in 1994 (the first democratic elections in South Africa) and had forgotten about Apartheid. Black South Africans had been extremely gracious and forgiving. Rwanda wasn't like that at all."

The third reason the King Faizel Hospital project failed was because the $85 million in aid provided by the United Nations and other agencies for the provision of health and infrastructure was never spent on these services.

Netcare also looked at opportunities in Tanzania and Kenya and at building hospitals elsewhere in Africa, but these efforts did not come to fruition. Its investigations revealed that the South African model had little opportunity of success in these countries, as there was no social funding and limited private medical insurance in Africa.

Through an international division, Netcare was expanding marketing activities beyond South Africa's borders. The primary focus of Netcare International was patient referrals, offering patients who resided outside of South Africa the opportunity to benefit from Netcare's excellent network of hospitals and health-care services. The division was currently involved in a number of health-care projects in sub- Saharan Africa and the Middle East and negotiations were in progress in several other countries. A referral network of more than 200 agents throughout Africa worked closely with Netcare International's Central Referral Office to offer a comprehensive referral service. This included hospital bookings, full travel and accommodation requirements and recuperative care. The African initiatives had focused on securing patient referrals and the marketing of insurance and health-care packages. Netcare International contributed approximately R80 million to hospital revenues in 1999, mainly through patient referrals from countries in Africa.

Netcare was also looking for public-private partnerships, such as in an 18-year contract Netcare acquired in 2008 to rebuild a large hospital in Lesotho and run most of the Lesotho health-care system, including its primary clinics. This project was funded by the Lesotho government and the World Bank. Netcare had also built and commissioned hospitals in Saudi Arabia and Bahrain.

Following its initial experience in the United Kingdom (prior to acquiring GHG), Netcare was on the lookout for other markets that were unconsolidated and it bid for a group of hospitals run by the Red Cross. These hospitals were later withdrawn from sale at the last stage of the bidding. In Portugal, Netcare tried to buy into a network of hospitals but was similarly unsuccessful.

NEW OPPORTUNITIES

Netcare was also considering expansion into other countries, either by making acquisitions or partnering with other health-care providers. Globally, health-care expenses varied considerably, even between OECD countries (see Exhibit 8), and many countries faced pressures from aging populations.

One of the countries under active consideration was Brazil, where Friedland saw large demand as well as an opportunity to consolidate the industry through the offering of an integrated health-care model.

Brazil, the largest country in South America, had a population of 184.2 million, with GDP in 2006 of US$1.1 trillion and a total labor force of 75 million. The private health-care system had 36.6 million members (approximately 20 per cent of the population), geographically concentrated in major cities. Total premiums paid in 2005 amounted to US$18.7 billion. Private hospitals were not required to serve the general public.[19]

The public health-care system provided universal coverage through a large delivery network of hospitals and clinics. There were no charges for usage, as the system was entirely funded by taxation. The public system faced substantial capacity and quality challenges. (Additional information on the Brazilian market is shown in Exhibit 9.)

CHALLENGES AND FUTURE EXPANSION

As he contemplated an upcoming retreat with his executive team, Friedland wondered how to proceed. He noted that his team had previously developed what he termed the Big Hairy Audacious Goal (BHAG) of having a presence on all continents. Netcare saw its core competence in consolidating fragmented markets and introducing efficiencies to them. It had not, however, established any timeline for further expansion, or any priorities for further market entry.

As of September 30, 2007, the Group managed 107 private hospitals and clinics, equipped with more than 12,240 beds. It had consolidated revenues of R19billion, operating profits of R3billion, and total assets of R50billion, with a market capitalization of R22billion. Netcare had clearly made much progress, but could it continue to grow as before? In doing so, would the South African market represent an opportunity or a hindrance, and where should the Group focus its efforts?

