CARE

EXTENDING THE LIFELINE – HEALTHCARE

Marmore Preparatory Briefs

A Brief that analyses the potential for healthcare industry investments in the GCC.

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Introduction

11:30 HOURS: SOMEWHERE on Sheikh Zayed Road

Travelling on the Sheikh Zayed Road, from Abu Dhabi to Dubai, Mohammed, the 40-something billionaire, gazed out of his limousine. He had received a proposal from the healthcare major, 'Care', which was planning to set up a chain of specialty hospitals across the GCC. These would provide healthcare services in the fields of cardiology, diabetology, gynaecology, and the three O's — ophthalmology, orthopaedics, and oncology.

Mohammed was the man Care had identified as a potential investor, as Mohammed's success rate in business was phenomenal. Popularly known as "King Midas" for his penchant to turn even sand to gold, he was the Gulf's lucky mascot.

For sure, Mohammed was touched and willing. You can own any number of luxury cars, you can court success in sectors like real estate, logistics and infrastructure; but if you want to leave footprints on the sands of time, you need to hog a place in people's mind. And what could be a better focus area than healthcare, he thought. Profit was not the primary motive; but money was nevertheless important. You needed good money and reasonable profits to provide good infrastructure and high quality treatment.

Care's Track Record

Care had courted early success in MENA. They had started operations in Lebanon, then spread to Egypt, Israel and Jordan, and currently operated 12 centres with bed strength of 1,500 and a decent EBIT margin of 12.3%. Its latest focus was the GCC. The management was keen to offer franchise to willing investors who would manage the operations and transfer a share of profits to the owners of Care. It was like how the hotel industry operated.

Mohammed saw the numbers in his laptop. (**Exhibit 1 and Exhibit 2**)

Exhibit 1A: Care: Segmental Revenue Breakup

Geography	2011	2012	2013	2014
Lebanon	24%	25%	27%	28%
Egypt	40%	39%	41%	40%
Israel	17%	18%	18%	18%
Jordon	19%	18%	14%	14%

Exhibit 1B: Care: Segmental Revenue Breakup

Business	2011	2012	2013	2014
Cardiology	24%	25%	26%	27%
Diabetology	40%	43%	44%	43%
Orthopedics	14%	15%	16%	15%
Others	12%	17%	14%	15%

Source: Markaz

Exhibit 2A:
Care: Segmental Net Income Margin

Geography	2011	2012	2013	2014
Lebanon	9.1%	8.0%	8.5%	9.0%
Egypt	10.3%	11.6%	13.0%	14.0%
Israel	4.9%	5.0%	5.1%	5.5%
Jordon	6.7%	7.0%	6.2%	6.1%
	8.4%	**8.7%**	**9.4%**	**10.0%**

Source: Markaz

Exhibit 2B:
Care: Segmental Net Income Margin

Business	2011	2012	2013	2014
Cardiology	14.8%	14.0%	15.0%	15.3%
Diabetology	9.0%	8.6%	9.2%	9.7%
Orthopedics	4.3%	4.1%	4.3%	5.0%
Others	5.2%	5.3%	5.4%	6.0%
	8.4%	**8.7%**	**9.4%**	**10.0%**

They looked interesting. The net margin had been steadily increasing, but obviously, it will have to stabilise somewhere.

GCC Healthcare Sector

As the vehicle raced, so did his thoughts. He noticed that Jumeirah, off Sheikh Zayed Road, was dotted with hospitals. Mohammed wanted to begin with Kuwait and then expand to other GCC countries. In Kuwait, the government was already encouraging Public-Private Partnership (PPP). Secondly, statistics showed that with a ten-year CAGR of 7.9% in health expenditure, people in the GCC nations had started spending more on healthcare. This spend was about a third of that of developed nations; possibly, a good indicator that there is scope for growth. Incidentally, Qatar, at USD 1,488, has the highest per capita spending on healthcare, followed closely by the UAE at USD 1,450.

Mohammed glanced at the healthcare research report that he had scooped up. It was prepared by Markaz, a Kuwait-based research house and was a compulsive read. The report suggested that there was plenty of scope for PPPs in the GCC. About 64% of total health expenditure was expected to be incurred by the public sector by 2015. "Well, I can be a part of the 36% in the private pitch," thought Mohammed. In America, President Barack Obama was pushing for a plan for providing more Americans with access to affordable high-quality healthcare, regulating the health insurance industry and reducing spending in healthcare. Mohammed was clear that unless private players participated in a big way, the government would one day go broke.

