Welcome to Coloplast Capital Market Day

21-22 June 2011, Hungary

Ostomy Care
Urology & Continence Care
Wound & Skin Care

Coloplast

Coloplast Capital Market Day 2011
Programme

Tuesday 21 June 2011

13:00	Informal lunch buffet at the Gerbaud
14:00	Welcome
14:05	Health care delivery and politics – structures, dynamics
15:00	Strategic pricing and reimbursement of medical devices
16:00	Health care delivery and financing in key markets
16:45	Health care trends and reforms
17:30	End of the Health Care Seminar
19:00	Drinks and dinner at Nobu

Wednesday 22 June 2011

08:30	Bus transfer from Kempinski Hotel to the Tatabánya factory
10:00	Welcome and introduction
10:05	Presentation on Coloplast, CEO, Lars Rasmussen
11:05	Presentation on Wound Care SVP Wound Care, Nicolai Buhl Andersen
11:35	Presentation on Emerging Markets SVP EM, AP and Canada, Christian Salling
12:05	Lunch
12:45	Presentation on Global Operations SVP Global Operations, Allan Rasmussen
13:30	Presentation on Sourcing VP Corp. Procurement, Jesper M. Kalenberg
14:15	Presentation on Hungary Site Director Tatabánya, Boris Kovac
14.45	Factory tour
16:00	End of the Coloplast Capital Market Day

Coloplast Capital Markets Day 2011

A Comparative View of Health Care Delivery and Financing Systems

Ostomy Care
Urology & Continence Care
Wound & Skin Care

Coloplast

Seminar Program

Health care delivery and politics – structures, dynamics

Strategic pricing and reimbursement of medical devices

Break

Health care delivery and financing in key markets – UK, France, Germany, U.S.

Health care trends and reform

Presenters

- Christian Bo Petersen – Director, Market Access

  Responsible for reimbursement and strategic pricing across all markets globally

- Mark Draper – Senior Public Affairs Manager

  Assisting business units and subsidiaries in the Americas, Asia/Pacific and Emerging Markets

- Louise Feilberg Levy – Senior Public Affairs Manager

  Assisting European subsidiaries and business units, coordinating EU policy

Seminar Program

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Health care trends and reform

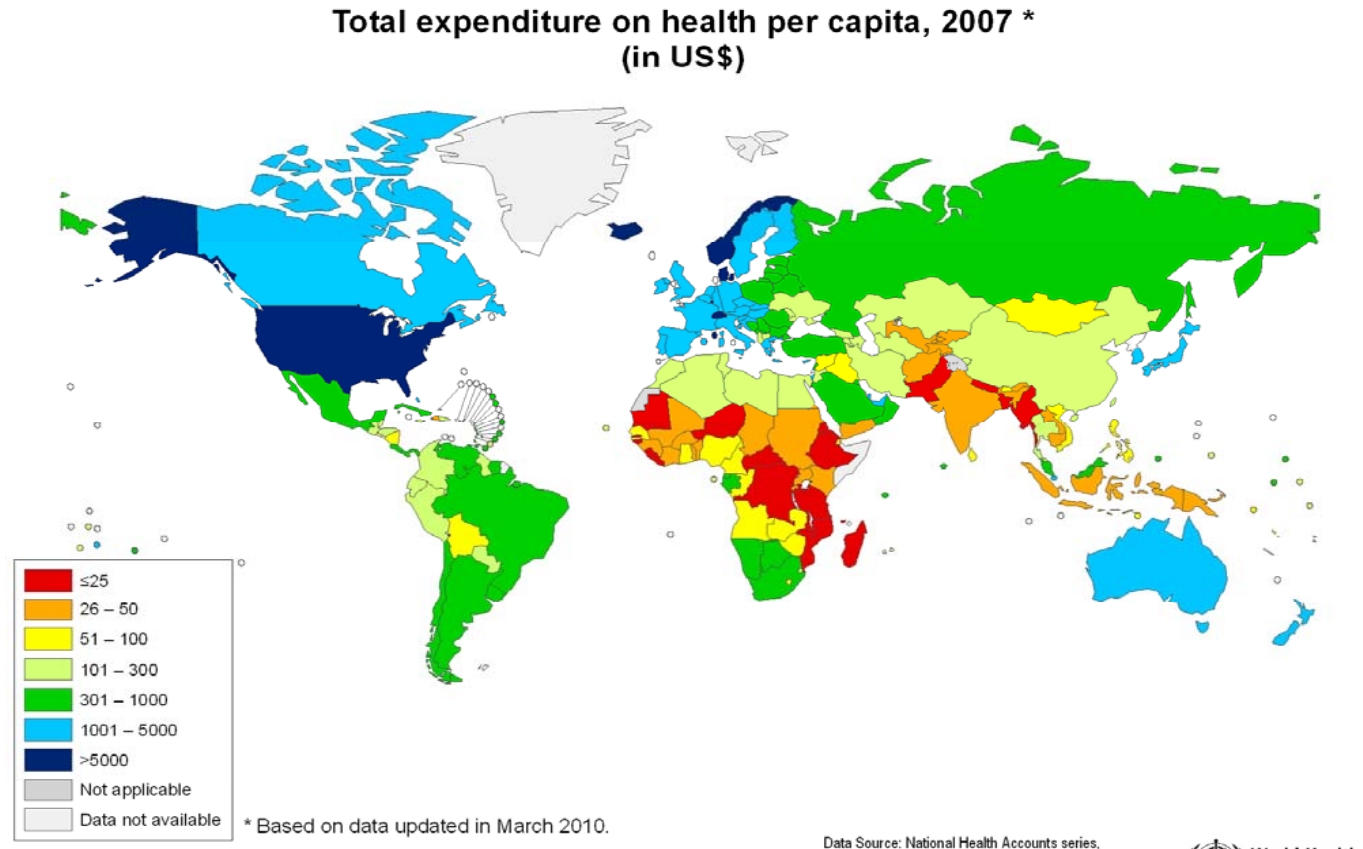
Health care delivery and financing systems are a choice

- Political setting – determines who makes health care delivery and financing decisions and how they are balanced against other priorities

- Budget resources – allocation decisions (control) vs. external factors, economic cycles (no control)

- Delivery and financing choices evolve, and lead to reform
  - *Changes in political setting*
  - *Budgetary performance and economic cycles*
  - *Consumer expections and demographics*
  - *Technology*

Choices are influenced by economic resources…



Health care choices balance the interests of three groups...

Consumers

- **Patients** *(inpatient, clinic settings)*
- **Users** *(outpatient, community settings)*

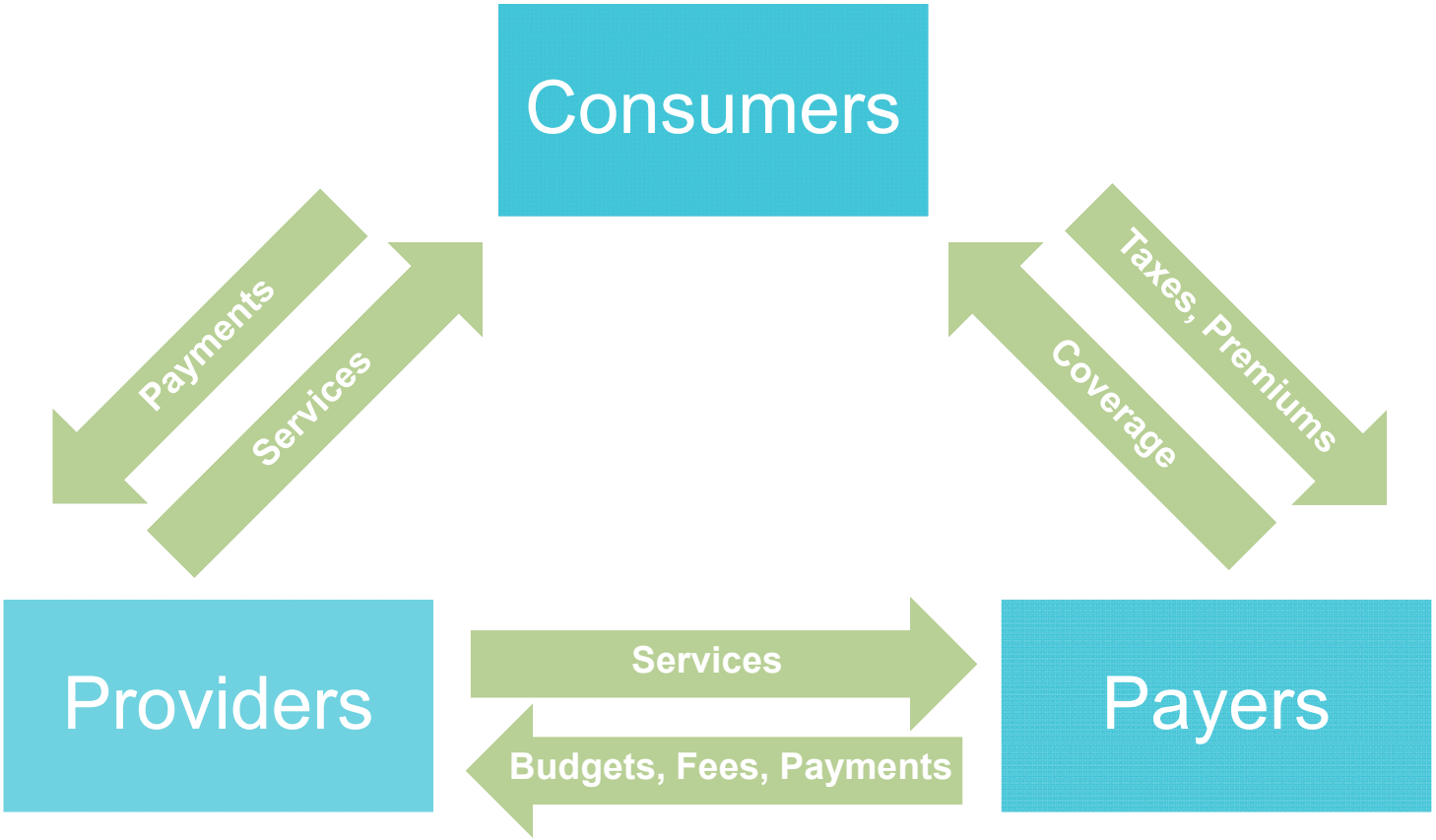
Providers

- **Services** *(physicians, hospitals, clinics)*
- **Products** *(med device companies, pharma, etc.)*
- **Distribution** *(GPOs, wholesalers, etc)*

Payers

- **Government** *(central or regional administrations)*
- **Insurers** *(for- and non-profit, state-subsidized)*
- **Employers**
- **Private Payers**

Choices must balance multiple interests among players…



... resulting in three primary delivery and financing models

Single Payer

- Tax-based
- Some consumer contributions
- Typically universal coverage
- **Examples**: UK, Canada, Denmark

Social Insurance

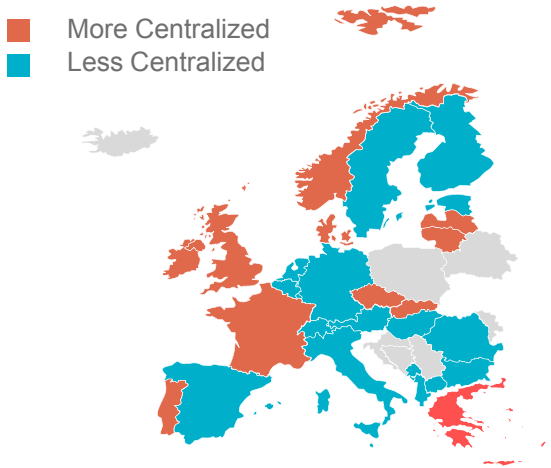
- State and employers jointly finance
- Some consumer contributions
- Typically universal coverage
- **Examples**: Germany, Netherlands

Private Payer

- Primarly self, employer financing, some support from state
- Significan consumer contribution
- Coverage varies according to ability to pay
- **Examples**: U.S., Emerging Markets

Categories can and do overlap…

Health care choices are decided in a political setting…



- Government structure
- Degree of centralization
- Budget authority and process
- Amount of policy coordination
- Regional variation
- Presence, role of gatekeepers

Why it matters…

- Who sets, allocates health budget?
- Where are reimbursement decisions made?
- Allowance for regional variation in policies?
- Divided/overlapping regulatory authority?

