Crossing borders:

How healthcare service organisations can explore new markets

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Healthcare services CEOs face a difficult dilemma. On the one hand, they want to pursue new revenue streams, including acquisitions, to offset the impact of tighter global budgets and slower organic growth. On the other, they're wary of going overseas because coping with fundamentally dissimilar—and heavily regulated—systems and cultures is very demanding.

Healthcare provision varies substantially from one country to another, with different care pathways, delivery mechanisms and reimbursement procedures. That not only complicates the overseas due diligence process; it also limits the potential for cutting overheads.

Moreover, although some healthcare providers have strong brands they can leverage abroad, most of them have been loathe to risk diluting those brands in unfamiliar markets. And few providers have had the financial resources or management expertise to pursue complex cross-border transactions.

The situation is rather different for healthcare payers with international ambitions. The biggest insurers have largely replicable systems and processes, as well as an extensive understanding of health outcomes, which can be transferred to other regions to realise economies of scale. Even so, many of the historical caveats about heading overseas still apply. Healthcare payers, like healthcare providers, can only expand into foreign countries with markets and remuneration systems in which their business models will flourish.

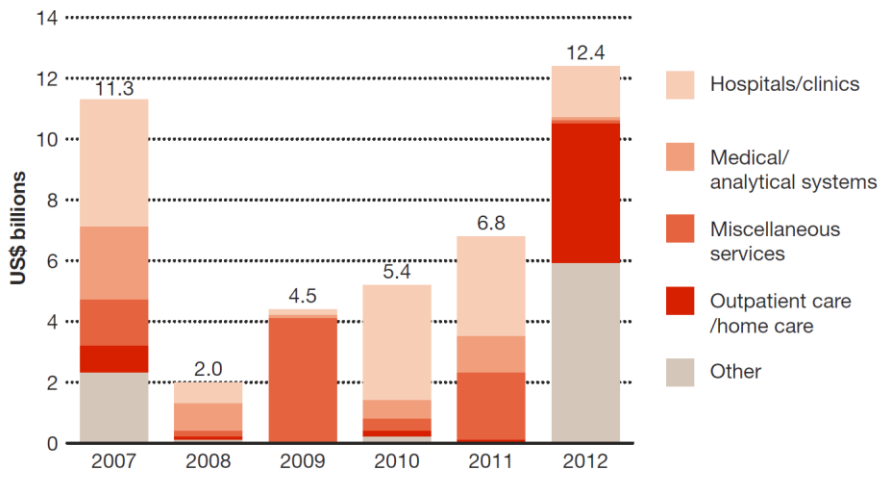
Resistance to the idea of crossing borders may slowly be softening, though, as an increasing number of healthcare organisations exhaust the opportunities for domestic growth. The playing field is also changing, as foreign targets become more sophisticated and more receptive to joint deals with outside organisations. The question is, how best to avoid the shoals when dipping a toe in foreign waters.

A stay-at-home past

Healthcare payers and providers have traditionally been quite insular. Only 12% of the healthcare CEOs who participated in PwC's 16th annual CEO survey are exploring new or existing foreign markets, for example, and only 10% plan to conduct a cross-border merger or acquisition (M&A) this year. That's less than half the overall average.[1]

The financial turmoil of the past few years has also taken its toll. Between 2007 and 2012, 557 cross-border deals took place in the sector. The 266 deals for which figures were disclosed were collectively worth US$42.4 billion, but their annual aggregate value still remains less than it was in 2007, before the global financial crisis began (see Figure 1).

Figure 1: Total value of disclosed cross-border deals by segment (2007–2012)



Source: *Dealogic*
Note: *Other includes health management organizations, practice management and nursing homes.*

Undercurrents of change

Yet there are signs that the mood is slowly shifting, as the most pioneering organisations look further afield and investors change their stance. Some of the best US teaching hospitals have formed foreign partnerships. Johns Hopkins Medicine is one such case; it's affiliated with 17 healthcare providers in Europe, Asia, the Middle East and Latin America.[2]

Several leading British medical institutes have followed the same path. Moorfields Eye Hospital has a subsidiary in Dubai, while Imperial College London has two diabetes centres in Abu Dhabi. And the UK government is now planning to set up overseas outposts of other well-known British hospitals, such as Great Ormond Street and the Royal Marsden.[3]

Private equity investors have also entered the arena. Between February 2012 and April 2013, Symphony International completed seven deals in Malaysia and Singapore, in a bid to capitalise on booming demand for high-quality healthcare in Southeast Asia. Meanwhile, Valedo acquired Norwegian laser treatment clinic Ellipse, and Gulf Partners bought a stake in two diagnostics imaging companies in Turkey and Jordan.[4]