He was looking at a couple of fellow angel investors to invest along with him. The project could take time to take off; it would take time to provide returns; but he was willing to wait. There was, however, one serious issue with the healthcare investment. And it had nothing to do with money. It had to do with shortage of trained doctors. Maybe he could open a medical college to support the hospital chain in Dubai's Healthcare City, attracting local aspirants, which could be modelled after the Harvard Medical School, US, one of the best medical schools in the world. "Another service to humanity," Rayhan thought. He recalled what the Saudi German Hospitals group had said: PPP was a sustainable and preferred model in healthcare, medical education and research. And the numbers spoke for themselves (**Exhibit 3 and Exhibit 4).**

Exhibit 3: Public and Private Expenditure on healthcare (Projected)

	Public		Private	
Year	**2015**	**2020**	**2015**	**2020**
Saudi Arabia	27.14	30.47	19.92	22.23
UAE	10.01	12.20	3.44	5.76
Kuwait	6.56	7.13	2.19	2.85
Qatar	2.85	3.32	1.12	1.53
Oman	2.94	2.90	0.86	1.34
Bahrain	1.46	1.49	0.53	0.75

Source: IMF, World Bank, Markaz Research

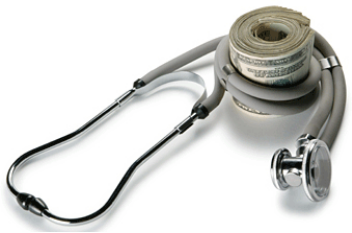

Exhibit 4: Health expenditure per capita in 2011

Country	Expenditure (% of GDP)
Bahrain	3.8%
Saudi Arabia	3.7%
UAE	3.4%
Qatar	2.3%

12:00 hours: Suite No. 2501, Burj-al-Arab Hotel

Mohammed checked into Royal Suite No. 2501 in the Burj-al-Arab Hotel. His room had two views: one facing the sea and the other facing Jumeirah Beach. "This view could heal anyone," he thought. He sat next to the sea view window and looked at the presentation. Healthcare made perfect sense. His oil contracting business was a gold

mine, but the party can't last forever. Logistics boomed, as the EMEA region was becoming the new hub, but he wasn't sure how long that will sustain. Infrastructure, although successful, was unpredictable. But healthcare was not sensitive to economic recessions and if nurtured carefully, would flourish.

Potential for Growth

A report[1] he had scooped estimated the healthcare market to grow at 11.4% CAGR; from USD 23.1 billion in 2009 to USD 44.1 billion. This was no small change. Moreover, with increasing population and rising diseases, the GCC governments were likely to gradually decrease their contribution to healthcare financing. This could mean more private players could enter the market. Ailments, once reserved for the elderly, are hitting people at an early age. Changed lifestyle is bringing diabetes, cardiac diseases and cancer closer to our doorsteps. He had scanned the business press to know that there were some large investments coming up in the UAE healthcare sector. For instance, over the next decade, the emirate of Dubai alone is expected to construct three new medical colleges and five schools for teaching nursing[2].

[1] Markaz GCC Healthcare Report
[2] Abu Dhabi Media

Exhibit 5: Insurance Regulatory Bodies in the GCC

Country	Authority
Bahrain	Central Bank of Bahrain
Saudi Arabia	Saudi Arabian Monetary Authority
Kuwait	Ministry of Commerce and Industry
Oman	Capital Market Authority
Qatar	Ministry of Business and Trade
UAE	Ministry of Economy Planning

Source: Various

The report suggested that GCC governments were strengthening the healthcare infrastructure, services and policies. There is a need to provide quality healthcare at affordable prices. In many of these countries, employers had to compulsorily sponsor insurance for their employees, much like what the USA is now wanting. Each country had insurance regulated by either the Central Bank or a Regulatory Authority (Exhibit 5). Affordability, decidedly, was important.

For the expatriates working in the GCC who earned well, the employer-sponsored insurance scheme worked well generally. The employee only had to pay the doctor's fees and about 10-20% of the cost of medicine. Further, out-of-pocket expenditure (OOPE) which is a direct payment by individuals to health practitioners and pharmaceutical suppliers not covered by insurance was high in the GCC. This was a disadvantage to the expat worker classes who earned just enough to send the money back home. They don't take care of themselves, because they just cannot afford to. "Another area of concern to the society," Mohammed thought. "Should I start offering free services to expat workers based on their type of visa sponsorship, once the business stabilizes?"

