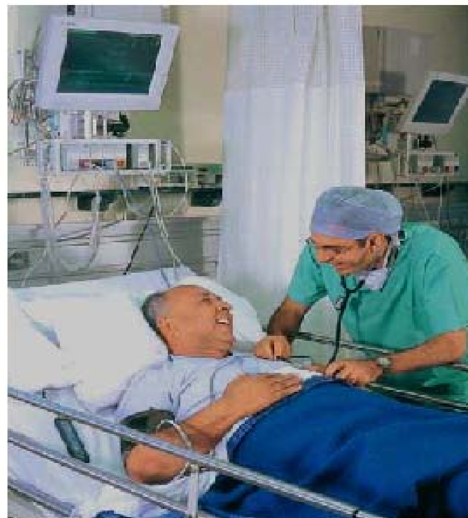
HEALTHCARE MODELS



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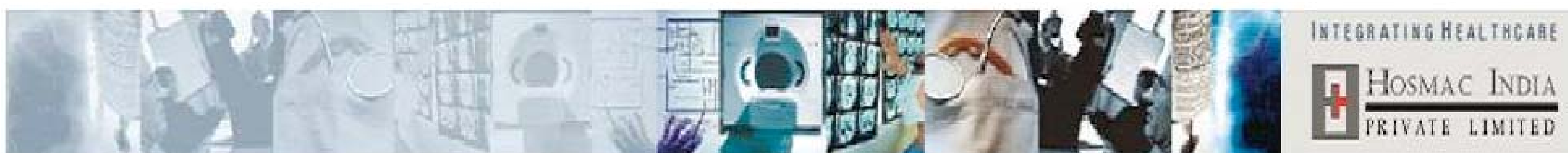
Payor Models in India

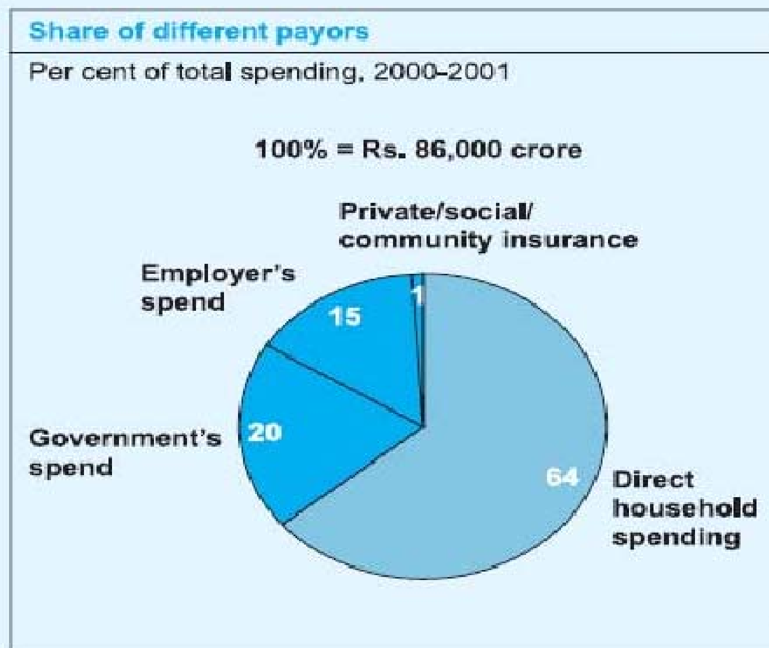


Different Payor Models & issues

Type of coverage	Key Issues
Private health Insurance	• Growth of private health insurance constrained by regulatory and systemic barriers
Social Insurance	• Insufficient utilization of healthcare funds • Poor quality of care at ESIS facilities
Employer's spend	• Healthcare is not part of employer's core business, but employers cover is necessary in absence of effective insurance schemes
Community Insurance	• No large scale developments of community schemes across the country
Government's spend	• Scale of government spending is low compared to other developing countries • Expenditure is inequitable as the spend mostly benefits richer segments of the population