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[19] *Merrill Lynch, Brazilian Healthcare Market.*

Exhibit 1

NETCARE FINANCIAL PERFORMANCE

Five year review, years ending September 30 in millions of South African Rands (Rm):

Balance sheet	2007 **Rm**	2006 Rm	2005 Rm	2004 Rm	2003 Rm
ASSETS					
Non-current assets					
Property, plant and equipment	**26,683**	27,246	3,109	2,880	2,704
Goodwill and intangible assets	**16,380**	17,016	350	227	170
Associated companies, investments and loans	**298**	255	791	597	491
Financial asset — Derivative financial instruments	**1,453**	834			^427
Deferred taxation	514	396	19	43	41
Total non-current assets	**45,328**	45,747	4,269	3,747	3,833
Total current assets	**5,211**	4,791	2,013	1,759	1,949
Total assets	50,539	50,538	6,282	5,506	5,782
EQUITY AND LIABILITIES					
Ordinary shareholders' equity	**4,132**	2,237	3,342	2,722	2,867
Preference share capital and premium	**644**	644			
Minority interest	**3,806**	3,355	76	74	72
Total shareholders' equity	**8,582**	6,236	3,418	2,796	2,939
Non-current liabilities					
Long-term debt	**28,944**	29,224	493	793	922
Financial liability — Derivative financial instruments	**1,156**	2,152			
Post-retirement benefit obligations	**115**	294	65	55	44
Deferred lease liability	**63**	64	159	153	141
Deferred taxation	6,073	6,399	62	203	227
Total non-current liabilities	**36,351**	38,133	779	1,204	1,334
Total current liabilities	**5,606**	6,169	2,085	1,506	1,509
Total equity and liabilities	50,539	50,538	6,282	5,506	5,782

Note: The financial results of the Group have been prepared in accordance with International Financial Reporting Standards (IFRS) from the beginning of the 2005 financial year.

Exhibit 1 (continued)

(Rm=Millions of South African Rands)