A look at the insurance premia (Exhibit 6) as a percent of GDP stumped Mohammed. Okay, the data may be a tad dated, but it still gave an indication of the shape of things. Despite the entry of new players, penetration in the insurance market was low due to ill-equipped technology and untrained manpower. Also, extremely high reinsurance rates were restricting profitability. Still, that didn't stop him from contemplating the investment in healthcare.

Exhibit 6: Insurance Premia as a percentage of GDP (2009)

Country	Non-life Premium	Life Premium	Assets
Bahrain	1.43%	0.70%	12.10
Saudi Arabia	0.46%	0.07%	NA
Kuwait	0.34%	0.09%	1.80
Oman	0.97%	0.20%	2.40
Qatar	0.67%	0.10%	2.70
UAE	1.34%	0.28%	3.10
GCC	0.87%	0.23%	4.40
Egypt	0.42%	0.37%	3.90
Morocco	1.54%	0.89%	19.00

Source: World Bank report-Nov 2010, ACO reports, Swiss Re.

Interestingly, Takaful, a type of Islamic insurance was popular in the GCC. Here members contribute to a pool to guarantee each other against loss or damage. A defined loss is paid out of a defined fund created out of the pooled contributions. Losses are shared by policyholders, thus making them both the insurer and insured. It grew at a CAGR of 41% between 2005 and 2009, but slowed to 16% in 2010.

Making the Decision

The fact that opportunities existed in the insurance market was comforting. While the insurance market was fragmented, there was huge scope for consolidation over the medium term. This was probably very important to get more international patients to visit the GCC who currently prefer India, Thailand and Singapore due to the lower costs and the state-of-the-art facilities in private hospitals in those countries.

He skimmed through the statistics of prevalence of diseases in the GCC. About 15% of the population suffered from diabetes, 30% from high BP and 35% suffered from obesity (Exhibit 7). His personal tryst with junk food, aerated drinks and love for fried stuff made him susceptible to it as well. He hated exercising, but had bought himself a treadmill to look good and fit in his social circle. Anyway, he was not concerned at the moment. He loved to live life to the fullest.

Exhibit 7: Disease prevalence in the GCC

	Adult risk factors, 2008 (percentage)					
	Diabetics (25+)		High BP (25+)		Obesity	
	Male	Female	Male	Female	Male	Female
Saudi Arabia	22.0%	21.7%	32.9%	28.7%	29.5%	43.5%
UAE	15.3%	15.8%	30.4%	21.2%	30.2%	43.0%
Kuwait	17.0%	14.8%	29.0%	23.7%	37.2%	52.4%
Qatar	12.4%	11.0%	34.4%	27.6%	30.8%	39.3%
Oman	12.0%	12.3%	32.4%	27.5%	19.4%	25.9%
Bahrain	13.5%	12.1%	34.5%	32.9%	28.9%	38.2%

Source: WHO

He had read somewhere that of the countries with the highest prevalence of diabetes, Kuwait stands third, Qatar ranks sixth; Saudi, Bahrain and UAE rank seventh, eighth and tenth respectively. The "silent killer" has major long-term complications including damage

to blood vessels, double risk of cardiovascular disease, visual impairment and chronic renal failure. Diabetes also leads to other complications like renal disease, poor vision, cardiac arrests, neurological diseases, etc. Pretty serious, but ironically plenty of business opportunity too! A diabetic centre could be an area he could personally look at in the future. UAE spends USD 272million to treat diabetic patients. The Dasman Diabetes Institute in Kuwait was one famous diabetic center which was promoted by the Kuwait Foundation for Advancement of Sciences.

He looked at the slides on pharmaceutical market. He was surprised looking at the near non-existence of medical equipment and drug manufacturing facilities in the GCC. Only generic drugs were manufactured, and it barely helped to sustain competition from foreign medicine. Unless restrictions such as price controls, foreign ownership and customs duty were imposed, the progress of the healthcare industry will continue to be hindered.

Mohammed switched his screen to Google. His curiosity about the pharmaceutical market was kindled. The screen showed that Saudi Arabia and UAE were the only countries that permitted duty-free manufacture of medicines. A legal website, Meyer Reumann & Partners, showed that the Pharmaceutical Manufacturers and Medical Supplier's Union is exploring possibilities to establish a pharmaceutical trade association for producers in GCC and Yemen. Unions were also expressing the need to harmonize registration procedures for pharmaceuticals in the GCC.

