

[Previous](#) | [Next](#)

&nbsp;

We talk to [Ambea](#) chief executive Ralph Riber about the opportunities and markets in the region, in particular the massive growth in outsourcing of primary and elderly care to the private sector in Sweden. Pan-Nordic player Ambea is firing on all cylinders - the company (in which 3i has a 75% stake) owns private healthcare operators Mehiläinen in Finland and Carema in Sweden and saw 2007 sales rise nearly 1bn SEK to 5.3bn SEK, with organic growth running at 12% and EBITA margins up 1.1 percentage points to 8.6%. 3i was reported to have put the business up for sale this spring with a price tag of \$1.4 billion, but then removed it from the market.

Suddenly, outsourcing to the private sector in Sweden has become big business. In the first half of 2008 Riber reckons that outsourcing contracts worth SEK 1,5 bn for primary and elderly care were won by the private sector. He says that Ambea's Carema business picked up SEK 0.8bn or a breath-taking 50% of the total. Riber says there is more to come:

Healthcare Europa suggest that outsourcing margins are much less attractive than pure private work. But Riber demurs. "Yes, they are lower - an average of, maybe, 8-9% ebita on sales, but look at the return on capital! In some cases you may need no capital at all! And there are specialist areas where margins can be much higher."

He is very keen to differentiate the Nordic outsourcing market from the UK. "London investors are a small club who tend to see everything through UK eyes. They see the property crisis and the squeeze on National Health Service contracts and they think it's like that everywhere. It's not. For example our Swedish arm, Carema, owns no property."

The perception is not helped by the slow pace of reform in certain areas of Swedish healthcare. The system is very decentralised and there has been a marked reluctance from the country's twenty counties to allow community hospitals to be run by the private sector, which Riber admits is "disappointing".

Seeing this, outsiders may feel that the Swedes are still wedded to a dogmatic, socialist model. But Riber argues that a consensus that the private sector should be involved has, in fact, emerged - it is simply the limits that are up for grabs.

Finally, there is a perception that consolidation has already happened in the Nordic private healthcare market and that there is nothing for private equity players to go for. Again, Riber argues that this simply isn't true.

"Yes, Attendo and us probably have half the out-sourced elderly care market in Sweden. But in Finland the top players are a quarter of the size of the Swedish players." He sees huge scope in elderly care in Finland, as strong links between municipalities and not-for-profit operators have now been cut and the market has been freed up.

Other markets are much more fragmented. In care of the disabled, Carema is the marketleader in Sweden with just 10%.

And the fast-growing primary care market remains wide open. Here, he claims that Carema is second to Praktikertjänst, a big Swedish doctors and dentist cooperative. Yet Carema only has only got just over 30 practices.

The bottom line for Riber is that Finland and Sweden remain fast growth markets. Indeed, Ambea expects the total private healthcare to double in size in the next 3-5 years in both markets.

So why has outsourcing taken off in Sweden and what form is it taking?

Riber sees a "great future" in primary care. He estimates the Swedish market at SEK 25 bn, or 3,000 SEK per Swede, with the private sector currently accounting for 20-25%. He expects that grow to 30% over the next 3 to 5 years, creating a further SEK 3 bn of business.

Elderly care is also set to soar. He estimates it at SEK 83-85bn, with the private sector fulfilling 12-15%, a figure he sees rising to 20% over 3-5 years adding an extra SEK 5-7 bn.

Riber says the key change is the introduction of patient choice. In the new model, the money follows the patient, who once they have been assessed, is free to choose a provider. This plays out across care homes, domiciliary services and general practitioners. It cuts both ways, however, as it means private operators have no guarantee that all their beds will be taken or that their services will be used and if they are not used then they will not be paid.

Riber says that the move to patient choice means that operators have more autonomy and fewer restrictions are placed in the contracts by local authorities: "So now we have the freedom to industrialise processes, to set up uniform clinical practices and to be cost effective but also attractive to the patient." This, he claims, confers "substantial competitive advantages" vis a vis the small practices which make up the main competitors in primary care.

He claims the new system plays to Carema's strengths - its ability to be close to the patient, to operate like a small company but with big company backing.

The new model can be fairly cut throat. Although only 1-2% of any family doctor's list is likely to move in a year, in some cases the system is set up such that if a patient who is on practice's books goes elsewhere for treatment, to, say, an airport doctor, or a practice near his work, then the practice he is registered with has to pay the bill.

In Stockholm, the centre of the choice movement, individuals who had not visited a doctor recently, were put into what was termed a free float and had complete freedom to choose which doctor to go to, leading to a scramble for business.

So what has happened to the political debate?

As we have seen, Riber argues that private sector involvement is now accepted by the left. "Our largest primary care contract is with a left wing, socialist council." The debate now is about how far patients should be allowed choice and whether choice will benefit the genuinely needy or will be exercised mainly by the middle classes. It is also about the degree of private involvement. Taking over hospitals is still politically unacceptable. Meanwhile, there should be reasonable stability until the elections due in 2010.

What of Finland? Here the system is more pragmatic with patients able to recoup private costs from the state. Private healthcare here already accounts for 19% of the total, compared to just 11% in Sweden and 3% in wealthy Norway, which remains pretty much wedded to the public sector. In Finland much of the middle class have effectively opted out of state provision making it possible to build large businesses based upon meeting their needs.

Ambea's strategy over the last year has been to go for outsourcing contracts in Sweden where it has also made various small infill acquisitions. In Finland Mehiläinen which has a strong brand name, specialises in delivering directly to private individuals and corporates. Here the focus has been on Building a national integrated network of clinics with integrated diagnostics.

Carema's outsourcing expertise is now being applied in Finland where has won a big contract in Karjaa municipality. Ambea is also looking at taking medical recruitment, where Carema is the marketleader in Sweden, into Finland. Conversely mammography may be introduced from Finland to Sweden.

What of the future? Riber says he has cast an eye over various businesses in the UK and mainland Europe, but sees such potential in his home markets that he is happy to stick to the knitting.

- [Ambea to expand abroad under new CEO](#)
- [Ambea to float in 2010?](#)
- [STOCKHOLM OUTSOURCES psychiatric care](#)
- [Interview: Matti Bergendahl, CEO Ambea](#)
- [CONTRACT book up 63% to Euros 1.15bn at Ambea](#)
- [3i sells Ambea](#)
- [BRIDGEPOINT SWOOPS on Terveystalo](#)
- [IS NORWAY'S largest private healthcare operator for sale?](#)
- [EQT hoists for sale sign at Aleris](#)

&nbsp; [Previous](#) | [Next](#)

&nbsp; [Back to top](#)