Income statement

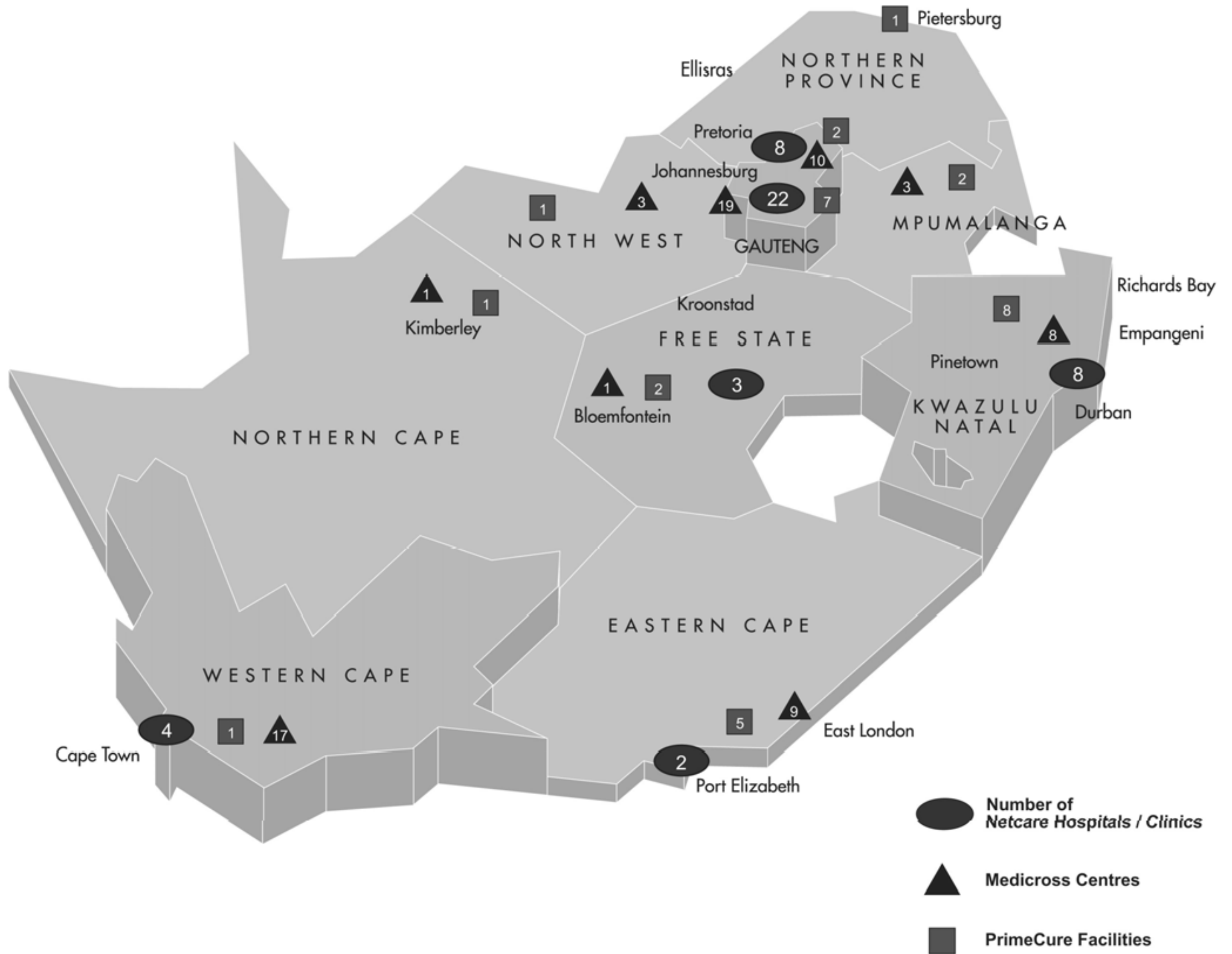
	Compound growth %	2007 Rm	2006 Rm	2005 Rm	2004 Rm	2003 Rm
CONTINUING OPERATIONS						
Revenue	32.6	**18,607**	11,152	7,534	6,853	6,013
Cost of sales		(10,856)	(6,376)	(3,651)	(3,490)	(2,753)
Gross profit		**7,751**	4,776	3,883	3,363	3,260
Other income, administrative and other expenses		(4,761)	(3,198)	(2,693)	(2,416)	(2,337)
Operating profit	34.2	**2,990**	1,578	1,190	947	923
Financial income and expenses	87.4	**(2,135)**	-927	-138	-102	-173
Attributable earnings of associates		32	28	63	25	
Profit before taxation	4.3	**887**	679	1,115	870	750
Taxation		99	-229	-300	-216	-169
Profit for the year from continuing operations	14.1	**986**	450	815	654	581
DISCONTINUED OPERATION						
Profit for the year from discontinued operation		109	87			
Profit for the year		1,095	537	815	654	581
Attributable to:						
Ordinary shareholders		**927**	729	813	652	580
Preference shareholders		**30**	12			
Minority interest		138	-204	2	2	1
		1,095	537	815	654	581

Stock exchange performance

		2007	2006	2005	2004	2003
Market prices per share						
– at September 30	cents	**1,193**	1,240	655	495	410
– highest	cents	**1,677**	1,318	670	535	440
– lowest	cents	**1,150**	611	470	400	265
– weighted average	cents	**1,368**	950	560	463	337

