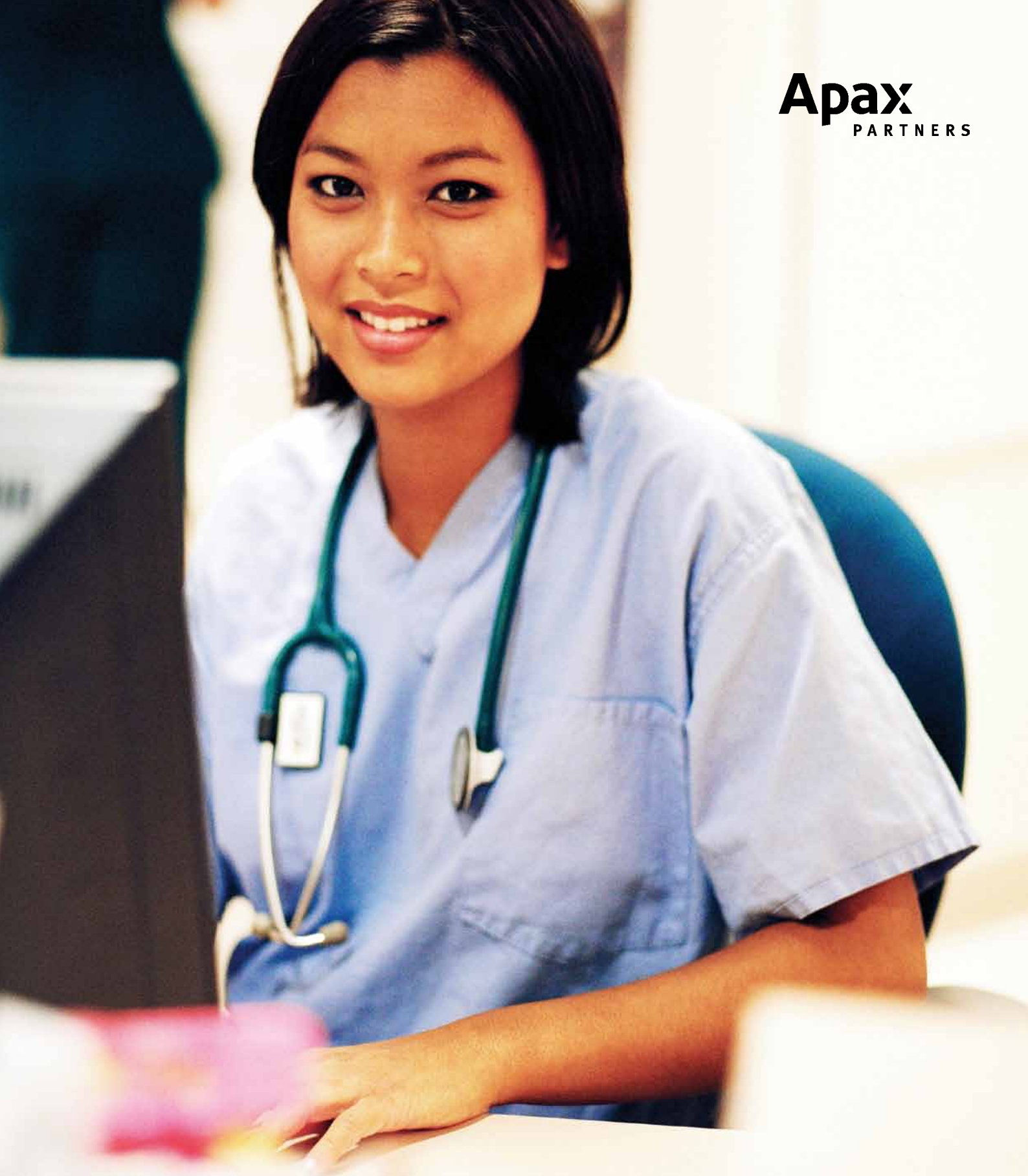


Apax PARTNERS

Opportunities Post Global Healthcare Reforms

Apax Global Healthcare Services Conference October 2010

Turning challenge into **opportunity**

Introduction

Contents

The Apax Partners Global Healthcare Conference, which took place in New York in October 2010, came at a momentus time for professionals across the healthcare spectrum. All around the world, those in the industry are grappling with the conundrum of how to provide for ageing populations and increasingly complicated healthcare demands in an age of budget cuts and deficit reduction.

Connecting healthcare expertise We started these conferences because we recognised that there were very few opportunities for those from all sides of the industry and from all parts of the world to get together and discuss current critical issues. Now in its fourth year, the conference brought together a global selection of senior level healthcare practitioners from across the sector. At a time of such immense challenges, these discussions felt more vibrant and relevant than ever.

Turning challenge into opportunity As with any period of intense disruption and widespread challenges there are also huge opportunities for those that are nimble and able to evolve. It is clear that the old ways of doing things are changing but, for much of the industry, it remains unclear what the new world will look like. For certain, true vision and a willingness to take risk will be critical to success.

Khawar Mann Partner and Co-Head, Global Healthcare Group

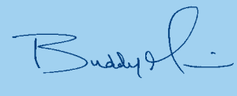
Buddy Gumina Partner and Co-Head, Global Healthcare Group

Global experiences Another key theme of the conference was the international nature of the speakers and attendees. A common thread running throughout many of the sessions was that the developed world does not have all the answers here. Indeed, it has much to learn from developing countries, which are approaching challenges without the 'baggage' of preconceived ideas and entrenched opinions.

Platform for debate Again this year we were pleased to host such high caliber attendees. As in the past, what unites the participants is a true passion to improve the healthcare delivery system and ever increase the quality of care for patients.

Given the monumental scale of this change, we were honoured to provide the forum for the kind of open debate which is so crucial to meeting the global healthcare challenges of the next generation.

Khawar Mann Partner and Co-Head, Global Healthcare Group at Apax Partners



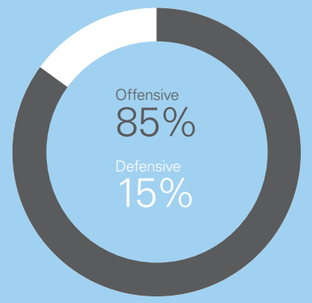
Buddy Gumina Partner and Co-Head, Global Healthcare Group at Apax Partners

Our healthcare survey

Prior to the conference we surveyed invitees from across the global healthcare spectrum. Insights from the survey have been scattered throughout this report.

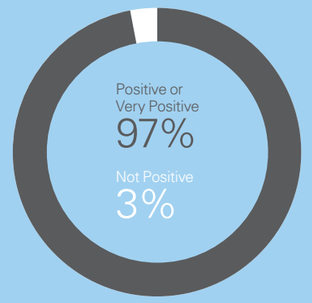
For more detailed analysis, please contact the **healthcare team** at Apax.