14:30 hours: Lunch and the decision

The phone in his suite rang. It was from Room Service. "Would you like lunch served at your suite sir, or would you like to come over to the dining room?" It was only then that he realized he was hungry. He had 18 hours until he took the flight back to Kuwait. He'll have to decide by then and let Care know of his plans. "Bring it to my suite please," he responded. Munching his lunch, doodling ideas on paper, and watching the google console, Mohammed didn't realize that 90 minutes had gone by until the door bell rang.

It was Jassim. Jassim was widely respected, had been Mohammed's business partner for the last 15 years, and was like a godfather to him. Mohammed had tremendous respect for Jassim, and Mohammed believed Jassim was a lost brother. "Let's look at country-specific details," said Jasim. He had already been briefed of the big picture over a conference call and was close to being convinced that Mohammed should go ahead with the proposal.

Exhibit 8: Summary of Key Indicators

	Kuwait	UAE	Bahrain	Qatar	Oman	Saudi Arabia
Life expectancy at birth, total (years), 2012	70	77	77	78	77	75
Birth rate, crude (per 1000 people), 2012	21	15	16	11	21	20
Death rate, crude (per 1,000 people), 2012	3	1	2	1	3	3
Health expenditure, public (% of GDP), 2012	2.1	1.9	2.8	1.8	2.1	2.1
Health expenditure, private (% of GDP), 2012	0.4	0.9	1.122	0.4	0.5	1.1
Hospital beds (per 1,000 people), 2012	2.2	1.1	2.1	1.2	1.7	2.1

Source: World Bank

Mohammed walked him through some key inputs.

The UAE government had identified cancer, nutritional disorder, diabetics and cardiac diseases, road traffic incidents and mental health as priority research areas. Private players could have 100% foreign ownership, 100% repatriation of profits and capital, tax-free income guaranteed for 50 years and exemptions from customs duty for goods and services. In Saudi Arabia, the Kingdom was encouraging new players in insurance market, surgical equipment and clinical trials. There was also focus on establishing medical centers and encourage nationals to adopt the profession.

In Kuwait, plans were afoot to integrate health information across hospitals and clinics in all departments of the Ministry of Health. Capacity of hospitals was proposed to be increased by 30%. In Bahrain, health insurance has to be provided to employees if the number exceeds 50 in a company. Electronic access to all medical records was a reality. In Oman, the Sultanate had focused on decentralization of hospitals, improving quality of healthcare and encouraging nationals to adopt healthcare as a profession. In Qatar, while the age dependency was a low 17%, there was a steady decline in the number of medical professionals including nurses and pharmacists.

Mohamed shared his vision with Jassim: of being a John Hopkins Hospital in terms of being the “best hospital in the world”, a Chris Hani Baragwanath in terms of being the “largest hospital in the world in size and scale”, a Stanford Hospitals and Clinics in terms of “pioneering treatments and breakthroughs”, a MD Anderson Cancer Center in terms of “top hospital for diabetes care.”

At the end of it, Jassim stretched his right hand with all his fingers, except the thumb, clenched. Did he give a thumbs-up or a thumbs-down?

TEACHING NOTES

1. Should Mohammed really be getting into healthcare where he has near-zero expertise? Does the diversification build a balanced portfolio?
2. Discussion on the regional aspects of healthcare in the GCC and which country could be a starting point for investment.
3. SWOT of healthcare industry.
4. Discussion on costs and benefits of insurance and reinsurance.
5. What makes GCC a good healthcare investment destination?
6. Analysis of the disconnect amongst different aspects of the healthcare industry (hospitals, pharmacies, diseases, insurance, affordability).
7. What can make GCC score over Asian countries as an attractive destination for medical tourism? (A comparative PEST analysis would help)
8. What is the flip side of setting up medical centers in tax-free countries?
9. What should be the vision of a hospital? Making USD "X" as turnover or having a ROCE of "Y%"
10. Is healthcare a business or profession? Should hospitals, as a rule, make profits?
11. Should hospitals be established as corporate entities?
12. On how lifestyle ailments can be avoided.
13. Are the projected margins good?
14. Is the franchisee model good for healthcare?
15. What do you think was Jassim's advice to Mohammed and why?