Choices – priorities and structures – evolve...

- *Differentiation*
- *Setting*
- *Demographics*
- *Technology*
- *Budgets*
- *Policy...*

… and drive speed and types of reforms (Session 2)

Graphics: SCA

Choices – priorities and structures – evolve...

- *Differentiation*
- *Setting*
- *Demographics*
- *Technology*
- *Budgets*
- *Policy...*

… and drive speed and types of reforms (Session 2)

Graphics: SCA

Wrap up – structure and dynamics

- Health care delivery and financing systems represent choices among many different social and spending priorities
- Most health care systems must balance the competing interests of consumers, payers and providers
- Health care systems tend toward one of three general types, with significant implications for reimbursement and delivery

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Strategic pricing and reimbursement of medical devices

Medical device reimbursement – the big picture

- The medical device reimbursement setting in perspective
- Medical device reimbursement setting across key markets (chronic care)
- From reimbursement to Coloplast sales price
- Strategic price setting at Coloplast

Reimbursement systems in key markets – a deeper dive

- Top 4 markets: France, UK, Germany & US *(> half of total Coloplast sales)*
- High potential markets: China & Brazil

Medical devices are different from pharmaceuticals…

…more complex product portfolio and more payer groups

Medical Devices	Pharmaceuticals
• € 250 Billion global market	• € 600 Billion global market
• ≈ 6 % of total healthcare costs	• ≈ 15 % of total healthcare costs
• Low similarity (i.e. syringes, implants, scanners)	• High similarity (i.e. small molecules ,biologics)
• Funded via multiple budget holders	• Funded via few budget holders
• Biggest market is the hospital market	• Biggest market outside of hospitals
• > 500.000 different medical devices	• 10.000 different drugs *(50.000 variants)*
• Often different product variants listed in different markets	• Same product/ dosage listed in all markets
• Simple regulatory process (CE mark)	• Comprehensive regulatory process (EMA, FDA)
• Clinical evidence: Optional & small scale	• Clinical evidence: Mandatory & global scale

Medical devices are less homogenous as a group…

…low correlation/ overview between price and product variant

…fast access in most markets is possible (if no price increase)

Medical Devices	Pharmaceuticals
• Reimbursement level historically linked to **product features**	• Reimbursement level historically linked to **clinical performance/ outcome**
• No unified product classification system o Many product variants / reimbursement levels o Low correlation between price and product variant	• Unified product classification system (ATC) o Few product variants / reimbursement levels o High correlation between price and product variant
• No international reference pricing post-launch (EU) • Big spread in reimbursement across markets • Low transparency on reimbursement levels *(many product variants + local procurement less accessible)*	• International reference pricing post-launch (EU) • Medium spread in reimbursement across markets • High transparency on reimbursement levels *(reference pricing)*
• Reimbursement at premium often requires clinical data o Evaluation time > 6 -18+ months	• Reimbursement at premium always requires data
• Reimbursement at parity rarely requires clinical data o Evaluation time < 6 months *(often < 2 months)*	• Reimbursement at parity always requires clinical data

Medical devices have no unified product classification system

…no objective system can classify products as being generic identical

Medical device: CE mark

CE Mark - Conformité Européene

CE mark is only based on safety profile

- Non invasive devices
- Invasive devices
- Active devices
- Special rules

- Class I
- Class II a
- Class II b
- Class III

All medical devices ends up in 4 classes

Medical device: GMDN

GMDN code: Global Medical Device Nomenclature

The GMDN is a system of internationally recognized coded descriptors in the format of preferred terms with definitions used to generically identify medical devices

GMDN is defined in the ISO 15225 standard, having a general structure of three levels:

- Device Category
- Generic Device Group
- Device Type

SelfCath Female: GMDN 45603
Single-administration urethral drainage catheter

SpeediCath Compact Male: GMDN 45603
Single-administration urethral drainage catheter

GMDN only matches ATC at 3rd level, hence not generic identical level

Pharma: ATC code

ATC code: Anatomical Therapeutic Chemical classification system

ATC code is based on active substances and classified in groups at 5 different levels according to the organ or system on which they act and their therapeutic, pharmacological & chemical properties

- 1st level, anatomical main group
- 2nd level, therapeutic subgroup
- 3rd level, pharmacological subgroup
- 4th level, chemical subgroup
- 5th level, chemical substance

Drugs are identified at generic identical level, and in principle at infinite level

Medical device reimbursement works differently across sectors

…community reimbursement is more static than hospital procurement

Community *(out-patients)*

- < 20% of sales comes from community
  - o **> 85 % Coloplast sales comes from community**
- **Reimbursement mainly via national listing**
  - o But some markets use regional/ insurance procurement
  - o Established national reimbursement processes
  - o Suppliers actively apply for reimbursement
  - o Reimbursement is linked to features or outcome
  - o DRG is not relevant in community and HTAs are mainly used for new technologies
- National listings are public accessible
- Big spread in EU Reimbursement levels
- **Reimbursement prices are national and rather static**

Hospital *(in-patients)*

- > 80% of sales comes from the hospitals
  - o Sales to hospitals to gain new patients
- **Reimbursement mainly via local procurement**
  - o 2 hurdles: Local budgets and procurement
  - o Budgets/ funding are often based on DRGs
  - o DRG is a lump sum for a total treatment cost
  - o Procurement rarely evaluates outcome
  - o Health Technological Assessments (HTAs) can be initiated to evaluate outcome vs. price
- Procurement prices are more difficult to access
- Big spread in EU procurement levels
- **Procurement prices are dynamic by nature**

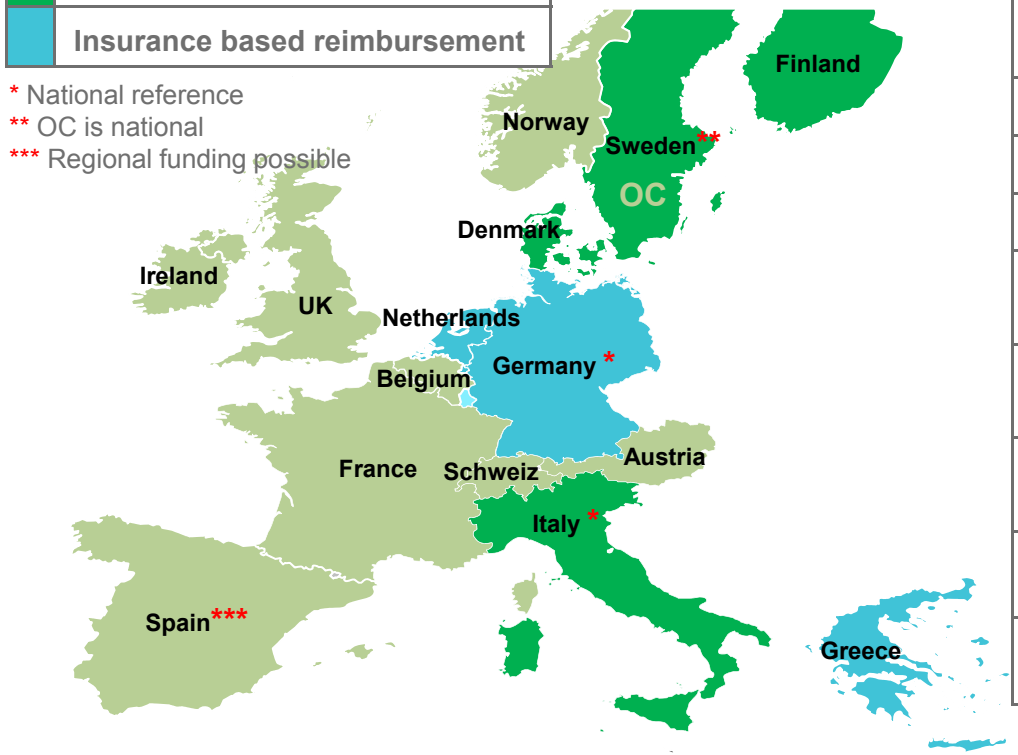
Community reimbursement across key EU markets…

…both national reimbursement and local procurement

…but product specific pricing is possible in most markets

	National reimbursement list
	Regional reimbursement – per region and/ or community
	Insurance based reimbursement

* National reference
** OC is national
*** Regional funding possible

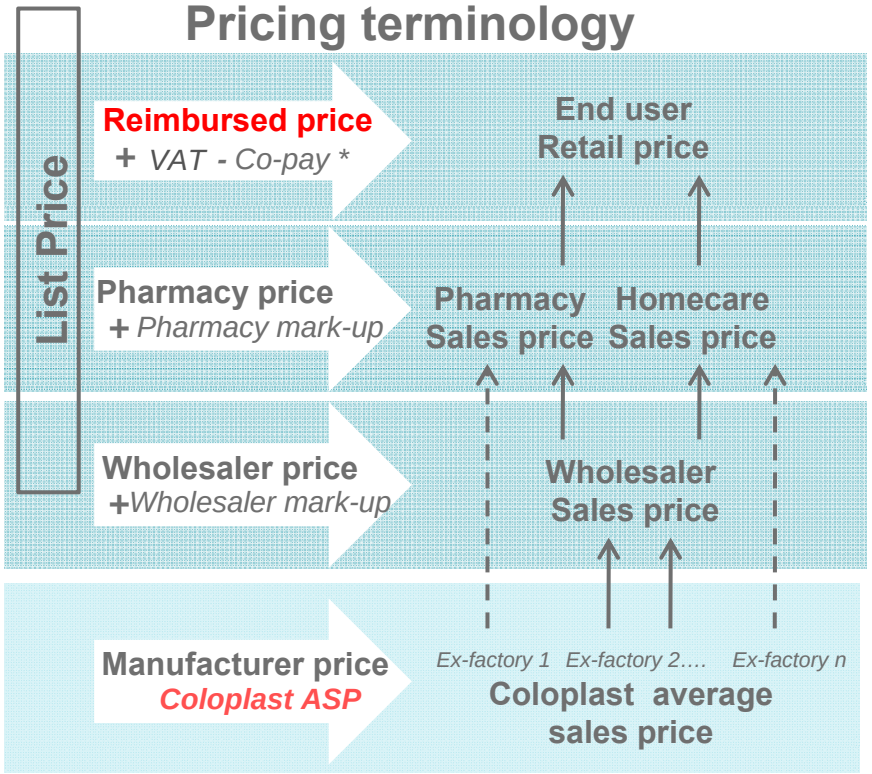


*Fixed or product specific pricing **	
UK	• Product specific pricing
FR	• Fixed category pricing *(broad categories)* • Product specific pricing in addition since 2001
ES	• Product specific pricing
NO	• many fixed categories, variance within intervals
BE	• Fixed category pricing, limits on usage
DE	• Fixed national category used as reference for negotiations with insurance funds (OC/ CC)
NL	• Individual negotiations with insurance funds • No public reimbursement list (only list prices)
IT	• Fixed category reference (national) individually applied by regions
DK	• Regional/ local procurement (i.e. tender) • No public reimbursement list (only list prices)
SE	• Regional/ local procurement (CC) • National reimbursement list (OC)

* Top 10 EU markets represents 60% - 65% of global sales

From reimbursement to Coloplast sales price

…average selling price is highly influenced by mark-up in distribution flow



Payers need to fund at reimbursement level
-Coloplast sales price is less than reimbursement price

Gap from reimbursement to average selling price is bigger and less regulated than within Pharma

Part of distribution outside of pharmacies is relative high in some markets

Strategic price setting at two levels:

- **Optimal reimbursement price/ coverage**
- **Optimal sales price to distributors**

* Approx half of the EU markets use co-payment
- Average co-payment is 10 % *(in reality < than 5 % due to limits)*

Strategic pricing…

...we recognize price as one of the strongest profit levers

Assuming a gross profit of 64 %...