What is the main driving force behind your attempts to adapt to healthcare reform?



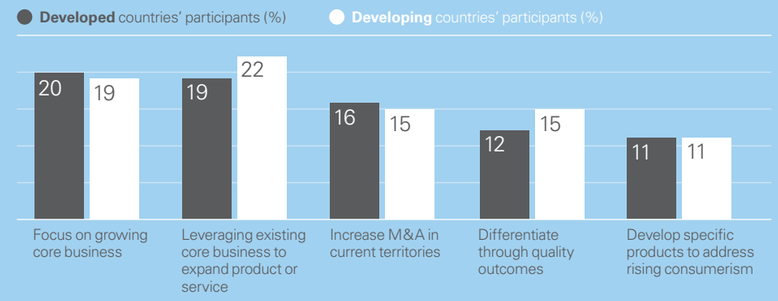
Global healthcare reform creates a positive environment for business and adapting to change is key.

How would you view increased consumer engagement in your business?



Consumerism in healthcare has arrived. That trend will continue/accelerate in the next five years, and will have significant impact on businesses across the healthcare spectrum.

What are the Key Opportunities for your business following global helathcare reform?



There are similar opportunities in developed and developing markets, but the challenges are different in the different types of economies. **The priority for both is on growing and leveraging the core business.**

Implications of **US Healthcare Reform**

Bob Kocher

The so called 'Obamacare' reforms have been among the most politically fractious, comprehensive and costly attempts to overhaul a healthcare system ever ventured. Healthcare has certainly been one of the defining themes of President Obama's first two years in office, and the polarising impact of the reforms was still much in evidence during the recent campaigning for the mid-term elections.

"I was called many things, including **a Republican** by Democrats **and a socialist** by Republicans."

Bob Kocher Special Assistant to President Obama on healthcare reform

Our healthcare survey

96%

of participants said that healthcare reform is changing the way they think about their business

Above: The 2010 Healthcare Conference brought together global industry experts.

There has probably never been a moment where debates around healthcare provision have been as prominent in the political discourse as they are right now in the United States.

With all this in mind, we were extremely fortunate to kick off the conference with a Q&A session with **Bob Kocher.**

Bob worked closely with President Obama as a key architect of the reforms programme, and has now returned to his day job as leader of the McKinsey Center for Health Reform. **Buddy Gumina,** global co-head of the Healthcare sector team at Apax Partners, led the discussion.

BG: What was your inspiration for what you did in the Obama administration? What was the key problem that you were trying to solve?

BK: There was a brief moment in time, which I now think has passed, where we could build a coalition of the willing to push through reform. We had to take action – this was a social and economic issue which had to be addressed in the depths of a recession.

During the course of our discussion, I was called many things, including being branded a Republican by many Democrats and a socialist by many Republicans. The fact is that many on all sides of the political spectrum had issues with the status quo. The left and the progressives were concerned with the level of uninsured Americans, which is about 50 million people without access to comprehensive care. This is clearly a big inequity problem and they were concerned about the social tension that it could generate.

The centre and the right were more concerned about the cost of the current system, and the impact this was having on US global competitiveness. It was also argued that the cost of healthcare provision on businesses proved a disincentive to hiring and this was a drag on employment rates.

Others had big concerns about efficiency and the large differences in quality, which are in evidence even here within New York.

BG: What other models did you look at?

BK: We would never have told anyone in America that we were looking at other models because Americans have all the answers, right? Joking aside, we did scour the world and looked, and found there were other systems to draw on.

To cite some examples of the many systems we looked at, we gained lot of knowledge from India on how to manage costs while achieving high quality in some of its leading private hospitals.

The way Singapore creates more informed patients is astonishingly effective and pretty elegant. We also looked at Northern European models of primary care and house calls in France, as well as health IT in the UK and Canada. That said we would often look to the US and the diversity of quality that exists on our own doorstep.

In short, what we learned is that a lot of things we were looking at in the US reforms had already been tackled on a larger scale elsewhere.

Continued overleaf...

Interview with **Bob Kocher** on the implications of US Healthcare reform continued

"The healthcare reform is revolutionary and will be phased in over ten years. Considering the scale of what has to be achieved and the nature of the labour market and capital requirements in the sector, this is quick."

Bob Kocher Special Assistant to President Obama on healthcare reform

Bob Kocher Special Assistant to President Obama on healthcare reform

Bob Kocher is a Partner at McKinsey and Company where he leads the McKinsey Center for Health Reform and a Non-Resident Senior Fellow at the Brookings Institution Engleberg Center for Health Reform.

Bob joined McKinsey and Brookings after serving in the Obama Administration as Special Assistant to the President for Healthcare and Economic Policy and a member of the National Economic Council. In the Obama Administration, Bob was one of the leading shapers of the healthcare reform legislation focusing on cost, quality and delivery system reform.

BG: And what are the learnings from these other countries?

BK: In my opinion, there has never been a better time to be a leader of a healthcare company either in the US or outside – there are more opportunities right now to create more value. There are several important drivers here: the convergence of healthcare technologies, the changing demands and expectations of patients with chronic diseases and also labour costs and scarcity within the sector.

One of the fundamental issues is how we invent new approaches to labour. This will be crucial not just in the US but around the world where systems do not delegate enough to self care, team-based care or the efficient deployment of IT – our systems are too labour intensive.

The new US system is like a child, it will grow up and run off somewhere but we are not sure where – it will evolve in ways which we can't imagine now, and businesses that want to profit will also have to adapt to this new reality. There is a huge opportunity for businesses that learn to operate under the new system to flourish. The healthcare reform is revolutionary and will be phased in over ten years. Considering the scale of what has to be achieved and the nature of the labour market and capital requirements in the sector, this is quick. In my view we are unlikely to realise the full effects and benefits for a generation.

BG: Are there any things that didn't make the legislation that you would have liked to see included?

BK: There are a couple of things that weren't included in the legislation that would have been great. Again, labour law reforms are hugely important.
At the moment, the US is a checkerboard, which differs hugely from state to state in all areas of the healthcare market. That distortion is a major problem for costs and meeting demand. We didn't address this issue because labour laws fall under State law, and it would have been very difficult politically.

Payment reform is another key area. We did a lot of testing of payment systems. Our goal is to shift from paying for volume to paying for results, but it is unclear what model will ultimately be most effective for achieving this goal.

BG: The real objective was to have one government payer, the nationalisation of healthcare services, is that what this was all about?