Share of the Market

Out-of-pocket
Prepayment



Limited prepayment is inequitable and inefficient

- No cross-subsidy between well and sick (inequity)
- No organised purchasing of healthcare (inefficient)

Source: National Accounts Statistics 2001; Annual reports; Employee Medical Benefits in corporate sector, 1993: Article by Dugal; McKinsey analysis

Key moves for Universal coverage by 2020

Current situation

2002:
- Private (0.4%)
- Social (3.4%)
- Employers (5%)
- Community (5%)
- Uncovered (76%)
- Public welfare

Short-term moves (within 5 years)

- Stimulate growth of private
- Restructure ESIS
- Drive the growth community insurance schemes
- Charge user fees to richest

Medium-term moves (5-15 years)

- Mandate insurance for all urban residents
- Formalise schemes around geographical/professional bodies
- Allow external purchasing and decentralise purchasing

The improvement of purchasing will be a key condition to increase coverage

Vision 2020

2020:
- Private (15%)
- Social (25%)
- Community (20%)
- Public welfare (40%)

Source: McKinsey analysis

Provider Models in India

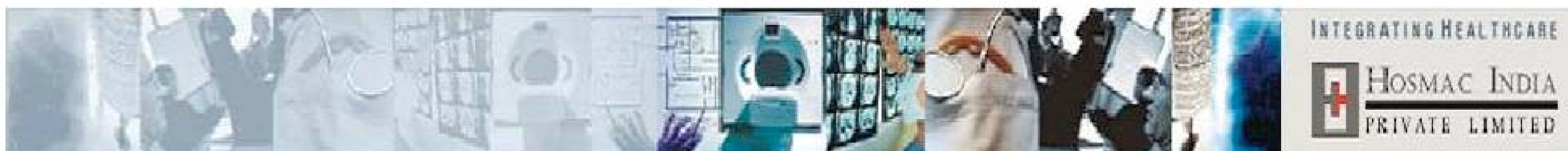
Providers need to focus on three issues

Issues

- What is the overall market and what are the economies of the business model
- Based on the economics what portion of the overall market can be targeted
- To successfully target this market, what are the major issues that individual private providers need to resolve

These issues are discussed for

- A super-specialty cardiac care facility (200 bed)
- A multi-specialty secondary care facility (100 bed)
- A GP clinic (6 consultants)

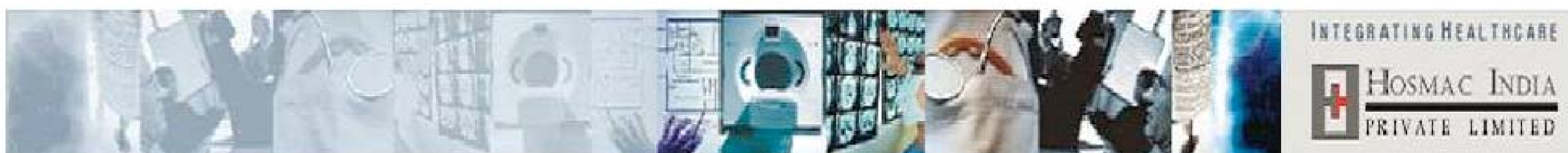


Providers deliver Healthcare through 3 formats

Delivery format	Patient need served	Description
Tertiary care facility	• Primarily inpatient	• High investment • Capable of conducting complex procedures using sophisticated equipment • Total market of ~Rs. 10,000 crore* in 2000-01
Secondary care facility	• Inpatient and outpatient	• Medium investment • Capable of conducting simple surgeries using basic diagnostic and OT equipment • Has medical specialties such as internal medicine, obstetrics and gynaecology, pediatrics • Can offer additional specialties such as gastro-enterology, urology, dermatology (and even cardiology in a limited way) • Total market of ~Rs. 25,000 crore in 2000-01
Primary care unit	• Outpatient only	• Low investment • Capable of providing consultation to patients for select disease groups including infections, asthma, diabetes, etc. • Total market of ~Rs. 37,000 crore in 2000-01