Exhibit 2

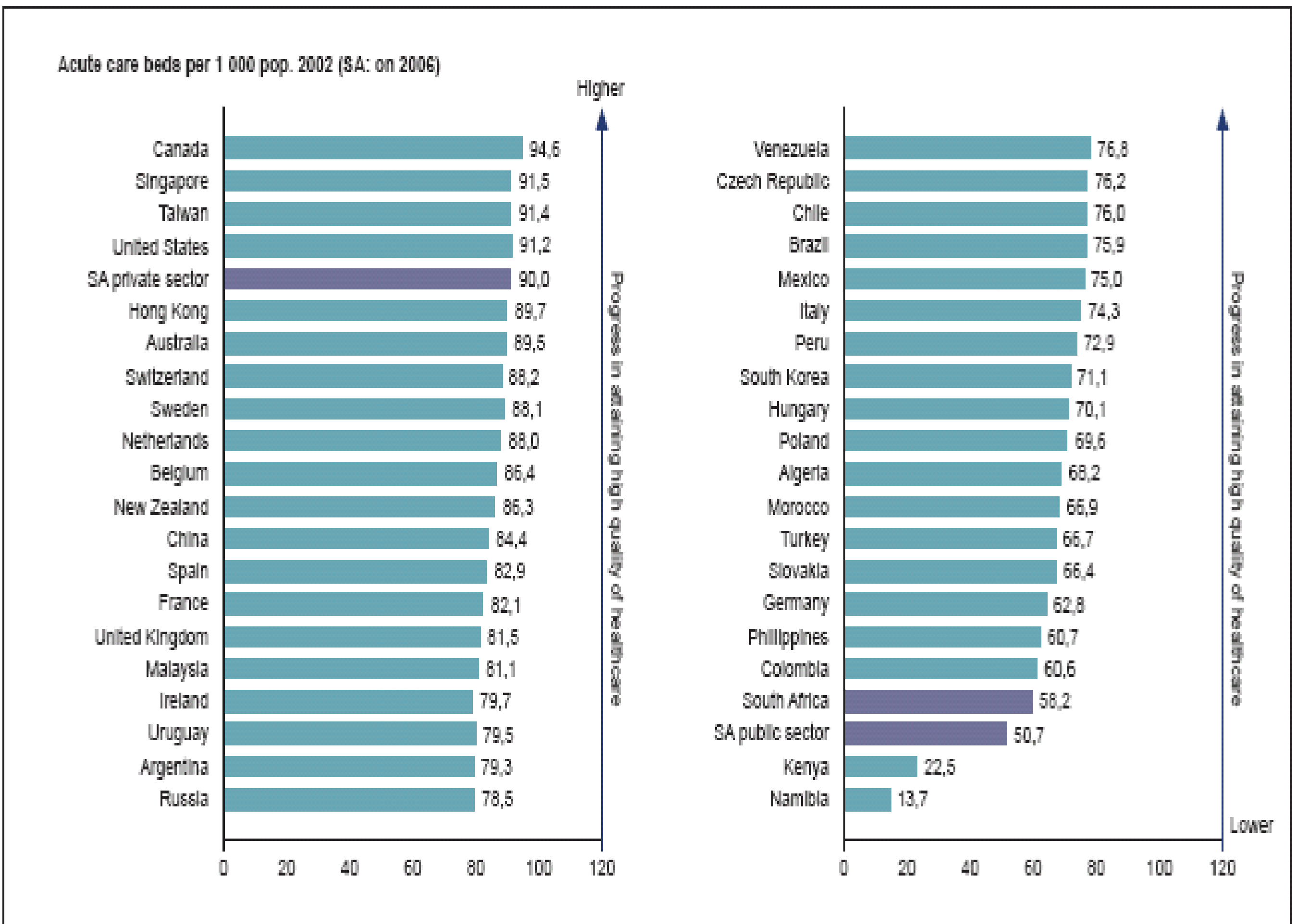
NETCARE LOCATIONS IN SOUTH AFRICA



Source: Netcare.