Interest rose even higher with the announcement of the two biggest ever deals in the sector (see Table 1). In July 2012, German conglomerate Linde acquired the US-based Lincare Holdings for US$4.5 billion, a move that put it at the forefront of the fast-growing market for respiratory therapies taken at home.[5] And in October 2012, US health insurer UnitedHealth bought a 90% stake in Amil Participacoes, Brazil's largest health insurer and hospital operator, for US$5.1 billion.[6]

Table 1: Top 10 cross-border deals by value (2007–2012)

Date deal announced	Target company	Target company's country	Acquiring company	Acquiring company's country	Value (US$ millions)
8 Oct 12	Amil Participacoes (90%)	Brazil	UnitedHealth Group	US	5,090.69
2 Jul 12	Lincare Holdings	US	Linde	Germany	4,548.08
2 Aug 07	Klinik Hirslanden	Switzerland	Medi-Clinic Corp	South Africa	2,996.38
27 May 10	Parkway Holdings (76.8%)	Singapore	Khazanah Nasional Bhd	Malaysia	2,893.18
2 Aug 11	Liberty Dialysis Holdings	US	Fresenius	Germany	1,700.00
23 Dec 11	Acibadem Saglik Hizmetleri ve Ticaret (75%)	Turkey	Integrated Healthcare Holdings; Khazanah Nasional Bhd	Malaysia	1,588.20
6 Nov 07	Alliance Medical	UK	Dubai International Capital	UAE	1,250.78
6 Aug 07	Nursing Homes (15 nursing homes)	UK	Morgan Stanley Real Estate	US	1,100.00
7 Apr 11	Integrated Healthcare Holdings (30%)	Malaysia	Mitsui & Co.	Japan	1,091.16
3 Oct 07	DCA Agedcare Group	Australia	Bupa	UK	1,087.01

Source: *Dealogic*

More significant still, perhaps, was the reaction of the capital markets. Institutional investors have generally frowned on foreign acquisitions in the healthcare services sector, believing the risk/reward ratio unattractive. Witness the response when US hospital operator Tenet Healthcare's plans to acquire Australia's Healthscope leaked in June 2010. Tenet's shares plunged by more than 10% and the firm had to cancel the deal.[7]

However, when UnitedHealth announced that it was entering Brazil, its stock price rose 4%, compared with the average over the previous 30 days.[8] And though Linde's shares fell nearly 7% on news of its plans to buy Lincare, they had recovered by the end of the next week.[9]

In short, the two deals may mark a turning point in the investment community's sentiments. Faced with a difficult domestic earnings outlook, as budgetary pressures continue to constrain payers and providers in the mature markets, and declining risk in the emerging markets, where targets and their management teams are gradually becoming more sophisticated, institutional shareholders seem to be relaxing their opposition to foreign forays.

But though a more favourable reception from the capital markets can make the prospect of a cross-border transaction more appealing, handling the nuts and bolts of the actual transaction remains a significant challenge. So what do healthcare providers and payers need to consider before taking the plunge?

Defining your core proposition

Any healthcare services company that wants to go abroad should start by asking itself what it can offer, whether there's demand for its offering and how it will be remunerated. That's a particularly complex question for healthcare providers because healthcare delivery in many countries is evolving, as demographic and economic pressures dictate the switch to more-cost effective methods.

In essence, there are two delivery models: the asset-heavy model, where a provider builds or buys a hospital, nursing home or clinic; and the asset-light model, where a provider offers a service, such as laboratory testing, dialysis or domiciliary care. These two models are quite different. The former entails filling beds, while the latter entails running a logistics operation.

Asset-heavy businesses have historically been more attractive to investors because they include tangible property. Sales of these assets have continued to command rich valuations. In October 2012, for example, Russian private healthcare provider MD Medical Group completed an initial public offering (IPO) that raised US$300 million—the equivalent of 22 times earnings before interest, taxes, depreciation and amortization (EBITDA).[10]

But updating crumbling hospitals is an expensive business, and reimbursement models rarely cover the costs. So footing the refurbishment bill is a considerable deterrent. Asset-heavy businesses are also less flexible than asset-light businesses, as the owners of British private hospital provider General Healthcare Group have discovered.[11]

In asset-light businesses, by contrast, it's easier to control costs and manage fluctuations in demand by hiring and dismissing staff as necessary. Indian hospital group Fortis has already recognised as much. The group is expanding aggressively but, rather than building new hospitals, it's leasing existing hospitals and operating them on a revenue-sharing basis.[12]

Asset-light business models also offer greater potential for growth, as cash-strapped governments transfer services out of the hospital setting—a trend that has attracted several new market entrants. In March 2012, for example, Virgin Care (a subsidiary of Virgin Group) won a five-year contract to deliver community health services in Surrey, southern England.[13]

Thus the issue for healthcare providers is not whether people require care but how that care should be delivered. Do they have the right expertise? Can they tailor their offerings to the needs of the local population? And can they get fairly paid for the services they provide?