BK: Healthcare reform is not about nationalisation. It's true that about 15 million people will go into Medicaid which is state run, so it is true that state provision

grows, but the reform does not have a public plan. People like the innovation and choices that come from the private sector – people don't believe that the central governments should be the single payer. Ultimately, the American people do not have confidence that the government as a single payer would invent the new approaches to care as quickly or creatively as the private sector.

BG: Who do you think the winners and losers will be?

BK: The reform has impacted all aspects of the healthcare system, but there will be big winners in each category of the value chain. There will be people that take advantage and create a lot of value.

Health IT will be a big growth area, helping to identify patients that will benefit from more aggressive management and allow for greater personalisation.
IT companies that can help to create scale among doctor groups to take advantage of new payment approaches and incentives will also do well.

There are a whole host of people that will prosper: hospitals that can create total value over a short period of time; low acuity hospitals; people that figure out how to employ doctors and not lose money.

In terms of payers, the world has changed; the benefits may have been commoditised to an extent, but we have about 15-20 million new customers. The question going forward will be how do you attract and retain the right customers? I think we are moving to a model that will look more like the cell phone market and less like insurance in terms of achieving loyalty of profitable customers – how you take advantage of these developments will be critical.

BG: And who will be the losers?

BK: If you are a high cost, undifferentiated community hospital focusing on volume you are not going to do well. You are going to have to become higher value or lower cost. If you're a five person doctor group without computers you are not going to be able to able to play in a risk-sharing pricing model.

If you're a drug company only developing higher cost drugs that can't demonstrate better total cost of ownership you're not going to do well.

If you don't evolve, you're not going to do better. I am pointing out however that if you evolve there are a lot of opportunities.

Opportunities in **emerging market healthcare growth**

Dr Hatem El-Gabaly

The challenges faced by our next speaker, Dr Hatem El-Gabaly, Minister of Health and Population in Egypt, provided a very interesting counter-point to the issues discussed by Bob Kocher. Egypt spends around 4.75% of its GDP on healthcare, equating to $110 per person per year.

"...by pushing services out to the people we brought infectious diseases down from 50% to 8%."

Dr Hatem El-Gabaly Egypt's Minister of Health

1,800+

Over 1,800 Primary Care Units have been built across Egypt as a result of the reform program

Healthcare in Egypt Contrast Egypt's healthcare spending with the US, where healthcare spending in 2009 was over 17% of GDP, equating to $25 trillion or $8,160 per person and you begin to see how markedly the challenges differ. Despite the relatively low levels of investment, as Dr Gabaly points out, Egypt is one of the few countries in the world to have met the millennium development goals.

The challenge of meeting the needs of 83 million people was intensified by the fact that he had never had a job in politics before: "I had a call one day from the Prime Minister out of the blue to say that I had been selected as the Minister for Health."

Reform program In the five years since that call, Dr Gabaly has spearheaded an ambitious reform program in the Egyptian Health Sector aiming to secure universal medical coverage for all, expand primary health care services and modernise and upgrade the quality of the country's medical institutions.

From the outset, Gabaly saw reform as much about personnel as financing: "The reality of reform is very different from what professors will give you in the classroom. You don't find it in Harvard or Princeton or Oxford or Cambridge. The reality is about changing the mindset and changing entrenched thinking among professionals who have done their job for 35 years."

Dr Gabaly outlined some of the initial problems: "What we had was a very well established structural organisation that was not easily run. The quality of care was very variable; the outcomes in Cairo were much higher than in the rural areas."

Three steps to success Working with a team from McKinsey, Dr Gabaly devised a programme of reform based on three separate waves over the short, medium and log terms, see opposite.

One of the initial quick wins, so essential in building political support, was to bring medicine to the people via a vastly increased fleet of mobile hospitals and Ambulances. In four years, over 5,000 'rural convoys' provided medical care to 13.5 million patients in the under-served rural areas of the country. A massively increased Ambulance service quickly achieved developed-world standards of coverage and responsiveness.

Modernising primary care hospitals was also a key priority and, alongside the EU, a standardized hospital template was devised that could be easily replicated across the country and incorporated accommodation for physicians and nursing staff. Over 1,800 Primary Care Units have since been built across the country.

Gabaly stressed the importance of primary care: "My predecessors forgot about Primary Care, but by pushing services out to the people we brought infectious diseases down from 50% to 8%, which looks more like the pattern in the developed world. We were also mindful of the need to invest in the priorities of the population – for us it was increased maternal care and decreased child mortality rates."

Secondary Care In terms of secondary care, major hospitals were renovated and rebuilt and new equipment, such as CT units and MRI scanners have been added. Supply chain management was also a challenge, which has been addressed by outsourcing logistics to third party suppliers and restructuring procurement policies. Among the exciting new steps being undertaken are a series of public private partnerships, which will result in five new hospitals being built.

Gabaly's success in reforming the Egyptian healthcare system has been based on the hard-headed imperative of building political support with early quick wins in primary care, combined with a long-term aim of training the next generation of management to ensure that the momentum is continued into secondary and tertiary care. This pragmatic approach has transformed the life chances of millions. A fact that is borne out in a recent independent survey, in which Egyptians ranked healthcare as the second most improved service in the country, second only to mobile phone services.

Dr Hatem El-Gabaly has been Egypt's Minister of Health and Population since 31 December 2005. He has actively led an ambitious reform program, aiming to secure universal medical care for all Egyptians. He is expanding primary health care services throughout Egypt, and modernising and upgrading the quality of its medical institutions. The challenge to improve healthcare for all Egyptians required a radical overhaul of the healthcare infrastructure

Dr. El-Gabaly is also a pioneer in medical business. He established Dar Al Fouad Hospital, the leading hospital in the Middle East in cardiothoracic surgeries, neurosurgeries and organ transplants. He also founded Cairo Medical Tower, the largest polyclinic in the Middle East.