In order to increase <u>absolute</u> gross profit by 10 % we need to:

- **Increase sales by 10%,** *without* increasing Sales & Marketing cost, *or*
- **Reduce Costs of Goods by 18 %,** *or*
- **Increase price by 6,4 %**

Premium price is a trade off…

...we need to balance a premium price against volume and risk

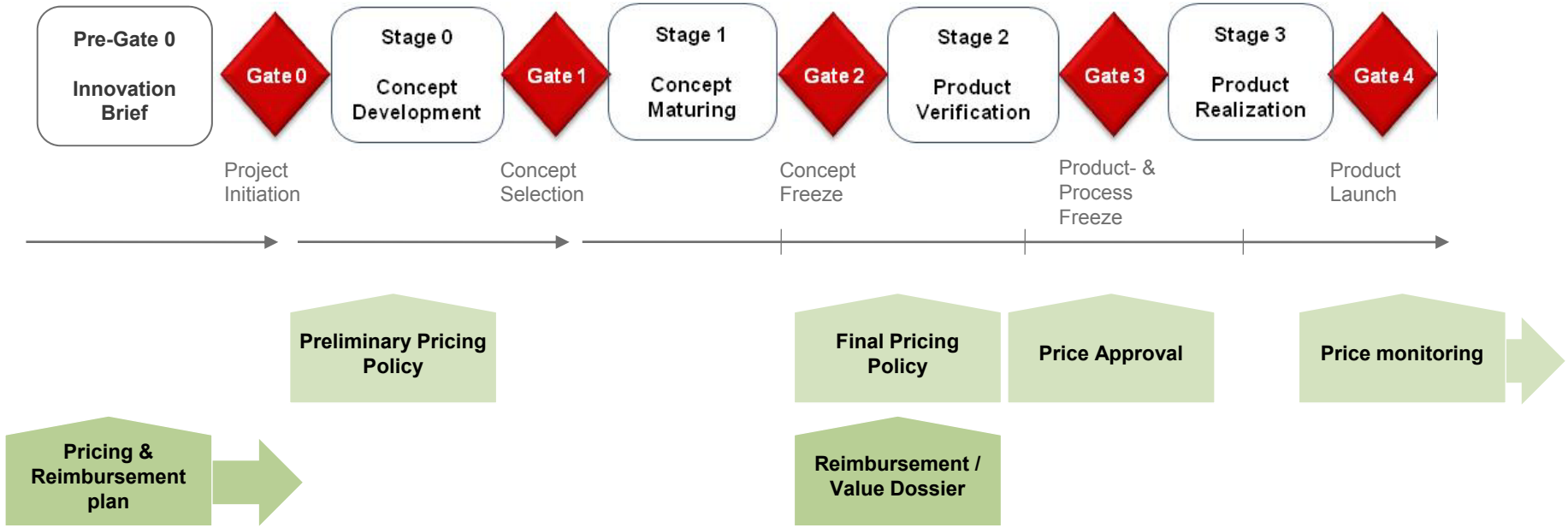
Pricing and reimbursement defines the business case.....

Premium price ? **Business case**

- Cost of clinical study
- Time to market *(study + evaluation)*
- Risk of negative outcome
- Risk of no price premium
- Price sensitivity *(value vs. volume)*
- Profitability *(gross margin vs. cannibalization)*

Strategic pricing & reimbursement in early development...

...early input to assess business case, product development and evidence



Strategic pricing & reimbursement assessment...

...starting from highest possible price - ending with most optimal price

1 Value Based Pricing

Building the "right" value of the product

what is the product worth to payers when taking a total treatment cost perspective:

- Converting direct & indirect cost savings, medical performance and features into price

Unlike a cost+ approach that is mainly used when pricing low quality products

2 Reimbursement/ market access

Limitations to price / reimbursement / access

- Reimbursement/ funding setting in key markets
- fixed categories or product specific pricing
- Requirements for clinical/ economical data
- evaluation time/ risk
- Features/ category optimization
- distributor set-up/ margin optimization

3 Market situation

Optimal price in the marketplace

- Competitive landscape (incl. pipeline)
- Price sensitivity
- Gain / defend market share
- Growth opportunities / expand market

4 Commercial evaluation

Profitability / portfolio aspects

- Profitability (gross margin, absolute profit)
- Business case (optimizing all variables)
- Portfolio strategy (current/ future/ competition)
- Market segmentation/ product variants

Wrap up – strategic pricing and reimbursement

- Medical devices are not homogenous as a group – with a complex product portfolio difficult to compare across brands and markets
- Reimbursement works very different across sectors – whereas most devices are sold to hospitals, Coloplast primarily sell via community
- We are given two fundamental choices when pricing our products – fast access at same price or price increase vs. time, risk and cost
- The regulatory and reimbursement framework gives us the opportunity to meet different country and payer priorities with different products …..a segmented portfolio to segmented needs

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UK – Health Care Environment

Coverage: All legal residents – 11% patient co-payment

Health care spending: 8,4% GDP

Financing: Tax-financed, on the national budget

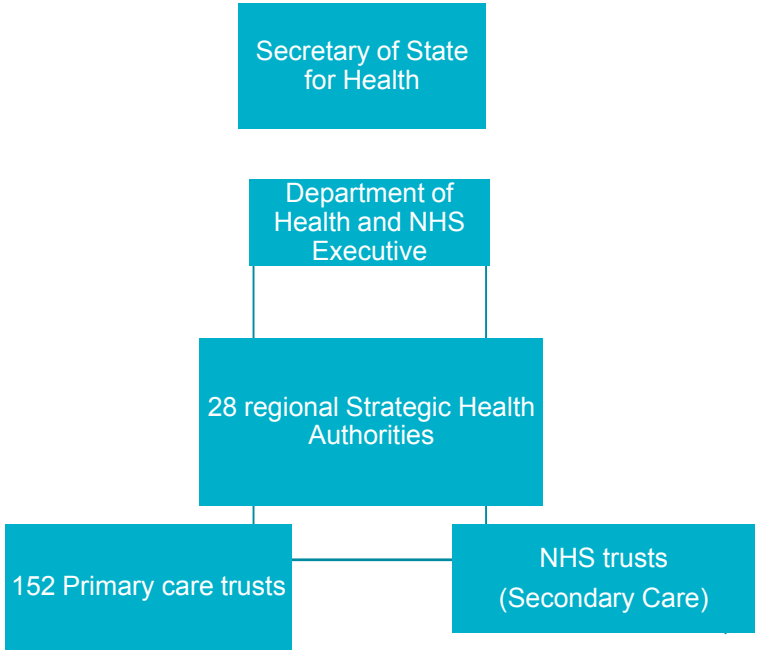
Reimbursement: A device or service has to be listed in Part IX of the Drug Tarif or there is no reimbursement!

Centralized delivery system: Overall health care policies and general standards of care are set by central authorities

Health Care Delivery: Primarily through public providers (95% of acute hospital beds are in public hospitals, specialists are employed by hospitals, GP are self employed but on public contracts)

Political reality

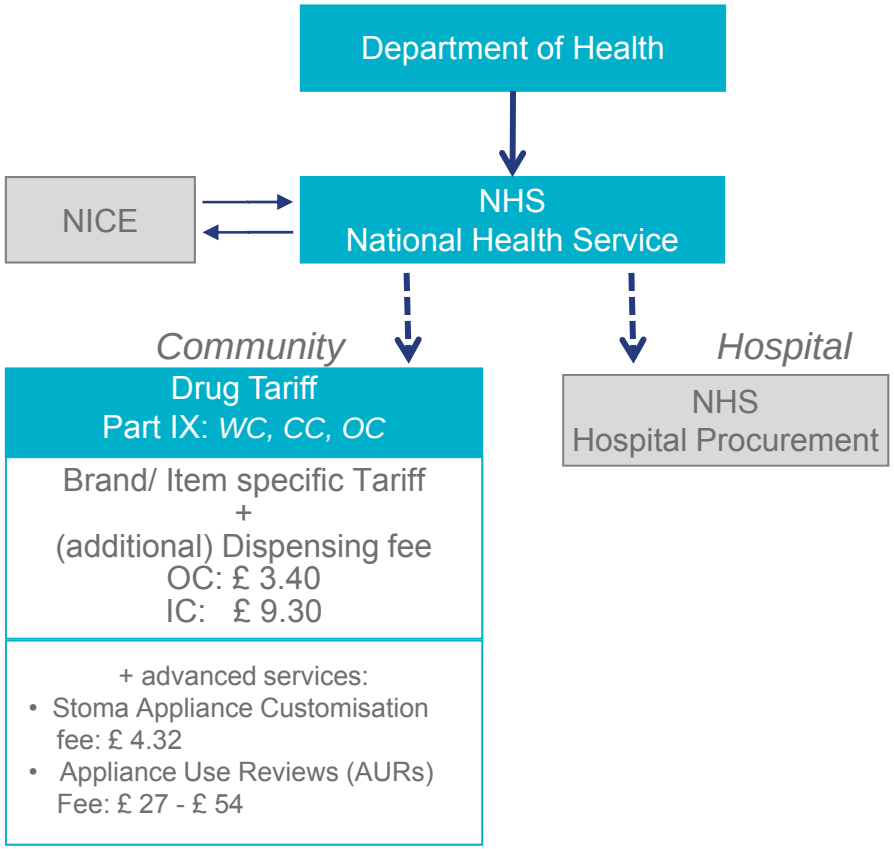
- Large budget deficit (12% of GDP) = serious cost cutting
- New government with many new initiatives involving the health care system
- Health care is almost a religion in the UK = no cuts in scope