Private insurers face a different quandary. There's little call for the services they offer in markets where healthcare is publicly funded. Demand for top-up services certainly exists, but that's been hit by the financial woes of the past few years. So the markets where payers have most to offer are those with a fragmented insurance base or where the state plays a small role.

Defining your goals

It's essential to have a clear goal. Many healthcare organisations head overseas looking for growth, but the opportunities vary significantly. For example, one source of growth in the mature economies comes from outsourcing as a result of overt or covert privatisation and integration in unconsolidated subsectors like diagnostics and fertility clinics. The inducements the emerging markets offer lie in serving more patients or covering millions more lives.

But this broad distinction hides some major intra-national variations, with different populations requiring different business models. Wealthy locals and expatriates sit at one end of the spectrum. Bupa has built a successful operation serving such people; it now works in more than 190 countries.[14] And the market for high-end healthcare services, albeit small, is rapidly increasing. Mass populations with low per-capita incomes sit at the other end of the spectrum, although few Western healthcare companies can yet provide the services these patients want at prices they can afford.

Moreover, there are other reasons to explore international markets. One such motive is the desire to tap into new sources of capital. In late 2012, for example, Fortis completed a landmark IPO on the Singapore stock exchange, raising more than US$400 million to finance its long-term strategy of domestic and global expansion.[15]

Game-changing innovations

Narayana Hrudayalaya Hospital in Bangalore has mastered the science of high-throughput heart surgery. In 2008, its 42 surgeons performed 3,174 bypass operations—more than double the number performed at the Cleveland Clinic. The average cost of each operation was just US$2,000, compared with between US$20,000 and US$42,000 in the US.[17]

Narayana Hrudayalaya is one of several Indian healthcare providers using assembly-line techniques to change the way healthcare is delivered. LifeSpring has reduced the cost of giving birth in a private hospital to US$40 by looking after many more mothers.[18] And Aravind, the world's biggest eye-hospital chain, performs about 350,000 operations a year. Its operating rooms have at least two beds, so that surgeons can swivel from one patient to the next.[19]

Meanwhile, Apollo Hospitals uses telemedicine to serve people in remote locations.[20] And Kenya's Child and Family Wellness Shops have combined horizontal scaling—i.e., adding more nodes—with commercial incentives. The nurses who work in its chain of micro-pharmacies and clinics covering Kenya's urban slums and rural areas get shares in the company, which encourages them to serve more children.[21]

A second incentive is the opportunity to learn from other healthcare providers and payers. Chinese radiotherapy and diagnostic imaging business Concord Medical Services Holdings is a case in point. In December 2012, the company bought a 20% stake in the University of Texas MD Anderson Proton Therapy Center. "This transaction will enable us to gain valuable experience and knowledge of the operations of a proton therapy centre from the world leader in proton therapy cancer care," chairman and CEO Dr Jianyu Yang explained.[16]

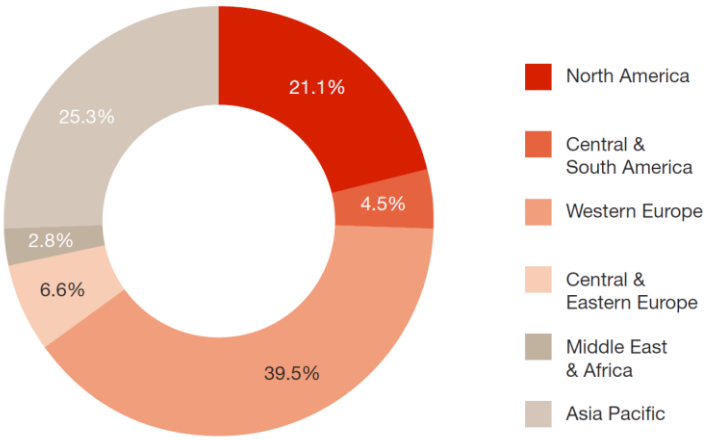
But the traffic isn't just one way. The most advanced healthcare organisations in the emerging economies also have much to teach their mature-market counterparts (see sidebar, ***Game-changing innovations).*** So any healthcare company planning to cross borders should have a well-defined objective—or set of objectives—in mind, when it decides where to go.

