Global Health goes global

Saturday, 26th of July 2014

Alan Kohler: Well, Mathew Cherian, welcome to Eureka Report. Thanks for joining us.

Mathew Cherian: That's a pleasure. Thanks for having me.

AK: Now look, I think probably the best thing to do is start at the beginning, the history of Global Health and we'll get into what it does now, but… because you started the company as Working Systems?

MC: Working Systems. That's right.

AK: Working Systems in 1985.

MC: Correct.

AK: So, tell us about what it was when you started it.

MC: So, I, without giving away too much, I did a…

AK: You can give away too much if you like. That's fine.

MC: …double major in business and in technology and systems back in the late '70s, early '80s and in those days…

AK: And you're in Perth, right?

MC: In Perth. That's right. I was in Perth. And in those days software, the software business was very much about writing for a particular brand, so you'd write software for IBM or NCR or Burrows, so you'd be a software house for a particular hardware vendor. In the early '80s a couple of things happened. AT&T started commoditising operating systems with something called UNIX which is what the Apple computers still run today or derivatives of that and of course Bill Gates with Microsoft started commoditising operating systems, so you had this great opportunity to write software that was decoupled from a particular brand. And so, in '85 I got pretty enthused by that opportunity and set up a bureau which is where you develop application software and you rent it out to people who can't afford the whole infrastructure. So, you buy a little mini computer, you write software and being out of Perth which was in those days…

AK: So, what sort of customers are we talking about? Just kind of small companies that needed an application to help their business?

MC: No. We actually had customers that… Being in Perth we had a whole bunch of mining companies, you know, the usual suspects in those days and Crown Casino, Wesfarmers customers and a lot of small businesses as well. But because it's the most isolated city in the world – this is pre internet, pre mobile – you really had to diversify across industries, so your core competency was writing something that applied across businesses and I love that little business model because you get the recurring revenue. And then in the early '90s… So, I set up the company, as you said, Working Systems.

AK: And it was successful? You were going okay?

MC: It was successful. That's right. I mean timing's never been the best. You had '87. You had '92. And in the early '90s during that recession, one of the projects we did was developing a system for a public hospital which they'd been having trouble with for the last three or four years and we were successful and they were happy and the health department said look, would you be able to write a hospital system for us because one of the multinationals that had been given the gig had basically decided to pull out of Australia. And so, that got us into health.

AK: At some point along that you merged with Grant Thornton Consulting.

MC: That was a bit later.

AK: Later. Okay. Righto.

MC: Yeah.

AK: So, who owns the business at this point?

MC: At this point it was me and a couple of other minority shareholders, you know, a bit of sweat equity. And in the ‘90s we got into health. That particular project was for a hospital in country WA and that was very successful and eighteen months we rolled it out to 60, 65 hospitals and I think that project had an award, so we started to get a little bit more recognised. And across the ‘90s, you know, we were still a kind of broadly based technology company.

AK: And were you writing tailor made systems for hospitals or were you starting to do cookie cutter approaches?

MC: It’s starting to do cookie cutter approaches, so, you know, which is one of the benefits of writing it for sixty hospitals because you’ve got a hospital that’s… You know, a regional hospital is quite different to… In the Victorian context a hospital like The Alfred is quite different to a hospital in Omeo or Bendigo, right, so you have to start thinking in terms of commodity. You know, what’s going to work across a broader variety of settings? So, in the ‘90s… Based on that we picked up another tender for South Australia with another sixty hospitals and IBM came knocking and they started marketing our stuff in Singapore and in the eastern seaboard and being in Perth again.

AK: Oh, they… IBM started marketing it for you?

MC: Yeah. That’s right. Yeah.

AK: What just simply as a distributor?

MC: As a distributor. That’s right.

AK: Right.

MC: And being in Perth and I grew up in Singapore, so I tended to think that well the next million people, if you like, and you can fly four hours and get to Adelaide or you can fly four hours and get to 250 million people, so put a lot of time into developing export markets in Southeast Asia and that was successful. And then towards the end of the ‘90s with the internet taking off, one of my colleagues at the time was managing the Grant Thornton management consultancy in Perth and we were both really excited about, you know, the opportunities of the internet, so Grant Thornton helped list the company and we acquired the management consulting business of the WA Grant Thornton business.

AK: What did that mean? What did you acquire?

MC: So, we acquired a services business that was doing a lot of consulting for businesses that were saying, what is this internet gig? You know, what’s it going to do to my business, how do I get ready for the business?

AK: So, they were just charging by the hour. They weren’t actually providing software solutions.