Egypt addressed the reform program in three waves

1. Short-term / Quick wins

- Modernised ambulance system
- Rural convoys
- Increased compensation for physicians and nurses
- A better base for accurate information (DHS IT system)

2. Medium-term

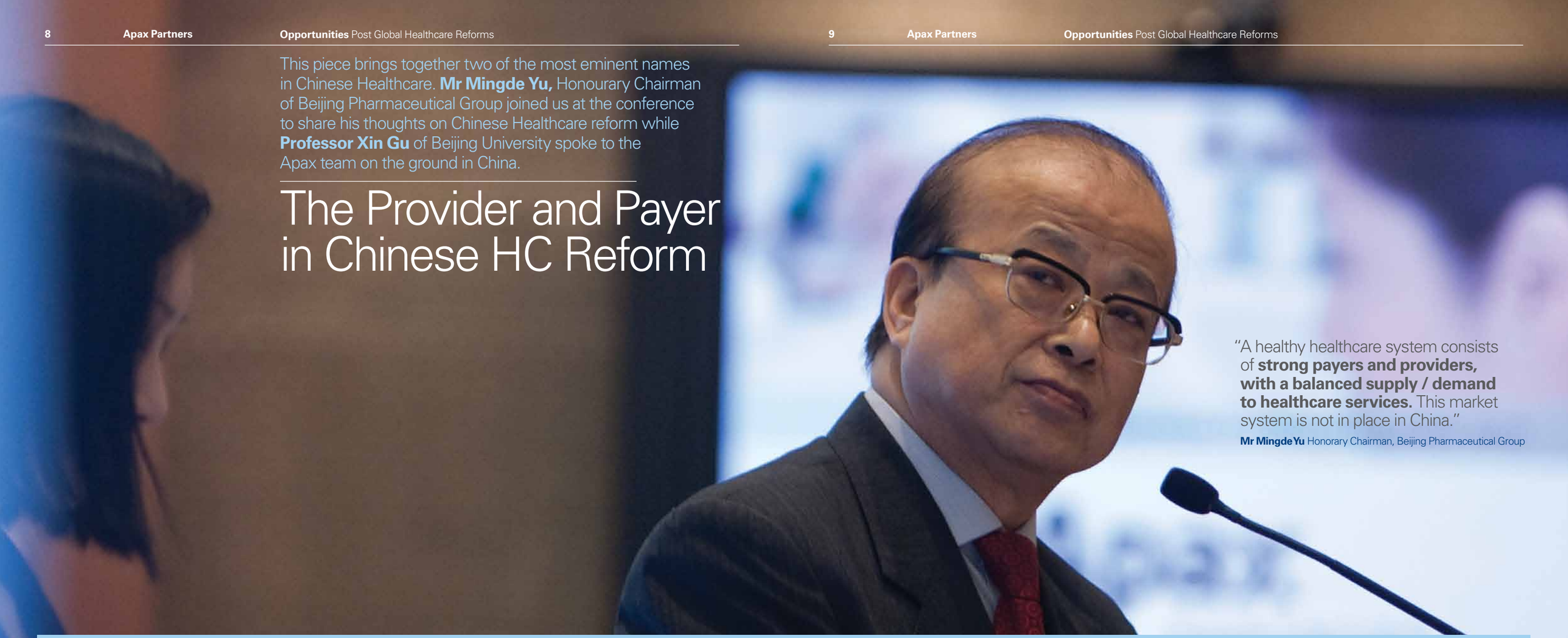
- Sustainable primary care model
- Social health insurance and integrated health system pilot Transparency over health expenditure
- Draft of social health insurance law

3. Long-term

- Transformation of hospitals and specialised centers
- Enabling factors to support future development
- Capability building

This piece brings together two of the most eminent names in Chinese Healthcare. **Mr Mingde Yu,** Honourary Chairman of Beijing Pharmaceutical Group joined us at the conference to share his thoughts on Chinese Healthcare reform while **Professor Xin Gu** of Beijing University spoke to the Apax team on the ground in China.

The Provider and Payer in Chinese HC Reform



"A healthy healthcare system consists of **strong payers and providers, with a balanced supply / demand to healthcare services.** This market system is not in place in China."

Mr Mingde Yu Honorary Chairman, Beijing Pharmaceutical Group

"Healthcare reform has been ongoing in China for the last twenty years, although many obstacles still remain, the next four years will be critical in building a safe and effective healthcare system." Mingde Yu, sums up the challenges for the next huge wave of reform in a country which is in huge flux as populations age and urbanise.

The long awaited China healthcare reform kicked off with a massive investment budget, aggressive timeline and ambitious goals. As professor Gu outlines: "It aimed to mitigate the deep rooted issues surrounding the two sides of healthcare services: weak providers and struggling payers. Low insurance coverage and high out-of-pocket payment costs make healthcare provision a heavy financial burden on many Chinese. Meanwhile, the malpractice of public hospitals is frequently reported; people sometimes can't even pay to get better service unless they go to ultra expensive clinics for expatriates."

China started to improve its healthcare insurance system in 2006 based on two original plans: Basic medical insurance for urban employees ("BMIRE") and New Rural Cooperative Medical System ("NRCMS") – the former covers urban employees while the latter covers the rural residents. A new plan, namely Basic medial insurance for urban residents ("BMIUR"), commenced to cover the ignored urban non-working population (including children, students, the unemployed, and the elderly who have never employed). The goal was to increase coverage, as well as reimbursement ratio.

It is estimated that four years later, more than 90% of the Chinese population will have basic insurance. However the reimbursement ratio is still low: The government minimum contribution to NRCMS and BMIUR is USD$18 per year per capita (120RMB), and individuals top up the additional USD$5–20. Some local governments may contribute more if they have additional funds. The contribution to BMIRE is much higher, as employers usually contribute more money to the plan for their employees. Although everyone is covered by one or the other basic healthcare insurance, people still need to pay around half of their healthcare bills

Nevertheless, this plan of improving the so-called "basic healthcare security system" is on track to cover 100% of the Chinese population in the next two to three years, according to Professor Gu, and the out-of-pocket ratio may reduce to around 30% in next five to ten years. Gu thinks the next challenges for the healthcare security system would be to reform the provider payment mode, and to increase plan contributions for unemployed urban residents and rural residents.

On the other side, the providers haven't posted much significant improvement. The long standing state-owned structure is difficult to break, and the corporatization of public hospitals will affect various stakeholders. Professor Gu comments: "At the moment, public hospitals can't deploy their resources and personnel freely to optimize services and to maximize profit – most of them still belong to a different level of healthcare administrators, namely health bureaus at different administrative levels." This also incurs conflict of interest in hospital supervision and regulation: the regulators hesitate to disclose and punish wrong doings or even unlawful practices in affiliated hospitals, since they're responsible for the issues. Wandering between the market demand and administrative burden, hospitals are still far away from becoming strong providers.

Although there are some pilot "market-oriented public hospital reform" programs, Professor Gu thinks there is still a very long way to go. He recognizes that there are local actors who can be motivated to have successful trials; but at a national level reform may take decades to see substantial progress. Mingde Yu added: "Healthcare reforms will clash with existing vested interests. We want to push hospitals to a more market-based solution but this will upset people in regional government."

Opportunities When asked about the opportunities for private capital in healthcare services in China, Gu thinks the pending new regulation regarding private capital participation in the healthcare sector will help clearthe mist: it will be made public either later this year or early 2011. The most critical terms would be whether foreign investors will be allowed to have more than 50% stake in healthcare service institutions, and whether the public hospital reform will be substantially triggered.