Choosing the right location

Western Europe has attracted the biggest share of interest in the past few years (see Figure 2). That's hardly surprising, since the mature markets typically carry fewer risks, although they also present fewer opportunities. Again, however, there are some notable national variations.

Outsourcing of publicly funded healthcare services to private contractors is firmly entrenched in Sweden, for example. Management of both good and bad facilities is routinely put in private hands, enabling the providers to create a portfolio and spread their risk.[22]

Figure 2: Target companies by region (2007–mid 2013)



Source: *Dealogic*

In Germany and the UK, by contrast, outsourcing is usually seen as a last resort. Hinchingbrooke Hospital, Cambridgeshire, is a classic instance. The hospital was on the verge of going bust when the British government appointed Circle to run it in February 2012.[23]

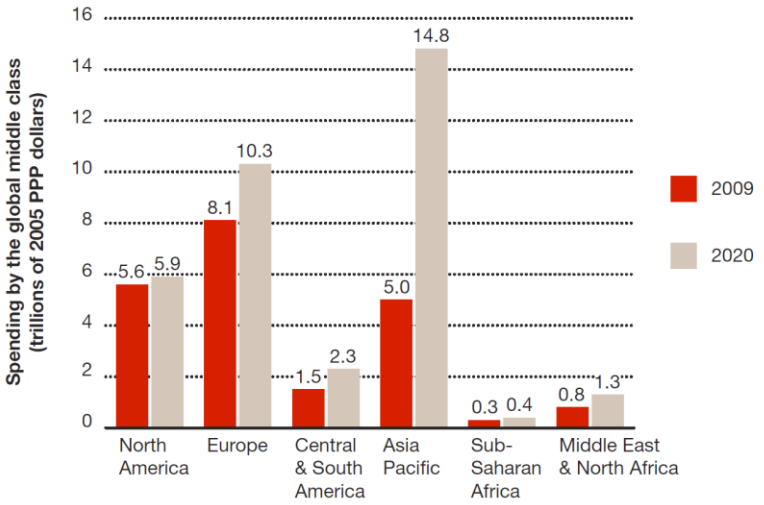
Thus private contractors in these two countries often take on the most challenging situations, which makes their job more difficult and means they're more likely to fail.

That said, regulators don't intervene directly in the running of hospitals in Germany, France and certain other European states—as they do in the UK. So the hospital sector in these countries is still attractive to many private investors.

The Middle East has also generated some interest. In April 2012, US dialysis services provider DaVita bought a majority stake in Saudi kidney care clinic operator Lehbi Care.[24] And in August 2012, South African hospital chain Mediclinic International topped up its 50% stake in Emirates Healthcare Holdings, with the purchase of the remaining shares for US$220 million.[25]

But many more companies have their eyes on Asia—a trend that's likely to continue, given the lure of large underserved and increasingly affluent populations. The OECD predicts that, by 2020, the spending power of the global middle class will reach US$35 trillion a year, up from US$21 trillion in 2009. More than 80% of this growth is expected to occur in the Asia Pacific (see Figure 3).[26]

Figure 3: The projected increase in spending by the global middle class between 2009 and 2020



Source: *OECD, 'The Emerging Middle Class in Developing Countries'.*

To date, attention has focused primarily on India, with 39 deals completed between 2007 and May 2013. The vast majority of these transactions were private equity investments in hospitals, clinics and diagnostics providers. But in January 2012, DaVita made its first Indian sortie, with the acquisition of a stake in Bangalore-based renal care services provider NephroLife Care, and other healthcare providers will probably follow suit.[27]

In October 2012, the Indian government also announced plans to increase the limit on foreign investment in the insurance sector (including health insurance) from 26% to 49%, although it has yet to implement the change.[28] But any Western insurer entering the country will need to work out how its business model can be applied in a highly price-sensitive market where out-of-pocket payment for healthcare services predominates.