UK – reimbursement setting and key facts

Premium price possible based on clinical evidence and/ or features

Community reimbursement system

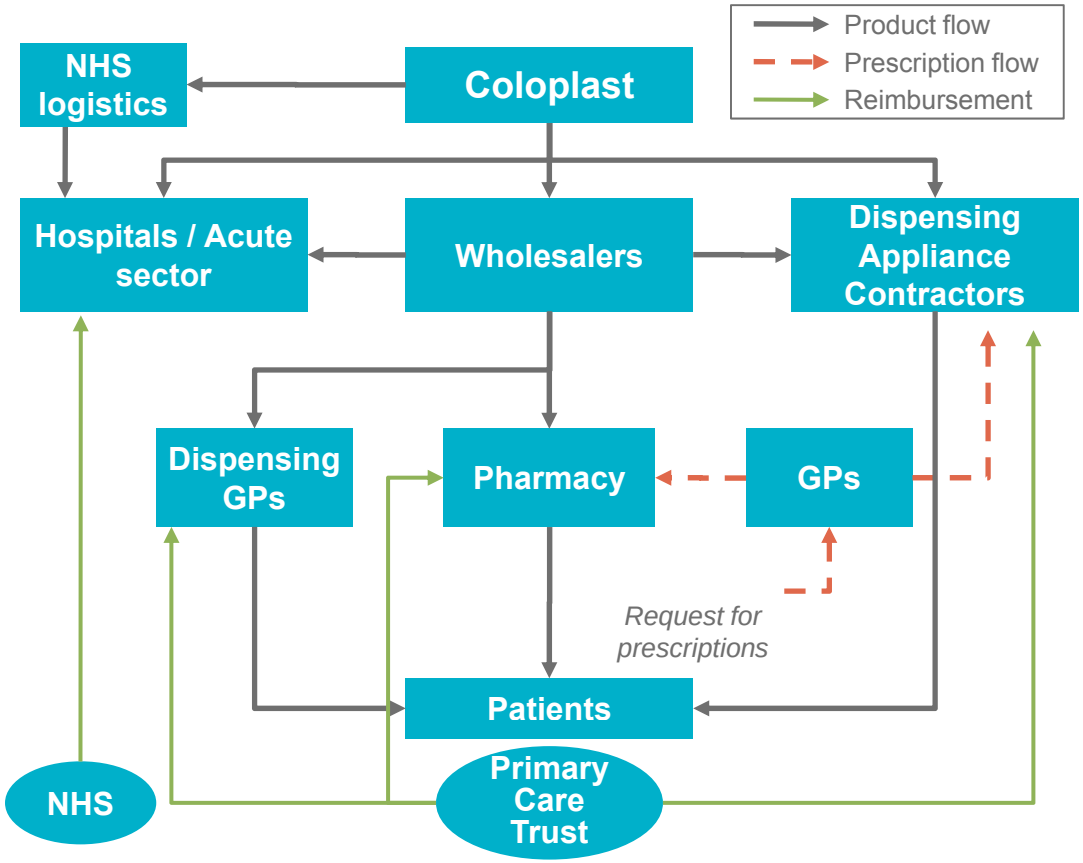


Key characteristics

- **National product specific reimbursement:**
  - … Price is benchmarked to comparator
  - … Clinical evidence preferred, but…..
  - … Supporting arguments can be accepted
  - … A dispensing fee can be added to the Drug Tariff
  - … No periodic review (only ad hoc)
  - … Yearly inflation increase possible
- Application time line extension < 4 months
  - … Clinical data preferred but not required
- Application time new product: 6 - 12 months
  - … Clinical data required (if no comparator)

UK – distribution and prescription flow

...new planned structure in 2013 could change prescription patterns



- Department of Health sponsor NHS and PCTs
- Acute/Hospital budget = NHS
- Community = Primary Care Trust PCT
- New NHS reform planned for 2013 => GP consortias and abolishing the PCTs
- 152 PCTs
- 12. -13.000 pharmacies
- 30 DACs
- 23 Wholesalers

France – Health Care Environment

Coverage: Coverage is universal

Centralized system: But moving towards decentralization

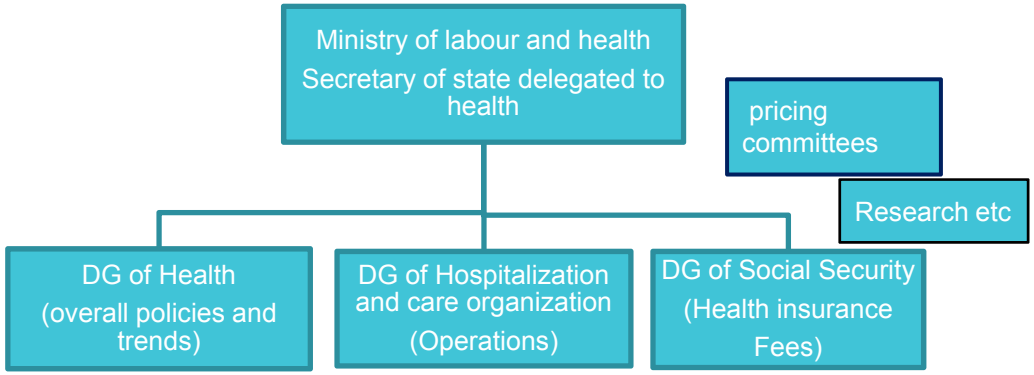
Financing: Public health insurance scheme: 76,6 % of total health care expenditure. Complementary private insurance reimburses statutory cost-sharing

Reimbursement: Based on a reference price (UK inspired system)

Health Care Delivery: Primarily publicly (2/3 of hospital beds are government owned/non profit hospitals), gate keeping system introduced 2004

Political reality:

- The French health insurance scheme suffers from large deficit:
- Very heavy bureaucracy and administration
- Budget deficit : 8 % of GDP/ Public debt: 83,6 % of GDP



De-centralized services. Regional/county
•Health delivery
•Control
•Implementation of health regulation and financing set at national level

France – reimbursement setting and key facts

...both fixed price categories and product specific pricing possible

Community reimbursement system

The French National Authorities for Health evaluates reimbursement in 2 steps *(new category / product speciific)*

1st step: Medical evaluation

TECHNICAL & MEDICAL EVALUATION
Committee 1 (CNEDiMTS/ HAS)

- ❑ MEDICAL SERVICE : YES/ NO
- ❑ MEDICAL SERVICE IMPROVEMENT:

5 grades

I. **Major** improvement
II. **Important** improvement
III. **Moderate** improvement
IV. **Minor** improvement
V. **No improvement**

Decision-makers = physicians
↓
Spotlight clinical data

2nd step: Economic evaluation

ECONOMICAL EVALUATION
Committee 2 (CEPS/ Health Min.)

- ❑ REIMBURSEMENT PRICE -> LPPR

→ **high premium price**
→ **premium price**
→ **price level ?**
→ **parity price**
→ **Parity / low price**

Cost-minimisation politic
↓
Spotlight budget impact and EU prices/ reimbursement

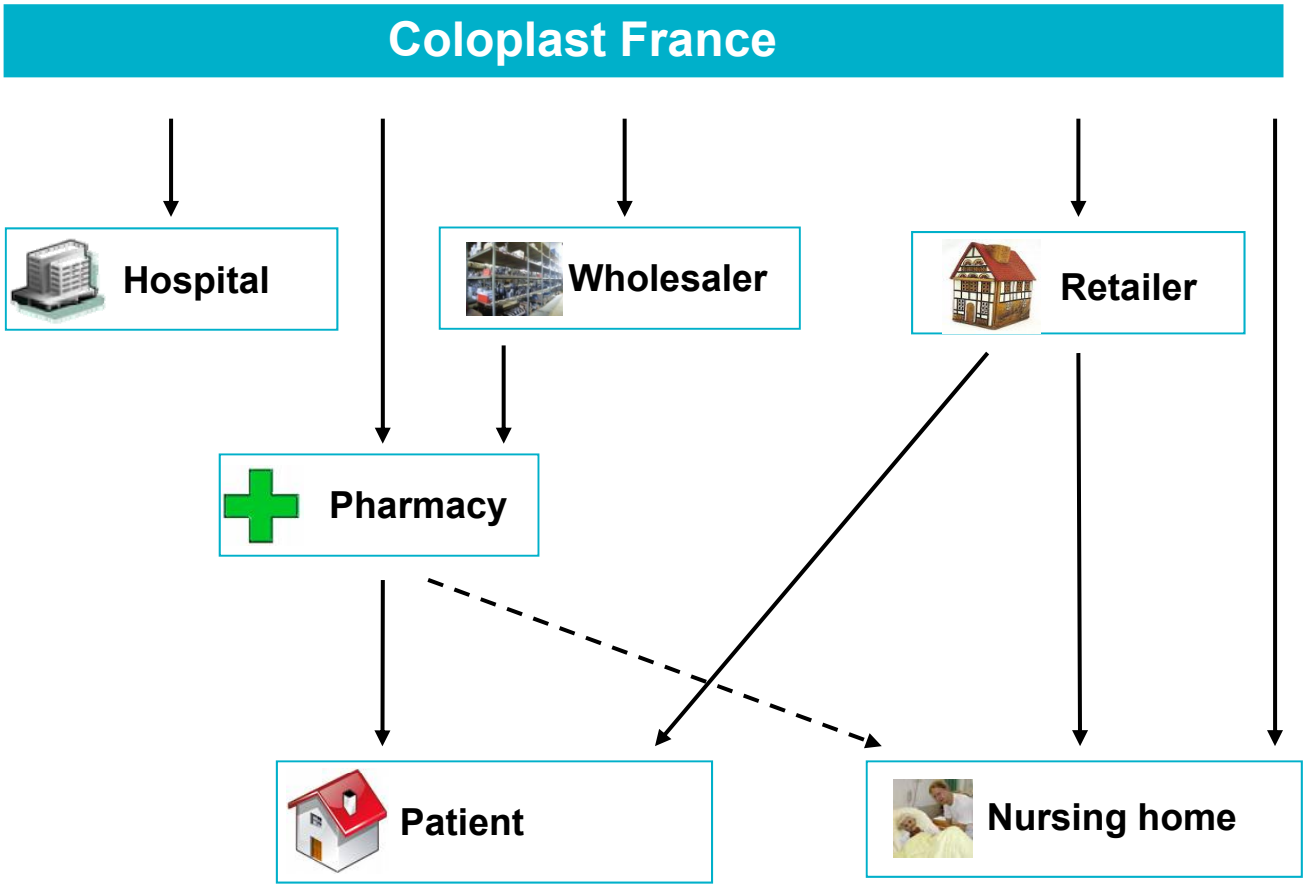
HAS: French National Health Technology Assessment body
CNEDiMTS: Commission Nationale d'Evaluation des Dispositifs Médicaux et des Technologies de Santé
CEPS: Economic Committee on Health Care Products / LPPR: The positive reimbursement list

Key characteristics

- **National categories with fixed prices:**
  - … Ostomy: 17 sub-categories
  - … Intermittent catheters: 3 sub-categories
  - … Collecting: 8 sub-categories
  - … Wound dressings: multible sub-categories
- Application time within category: < 1 week
  (only need safety registration in Afssaps)
  - … Clinical evidence not required
  - … No international reference pricing
  - … Periodic review (upcoming in ostomy/ continence)
- **Product specific reimbursement**
  - … Application time: 8 – 12 months
  - … Clinical evidence required
  - … International reference pricing
  - … Review every 5th year