Yu took a more positive stance on opportunities for foreign companies: "We welcome private sector input in the reform to enable us to build the healthcare institutions we need. There is also a role for profit making companies in the insurance plan. In China we are not just after investment but also high value management, services and technologies." Yu pinpointed specialist sectors such as dentistry and gynaecology as better areas for private capital to focus on rather than more generalised hospitals. In geographical terms, Yu identified East and Mid China.

At the moment, most investments still cluster around the high-end specialized areas: United Family Healthcare by Chindex is an example. The demand for better quality healthcare services from the large middle class population is still not met. However, without a market mechanism bridging the providers and payers, and to allow the providers to finally become an independent entity in the healthcare system, both Gu and Yu doesn't think that foreign investors should rush to this party too soon. "We have already seen the first wave of investment in Chinese healthcare," says Yu, concluding: "The future is bright but you will need to be patient"

Changes in healthcare across **developed and developing economies**

Global growth opportunities

The global healthcare market is changing fast, and many countries are **approaching reform in very different ways.** We discuss some of these differences in approach with healthcare experts from around the world and **assess where the opportunities lie** in various models.

Pictured: Suneeta Reddy, Apollo Hospitals

The changing face of global healthcare While there are common underlying themes impacting the global healthcare market, political and historical differences have left a very uneven jigsaw of progress in both the developed and developing world. The recent global financial crisis has also created marked polarisation in terms of thinking on healthcare. In the developed world, budgets are being squeezed and 'value' is the new watch word. Continued strong growth rates across much of the emerging economies have created a different picture, where emerging middle classes and increasingly aged populations are demanding a better quality of care than that imagined by previous generations.

UK and the 'developed' market, squeezing more out of less In many ways the situation in the UK typifies the dilemma for many developed economies. The existing regime is becoming financially unsustainable as the demographic profile of the country changes and expectations rise.

With over 1.3 million employees, the UK's National Health Service (NHS) is the world's fourth largest employer and one of the most monolithic state providers of healthcare services. After many years of record investment, the emphasis now has switched to value for money and, in order to achieve its goal, the new government has opted for a programme of de-centralisation and liberalisation.

As KPMG's Global Head of Health with 20 years experience in public and private healthcare administration, Mark Britnell is very well placed to comment on the next wave of reform. "In ten years under New Labour, a lot of money has been spent, outcomes are slightly better and staff are better paid." As Fergus Kee, formerly of Bupa, comments: "We had a good decade or two for most developed economies in terms of funding, including very extravagant funding in the NHS, which has doubled in real terms over ten years." Although the coalition has promised to ring-fence NHS spending, healthcare inflation rises faster than real inflation so as Britnell goes on to state: "The NHS has been challenged to improve outcomes on a budget that will fall in real terms." Kee quantifies this impact: "The NHS will need 4-5% productivity improvement per year over the next 4-5 years."

The incoming health minister has embarked on radical decentralisation in order to take power away from the managerial class that had grown rapidly in the Blair years and place it firmly in the hands of General Practitioners (GPs).

Continued overleaf...

Global growth opportunities continued

Left to right: Suneeta Reddy, Fergus Kee, Franz Knieps, David King

"Universal free healthcare in India is not a given, there has to be a sustained move away from government solutions to the private sector. A growing middle class that is more wealthy and more discerning is also driving change."

Suneeta Reddy Apollo Hospitals

"There is huge consolidation going on at the moment. Cost structures everywhere are changing and capacity will be rationalised across the system."

David King CEO & Chairman, LabCorp

In a radical departure for the NHS, some 40,000 GPs will control 80% of the budget. Britnell estimates that this move will result in the loss of 60-70% of the managerial class and a more rigorous focus on costs: "Because it is their business, GPs are likely to be far more hard-nosed than the state was in negotiating prices." While the incentive to drive down prices is clear, the lack of bulk purchasing power will have the opposite effect. "GPs will have to aggregate purchasing power," continued Britnell, "and there will be a big opportunity for those companies that can facilitate this process."

Franz Knieps, Former Director General for Public Healthcare in Germany, paints a similar picture: "Central regulators should set the framework and not get their hands into the operational detail." Knieps sees integration as critical in Germany: "We have a system that is rooted in history, and there was no fundamental change between 1911 and 1988. The next stage of reform must be integration, ensuring that all of the management tools at our disposal are properly utilised and that human resources are deployed efficiently."

From deliverer to insurer

The other change that Britnell sees in the UK is even more fundamental: "In future, The NHS will be a state insurance provider not a state deliverer." In future 'any willing provider' from the private sector will be able to sell goods and services to the system. Britnell comments: "The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years."

The monolithic arm of state control will be relaxed which will provide a huge opportunity for efficient private sector suppliers.

The US market The picture is similar in the US, where inefficient players will simply be driven out of the market. David King, Chairman and CEO of LabCorp comments: "There is huge consolidation going on at the moment; for instance, I would say that a meaningful percentge of hospitals in certain states will close in the next five years in a pattern that will be replicated across the Country. Cost structures everywhere are changing and capacity will be rationalised across the system."

The implications of the end of 'universalism' in healthcare provision are clear. Consumerism will take root. As greater choice and transparency emerge, the market will open to a more diverse range of private sector players. Political inertia and the 'old way of doing things' ensure that this transition will be long and bloody but the direction of travel is clear. Sally Pipes, CEO of the Pacific Research Institute, says: "Understanding healthcare reform is like an onion – there are many layers and many tearful moments."

60-70%

projected reduction in NHS managerial class, and a more rigorous focus on costs.

Source: Mark Britnell

Left to right: Khawar Mann, Mark Britnell, Sally Pipes and Claudia Suessmuth-Dyckerhoff

Left to right: Mike Ross, Michael Flammini and John Driscoll

"The developing world has the opportunity to leapfrog the developed world... to create the right system the first time round."

Mike Ross Chief Marketing Officer, CIGNA International

Pipes is critical about the lack of consultation by Obama and also by, what she see as nationalisation: "He did not seem to care about the views of the American people. What we will be left with at the end of all this is a Medicare for all at the same time as countries like Canada and the UK are moving away from centralised state control of their healthcare systems."

China vs India – public and private conceptions of healthcare reform

There are two fundamental differences across many of the emerging economies. The first is that the development of healthcare systems is at an earlier stage in the cycle so thinking is not nearly as entrenched. The second is that growth rates in many of the larger emerging economies continue to be strong. Fergus Kee comments: "The financial squeeze in China, India or Brazil will not come in quite the same way as it has done in developed economies. There is a good opportunity for these countries to lead best practice.