Other firms have been exploring the opportunities in China, now that Beijing is relaxing the restrictions on overseas ownership of private healthcare facilities. In fact, interest in China is growing fast. Ten of the 21 cross-border deals struck between 2007 and mid-2013 have taken place in the last 18 months. In February 2012, for example, the International Finance Corporation invested US$20 million in Asia Pacific Medical Group.[29]

But interest in Latin America has been more subdued, with the marked exception of UnitedHealth's bold venture into Brazil. And most investors have shied away from Russia and Africa, for a variety of reasons. Russia comes 112th in the World Bank Group's ratings for ease of doing business, for example, while a number of African states fare even worse.[30]

As a general rule, then, the mature economies offer less potential for growth, whereas the emerging economies carry more risk. Yet there are subtle distinctions within these two categories, so it's imperative to assess each market individually—including the local regulations. An instance: In Indonesia, demand for healthcare is soaring and there's a huge shortage of qualified personnel. But foreign doctors are banned from practising independently, so the downside may outweigh the upside for many overseas investors.[31]

Striking the right sort of deal

It's also important to choose the right deal structure and here the options are increasing, as technological advances change the way businesses operate and compete. Briefly, deals come in one of two forms: corporate or contractual.

In a corporate structure, two or more parties create a standalone legal entity, such as a joint venture, limited liability company or partnership. They jointly fund and manage the entity, and share in its profits and losses. In a contractual structure, by contrast, the parties rely on a contract to allocate risk and reward, and manage the collaboration.

Each structure has pros and cons. A corporate structure permits the investors to pool their resources (including assets, technologies and people) and create synergies. It may also offer certain tax benefits (such as the accelerated use of tax attributes) and provide a vehicle for further deals in other regions or markets. But such arrangements are complex to negotiate, set up and dissolve, have a limited useful life and create a corporate tax liability when terminated.

Contractual structures are easier to negotiate, create and unwind. They may also require less upfront capital. And they offer access to a wider range of resources, since the parties can draw on all the assets they own, not just those they've contributed to a separate entity. But it's more difficult to oversee the activities of the partners. So the reputational risk is higher, as are the risks of a data security breach and loss of intellectual property.

Occasionally, tax or accounting factors, such as where to locate ownership of an intellectual asset, will determine the best arrangement to adopt. In general, though, business objectives should be the main consideration. Whatever structure a healthcare provider or payer chooses, it should also agree and document a set of organisational and operating assumptions, including a framework for sharing costs and profits, and management and financial reporting requirements. And it should bear cultural and jurisdictional differences in mind.

Taking things one step at a time

Lastly, it's crucial to tread carefully—as, indeed, many healthcare companies are doing. They're starting with strategic alliances and progressing to joint ventures before going for a full-scale M&A. Even then, they're exercising caution. All but 49 of the cross-border deals completed since 2007 for which values have been disclosed were worth less than $100 million.[32]

Nevertheless, we expect the trend towards globalisation in the healthcare sector to accelerate, especially among publicly traded companies beholden to shareholders requiring growth. And some companies will look beyond the more obvious locations as new markets open up. Emerging economies like Mexico are picking up speed, for example. Vietnam, Malaysia and Nigeria also have strong long-term growth potential.[33]

So, while it would be foolish to rush abroad without regard for the perils, it would be equally unwise to ignore the wider world. Healthcare services CEOs who stick to their home turf without considering the international scene may be missing out on some major openings.

How to cross borders safely

1. **Define your core offering**. What unique features does it possess? And how much demand is there?
2. **Define your goals.** What do you hope to gain from going overseas? Do you want to generate more custom, attract new capital or learn from other organisations?
3. **Target the most promising opportunities.** Focus on asset-light delivery models and undeveloped areas that are ripe for consolidation.
4. **Get independent advice,** particularly if your management team has no international expertise.
5. **Start small.** Begin with a strategic alliance or joint venture. Consider an M&A only when you're confident that you know what you're doing.
6. **Make sure you have a clear understanding of the reimbursement system** in the country you're targeting.

Notes

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For a deeper conversation, please contact:

Global
Patrick Figgis
Leader, Health Industries
+44 207 804 4310
patrick.figgis@uk.pwc.com

Africa Central
Simon Mutinda
+254 20 2855000
simon.mutinda@ke.pwc.com

Argentina
Norberto Rodriguez
+54 11 4850 0000 ext. 4512
norberto.rodriguez@ar.pwc.com

Australia
David McKeering
+61 7 3257 5029
david.mckeering@au.pwc.com

Austria
Gerhard Prachner
+43 1 501 88 1800
gerhard.prachner@at.pwc.com

Belgium
Romain Seffer
+32 2 7109505
romain.seffer@be.pwc.com

Brazil
Marcio Vieira
+55 11 3674 3854
marcio.vieira@br.pwc.com

Canada
William Falk
+1 416 687 8486
william.f.falk@ca.pwc.com

Central & Eastern Europe
Mariusz Ignatowicz
+48 22 523 4795
mariusz.ignatowicz@pl.pwc.com