Exhibit 3

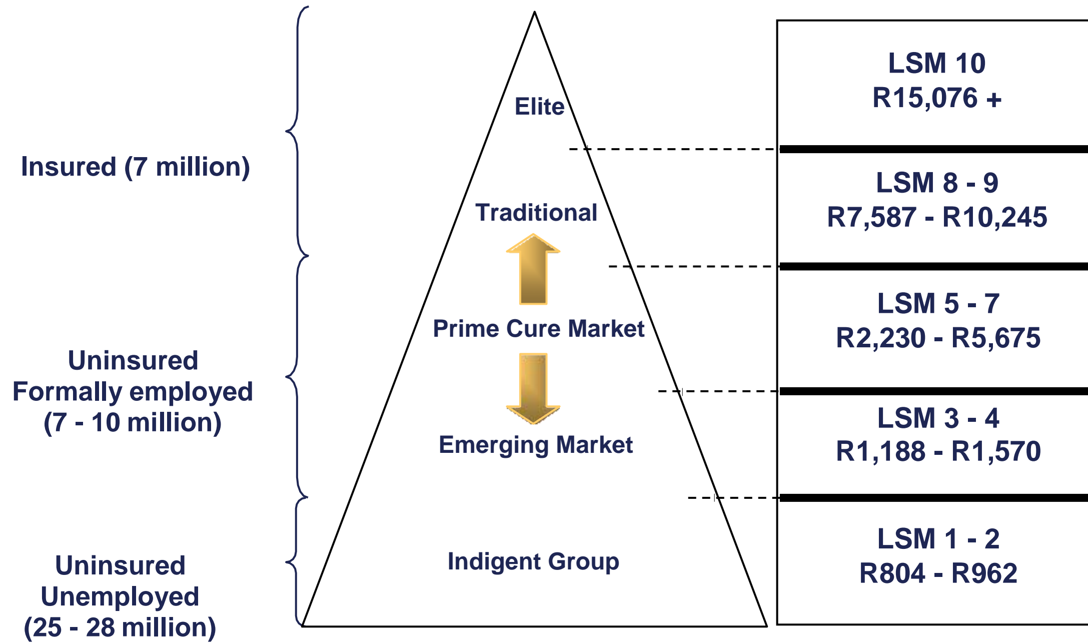
HEALTH-CARE SYSTEM PERFORMANCE ON ACCESS AND QUALITY



Source: Monitor Group, January 2004.

Exhibit 4

HEALTH CARE IN SOUTH AFRICA

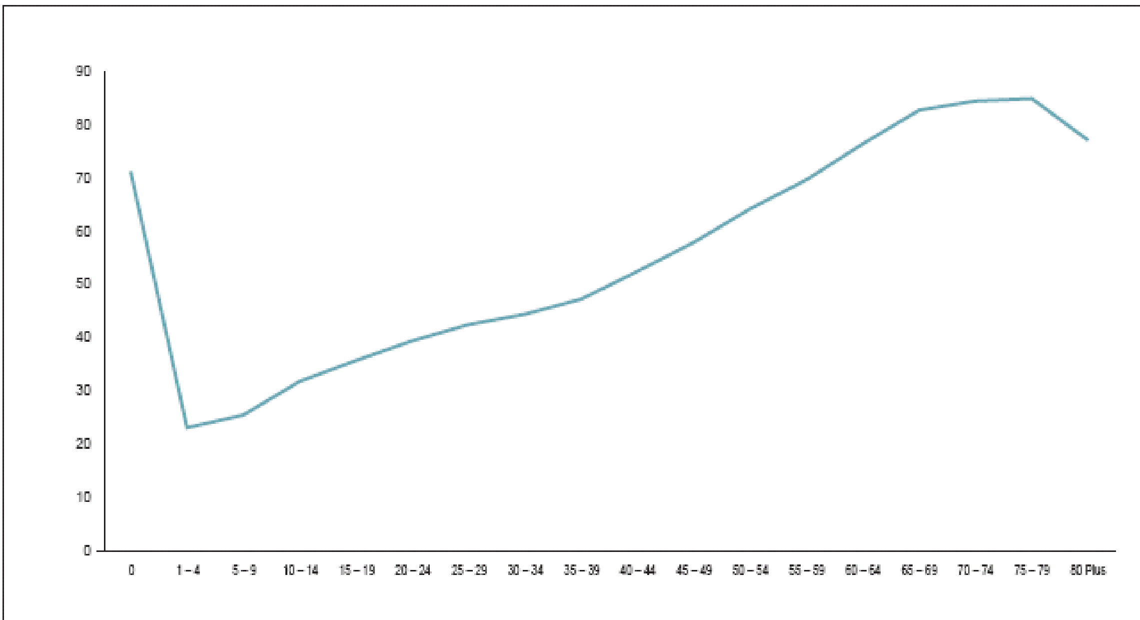


Source: SAARF Trends, 2002-2006.