AFSSAPS: The French Health Products Safety Agency

France – distribution flow



Germany – Health Care Environment

Coverage: universal – roughly 10% with private insurance

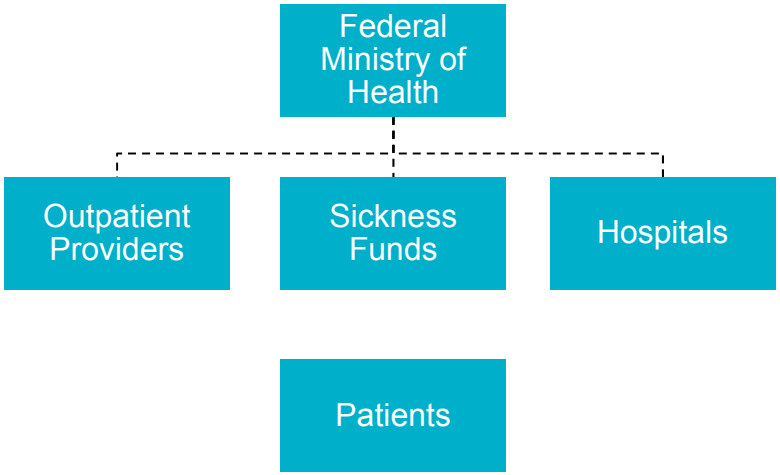
Decentralized system: federal structure, 2-chamber parliament, 16 Länder

Financing: social insurance via approx. 160 Krankenkassen; trend has been toward consolidation of KK, but with regional variations

Reimbursement: centralized management sets baselines, but negotiated with individual Krankenkassen

Health care delivery: public and private providers, no single gatekeeper

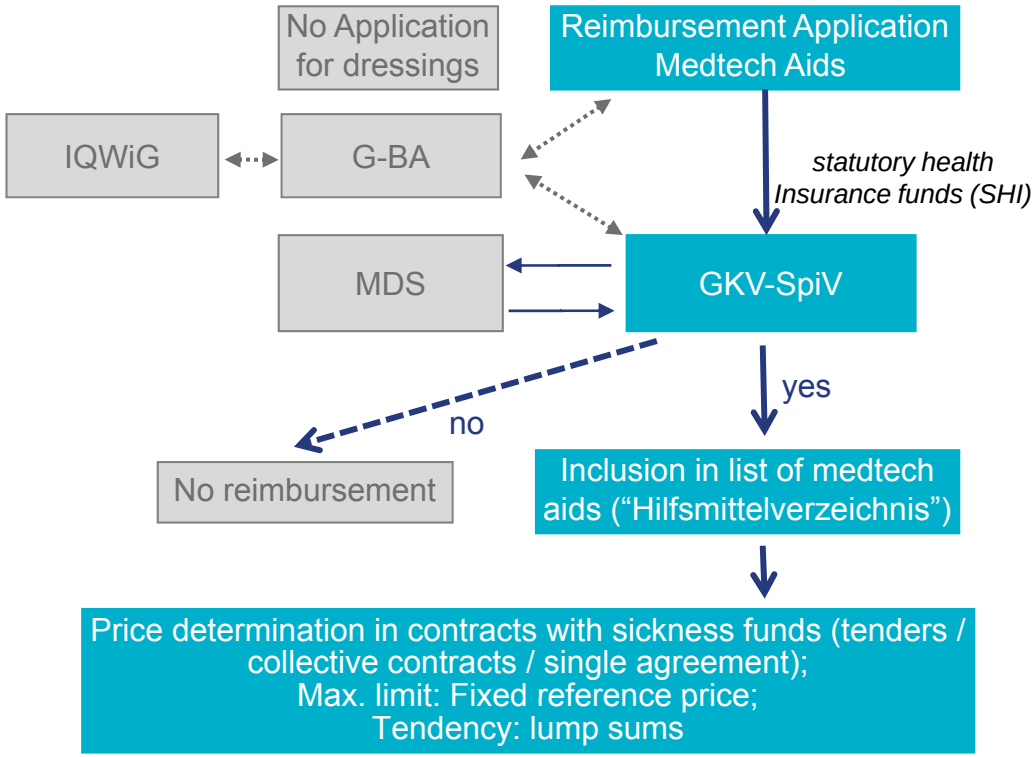
Political reality: coalition governments normal; just recently enacted largest budget austerity package ever; no pending reforms for medical devices



Germany – reimbursement setting and key facts

...national reimbursement is only reference – increased use of lump-sum

Community reimbursement system



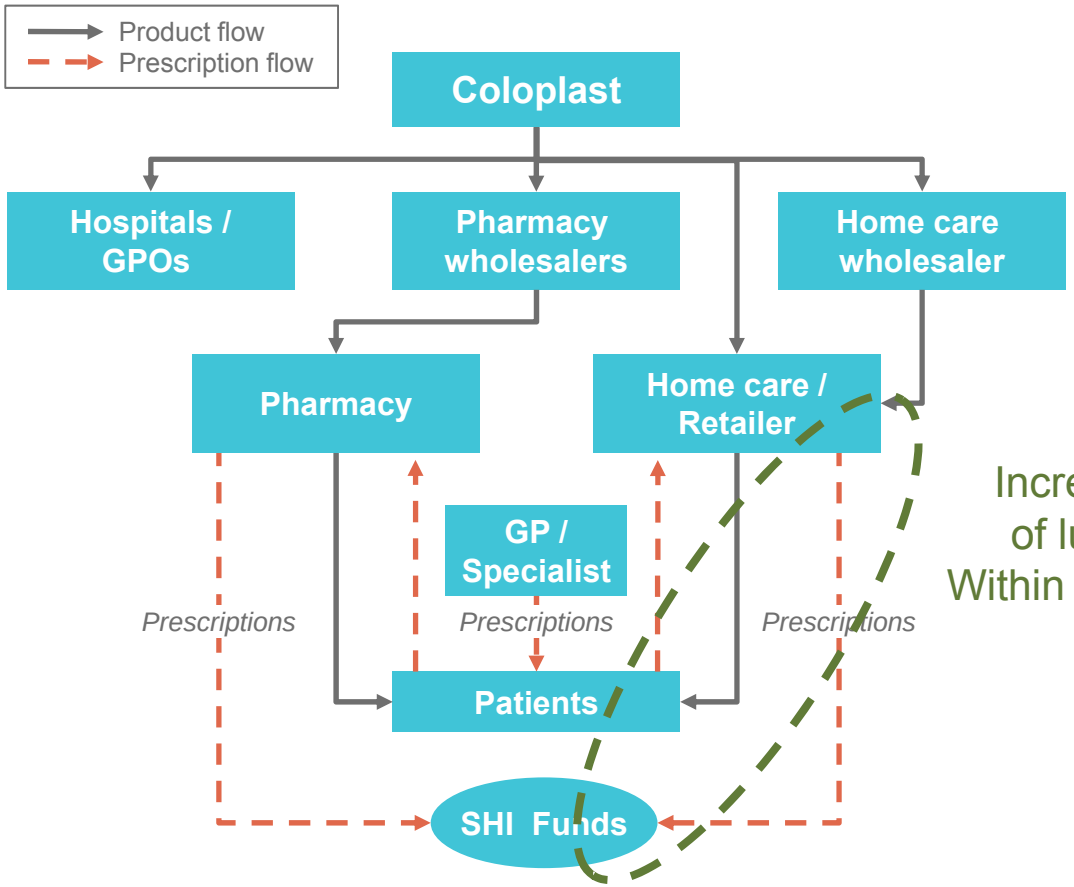
GKV: National Association of Statutory Health Insurance Funds (Gesetzliche Krankenversicherung GKV – Spizenverband)
MDS: Medizinische Dienst des Spitzenverbandes Bund der Krankenkassen. Council for GKV in all medical issues
G-BA: The Federal Joint Committee (Gemeinsamer Bundesauschuss)
IQWiG: Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirkschaftlichkeit im Gesundheitswesen)

Key characteristics

- **National reimbursement categories with fixed prices** (Ostomy /Continence)
  - … Ostomy: 31 sub-categories
  - … Intermittent catheters: 6 sub-categories
  - … Collecting: 21 sub-categories
  - … Wound dressings: Free pricing (but € 40/ Qtr/ pts)
- Application time within category: < 3 months
  - … Clinical evidence not required
- Application time new category: 6 – 30+ months
  - … Clinical evidence required
- National fixed prices at EU high end, but…
- **National fixed prices only used as reference**
  - … Insurance funds committed to Tender/ contract with suppliers by law
  - … Increased use of lump-sum concept in ostomy, i.e. fixed sum incl. product and nursing service/month
- Co-payment: 10% but max € 10/month

Germany – distribution and prescription flow

...increased use of lump-sum changes payment/ pricing dynamics



- Approximate 155 SHI funds
- Approximate +20 Home care companies

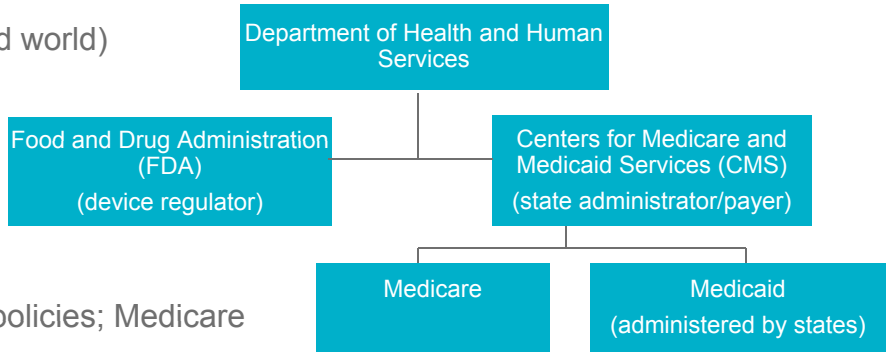
Increased use of lump-sum Within ostomy care

U.S. – Health Care Environment

Coverage: 50 million uninsured Americans

Health care spending: 16% of GDP (highest in industrialized world)

Financing: Predominantly employer-based insurance, but with state-financed programs for elderly (Medicare) and poor/disabled (Medicaid)



Reimbursement: Private insurers determine own coverage policies; Medicare and Medicaid have standardized coverage policies

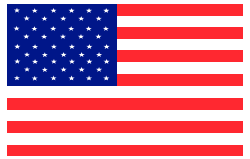
Health Care Delivery: Wide variety of for- and non-profit hospitals and clinics; delivery systems increasingly integrated into large provider networks

Political reality

- Large public deficit and debt, serious disagreements regarding health care policy and financing
- New reform legislation is being implemented, with resistance from some states

US – reimbursement setting and key facts

...Medicare reimbursement is anchor – but commercial incentives are drivers



Health Insurance by Payer

2009	**Persons** (mio.)
Medicare *(age 65+ or with certain disabilities)*	43.4
Medicaid *(state-adm. for low-income persons)*	47.8
Employment-based Insurance *(private payers)*	169.7
Direct purchase *(private payers)*	27.2
Other/ Military health care coverage	12.4
Uninsured	50.7
Total Coverage Arrangements	351.2