China/Hong Kong
Mark Gilbraith
+86 21 2323 2898
mark.gilbraith@cn.pwc.com

Denmark
Christian Klibo
+45 8932 5514
christian.klibo@dk.pwc.com

Finland
Karita Reijonsaari
+358 20 787 8196
karita.reijonsaari@fi.pwc.com

France
Elisabeth Hachmanian
+331 56 57 5876
elisabeth.hachmanian@fr.pwc.com

Germany
Michael Burkhart
+49 69 9585 1268
michael.burkhart@de.pwc.com

Alexander von Friesen
+49 69 9585 5487
alexander.von.friesen@de.pwc.com

Greece
Kelly Vamvaka
+30 210 6874400
kelly.vamvaka@gr.pwc.com

India
Rana Mehta
+91 124 3306006
rana.mehta@in.pwc.com

Abhishek P Singh
+91 22 66691830
abhishek.p.singh@in.pwc.com

Indonesia
Triono Soedirdjo
+62 21 521 2901
triono.soedirdjo@id.pwc.com

Ireland
Aidan Walsh
+353 1 792 6255
aidan.walsh@ie.pwc.com

Jimmy Tolan
+353 (0) 1 7927827
jimmy.tolan@ie.pwc.com

Israel
Arik Reizner
+972 3 795 4 537
arik.reizner@il.pwc.com

Claudio Yarza
+972 3 795 4 590
claudio.yarza@il.pwc.com

Italy
Lino Mastromarino
+39 02 66720554
lino.mastromarino@it.pwc.com

Japan
Naoya Takuma
+81 80 4959 7701
naoya.takuma@jp.pwc.com

Luxembourg
Guy Brandenbourger
+352 494848 2386
guy.brandenbourger@lu.pwc.com

Malaysia
Andrew YH Chan
+60 3 21731219
andrew.yh.chan@my.pwc.com

Mexico
José Alarcón
+52 55 5263 60 28
jose.alarcon@mx.pwc.com

Middle East
Simon Leary
+971 5668 20513
simon.leary@ae.pwc.com

Netherlands
Jeltje Schraverus
+31 6 12 83 04 37
jelte.schraverus@nl.pwc.com

Norway
Dagfinn Hallseth
+47 95 26 12 48
dagfinn.hallseth@no.pwc.com

Philippines
Rose S. Javier
+63 2 459 3016
rose.javier@ph.pwc.com

Portugal
Luis Boquinhas
+35 12 1359 9239
luis.boquinhas@pt.pwc.com

Singapore
Abhijit Ghosh
+65 6236 3888
abhijit.ghosh@sg.pwc.com

South Africa
Denis von Hoesslin
+27 11 797 4285
denis.von.hoesslin@za.pwc.com

South Korea
Hyung-Do Choi
+82 (0) 2 709 0253
hyung-do.choi@kr.pwc.com

Youn-Hoon Joo
+82 (0) 2 709 0353
youn-hoon.joo@kr.pwc.com

Sweden
Roine Gillingsjo
+46 (0) 8 57887716
roine.gillingsjo@se.pwc.com

Switzerland
Rodolfo Gerber
+41 (0) 58 792 5536
rodolfo.gerber@ch.pwc.com

Taiwan
Alan Lin
+886 2 2729 6702
alan.lin@tw.pwc.com

Thailand
Charles Ostick
+66 2 344 10001167
charles.ostick@th.pwc.com

Turkey
Serkan Tarmur
+90 212 376 53 12
serkan.tarmur@tr.pwc.com

United Kingdom
Dean Arnold
+44 20 721 38270
dean.c.arnold@uk.pwc.com

Andrew McKechnie
+44 207 212 6327
andrew.mckechnie@uk.pwc.com

United States
Kelly A. Barnes
+1 214 754 5172
kelly.a.barnes@us.pwc.com

Steven Elek
+1 267 330 2240
steven.elek@us.pwc.com

Shelley Gnall
+1 646 471 3146
shelley.a.gnall@us.pwc.com

Vietnam
Dinh Hong Hanh
+84 4 3946 22461602
dinh.hong.hanh@vn.pwc.com

New Zealand
Neil L Haines
+64 9 355 8625
neil.l.haines@nz.pwc.com