Exhibit 5

EFFECTS OF AGING POPULATIONS

Average revenue per age band (indexed) for South Africa's Major Private Hospital Groups (similar to developed country profiles)



Source: Regional Business Analytics.

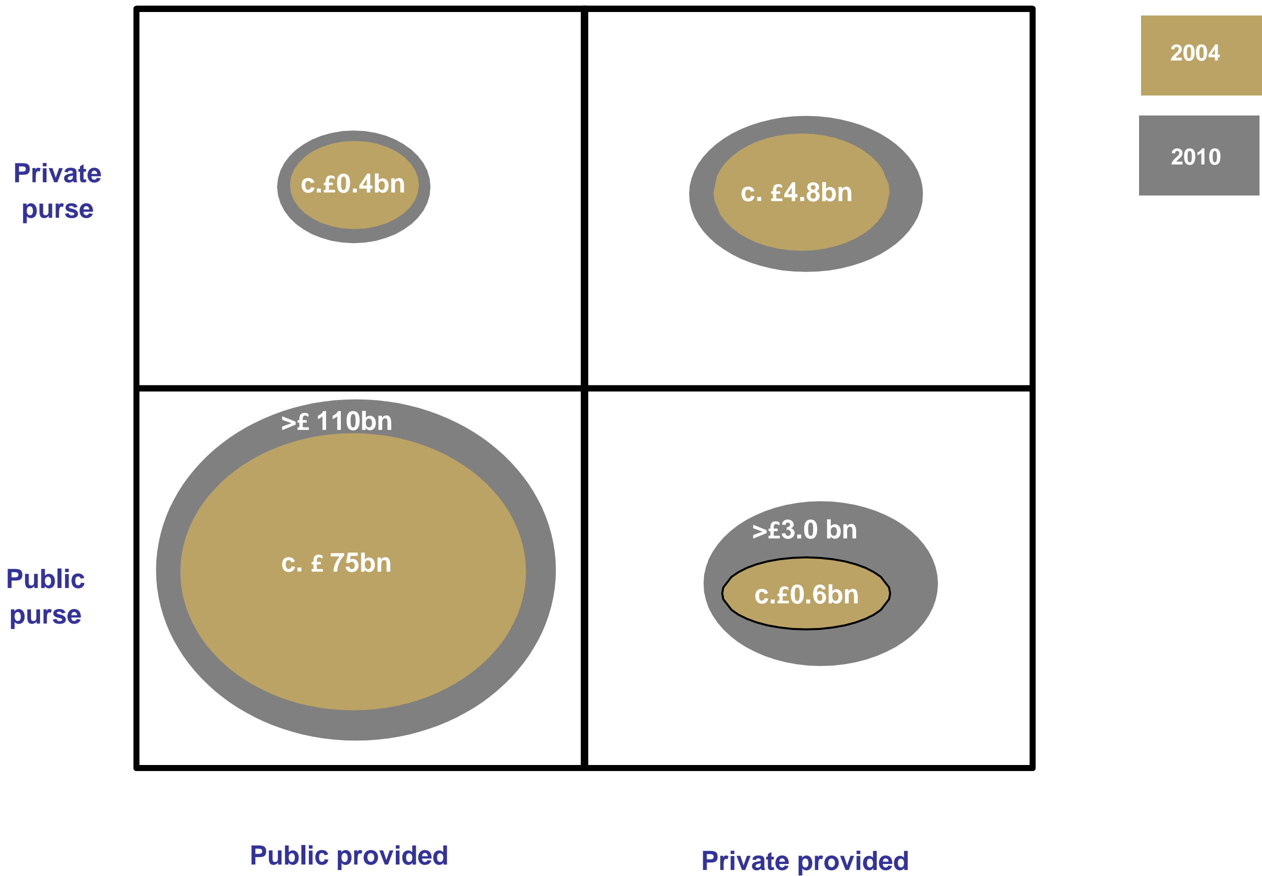
- The average age of a patient in a private sector hospital was 42.5 years old in 2006, compared to 36.9 years in 2002. This trend translates to an approximate "age creep" of 1.4 years per annum.