"In China, the ageing population and urbanisation are the two major drivers of change," says Claudia Seusmuth-Dyckerhoff, a Director of McKinsey in Shanghai. The one-child policy in China has created a demographic time-bomb, coupled with massive rural-urban migration which will result in 65% of the population residing in cities by 2025. It is clear from the statistics that the massive reform programme covered earlier in this brochure is critical. "What we are talking about is a market with 20,000 hospitals and 2.3m physicians with no GPs and no gatekeepers. Hospital specialists may be consulted by patients that are suffering from the symptoms of a common cold!" continued Seusmuth-Dyckerhoff. Reform in China is happening, and as we saw earlier the potential for private business is massive.

The Indian story is different. Healthcare provision in the Indian market has always been more skewed toward the private sector, of the 5.6% of GDP spent on healthcare, government spending only accounts for 1%. Suneeta Reddy, a Board member at Apollo Hospitals comments: "Universal free healthcare in India is not a given, there has to be a sustained move away from government solutions to the private sector. A growing middle class that is more wealthy and more discerning is also driving change. Transparency will be key to get the buy-in of the consumer and the government."

A unique opportunity While different countries will adopt in different ways there is a palpable sense of excitement about emerging market opportunities which is shared by Mike Ross, Chief Marketing Officer of CIGNA International: "The developing world has the opportunity to leapfrog the developed world. There is an opportunity to create the right system the first time round and all of us are trying to participate in that."

Lessons learned on adapting to the **rise of healthcare consumerism**

Power to the patient

Left to right: Richard Alvarez, Marcus Osborne, Ruben Toral

Patient Power has been a buzzword in healthcare circles for years. Our final panel brought together three people with intimate knowledge of the subject to discuss **whether the hype was becoming reality**.

Our healthcare survey

80%

of participants believe consumer will engage More or Much more in the healthcare industry

"If closed systems are allowed to prevail in the US, we will not be able to make the choices we want to make."

Richard Alvarez CEO, Canada Health Infoway

Patient empowerment In our conference survey, 80% of respondents said that consumers are going to engage in a much more significant way with their healthcare choices. Buying healthcare is surely one of our most important choices, but the current reality of consumerism in healthcare often seems to be more like Ruben Toral's assessment: "Most consumers know more about the phone they are buying than the doctor they are choosing."

Toral, who is CEO of Mednet, a tool for information sharing among healthcare professionals, added: "Globalisation, the internet and consumerism are the three biggest drivers behind patient power, what we are seeing is the emergence of mobile global consumers."

Muddy waters While the direction of travel seems clear, the journey ahead will be bumpy and the pace slow. One of the key stumbling blocks along the route is transparency. Unless the consumer is armed with the information on which to base informed decisions, they will continue to opt for the status quo. In the current scenario, localism generally trumps consumerism, because decisions are not being made on the basis of quality or value.

Marcus Osborne, a Senior Director in the healthcare division of Walmart, believes that information is the key: "The transition to consumerism is moving very slowly because the consumer often has no idea in terms of quality what he is buying. It will require a lot more transparency. The negative side of the consumer choice debate at the moment is that we have incomplete data sets which make people make bad choices. We need to get to a point where the consumer feels that there is a genuine choice – this certainly isn't the case right now in the US."

As Osborne points out, transparency is not just a matter of quality: "You can't have consumerism without price transparency. In my opinion, primary care has become commoditised; the future is in distinguishing between commodity and non-commodity areas. In the commodity areas, we have to move toward total price transparency for the market to work."

Richard Alvarez, CEO of Canada Health Infoway, believes that it is the providers that are being less than open: "Providers are guilty because they don't want information to get out there. If closed systems are allowed to prevail in the US, we will not be able to make the choices we want to make." For Alvarez, the consumer will only really start to change when the providers go with them: "Consumers do want to be more involved in decisions but want to do it in conjunction with their providers."

As providers begin to be judged on the value of the service they provide and competition for patients intensifies, the momentum toward greater transparency will be inevitable.

Healthcare tourism – a global market
The nascent market in healthcare tourism has been a pivotal force in changing perceptions about healthcare treatment, and nowhere is this more prevalent than in South East Asia, where the service mentality is reaching new heights.

"Medical tourism is like buying a holiday on Expedia and the options are no longer local, they are global. Is healthcare inherently different to buying a car or vacation online?"

Ruben Toral CEO, Mednet

15%

Only 15% of US healthcare consumers 'shop' for their provider, even in one of the most consumerist societies.

"Asians are re-defining what the healthcare experience is about," explains Toral. "They are really breaking new boundaries in terms of the levels of service and innovation around the patient experience. This has made the Asian healthcare consumer very brand conscious, but it is over-simplistic to say that they are slaves to marketing – they are also looking at outcomes and therapeutic measures and again, the internet is playing an important role in informing these choices."

The power of the brand is reinforced in terms of healthcare tourism, by the experience of fellow travellers as Alvarez explains: "Consumers want to judge the service based on the experience of other consumers – it has become a trip advisor model. In terms of health tourism, we are already seeing the emergence of disciples; but strangely this emotional quotient does not exist within domestic US healthcare.'

We should also not assume that healthcare tourists are motivated purely by greater levels of comfort and customer service. For many in the Western Developed world, the decision to jump on the plane is motivated primarily by cost considerations as Toral explains: "I have seen people who have never left their state travel 10,000 miles for a hip replacement, what we are starting to see is the globalisation of healthcare. The only reason someone travels 10,000 miles to somewhere they couldn't locate on a map is because they are a medical refugee." Cost, service and access to information are the drivers behind increasing globalisation in healthcare services, and while the numbers are still small, the healthcare tourist is certainly here to stay.

Finally, the internet has made doctors of us all. Easy access to broadband internet and mobile devices is driving patient empowerment and choice. Via chatrooms, forums and comparison sites, the internet could be the catalyst which accelerates the move toward greater patient power. As information is standardised and made more readily available, the internet will surely become a powerful tool of patient empowerment.

Across the world, consumers are looking at healthcare services in more consumerist terms, but we should not underestimate the power of fear and inertia in decision making. Even in the US, which is one of the most advanced healthcare markets in the world and also the most consumerist of societies, the amount of shopping that goes on in is still very limited, at around 15%. Here, the consumer has the choice but chooses does not take it. As more people pay for these services with their own cash rather than taxation or insurance-based models, the user will surely become more discerning. The patients are taking charge, but they are currently doing it in baby steps. The giant strides will occur when there is a critical mass that has access to the right information and is willing to question the status quo.

Key conclusions and shared learnings

Conclusions

Across the **healthcare** spectrum, businesses are changing their thinking. In our survey, 96% of respondents said that their firms were having to adapt because of the impact of reform.