Payer Mix for Product Categories

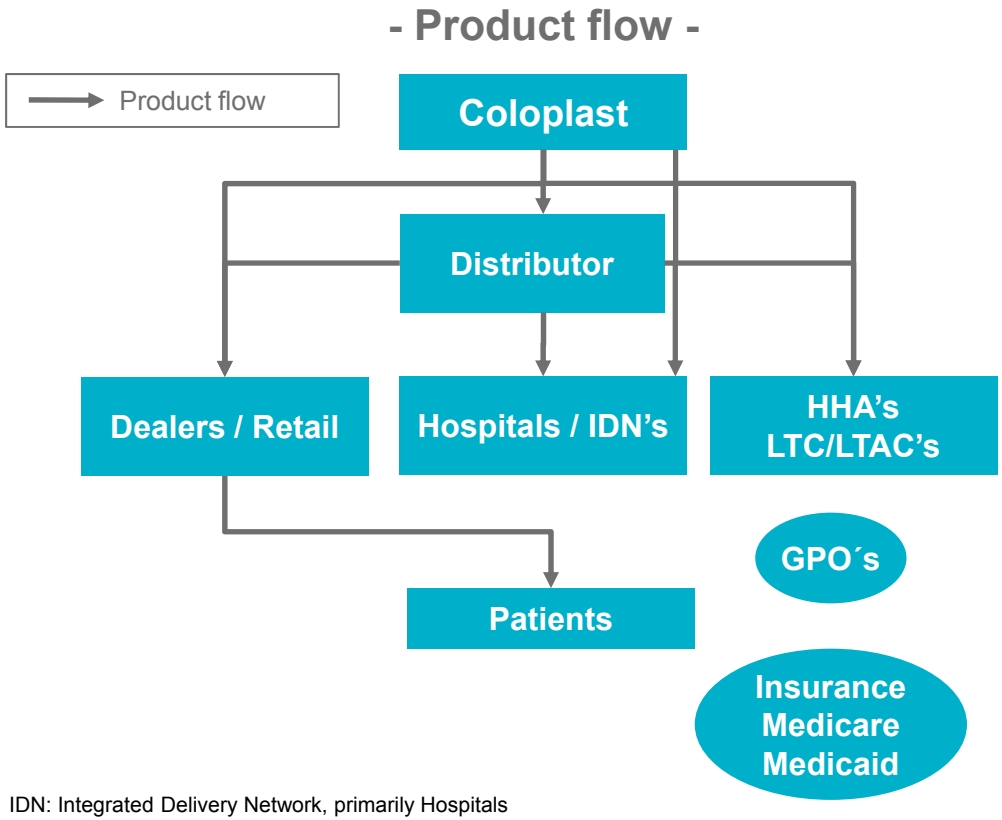
	Medicare	Medicaid	Private	Self Pay
Continence Care	63%	<--------	37%	-------->
Ostomy Care	70%	<--------	30%	-------->
Wound Care	40%	25%	25%	10%

Key characteristics

- **Multible Payer groups**
  - … Patients move across payer groups during time
- **Medicare is the anchor** *(minor national differences)*
  - … Medicare operates on a federal basis
  - … Medicare covers disabled and elderly (CP target)
  - … Medicare defines fixed reimbursement rates
  - … Medicare defines fixed utilization rates
  - … Ostomy: 12 sub-categories (20-60/ month)
  - … Intermittent catheters: 3 sub-categories (200/ month)
  - … Collecting: 4 sub-categories
  - … Wound dressings: 16 sub-categories
- Difficult to get a new reimbursement code
  - … Takes long time + high denial rate at CMS
- Reimbursement rates at EU avg. but big spread
- **Distributor/ commercial incentives are key**
  - … Large gap from reimbursement to sales price

US – distribution flow

…commercial incentives determines both volume and price



- 90% of volume goes through distributors
- 30-40 key distributors
- 20.000 retail customers (including indirect)
- 25.000 hospital and institution customers (including indirect)

IDN: Integrated Delivery Network, primarily Hospitals
HHA: Home Health Agencies
LTC/ LTAC: Long Term Care/ Long Term Acute Care, i.e. rehabs
GPO: Group Purchasing Organizations , primarily Hospitals

Brazil – reimbursement setting and key facts

...national reference but local funding - local funding improves gradually

Community reimbursement system

"Two-tier" health care system: people with sufficient funds or insurances (24%) have access to private sector medical facilities and treatment, whereas the vast majority of the population only have access to the public health care system, SUS

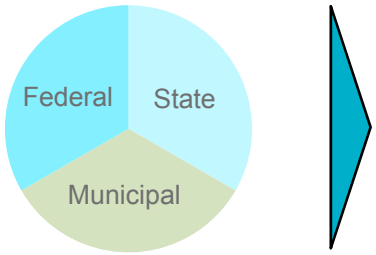
Federal reference

Sistema Único de Saúde or SUS (Unified Health System)

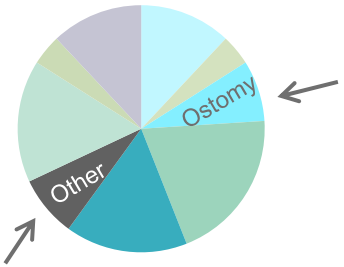
- National reimbursement rate for ostomy
- APAC National guidelines on ostomy care

Local funding

Health care funding



Local product funding
State / municipal



I.e. Wound & Continence Care

Key characteristics

- **National reimbursement only used as reference / guideline**
  - … Specific reimbursement rates on ostomy
  - … Reimbursement rates at EU level
  - … National guidelines on utilization at EU level
  - … No reimbursement rates on Wound or Continence
- **Products are funded at State/ Municipal level**

  Ostomy Care:
  - … Ostomy budgets allocated linked to federal rates
  - … Local utilization rates lower than national guidelines

  Wound Care & Continence Care:
  - … Big spread in funding across states/ municipalities
  - … Funding possible but based on other product categories or overall budgets
- **Private funds / Insurance possible**
  - … Approximately 24 % of population is covered
  - … High end product funding possible but bureaucratic

China – reimbursement setting and key facts

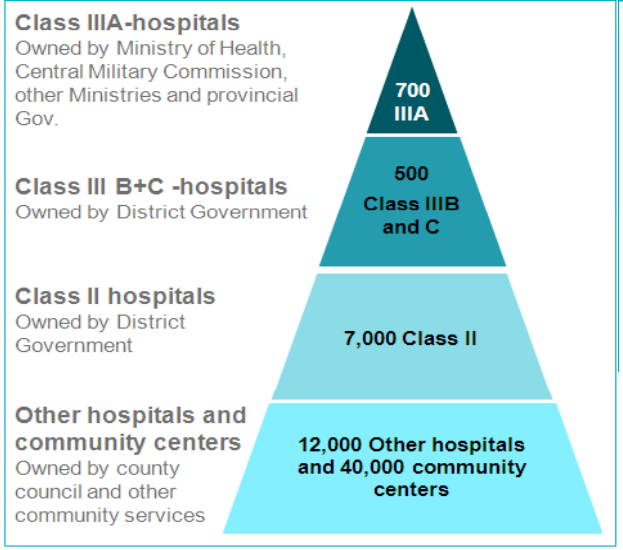
The Chinese system provides only very basic coverage and China remains as a major out-of-pocket payment healthcare nation

Reimbursement system also known as "3-2-1"

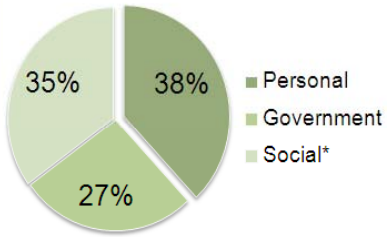
Governance (*three* catalogues)	Implementation (*two* institutions)	Control (*one* payment)
1 Reimbursement Drug List (RDL)	4 Hospitals	6 District Reimbursement bureau
2 National Medical Service Catalogue (NMSC)	5 Pharmacies	
3 National Medical facility catalogue (NMFC)		

- Coloplast products listed in NMSC
- Medical devices mainly reimbursed at Hospitals

Chinese healthcare system



Healthcare expenditure split (2009)



* Include employer contribution to insurance premium, charitable donations

Key characteristics

93 % of the population are entitled to some kind of health care insurance/ reimbursement

… Going for full population coverage in 2012

3 basic medical insurance (BMI) schemes

Reimbursement scheme	Target group (2010)	Coverage
Urban Employee Basic Medical Insurance (UEBMI) I	235M urban employees and retired	• Mandatory
Urban Resident Basic Medical Insurance (URBMI) II	181M Urban residents	• Voluntary
New Rural Cooperative Medical Scheme (NRCMS) III	833 Rural residents (peasants)	• Voluntary

… Easy reachable ceiling and high self-payment

…2 of 3 main insurance schemes offer no coverage for outpatients

Reimbursement levels within EU range

… on mature portfolio (but low community coverage)

Wrap up – key markets

- Our key markets all represent very different delivery and reimbursement systems – even across business areas
- This complexity can work for and against Coloplast – often both the challenges as well as the solutions lies in the system details
- Emerging markets represent growth opportunities with reimbursement mechanisms reflecting both the ability and willingness to pay for Coloplast products – however better access and funding improves year on year

Seminar Program

Health care delivery and politics – structures, dynamics

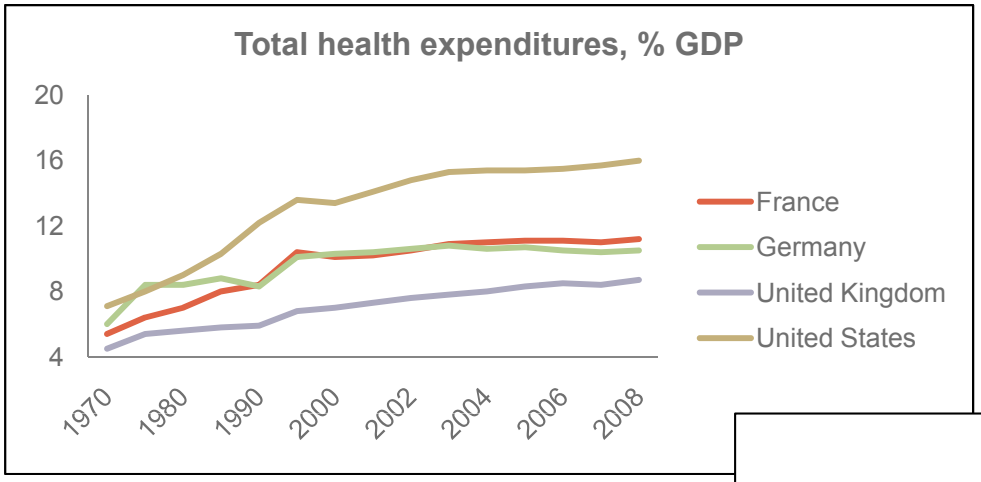
Strategic pricing and reimbursement of medical devices

Break

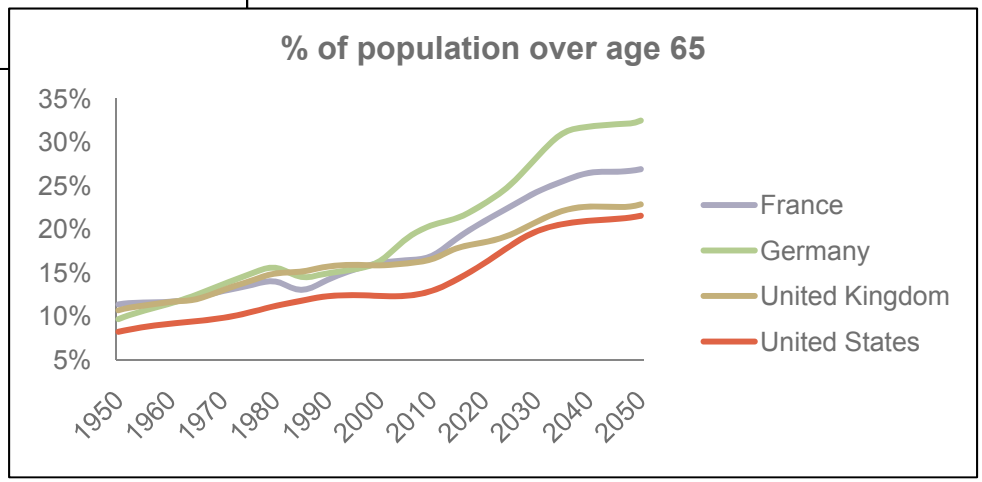
Health care delivery and financing in key markets – UK, France, Germany, U.S.