- There is a strong linear relationship between age and hospital billings.
- The average "cost creep" due to "age creep" cost medical schemes in South Africa was R936 million from 2002 to 2006.

Source: Hospital Association of South Africa (HASA), 2007.

Exhibit 6

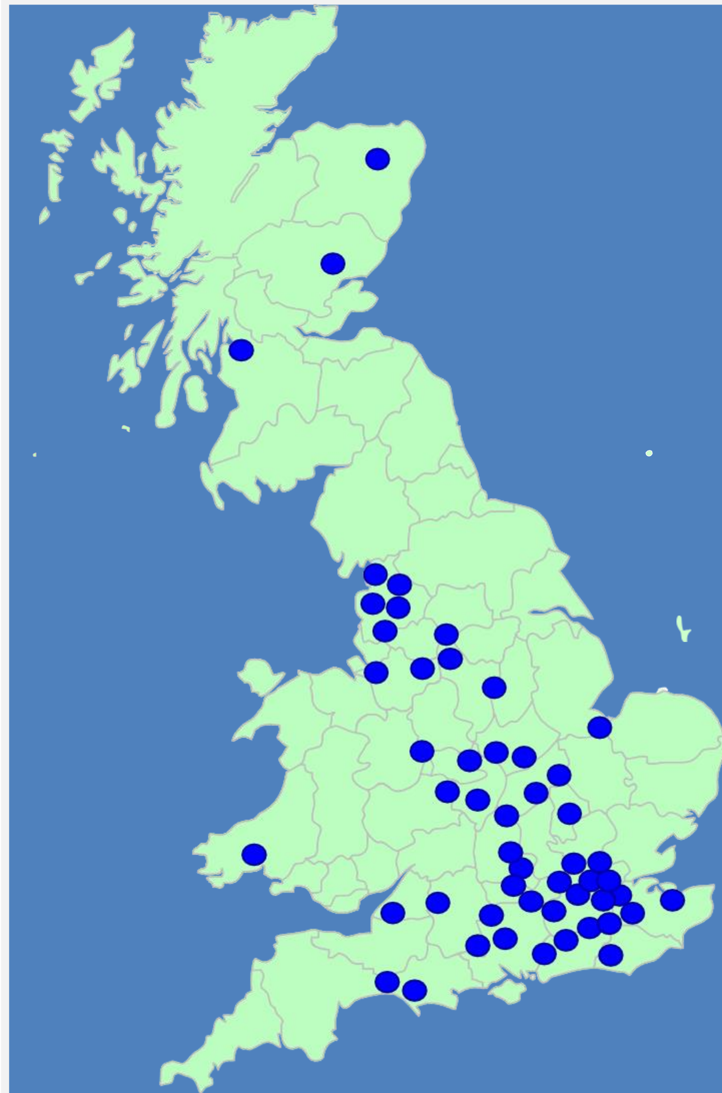
THE CHANGING BALANCE OF PUBLIC/PRIVATE FUNDING AND PROVISION IN THE UNITED KINGDOM



Source: NHS, 2000, & Netcare UK.

Exhibit 7

BMI LOCATIONS IN THE UNITED KINGDOM



Source: Netcare.