A global phenomenon The issue of how to care for populations in an equitable way has moved to the front of the political agenda around the world. Many have talked about a healthcare revolution, but a revolution implies a quick and violent break with the past. While the reform programmes are certainly monumental in scope, the pace of healthcare change can rarely be described as revolutionary, to quote one of our speakers, this looks more like 'aggressive evolution'.

Market differences Many speakers remarked on the differing characteristics of developed and developing world healthcare reform. The established systems in the developed world are creaking under the weight of ageing populations, the spiralling cost of pharmaceuticals, equipment and labour and the huge pressure on government finances. The reform packages that are designed to address these issues will disrupt all aspects of the healthcare value chain, from pharmaceutical companies, to acute care hospitals to the medical insurance sector. Everything is up for discussion, everything is subject to change.

Many countries are grappling with the question of how market-based solutions can co-exist with state-led systems. Every country will arrive at a different solution based on the unique development of their own healthcare system, but one thing is certain, the transitions will be slow and politically painful. In other developed countries, the US being the best example, the government is taking an increased role in order to ensure more uniform coverage is achieved.

The importance of value From all this discussion, a common theme has emerged: Value. The healthcare industry is being asked to do more with less. To provide care more efficiently, utilise physicians more effectively and empower the patient to make the decision about their own treatment.

This 'age of austerity' does not appear, at first glance, to offer the best environment for business to flourish. However, 85% of our respondents said that they were adapting to healthcare reform for offensive reasons, because they sensed opportunity for growth. A period of 'aggressive evolution' surely benefits the nimble, those which are able to aggressively evolve. As another speaker said: "At times like these, the good idea becomes the great company."

Developed-world differences The story is different in much of the developing world. The issues being addressed include how you cope with a rising middle class which has vastly differing expectations to the previous generation? How do you deal with a population that is in flux, that is moving from the countryside to the towns? How do you deal with the shift from infectious diseases to lifestyle diseases? How can you educate the population?

On the plus side, many of these countries do not have the same powerful vested interests and entrenched ways of thinking. In many of the economically vibrant developing world economies there is tremendous optimism that they can get healthcare provision right the first time around. There is also a desire to explore new ways of thinking, our speakers talked of mobile hospitals in Egypt and applications for smartphones that would help reach millions of patients in India. There is a thirst for solutions in the developing world, but it is not based on deference to the more established healthcare systems.

Shared thinking The conference highlighted that in this period of radical change, players from all segments of the market and from all corners of the globe have much to learn from each other. Once again, Apax Partners was delighted to help facilitate this debate.

The healthcare conference

Who's who?

Conference speakers

Bob Kocher Special Assistant to President Obama on Healthcare Reform

H.E. Prof. Dr. Hatem El-Gabaly Minister of Health, Egypt

Mark Britnell Former Director General for Commissioning and System Management, NHS UK. Currently partner and Head of Healthcare, Europe & UK for advisory firm KPMG

Sally Pipes Healthcare Expert. President and CEO, Pacific Research Institute

Claudia Suessmuth-Dyckerhoff Director, McKinsey & Company China Office

Fergus Kee Former Managing Director of UK & North America, BUPA

David King Chairman and Chief Executive Officer, LabCorp

Franz Knieps Former Director General for Public Healthcare in Germany

Suneeta Reddy Executive Director Finance and Board Member, Apollo Hospitals

Dr. Mingde Yu China Pharmaceutical Enterprise Management Association

John Driscoll President, New Markets, Medco

Richard C. Alvarez President and CEO, Canada Health Infoway

Marcus Osborne Senior Director Healthcare Savings Programs & Global Sourcing, Walmart

Ruben Toral CEO Mednet Asia and Founder Medeguide.com, former Marketing Director of Bangkok's Bumrungrad International Hospital

Apax Partners' Healthcare team

Ameya Agge Principal, Apax Partners

Arthur Brothag Senior Associate, Apax Partners

Hector Ciria Principal, Apax Partners

Steven Dyson Partner, Apax Partners

Luther Gatewood Associate, Apax Partners

Ariel Goldblatt Senior Associate, Apax Partners

Buddy Gumina Partner & Co-Head of Global Healthcare, Apax Partners

Bo Huang Associate, Apax Partners

David Issott Principal, Apax Partners

Kevan Larizadeh Associate, Apax Partners

Irene Liu Senior Associate, Apax Partners

Khawar Mann Partner & Co-Head of Global Healthcare, Apax Partners

Sandeep Naik Principal & Co-Head India Office, Apax Partners

Hannes Rumer Principal, Apax Partners

Ali Satvat Principal, Apax Partners

Bill Sullivan Partner, Apax Partners

Richard Zhang Partner & Head Greater China, Apax Partners

Conference attendees

Swati Abbott President, MEDai, Inc.

Ihsan Almarzouqi Business Development Manager, Mubadala Healthcare

Richard Alvarez President and CEO, Canada Health Infoway

Tracy Bahl Former CEO, Uniprise division of UnitedHealth

Richard Barasch Chairman & CEO, Universal American Corp.

Per Båtelson CEO, Global Health Partner

Joseph Berardo, Jr CEO and President, MagnaCare

Thomas Berglund Chairman and CEO of Capio Group

Ranjit Bhonsle Partner and Member of the Board of Directors, Ithmar Capital

Mark Blake Executive VP of Strategy & Corporate Development, Cardinal Health

Jason Blank Co-Managing Partner, Brockton Capital

Mark Britnell Global Head of Health, KPMG

Kyle Burtnett VP, Outpatient Services, Tenet Healthcare

Sven Byl Global Executive Director, Healthcare Sector KPMG International

Christopher Coloian Senior VP, Health Dialog

Ivan Colombo CEO, Humanitas Group

Mike Coyne President, Verisk Health

Melanie Da Costa Director Strategy & Health Policy, Netcare

Stephen DeCherney Former President of Clinical Development, Quintiles

John Driscoll President, New Markets, Medco Health Solutions, Inc.