MC: That’s right. They were a services business. We’re a consulting business. That’s right. And original Working Systems had a kind of mixed model. So, we had products for the hospitals and we also had services business because we still had that customised solution for different clients. But the opportunities of the internet were, you know, pretty much like what happened in the mid ‘80s. You know, suddenly you had this connectivity and you had access to a global market and you had

access for connectivity, and in those days there were lots of start-ups and so the reality is we had to list, so that we could compete on a far more equal playing field. So, we listed in April 2000. It was a Grant Thornton business which was basically an e-business consulting business and then the e-learning business which we set up and I put my mind to the e-health opportunity. Health and education we felt were two of the most information intensive industries and at the same time they were probably the most archaic in terms of adoption of technology. That's probably unfair with education, but one of the courses I did in trying to find out about the internet was purely online and we were the first cohorts, my partner and myself, and the first tutorial had about 18 of us and we had no face-to-face, so everything was done through chat and webinars or the equivalent and by the third semester there were 110 of us and then you start to realise that the internet suddenly removes all the physical constraints of a business. So, there was a lot of excitement and so we listed in 2000, but unfortunately it was the day of the Nasdaq crash.

AK: Well, I was going to say the excitement went away.

MC: The excitement went away very quickly, very quickly.

AK: There was no excitement April 2000, no excitement.

MC: Yeah. I was wondering, why isn't anybody excited? You know, we've just listed and they said well Mathew, did you see what happened in the US yesterday? Okay. Fair enough. But, you know, by then, we were quite pleased. I was quite pleased because, you know, we had survived.

AK: Just before you go on, how much of the business did you and your partner retain at listing?

MC: Look, Grant Thornton I had about, from memory, 55 per cent, so it wasn't an exit; it was a genuine attempt to say let's raise what we need to get our e-health portfolio happening and, you know, the market's going to go up. We'll raise the$50 million when the price is a bit better.

AK: You wished.

MC: It didn't work. So, because of the crash, but because we had made commitments in terms of the e-learning and the e-business consulting and the e-health side, it was pretty tough times for the next five years. I had focussed on developing, we set up an offshore development centre, so one of the positives that came out of it was that demand for technology people was dead, you know, so we had this Y2K boom and then you had the crash, so you had lots of really good people out there that we could access, you know, despite being a small business. We set up a little offshore development centre in Singapore and started building the product set that we have today. But by 2004…

AK: Well, I suppose the key advantage is you got your money in the bank.

MC: Oh look, it didn't last very long, I can tell you, because at that time we had about 110 staff and what occurred to us as a board was that… two things. One was that services doesn't necessarily have a competitive edge in Australia or for Australia, if you like, because we haven't got access to the scale that a services business requires. So, we made some important decisions. We ran down the consulting side of the business and, you know, at that time within two years we only had a quarter of mill in the bank, so we started off with eight million in the bank in 2000 and then a quarter of a million in the bank, so there were some hard times. And we decided then to focus on products as opposed to services. It's a fundamental problem when you have a services culture.

AK: Well, products are scalable, services are not.

MC: Yes. And products. People who develop products the mindset is very much about, you know, I want a product in February because I want to sell it between February and November, don't give it to me in October, right, and if there are couple of key features that are not there yet, I still want it out in February. Whereas with services there tends to be a less of a focus on deadline, if you like, right. I mean there are far more variations. So, with products you want a commodity. You want a commodity that can scale and you have a culture that's very much quality driven because you've got to support the product and you've got a culture that's very much about delivering commitments. So, we made a couple of other acquisitions in the health space; a company in Melbourne that had a good base of private hospitals and a company called Global Health which was a KPMG start-up. So, KPMG had set up an incubator, if you like, that was developing software that supported clinicians and consumers. Whereas our background in the '90s was in, if you like, the business of health, so it was more.

AK: The hospitals.

MC: Hospitals and billing and appointments, theatre management, you know, emergency departments. It's all the workflow of a patient through a hospital.

AK: So, when you bought Global Health had they already written their software?

MC: No, it was very much early stage.

AK: But they knew what they wanted to do?

MC: They knew what they wanted to do. The key thing was the people we picked up. They had some nice cornerstone projects, if you like.

AK: Did they have any contracts? And when you say projects were they actually commitments?

MC: Yes. They had commitments from Royal Women's, Royal Children's here in Melbourne and we won a tender in ACT for a mental health application back in 2002 and now we had clinical expertise as well as connectivity expertise as well as the back office expertise and consumer expertise and we did a lot of trials over the mid noughties, if you like, in shared care, so this is where consumers or patients are working with their carers, with their providers as they're called, whether they're specialists or dieticians or endocrinologists or GPs in terms of all working together to a plan to sort of manage outcomes better. So, by 2007 we had run down the non-health business and effectively the non-product business and in December 2007, by then we had probably70 per cent of our revenue from the health sector and probably 50 per cent of it or probably 70 per cent of it from product.