Note: The estimates of total market across the three delivery formats will not add up to Rs. 69,000 crore because there are overlaps
* Excluding outpatient spend

Source: McKinsey analysis



Within each Format, various types of Facilities…

Delivery format	Types of facilities	Differentiation parameters	
		Investment levels*	Size
Tertiary care facility	• Super-speciality tertiary care (e.g., Escorts Heart Institute)	High	150+ beds
	• Multi-speciality tertiary care (e.g., Apollo Hospital)	High	150+ beds
Secondary care facility	• Single-speciality secondary care (e.g., Indian Spinal Injury Centre, Delhi)	Medium	50-200 beds
	• Multi-speciality secondary care (e.g., First Med, Chennai)	Medium	50-200 beds
	• Nursing home	Low-medium	<50 beds (typically)
Primary care facility	• Clinic having a group of GPs and specialists (and maybe basic diagnostics)	Low	3-10 doctors
	• Single GP outfit	Low	1 doctor

* Driven by a combination of size of facility and sophistication of equipment

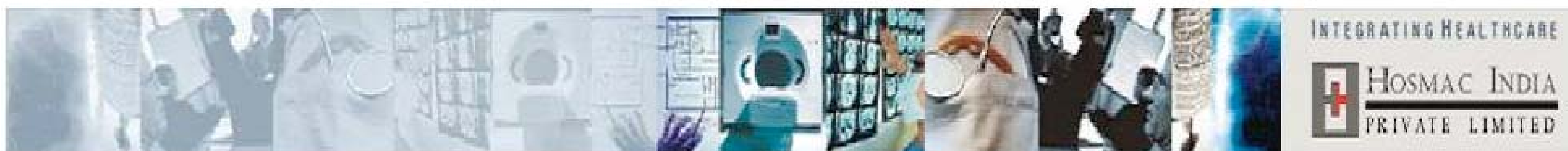
Source: CRISIL; Interviews with industry experts; McKinsey analysis

Within primary care, 2 models exist…

Growth model	Description	KSFs for the private provider
1 Franchisee model	• An entrepreneur sets up the facility and manages day-to-day operations • A corporate provides its brand name and management expertise • A fixed-fee and/or revenue-sharing agreement exists between entrepreneur and franchiser	• Control over quality of care delivered at the franchisee • Consistency of customer experience across multiple touch points that is aligned with brand image • Ability to manage a group of significantly dispersed entrepreneurs on an ongoing basis • Ability to create a 'brand-pull' in an industry where physician relationships have traditionally driven patient flows
2 Fully owned clinics	• The corporate entity invests in infrastructure and marketing • GPs and specialists are either employed on salaried basis or on revenue sharing basis	• Managing productivity of GPs and specialists • Ability to drive patient flows • Aggressive "retail mindset" to manage a large network of such clinics • Ability to employ high-quality, reputed, and experienced GPs and specialists

The franchisee model offers an opportunity for practitioners to affiliate with larger players who have access to capital, health administration expertise and scale in purchasing and operations

Source: McKinsey analysis



Beyond these, 4 additional models exist…

	Description	Indian Examples
Integrated Delivery Network	• Delivered through an integrated network of primary, secondary and tertiary facilities that is capable of tracking a patient (e.g. reminding a cardiac patient about a treadmill test that is due)	• Fortis
Telemedicine	• Use telecommunication facility to diagnose and/or treat patients in remote facilities that cannot afford full time specialists	• Fortis • Apollo • Narayana Hrudalaya
Mobile care	• Provide primary and/or secondary care in rural areas through mobile units (trains, vans)	• Helpage India • Lifeline Express
Home care	• Provide post-acute care to patients recovering from surgery in their homes at low cost	• Hinduja Hospital • Metro Health Services