Exhibit 8

HEALTH CARE EXPENDITURES (SELECTED COUNTRIES)

(USD- US Dollars)

Per capita total expenditure on health (WHO 2004)

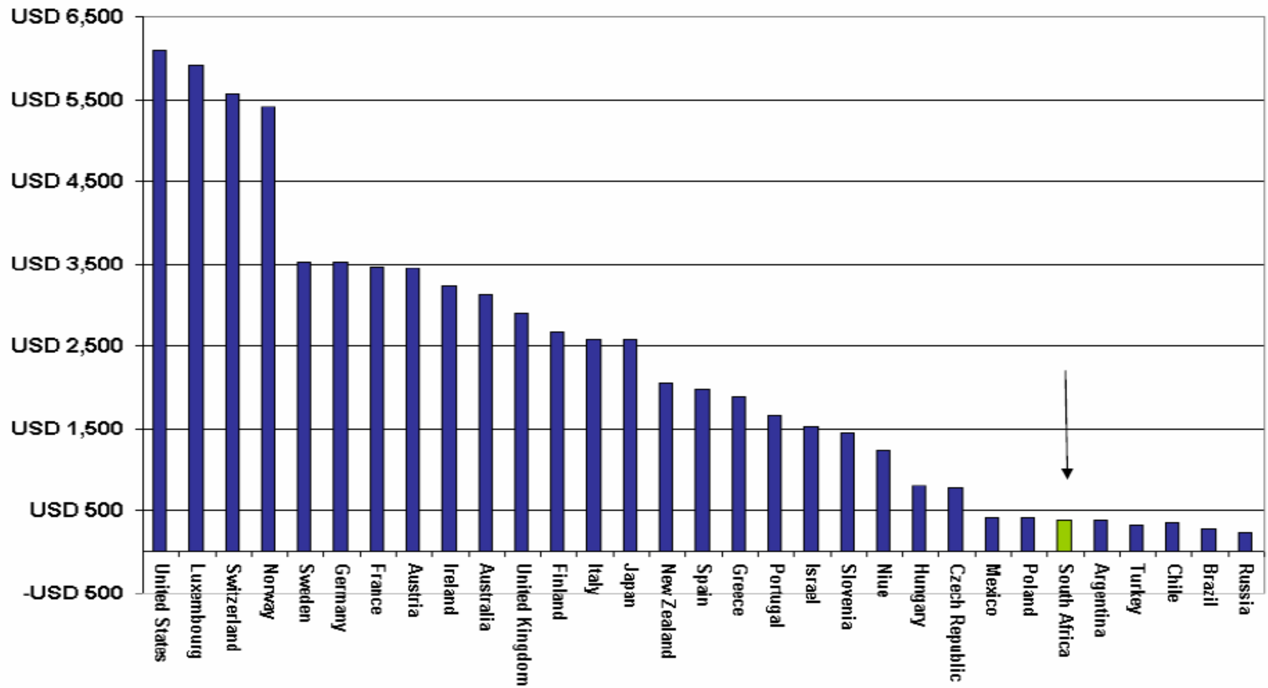


Exhibit 9

FACT SHEET: OPPORTUNITIES IN BRAZIL

- Brazil has several private hospitals that can compete with top American and European hospitals
- Lower levels of consumer spending power have forced private hospital managers to seek new ways to deliver high-quality care from fewer resources. Notable examples are:
  - The creation of purchasing groups to manage relationships with suppliers
  - A variety of services have been outsourced
  - Partnerships have been formed with real estate developers and investment funds to make hospital expansions viable
  - There has been an increased focus on illness prevention, the use of day-hospitals and homecare nursing programs to reduce costs
  - Safety and quality of care have received attention, with 34 hospitals in Brazil receiving accreditation by 2004
  - Health-care insurance plans are responsible for between 80 and 90 per cent of hospital revenue

HOSPITAL STATISTICS (Public and Private)	
Hospitals	7,687
Hospital Beds	483,495
Average Number of Beds per Hospital	63
ICU Beds	20,462
MRIs	341
CT Scanners	1,497

Source: Research commissioned by Netcare.