Health care trends and reform

Health care budget pressures are not new…



Health care expenditures continue to rise…



… in part due to long-term demographic trends

Source: OECD data and projections

Key medical device industry trends…

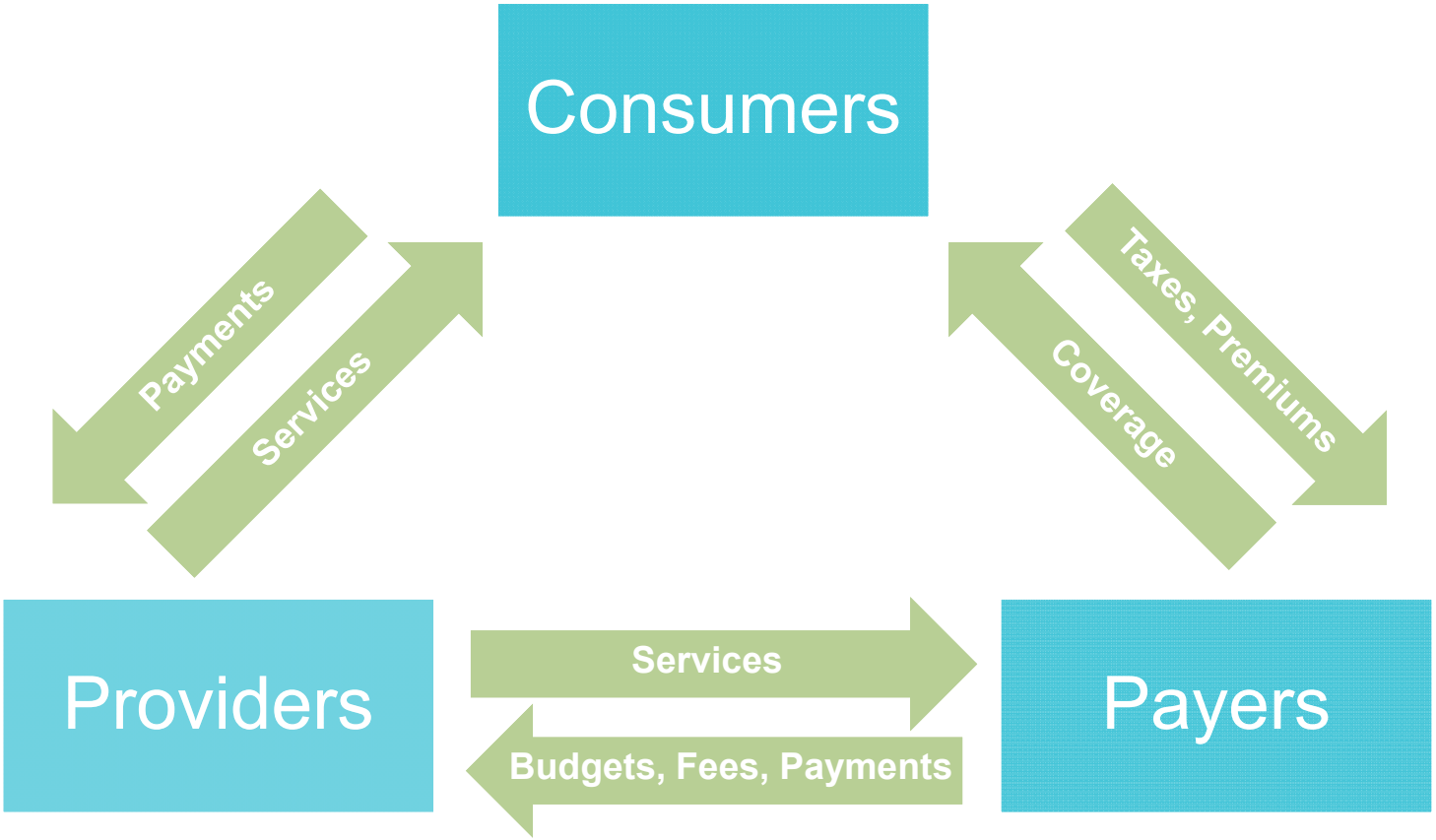
- Cost containment (due to increased constraints on health care budgets)
- Regulatory drive (more rules & increased clinical safety data and evidence)
- Increasing demand health economical data and clinical outcomes
- Increase of transparency (prices, processes, performance, etc.)
- Increasing focus on ethical compliance
- Increased demand of medical technology products and services (changing demographics)
- More empowered patient / consumerism
- Impact of E-health
- Shift to community and homecare
- Consolidation of payers and buyers
- Declining power of HCPs and integrated disease management
- Shift from public to private funding and investment
- Increased focus on prevention, early diagnosis and intervention
- Increased importance of ‘patient safety’
- Increased Europeanization of health policy
- Greening of all aspects
- Low cost competition from emerging markets

Source: Eucomed Board of Directors

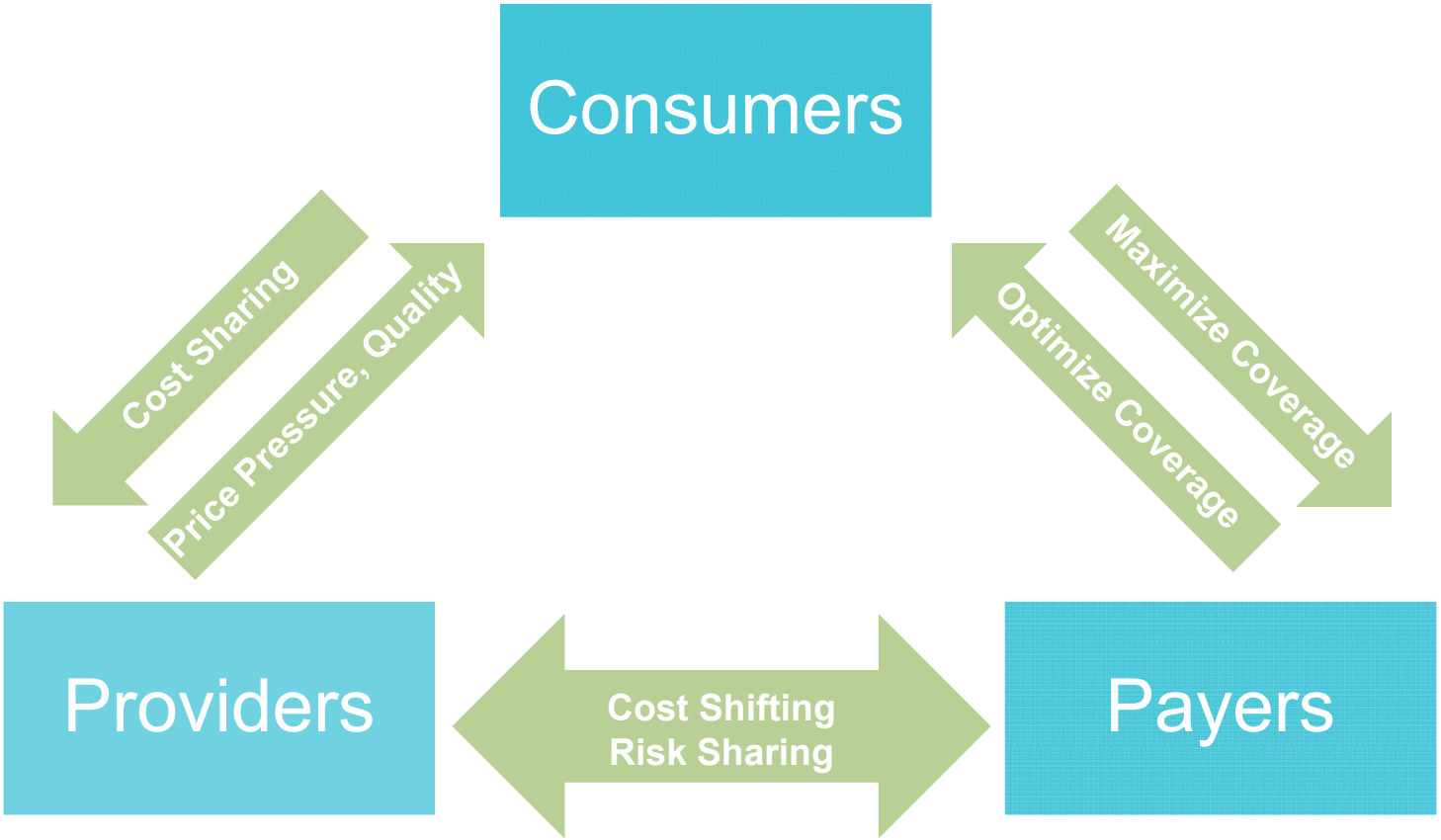
… and those most important to Coloplast

Trend	Relevance
Cost containment (increased constraints on health care budgets)	• *Increasingly tight government budgets* • *Coloplast is in high end of market*
Increasing **transparency** (prices, processes, performance, etc.)	• *Wholesalers and distributors merging* • *Greater European integration (more cooperation and legislation)* • *Price differentials across markets*
Low cost competition	• *Increasing demand for cheap products that are "good enough"* • *Low cost competition improving*
Increased demand for **health economic data and clinical outcomes**	• *Cost containment, focus on value for money*
Shift from **public to private funding**	• *Happening already* • *Implications for Coloplast?*
Shift to **community and homecare**	• *Challenge for most medtech companies* • *Opportunity for Coloplast*

Dynamics change when countries reform…



… and actors move to rebalance relationships



Long term trends drive reforms…

Long term health trends

- Demographics, Economics, Technology

Health care delivery and financing choices

- Structure, reimbursement mechanisms

Health care reform

- In several different forms…

Assessing reforms – what matters…?