Other potential ideas include chain of diagnostic labs, clinical trials and medical tourism

Telemedicine Model

Objective

- Create a low-cost model of providing specialist opinion in remote areas for diagnosis, treatment and referral

How it works

- Simple model
  - Use telephone line for communication between GP and specialist
  - Share diagnostic reports through modem or fax
- Sophisticated model
  - Set up satellite links to enable video conferencing between GP and specialist
  - Use specialised digital e-equipment (e.g., digital microscopes) for complex diagnosis and sharing of reports

Key success factors

- Optimal investment in technology (based on need-gap analysis, expected patient flows, benefits from referrals)
- Quality of GPs in the remote facility
- Ability of specialists to effectively communicate with the GP and diagnose/ treat without physical examination

Likely Barriers

- Weak telecom infrastructure and high telecom costs
- Expensive nature of specialised digital equipment
- Lack of standardisation of digitised data (especially diagnostic reports)
- Uncertainty about acceptance among patients

Source: Interviews; McKinsey analysis

Mobile care Model

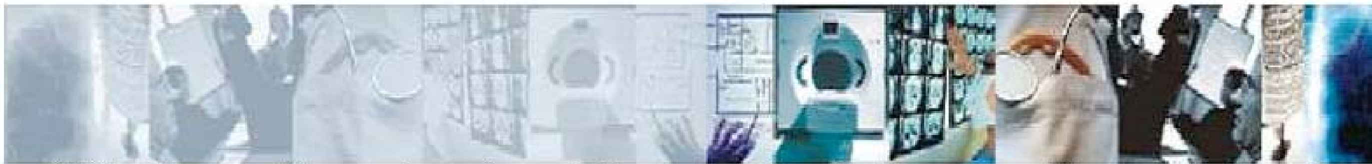
Objective	• Provide healthcare in remote areas by bringing doctors and equipment directly to those areas using a mobile medical unit
How it works	• Resources – Staffing of the van – 2 doctors (GPs or specialists), 1 nurse, 1 pharmacist and 1 driver – Diagnostic could range from basic path lab to full capability including X-rays, ECG machine, ultrasound – Full range of medicines, immunisation, syringes, IVFs • Van stationed at district HQ, travels to villages to spend 1-2 days per village (each village gets 3-4 visits per month) • Charge patients for consumables and a fixed fee for service • Could leverage existing infrastructure in villages (e.g., CHCs, schools)
Key success factors	• Ability to target high volume villages within a small radius of travel • Adequate publicity of visits to ensure patient flows • Consistency of quality of doctors/specialists across visits
Likely Barriers	• Travel-intensive lifestyle for doctors • Poor road infrastructure in remote areas • Low affordability in rural areas • Limited secondary care capabilities of van-based infrastructure