AK: And did you have the full product suite that you wanted?

MC: We…

AK: I mean… Well, first I suppose the question is in the mid 2000s did you have an idea of what the product suite that you needed to have…?

MC: Absolutely. Absolutely.

AK: You had the vision of what it was going to be?

MC: Yeah. So, the vision was very much about connectivity.

AK: Connectivity between?

MC: Between software applications.

AK: Yeah. But between consumers and clinicians and hospitals?

MC: And clinics which enables that connectivity for the businesses, for the participants of health. So, we had connectivity products, we had clinical products and we had business products and we had consumer products. They were not all making us money obviously because I'd like to think that we were pretty much in start-up mode as an e-health business.

AK: Well, I presume they all had different customer bases, didn't they, or not?

MC: Correct. Correct. So, the mental health application, for example, was very much community focussed, so a lot of mental health occurs outside the hospital setting, but that particular project that we did for ACT Health actually was a statewide project which involved patients moving between the acute and the non-acute sector and multi disciplines involved, so you had social workers, psychologists, triage, emergency helplines and that's the way healthcare is moving.

AK: So, is your mental health application a diagnostic tool?

MC: It is very much a diagnostic tool. It's also a team based tool. So, a lot of systems, traditional systems tend to be either I want to run my hospital, I want to run my clinic, so it's still a silo. A lot of systems might be focussed on the needs of a GP or a psychologist, but we built a system that actually was very much from the get go built for multiple disciplines that are involved in the recovery of a particular condition and that's the reality. So, in mental health, for example, you know, it's pretty much a lifelong condition. It involves encounters in the community with a psychologist, with psychiatrists and sometimes you move into a hospital. You know, there are issues about suicide, depression.

AK: And so each healthcare operator can call up that person's file?

MC: That's right. Exactly.

AK: …and add to it and learn from it.

MC: That's right. So, they see the full history. They see what they're entitled to see. So, if I'm a social worker I might see enough to make me to do my job.

AK: Yeah, but who pays you for it? And how much do they pay?

MC: Okay. So, our software currently are sold to businesses, so either public sector businesses… providers or private sector providers, so it tends to be a payment made by the health provider organisations. We have always had a real strong view that we need to get consumers engaged, that there's a huge opportunity for getting you and I as consumers of healthcare services to participate in

the management in staying healthy longer and avoiding those expensive and traumatic episodes of care which is a universal issue the spiralling cost of health. And there's a lot of focus on the sick and our vision has always been to say yes, we want to provide software that supports the treatment of the sick, but we also think the huge opportunity is in, if you like, whether the emerging at risk, if you like, right, by keeping people out of the expensive hospitals and so on. So, even though our systems involved consumer engagement what we had until very recently was little pockets of applications, you know, so a set of applications that would help a hospital, a set of applications that will help a mental health service like headspace or a community health service like the Medicare local and a set of applications that might connect five thousand different organisations within a particular region like we have with our connectivity product. But in the last few years what we've really done is start to put that all together and connect the sector and start looking at the global view of healthcare, if you like, so what we're now working on is connecting all the dots and getting information to flow across the 10 or 11 different businesses that are involved in a single episode. Does that make sense? Okay. Let me explain that. If you look at a typical episode, right, you might start off by visiting a GP.

AK: An example of an episode, what are you talking about?

MC: You've got a condition. You've got a pain. You've got a symptom.

AK: You've had a heart attack.

MC: You've got a symptom, right, and you present to the GP and the GP says well I think you've got this, I'm going to send you off to a pathology provider to do some blood tests. The results come back to the GP and the GP says yes, I think I need to send you to the specialist, your PSA is a bit high, right. The specialist looks at you and does some tests and he might say I think I'm going to have to…

AK: Puts his rubber glove on.

MC: Puts his rubber glove on. And he might say I think I'm going to have to put you into a day surgery, so that I can cut the problematic area out, for argument's sake. You might have some scans, diagnostic services and then he's got to book you into a hospital and manage the theatre list with the hospital. At this point in time you've probably encountered six different businesses, you know, a Melbourne path, a diagnostic service, the GP's his own business, the specialist's his own business and you probably had some scripts that you had to take to the pharmacy as well. You go to the hospital and you've got an anaesthetist, yet another bill, and when you come out, you know, you might have some rehab, so you're starting to involve allied health. So, that little episode where you had some symptom, a weak bladder, and you've got a recovery plan which involves engagement with about a dozen different individual businesses and each one of them has their own history, you know, family history, symptoms and meds and allergies and so on, so you've got twelve different databases and that's one of the huge drivers of the increasing cost in health.

