Healthcare for All - A distant dream or a reality?

The healthcare delivery systems in India effectively cater to only 10% of the population and mainly to the affluent section of the society. Is it possible for this highly capital intensive industry to serve the rest of the population without any subsidies and government support? Yes, in fact it makes a good business proposition say Susnato Sen, Practice Head-Infrastructure, Saurabh Jain and Dhruv Thakkar of Tata Strategic Management Group.

Healthcare Scenario in India

India has shown steady improvement in basic health indicators such as life expectancy at birth, infant mortality etc. However, a very large part of the population continues to be deprived of basic and quality healthcare facilities. Some of the key indicators of the current scenario are as follows:

Accessibility to Healthcare Facilities

India’s bed availability per thousand population is 1.5 as compared to 4.3 in middle income countries like China, Brazil and South Africa and 7.4 in high income countries of the US, Western Europe and Japan. The divide is more staggering between urban and rural India where bed per thousand population is 1.8 in urban area as compared to < 1 in rural areas. Considering a population of over one billion in India, this translates into a huge unmet demand.

The government healthcare sector is inadequate to meet this demand. As per a Planning Commission estimate the private sector constitutes over 80% of the total healthcare service providers.

Affordability of Healthcare Facilities

But how affordable is the private healthcare? According to the Planning Commission, outpatient services are 20-54% costlier and inpatient services 100-740% costlier than public healthcare. This pushes up the cost of healthcare.

As per NCAER survey in 2005-06, there were about 204 million households in India with 91% of these in mass and middle income group (Refer Fig 1).

Also in general, there is very low penetration of health insurance (3-5%) across the population, only catering to the affluent class. Thus most of the healthcare expenses are paid out of pocket. It is indeed paradoxical that health insurance is available to those who can afford expensive healthcare treatment and facilities and is largely beyond the means of those who are needy.

Increasing Need of Healthcare Facilities

Another trend is a shift from communicable diseases such as tuberculosis, leprosy to non-communicable/lifestyle diseases such as cardiovascular diseases and diabetes. While many of the communicable diseases have been controlled to an
extent and are expected to be eradicated in the coming decade, lifestyle diseases are expected to grow (Refer Fig 2). This shift is resulting in not only higher cost of treatment but also lengthier period of treatment.

Contrary to popular perception, these diseases are not only prevalent among the rich and the affluent but also among the middle and lower income segments. Often such expensive treatment is undertaken through high interest rate borrowings from private money lenders and by selling assets such as land or borrowing from family and friends, thus creating tremendous financial burden.

Hence, there is a need to address this huge demand from the mass category present in both rural and urban areas through cost effective innovative business models.

Innovative Business Models in Mass Healthcare

The needs of the customer are broadly segmented under three clusters- Rural, Tier II/III cities and Metro/Tier I cities and possible business models to address these needs are discussed below:

- **Rural Area:** It remains deprived of even the basic healthcare facilities. Accessibility is the primary need. Thus the value proposition that a private player can provide is access to qualified medical personnel at the doorstep (e.g. Care Shop Ghana and Healthstore Kenya) or to a qualified doctor via telemedicine (e.g. SehatFirst in Pakistan). Contrary to common perception, these facilities can be a viable business proposition (Refer Case Study 1).

- **Tier II /III cities:** The primary need for people in these cities is the access to affordable and quality secondary healthcare facilities. The value proposition that a private player can provide is quality services at a lower cost – a model pioneered by Aravind Eye Care System (Refer Case Study 2). Many new hospital chains such as Lifepro (in maternity care) are now emulating this business model in specialized treatment facilities. At the same time, hospitals such as Columbia Asia are offering affordable general hospital facilities with specified standardized treatments/procedures. The fact that they are expanding at a rapid pace indicates the viability of such business models.

- **Metro / Tier I Cities:** These cities typically have large number of hospitals in all the three segments-primary, secondary and tertiary. But here the biggest concern is the affordability. A

**Case Study 1: CareShop-Ghana**

CareShop is a franchise of licensed over-the-counter drugs retailers designed to improve the quality, accessibility, and affordability of essential medicines across Ghana on a for-profit basis by Ghana Social Marketing Foundation Enterprises Ltd (GSMFEL)

While GSMFEL ensures training of basic healthcare personnel, supervision and monitoring, marketing and promotion and a reliable supply of low cost medicines, franchisees are responsible for maintaining quality as per laid down rules, buying goods exclusively from GSMFEL and payment of franchisee fees.

Today 276 stores are operating, most of them profitably.

A similar initiative “Sehat First” has been launched in Pakistan consisting of a telemedicine centre along with the basic facilities of Careshop model. The telemedicine connectivity allows the facility of consulting experts at the hour of need. Currently 3 pilot shops are operational. These are expected to increase to 500 by 2012. This initiative has also attracted venture capital.

good case for affordable healthcare delivery is the Narayan Hrudayalaya, Bangalore (Refer Case Study 3). They ensure high quality affordable treatment through high utilization of resources at their disposal.