Source: Interviews; McKinsey analysis

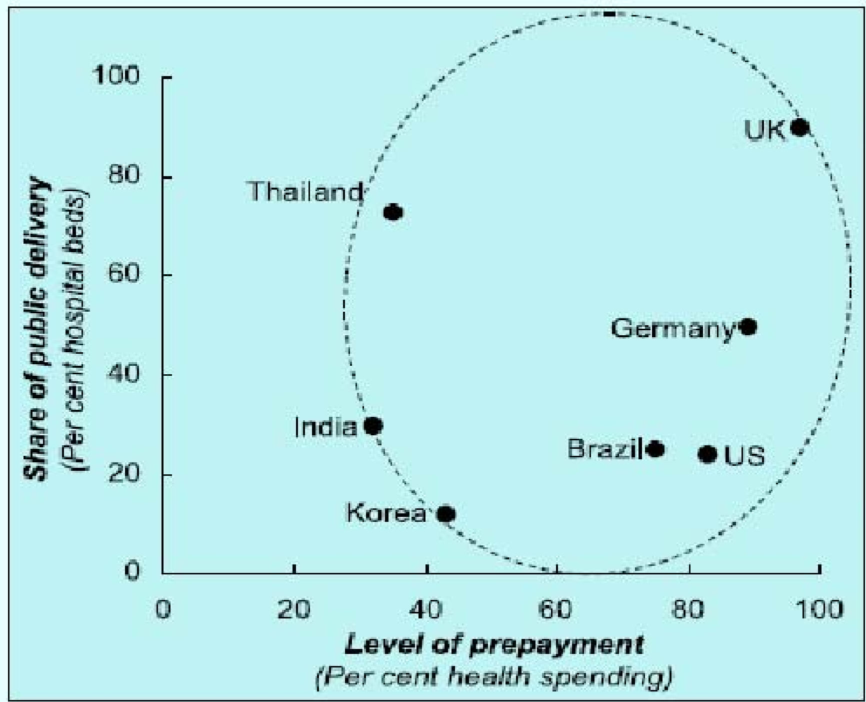
Home care Model

Objective	• Provide low cost, post-acute care to patients in their homes
How it works	• Used with patients who have had surgery and can spend their recovery time at home (instead of the hospital). Applicable primarily to a few disease categories such as internal medicine, orthopedics, rheumatism, gastro-enterology • Nurse visits home to change dressings, administer medicines for pain, do physiotherapy • Minimal investment – requires 5 full-time nurses to manage about 25 patients at any given time • Charges are ~Rs. 500-750 per visit (i.e. about 25% of the cost of staying in a hospital)
Key success factors	• Ability to identify patients who can manage with home care (on the basis of physical condition, complexity of care required, location of residence) • Consistent monitoring of patient condition without hospital infrastructure
Likely Barriers	• Inability to expand to chronic care requirements of patients due to – Low affordability (Rs. 500-1000 per day for a nurse) – Difficult to ensure security of the nursing staff visiting the patient

Source: Interviews; McKinsey analysis



Whatever the mix of public-private delivery, all countries have to ensure cost-effective, accessible care



- The mix of public-private delivery is not correlated with the level of prepayment
- All countries face the same challenges
  - Public delivery: ensure accessibility and efficiency
  - Private delivery: enforce regulation and promote participation of organised providers