AK: I suppose the thing that springs to mind is you can see the problem absolutely. I mean we all encounter it all the time. The question is who's going to pay you to fix it up?

MC: So, our current business model is very much about subscriptions for our software.

AK: Paid by who?

MC: Paid by the providers or the provider organisations.

AK: Would that subscription replace existing costs that they have?

MC: Absolutely. You know, the stats that I've seen talk about 30 per cent of the cost of healthcare being administration, administrative costs and in fact some stats I've seen say that in the US for every dollar spent on clinical services there's $6 to $7 dollars spent on overhead, if you like. So, to put a little bit of perspective there, in the US that overhead is over $1 trillion in health – that's why they've got that huge problem – which is China's GDP from 2006. And in Australia 20 per cent of the government budgets go on health. But how much of it goes on the clinical or clinical services? Probably 50 per cent. There is a huge room for productivity gains in health. And I think what our software does and what our connectivity does is avoids all the paper that flows through health, all the risks that are associated with having incomplete information, especially when you need it, by having access to a full patient history and by ensuring that that information when it's collected it the GP can flow through to the specialist and to the pharmacy and to the pathology and to the radiology and to the day surgery and to the allied health worker and everyone's got all the information they need to do a job well.

AK: I suppose the question that investors are going to want to know is why is a little small cap on the Australian Stock Exchange going to be the one that solves this problem?

MC: Well, innovation happens from small companies. Yeah. I like to think of what happened in the hardware business that I started off. So, when I started in this caper of technology computing was expensive. It was a two million dollar mainframe that very few organisations could afford and there were major players there. Then along came the mini computer and suddenly you could have departmental machines for $200,000. But the incumbents, the ones that were very successful in the era of mainframes had a real problem trying to cannibalise their own business because now you had a price point that was a tenth of what it was before.

AK: Sure. And that happened again. Another tenth.

MC: It happened again. It went to PCs which is $2000. Now, we're going to phones which is $2000, and iPads, right. So, if you compare what's happening in the software business, it's exactly the same thing that's happened. Pre internet, pre connectivity software was… everyone built monolithic large systems that tried to be all things to all people. So, why will a small company succeed? Because our philosophy is very much about saying look, we're not going to build one monolithic solution, we're going to build a bunch of solutions that do something well. Some of them might be broad in scope like running a business, some of them might be narrow in focus, but they all do things well and there's no reason why you have to spend the tens of millions of dollars that large computing projects tend to consume because in this day and age with connectivity there's no reason why you can't architect a solution that is commodity based, that has access to a global market place and that's not going to cannibalise your own business. You can't do it very well if you are incumbent.

AK: So, who are your competitors?

MC: Okay. That's interesting because there are no companies I know of that have got the broad range of product that we have. So, we have, you know, at least 15 different applications; a bunch that we are aiming at consumers, a bunch that we are aiming at connectivity and a bunch that we

are aiming at running hospitals, running clinics and another bunch that are supporting, you know, clinical needs, prescribing, results, orders, recovery plans, all that sort of stuff. So, we try and compartmentalise our products into three categories. We have a MasterCare brand which is for our applications that support the business of healthcare, either from a management perspective or from a clinical perspective. We have a bunch of products called ReferralNet which support the needs of connectivity within a large organisation or with your colleagues that are running their own businesses. And then we have a bunch of applications for the consumer which is, you know, a patient portal, life path and so on. And in each one of those segments we have a different set of competitors. So, if we and we often are obviously invited to bid for mental health projects, we have three or four different competitors; some of them are small and some of them are huge. And if we are bidding for a hospital, we will have a completely different set of competitors and we're bidding for connectivity.

AK: So, what's your revenue run rate now?

MC: So, I think we've been through some hard times and we've had two years of good revenue growth and good earnings growth, so last year, based on our management accounts which are… advise the market and obviously we're not in a position to give the audited result yet, but based on the management accounts we, you know, increased our revenue by 18 per cent, so we… in…

AK: To what?

MC: $5.2 million to $5.3 million.

AK: Right. And are you making a profit?

MC: And our profit at this point in time is appearing to be $1.4 million, $1.45 million, so somewhere between $1.4 million and $1.5 million.

AK: And is that broadly speaking the margin that you can sustain, a 20 per cent, roughly 20 per cent margin?