John Duguid Healthcare Analyst, Olayan Group

Michael Flammini Head of Enterprise Strategy at Aetna

Howard Gold Senior Vice President Managed Care and Business Development, North Shore-LongIsland Jewish Health System

Vicky Gregg CEO, BlueCross BlueShield of Tennessee

Marc Grodman M.D. Founder, Chairman, President & CEO, BioReference Laboratories

Michael E Hansen CEO, Elsevier Health Sciences

Brad Hayes Executive Vice President & CFO, LabCorp

Peter Hudson Ellis, C.H.E., A.H.A. Managing Director of PharmaTrust UK

Steven Epstein Founder, Epstein Becker & Green

Paul Hökfelt Executive Chairman, Unilabs

Nigel Jones Partner & Co-Head, Healthcare Sector, Linklaters LLP

Kris Joshi, Ph.D Global VP for Healthcare Product Strategy, Oracle

Fergus Kee Former Managing Director of UK & North America, BUPA

David P. King Chairman & CEO, LabCorp

Bob Kocher Special Assistant to President Obama on Healthcare Reform

Dr Sneh Khemka Medical Director, Bupa International

Julie Klapstein CEO, Availity, LLC

Franz Knieps Former Director General for Public Healthcare in Germany

Karen Koh Former Deputy CEO, Singapore Health Services

Andrew Kwee Principal, LGT Capital Partners (USA) Inc.

Christian Le Dorze President, Vitalia

Anjan Malik Co-founder & Executive Director, eClerx Services Limited

Jeffrey Margolis Founder & Chairman, The TriZetto Group; Chairman, Welltok

Mike McMaude COO, Harden Healthcare

Robert Mills President, Qualitest Pharmaceuticals

Jean-Baptiste Mortier CEO, Vitalia

H.E. Prof. Dr. Hatem Mustafa El-Gabaly Minister of Health and Population, Egypt

Michael Neeb President & CEO, HCA International

Gunnar Németh COO, Capio Group

Marcus Osborne Senior Director of Healthcare Savings Programs & Global Sourcing, Wal-Mart Stores, Inc.

Augusto (Augie) P Palisoc Jr Head, Hospital Group of Metro Pacific Investments Corporation (MPIC)

Sally C Pipes President & CEO, Pacific Research Institute

Martin Rash Chairman & CEO, RegionalCare Hospital Partners

Luciano Ravera CEO, Istituto Clinico Humanitas

Mrs Suneeta Reddy Executive Director-Finance, Apollo Hospitals Enterprise Limited

Kirk Rothrock President & CEO, Sentient Medical Systems

Michael Ross Chief Marketing Officer, CIGNA International

Marvin Samson Founder & CEO, Samson Medical Technologies

Ahmad Shahizam Mohd Shariff Director of Investments, Khazanah Nasional Berhad

Abhishek Sharma Director, Ithmar Capital

Claudia Süssmuth-Dyckerhoff Director, McKinsey & Company Shanghai Office

Ruben Toral CEO, Mednet Asia. Founder, Medeguide.com

Niels Vernegaard COO, United Surgical Partners International

Bill Ward COO, Bupa International Markets

Kerry Weems Senior Vice President & General Manager, Health Solutions at Vangent

Dr Amit Varma President Healthcare, Religare Enterprises Limited

David P Williams Executive VP & CFO, Chemed Corporation

Mr Mingde Yu Honorary Chairman, Beijing Pharmaceutical Group

Apax Partners

Experts in Healthcare

Our healthcare experience

Apax Partners' Healthcare team is made up of dedicated investment professionals based in London, New York, Hong Kong, Shanghai, Madrid, Munich and Mumbai, with specialists in four core areas: medical products, devices and supplies; speciality and generic pharmaceuticals; healthcare service providers; and healthcare IT.

The Healthcare team is characterised by its very strong scientific background, and many of the members have direct industry operating experience.

Over the past five years, the healthcare team have advised Apax Funds on equity investments totalling over $3.5 billion.

Apollo Hospitals Group Global hospital operator

Country: India **Deal date:** 2007

Capio AB European hospitals and diagnostics centres

Country: Sweden **Deal date:** 2006

GHG Healthcare The largest private hospitals operator in the UK

Country: UK **Deal date:** 2006

MagnaCare Provider of health plan management services

Country: US **Deal date:** 2002

Marken Leading pharmaceutical logistics and support services

Country: UK **Deal date:** 2010

Molnlyke Healthcare Surgical care and wound care products

Country: Sweden **Deal date:** 2005

Qualitest Pharmaceuticals Manufacture and distribution of generic pharmaceuticals in the US

Country: US **Deal date:** 2007

TriZetto A leading supplier of software and related services to the US healthcare industry

Country: US **Deal date:** 2006

Unilabs Leading pan-European healthcare diagnostics

Country: Europe-wide **Deal date:** 2006

Voyager Leading provider of hospice care

Country: US **Deal date:** 2004

Zeneus Pharma Specialty pharmaceuticals for oncology and critical care

Country: Europe-wide **Deal date:** 2004

Our healthcare team

Khawar Mann
Partner and Co-Head of the Global Healthcare Group

Khawar focuses on investments in healthcare delivery services, R&D and healthcare logistics.

Prior to joining Apax Partners, Khawar was at Linklaters and Weston Medical Group PLC. He has a degree in Medical Sciences and Law from Cambridge University and also an LLM Master of Law. He has an MBA from The Wharton School, where he was a Fulbright and Thouron scholar.

His recent deals have included:

- General Healthcare Group Ltd
- Capio AB
- Apollo Hospitals
- Unilabs
- Marken

Buddy Gumina
Partner and Co-Head of the Global Healthcare Group

Buddy focuses on investments in healthcare services, products, pharma and healthcare IT.

Prior to joining Apax Partners, Buddy was at Saunders Karp & Megrue and DLJ Merchant Banking Partners.

Buddy received an MBA from the Harvard Graduate School of Business Administration and a BA in Political Science from Yale University.

Some recent deals have included:

- The Trizetto Group, Inc.
- Qualitest Pharmaceuticals
- Spectrum Laboratory Network
- Encompass Home Health
- Voyager HospiceCare, Inc
- MagnaCare Holdings, Inc.

Bill Sullivan
Partner

Bill has been a partner of Apax Partners since February 2007.

Bill has over 22 years experience in the healthcare industry. Prior to joining Apax Partners, Bill was the CEO and remains the current Chairman of Magnacare Holdings, Inc. an Apax Partners portfolio company. Prior to acquiring Magnacare, Bill spent thirteen years at Oxford Health Plans. Bill obtained a Bachelor of Science degree with a concentration in finance and banking from Suffolk University in Boston. Bill is also the Vice Chairman of The TriZetto Group, an Apax portfolio company and healthcare technology company in the US.

His deals include:

- The Trizetto Group, Inc.
- MagnaCare Holdings, Inc.

Steven Dyson
Partner

Steven is a partner and joined Apax Partners in 2000.

His prior experience was gained at McKinsey & Company. He gained a BA in Biochemistry from Magdalen College, Oxford University and a PhD in Developmental Biology from Cambridge University.

His deal experience includes:

- Capio AB
- General Healthcare Group Ltd
- Unilabs
- Zeneus Pharma

Apax PARTNERS

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