Case Study 2: Aravind Eye Care System

Founded in 1976, Aravind Eye Care System today is one of the world’s largest and most productive eye care facility. The key characteristics are as follows:

- Wide range of services covering all income segments including free bed services to underprivileged people without dependence on grants / donations (High operating margins 40-45%)
- Lowest cost per patient compared to any other facility across the world achieved by rationalizing the capex costs and operational expenses (Aravind eye centre has entered into manufacturing of IOL lens)
- Higher productivity of manpower and efficiency through innovation (Over 2000 cataract surgeries per ophthalmologist per year compared to Indian average of 400 and South East Asia average of 300)
- Benchmarked with the international quality standards. Infection rate at Aravind is 4 per 10,000 cases compared to UK published rate of 6 per 10,000 cases
- Provide medical care in remote areas by maximizing the use of IT application such as telemedicine portals and conducting free eye care camps
- ECCE cataract surgery at Aravind with an IOL implant costs below Rs 5,000/- while an equivalent surgery in a general hospital would cost upward of Rs. 15,000/-

Source: Harvard Business School Case Study, Excerpts of Interview with Chairman conducted by IIM-B

All these models have an underlying focus on reducing cost through higher productivity of personnel, technology selection as per need, high asset turnover and innovation driven processes. Some other hybrid business models like HCG (16 cancer hospitals) & RG Stone Urology (~15 hospitals) are located in Metro, Tier I & Tier II cities across India. All these chains, founded by doctors & entrepreneurs alike are now attracting substantial private equity investments.

Implications

Emerging role of private sector players

These emerging models have profound implications for the current structure of the private healthcare delivery industry. We expect the industry to evolve into the following structure eventually:

- Franchisee based private healthcare chains will spring up in rural areas to cater to the primary healthcare requirements of the rural population. A typical centre would include a pharmacy, trained paramedical staff and access to a qualified physician via telemedicine platform. These centres would be for profit centres run by virtue of being cost effective per treatment basis and by catering to large unmet demand.
- Specialized treatment based hospitals are expected to replace the existing general hospitals in tier 1 & 2 cities. The critical success factor for these hospitals would be to develop expertise in specific procedures/treatments by focussing on such procedures only. Despite focussed on specified procedures, these hospitals will also have medical professionals from other disciplines to handle complications. Their business model will be based on high volume-low price treatment and economies of scale which would drive down their unit costs and protect margins. Majority of patients would be expected to shift from existing tertiary care hospitals to such hospitals.

Case Study 3: Narayana Hrudayalaya

Located in Bangalore, Narayana Hrudayalaya is a leading hospital in providing treatment services to heart ailments. The key characteristics of the business model pioneered by them are as follows:

- Cross-subsidization of costs of poor patients by rich patients (75% poor and 25% rich)
- Lowest cost per patient compared to any other similar facility across the world achieved by rationalizing the capex costs, and operational expenses
- Leverage the benefits of economies of scale by directly negotiating with the OEMs. The hospital intends to further scale up its operations to 5000 beds from 780 beds
- Benchmarked with the international quality standards
- Provide medical care in rural and semi urban areas as well by connecting to the primary health centres in villages and Government hospitals via telemedicine facility
- Runs micro-insurance scheme – “Yeshasvini” in villages, covering rural population
- Open heart surgery in Narayana Hrudayalaya would cost in the range of Rs 0.75-1lac , while an equivalent surgery in a similar private hospital would cost upward of Rs 2 lacs

Organized private players would replace current unorganized medical advisory clinics in cities/towns. These clinics would not only help to identify the ailment but also recommend the exact treatment / procedure while leaving the patient to choose the hospital (like the ones mentioned above) where he/she wants to get treated. These centres would have much superior capabilities to diagnose and recommend treatment than the current standalone physicians. Max healthcare neighbourhood plan has 50 clinics across Delhi, offering out-patient consultation and preventive health-checkups. These players would work in tandem with specialized hospitals to provide complete healthcare solutions efficiently.

Existing tertiary care hospitals in metro and tier 1 cities would evolve into world-class facilities offering the best treatment possible. These hospitals would increasingly cater to patients from countries like the US. The critical success factors for such hospitals would be international accreditation, world class facility and cutting edge technology.

The key to success in this evolved scenario would be customer centric efficient delivery, economies of scale and focussed approach.

Role of the Government

While we expect the private sector to cover the pyramid as far as possible with these cost effective models for mass healthcare, it would be practically impossible for the private sector to cater to the lowest section of the pyramid. This is where the Government needs to play a pivotal role. Besides ramping up the network of its hospitals and primary health centres, it needs to cover this segment under medical insurance schemes as well. In this regard schemes like the Rashtriya Swasthya Bima Yojana are steps in the right direction. This scheme provides free medical insurance by private players to BPL families.

Evolution of ancillary industries

- With average cost of treatment coming down insurance premium costs may reduce, fuelling further demand from the large uncovered population.
- Diagnostics industry may also witness consolidation. More and more standalone players are already aligning themselves with the emerging corporate chains such as SRL Diagnostics (Religare group), and Well Spring labs (A unit of Nicholas Piramal). We expect this trend to gain momentum over a period of time.
- Demand for medical equipments is being largely met by costly imports from Western countries presently. But with new demand being created, we expect India to evolve as a cost effective manufacturing hub catering to domestic demand as well as exports.

The healthcare delivery industry is poised to take off with new and innovative business models. The large unmet demand would create substantial business opportunities for the private sector across the value chain. Thus companies successful in aligning themselves with this transformation would stand to benefit immensely as this opportunity unfolds.
About Tata Strategic:
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- Optimization of Costs & Processes
- Predictive Modelling and Simulation
- Business Risk Management

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