Drivers

Characteristics Time horizons

Predictability

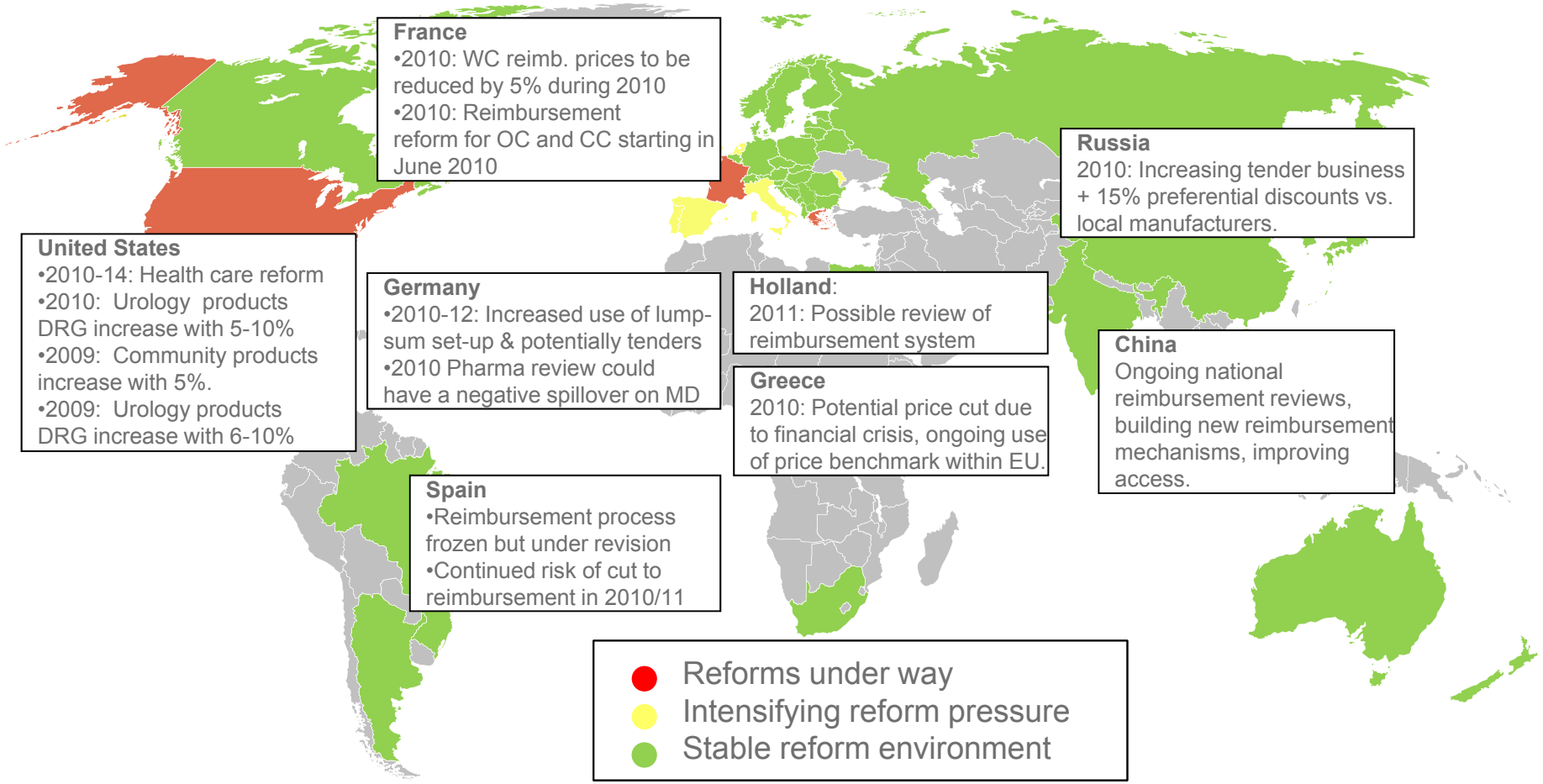
Impact Risk

Opportunity…

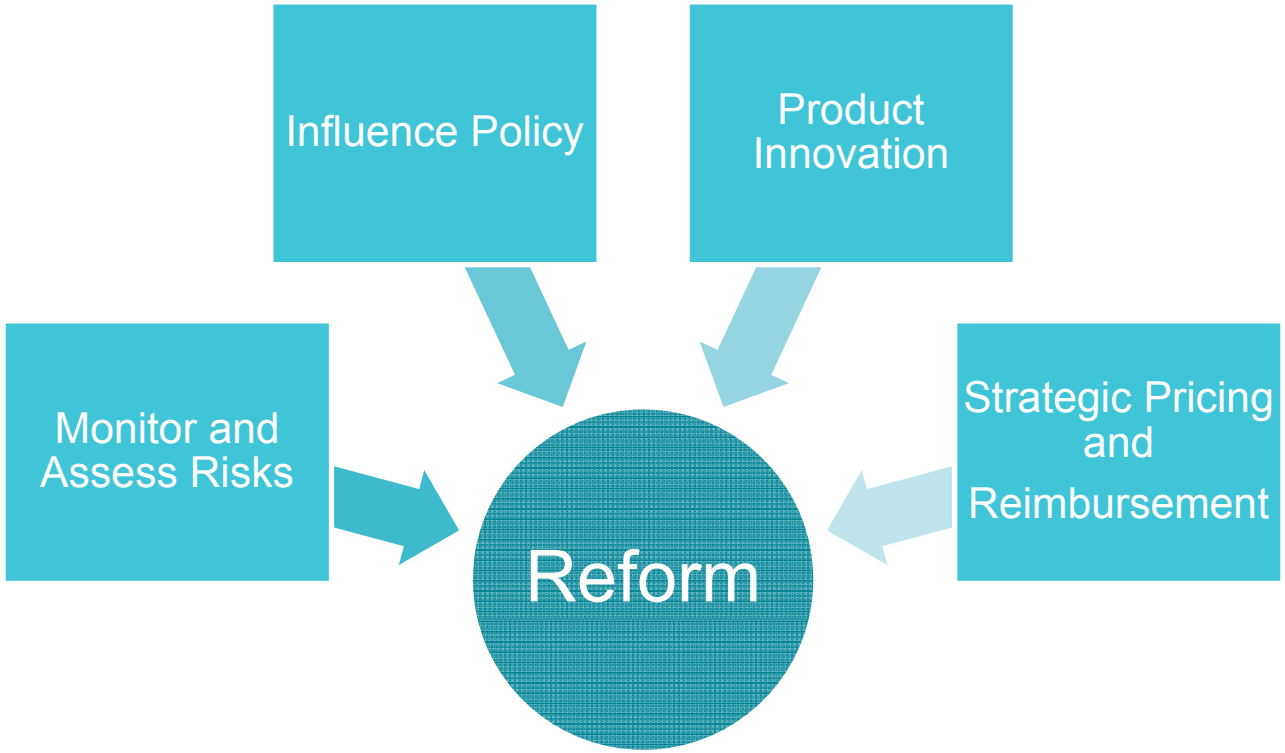
Reforms come in many shapes and sizes…

	Periodic Reviews	Structural Reforms	Crisis/Austerity Measures
Characteristics	Regularly scheduled reimbursement reviews	Fundamental changes in structure, roles, responsibilities	Budget and/or reimbursement cuts
Focus	Efficiency gains, reduced costs	Mid-/long-term cost savings	Immediate/short-term fiscal relief
Drivers	Calendar, budget cycles	Sustained economic, political pressures/trends	External shocks, internal economic performance
Timing	Cyclical, more frequent	Infrequent, longer cycles	Irregular
Predictability	Very predictable	Sometimes unintended consequences	Unpredictable, short notice
Opportunities	Can also result in upward adjustment	Potential for new reimbursement options	Opens discussion for broader, controlled reform
Impact	Limited, narrow; can trigger other reforms	Broad and deep	Broad, not necessarily ”deep”
Examples	France	U.S., UK	Spain, Greece

Reform pressure is a permanent part of the landscape…



The Coloplast toolbox for addressing reform…



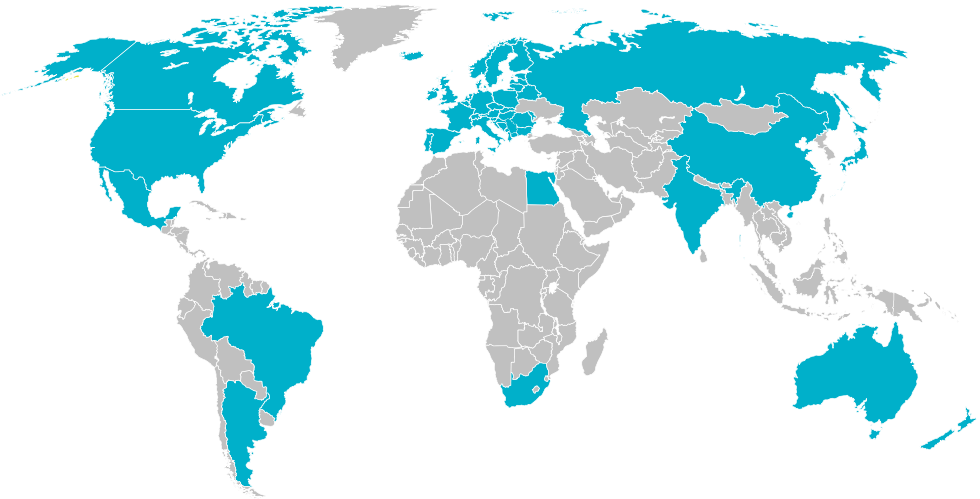
Better awareness, better risk mitigation…

- Coloplast has upgraded our reform monitoring and risk management mechanisms over the past 12 months
- Public Affairs and Market Access have worked with subsidiaries to collect, assess and operationalize reform-related business information across markets
- Provides solid knowledge management platform for assessing where Coloplast addresses current and emerging reforms

Influencing policy…

Internal Partners	Public Affairs	External Partners
Coloplast Senior Management	Communication	Danish Trade Council
Subsidiaries	Coordination	Consultancies
Market Access	Planning	Trade and Industry Associations

Alignment and Action



Examples:

- *UK – mitigating ostomy cuts*
- *Russia – resolving customs issues*
- *EU – improving action re late payments*
- *China – building ostomy reimbursement*
- *Issues – outspoken phthalate policy*

Wrap up – health care trends and reforms

- Trends are a consequence of demographics, economy and the choice of health care delivery and financing system, and through time exert pressures than can lead to reforms

- Health care budget pressure and reforms are a permanent part of our environment
  - Reforms + price erosion impact top-line with approx. 1%
  - Reforms can both be a risk and opportunity

- Coloplast has a toolbox to respond to reforms and budget pressure

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Conclusions – many challenges...

(……but more than a few opportunities along the way)

- **Health care systems are a choice**
  - ❑ Systems balance competing interests among consumers, payers and providers
  - ❑ Systems tend toward one of three general types, with significant implications for reimbursement and delivery
- **Reimbursement works very different across sectors and product types**
  - ❑ With a complex product portfolio difficult to compare across products and markets
  - ❑ We have the choice to launch fast at same price or invest in price increase
  - ❑ The regulatory / reimbursement framework gives us the opportunity to segment our portfolio to payer needs
- **Coloplast's key markets represent diverse and complex reimbursement/delivery systems**
  - ❑ Complexity can work for and against Coloplast - often challenges as well as the solutions lies in the details
  - ❑ Emerging markets represent growth opportunities with reimbursement mechanisms reflecting both the ability and willingness to pay for Coloplast products – however better access and funding improves year on year
- **Trends are a consequence of demographics, economy and the choice of health care delivery and financing system, and through time exert pressures than can lead to reforms**
- **Reform is a permanent part of our environment, and can be an opportunity**
  - ❑ Not all reforms are created equal
  - ❑ Coloplast has multiple tools to assess and respond to trends and reforms

Our mission

Making life easier for people
with intimate healthcare needs

Our values

Closeness... to better understand

Passion... to make a difference

Respect and responsibility... to guide us

Our vision

Setting the global standard
for listening and responding