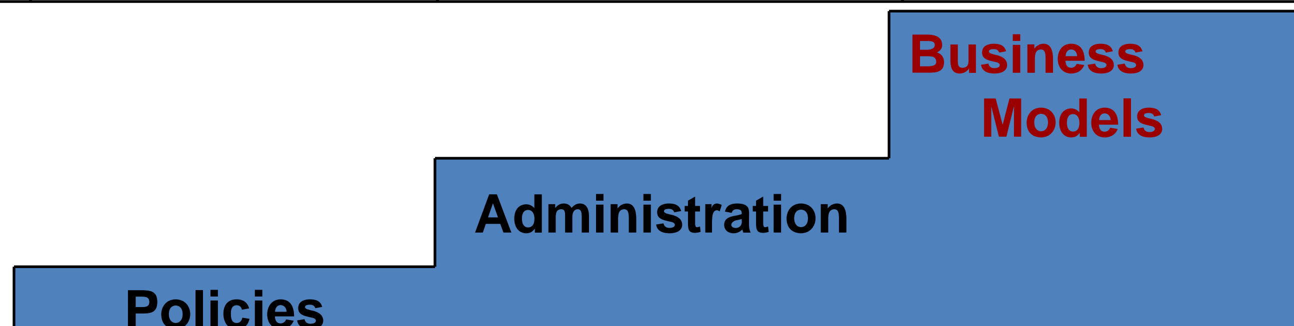
Source: WHO; Espicom; McKinsey analysis

Learnings for India

Dimensions of healthcare system	Types of population/payor /provider	Potential levers for India
Coverage	Formal Sector	• Mandate social insurance for employees (Thailand) or for both employees and self-employed (Korea) • Promote private insurance to relieve public welfare (Brazil)
	Informal Sector	• Mandate insurance for all residents (Korea) • Ensure free care through public welfare (Brazil) • Introduce voluntary community-based scheme (Thailand)
	Poorest segment	• Subsidise specific insurance scheme (Korea) • Ensure free care through public welfare (Brazil) • Limit free care to poorest segments (Thailand)
Purchasing	Payor integrated with provider	• Allow external purchasing (UK) • Decentralise purchasing (Brazil) • Create referral system (Thailand)
	Payor separated from provider	• Introduce capitation payment (US, Thailand) • Create referral system (US)
Delivery	Public provider	• Focus on primary rural health care (Thailand) • Give greater autonomy to hospitals (UK)
	Private provider	• Regulate unorganised providers (Brazil) • Promote participation of organised providers (Thailand)

Genesis of Business Models

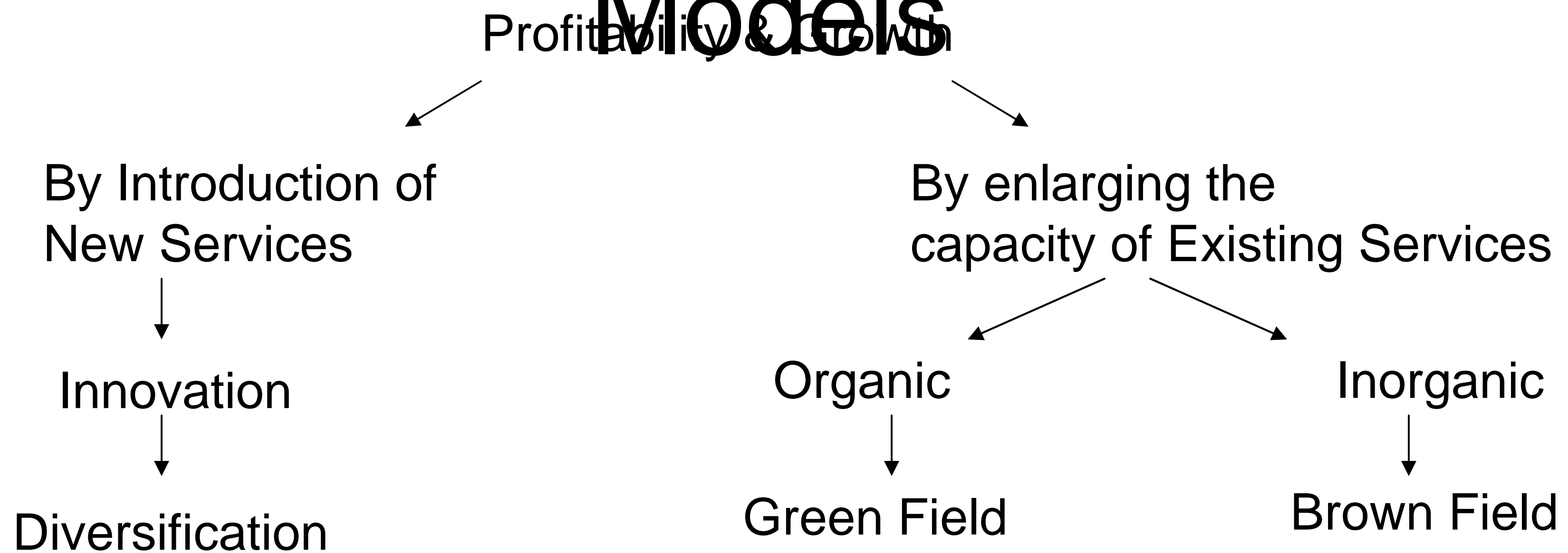
Evolution of Healthcare in India			
KFA	**40's - 60's**	**70's - 90's**	**90 onwards**
Providing Agencies	Govt	Trust	Corporate
Objective	Adequacy	Subsidy	Profit & Growth
Service Emphasis	Equality	Equity	Quality
Mode of Finance	Grants	Donations	Investment
Strategy Focus	Creation	Consolidation	Innovation