MC: I believe so. I mean the… one of the characteristics of a software company is that when you hit a tipping point, you've made the hard yards. Let's be straight about this. We've got accumulated losses of about 18 million, so it's cost us a fair bit of money to get to this point, but we've had eight quarters of revenue growth and earnings growth and I can't see any reason why that's at risk at this point in time.

AK: Is there any one or few of your products that dominate that revenue?

MC: Yeah. So, our traditional hospital based revenue is probably 40 per cent of our total revenue. Our mental health's been hugely successful for us. I think a lot of people would say that we're the market leader, aside from myself, and that's probably between 30 to 40 per cent of our revenue.

AK: And do you get much from consumers?

MC: No, we get nothing from consumers right now and I don't think our business model is based on getting money directly from consumers. I think the opportunity to monetise consumers will come and

we plan to start looking at monetising revenue from our consumer subscribers probably sometime in 2016.

AK: How? What, from subscriptions or advertising or what?

MC: So, there's a number of opportunities. Obviously there's sponsorship and advertising and identify data mining, the traditional ways of getting it.

AK: Because that's a tough game, that is.

MC: It is a tough game, but I think the emerging one is also crowdsourcing. So, in a generic sense, what that means is if you've got a hundred thousand members of your LifeCard, which is our product portal, then you're probably in a position to sort of negotiate some value for them by saying, you know, look, to a gym or to a health food company.

AK: Oh, I see. Yeah.

MC: You know, we want some discounts for our members and that's the way a lot of consumer models work.

AK: But it's probably never going to be a big part of your business. I mean well, I don't know. Is it? Do you think it will?

MC: Oh, okay. So, in terms of growth we've built our product set. We've proven it in what I think is one of the best health systems in the world, Australia. And we've spent a better time in the last six months, in particular, starting to look at accessing the global markets. So, in terms of consumers though, well I would tend to disagree because you've just got huge scale. See, in B2B you've still only got, you know, X number of clients. In Australia we've got a thousand clients in healthcare, but if each one of them services 10,000 patients a year, that gives us an ability to reach, you know, a 100,000 plus consumers and if… you don't need to get a lot of money. You know, you need to get… you need to find a way to provide $2 value to the consumer and take 50 cents, if you like, and that's when you're operating in a market like Australia which is 25 million people. I went on that trade mission with Austrade to China in April in terms of a bit of a discovery tour to see what we have to do to access the opportunities overseas. And we have in Australia 1300 hospitals, of which the public sector has 750 and the chains have probably another 200, so there are not many… it's not a big customer base. It's good because you have a moat, pretty hard for people to come in. But in China they have 26,000 hospitals, 26,000 and the briefings that we've had they talked about the need for a further 26,000 hospitals. And so, the real opportunity for growth, massive growth I think is how well we execute our ability to sort of engage with the developing countries. I think the more mature markets, the traditional mature markets like the US, Europe, Canada, Australia they're a churn market, lots of players, but the Chinas, the Indonesias, the Brazils, the Malaysias, the Vietnams, the Indias, the Africas of the world these are untapped markets that can't afford the huge price tag associated with these mainframe type software providers, large software providers and they also haven't got… they're also free markets and their price points are a lot less than what western countries can evolve, and that's where our price point is. So, if we can engage successfully with moving our reach to the global market – and I have no reason to doubt that we can because we've done it in the '90s, right – we then have access to tens of millions of consumers and that's really what we aspire to do, right. We want to move from a B2B to a B2C model. If you're just selling to the

healthcare industry, we're all aware of the cost pressures. You know, you've got governments cutting budgets. You've got improvements in technology, medications and all that sort of thing. But if you look at consumers and the emergence of wearable devices, home monitoring devices, social communities that support each other, you know, if I'm recovering from some mental health condition or prostate cancer or something, you know, and you can build communities of common interest, then you have opportunities to monetise those communities in a way that's going to drive costs down for the consumer, drive costs down for the health funders and everybody wins, and drive opportunities for vendors like us.

AK: But that's…

MC: A long way of answering your question about why small companies can succeed. Because I think everyone starts off small and we are in that nice point now where our revenues, our recurring revenues pretty much cover our fixed costs. We have a model that's scalable, so we moved all our infrastructure to the cloud, so a lot of our development work that's non-IP, if you like, goes to Argentina or Vietnam or Bangladesh or the US, for that matter, so we can drive our costs down and we can drive our reach tremendously through having systems in the cloud.

AK: We are going to have to leave it there. It's been a very interesting interview. Thank you very much, Mathew.

MC: It's a pleasure. Thanks for having me.

http://www.eurekareport.com.au/video/eurekatv/global-health-goes-global