Key Components of Business Model

- Vision
- Objective
- Demand & Supply Analysis
- Conceptualization
- Financial Feasibility
- Validation
- Execution

Classification of Business Models



E.g.
- **Pharma to Hospitals**
- **Primary HC to Secondary HC**
- **HC delivery to Education**

E.g.
- **Series of Delivery centres**
- **Chains**
- **Franchising**

E.g.
- **M&A**
- **JV**
- **OM**

Model of Focus

- Mergers & Acquisitions
- Joint Ventures
- Operations Management
- Franchising
- Public Private Partnerships

Mergers & Acquisition	
Definition	**Merger -** Two or more separate organizations come together to constitute one legal entity **Acquisition -** Acquiring Control of an organization in hostile or friendly manners
Benefits	• Quick Market Capture • Immediate Brand Recognition • Fast ROI • Less Infrastructure Cost • Enhanced TVM
Hurdles	•Cumbersome Documentation • Selecting the Right Partner • Criticality of Post Merger Integration • Clash of Cultures • Manpower Issues (downsizing/transfers) • Compensation & Remuneration

Mergers & Acquisition Contd…….

Demerits	- Short Term Growth Strategy - Chances of failure may be high - Liabilities may be high
De Risking	**Opportunity Evaluation** • Due Diligence (Valuation/Benchmarking) • Weighing of Ideologies • Sustain Communication **Change Management** • Addressing Fears • Orientation of employees • Identification of core team • Charting Career Growth • Avoiding redundancy

Joint Ventures	
Definition	**Joint Venture –** Two or more organization establish a relationship to start a new organization & jointly administer it & maintaining their own organizational autonomy Equity is a key component of JV and maybe in varying proportions (strategic v/s majority)
Benefits	• Synergy of ‘Core Strengths’ • Improve Learning Curve • Risk Sharing by both Partners • Minimal loss of Identity • Extra Muscle to acquire bigger Market Share
Hurdles	• Synergy of Vision (should be no conflict) • Managing Insecurities • Ability to take Timely Discussions • Creation of Unique Organizational Culture

Joint Venture Contd…….

<table>
<tr><td>Demerits</td><td>• Slow decision making
• Conflict of Interest in long run
• Difficult marriage problems</td></tr>
<tr><td>De Risking</td><td>Opportunity Evaluation
- Reference Check (Neutral Referee)
- Compatibility Index
- Transparency of Partners
- Well defined Exit Options
Management
- Crystallization /Documentation of Vision, Mission, Objectives of JV so as to prevent ambiguity
- By proper sharing of equity stake based on objectives of investors</td></tr>
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Public Private Partnership (PPP)	
Definition	**PPP –** It is a system in which a Govt service or a business venture is funded & operated through a partnership of Govt & one or more Pvt sector companies **Main motive for this model is cross subsidy**
Benefits	• Accessibility & Affordability of advanced healthcare for Common Masses • Decreases Resource burden on Govt • Enhanced Brand value for Private Player • Lowers Infrastructure Investment for Pvt player
Hurdles	• Infrastructure Quality • Establishment of correct service mix • Timely Decision Making • Change Management – Govt Work Culture

Public Private Partnership Contd…….

Demerits	• Sharing of Profit for private player • Change in Political scenario of the region substantially affects PPP's equation • High Risk for Private player if heavily investing in Infrastructure & Technology • Manpower & labour related issues
Models in PPP	• BOO, BOOT
De Risking	**Opportunity Evaluation** - Evaluation of Govt Terms & Conditions - Sensitivity analysis of Price Ceiling - Addressing Ownership & Right Transfer Issues - Exit Options **Management** - Creation of Acceptable Management Board - Reducing government interference & limiting role to policy level only

THANK YOU……..

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