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PRE CONFERENCE SYMPOSIUM

MANAGEMENT MANTRAS OF HEALTHCARE SECTOR: AN OVERVIEW

Panel Members: Dr B. Soma Raju, Dr Krishna Reddy, Mr B.K. Agarwala, Dr Chandrashekar Potkar, Dr Aloke C Mullick, Mr Anjan Bose and Dr Rakesh Kapur

CHAIRPERSON OF THE SESSION-

DR. NAROTTAM PURI, President of Medical Strategy and Quality; Fortis Healthcare, Delhi. He set the stage for the panel discussion by introducing the audience to the dynamics of the Indian Heathcare Industry.

- Healthcare globally
  It is the largest industry in the world with a 9% of global GDP spend.
  GDP spend: USA- 16% and India 5.5-6% of which the Government contribution is 1%.
- Opportunities in the healthcare sector include various aspects like telemedicine, medical equipments, health insurance, clinical trials, medical value travel etc with pharmaceutical being the most important.
- The Indian scenario
  India is the 2nd fastest growing major economy and the 3rd largest in the world based on purchasing power parity.
  Healthcare is one of the largest service sectors in India with an expected rise of 15% per annum.
  It's contribution to the GDP is expected to increase to approximately 6.1%
- Opportunity- Technopak study stated that,
  Healthcare industry is expected to grow to $ 75 billion by 2012 and double by 2017.
  A major bulk of this growth will be in the private sector.
  Note that 70% of the OPD contribution is by the private sector
  India also poses a huge investment opportunity amounting to approximately $80 billion.
- Indian Healthcare
  India has one of the largest private healthcare market, with 80% of all qualified doctors, 75% clinics and 60% of hospitals in private sector.
  WHO study stated that 70% of all OPD care among the poor too is provided by Private sector.
- Components of Healthcare-
  - ***Insurance*:**
    Insurance coverage in India was 12% in 2007 s compared to 85% in USA; thus stating that coverage in India is poor.
    It has a huge potential with a fast growth.
    In Holland every person covered by insurance.
  - ***Medical value travel***:
    Expected to reach from $0.3 billion to $3 billion by 2012.

The key drivers for the growth of Medical Value Travel are

1. Quality healthcare at fraction of the cost
2. Availability of skilled doctors and hospitals
3. Reputation of Indian doctors.

Challenges

1. Poor infrastructure
2. Low information levels on good quality hospitals
3. Lack of accreditation of hospitals.

- ***Indian Pharma*ceutical Industry:**

It has the highest number of U.S. FDA approved plants outside US.
Massive incremental growth owing to an increase in the healthcare spend in the country.
The other key drivers for growth are:

- ✓ Robust economy
- ✓ Increasing affordability
- ✓ Deeper penetration of Health Insurance
- ✓ Increase in organized retail chain
- ✓ Shifting disease patterns

- ***Medical equipment*:**

The value of the market is expected to increase by more than double from 2006 to 2012 indicating a strong growth rate.
However the market share is still small with low per capita spending.

- ***Information Technology*:**

He projected IT & Auto –technologies to be future engines of our country's healthcare industry.
IT encompasses HIS, Tele- health, Telemedicine, PACS, Personal Record platforms(launched by Google Health) and ePOM
ePOM ie Electronic Provider Order Manager, which is a small device used to place orders and the messages are passed to the suppliers.

The first speaker was then invited to throw light on the Hospital Sector.

Talk 1

HOSPITAL: Dr B. Somaraju ,CMD Care Hospitals Hyderabad.

Following key points were covered by the speaker:

1) Advances in modern medicine, Imaging technologies, & Diagnostics
2) Reach of major medical advancements to the common man- a major issue (Equity of care).
3) The care provided to the patient should be safe, effective, patient centred, timely, efficient & equitable.
4) Enduring edifice of character among healthcare professionals stressed upon.
5) Core ideologies comprising of core purpose, core value & core model(Healthcare delivery, Education & training and Research & Development) to be defined.
6) Striking of a balance between two extremes i.e. medicine being a science & being a business.
7) Shortcomings of modern medicine:
    a) Safety
    b) Medical errors
    c) Lack of professionalism
8) Fundamentals and core value to be remembered to deliver value service to people.

Talk 2

HOSPITAL: Dr Krishna Reddy , MD ,Care Group

Key points spoken about :

1) First principle of management – Reason for existence in a profession.
2) Shared the strategies, guiding forces & principles of his own organisation i.e. Care Group Of Hospitals.
3) Three elements of Vision for a Healthcare Organisation
    a) Quality
    b) Safety that they wish to provide.
    c) Cost – In terms of efficient services, optimal cost , cutting down on unnecessary services, affordability (reliable, scalable design to be formulated to serve all sections of society) & access.
4) Clarity of Core ideologies- values, principles; Patient interest to be given prime importance.
5) Called the ‘Clarity of Care’ model as the ‘DNA of Care’- to be integrated with Research & Development.
6) The growth of an organisation & the individual depends on the ability to adapt to market conditions and circumstances.
7) Stressed upon the need of value based organisations & importance of institutional culture with cherished values.
8) There is a lack of standardisation, proper auditing systems & good clinical governance in medicine.
9) Core Needs for any organisation:
    a) Core philosophy
    b) Adaptive behaviour
    c) Integrated community healthcare delivery system.

TALK -3

INSURANCE:Mr B K Agarwala ,Senior VP,ICICI Prudential

TOPICS COVERED

1. Need for better health coverage.
2. Health insurance: challenges.
3. Lessons for other countries.
4. Way forward.

NEED FOR BETTER HEALTH COVERAGE:

Need to introduce prepaid plans

In India over 85% population does not have any kind of health cover and the Government share of health care expenses less than 25%.The insurance market in the financial year 2008 was Rs 5125 crore.

High out of pocket spending is inequitable

About 40% of people who have inpatient treatment sell assets or borrow money from out of the household for the medical expenses. High medical expenses lead to postponement or non usage of the medical care at times. Health insurance is needed because in developing countries people mainly pay from their pockets and have to forego other important financial goals and aspirations. At times major household demands have to be postponed indefinitely to adjust the health care expenditures

Need to improve insurance penetration

Globally publicly funded healthcare is facing fiscal constraints in the time of this recession. Healthcare insurance is unsustainable except for targeted segments like elderly, chronically ill/ terminally ill. Tax financing requires a large formal sector. It has good tax or contribution collection capacity. Hence may not work in developing countries

HEALTH INSURANCE CHALLENGE:

Low penetration of HI

Lack of affordability :

It is an important issue that needs to be addressed in India because 1/4th of population below poverty line (BPL). There is a need for a large retail distribution. There is a high proportion of population in informal sector. Health insurance needs to have a large geographical reach in up to about 5000+ urban centers.

Consumer "apathy"

The Indian people usually are not in the habit of prepayment but always look for returns which may not always come fast with insurance .A large number of people do not find the whole concept relevant. This could also be due to poor experiences in the past [of self or others] at time of claims. There is also the important issue of limited product innovation as well as lack of data for pricing.

Poor Insurer – provider relations

Issues	Insurer	Provider
• **No accreditation/ grading of Hospitals** • **Lack of prescription control** • **No STGs** • **Limited tariff agreements** • **Lack of arbitration / ombudsman process**	• **Not possible to segment providers** • **Claim frauds** • **Over-utilization** • **No tariffs and arbitrary /inflated pricing for insured patients** • **Non-acceptance of cashless facility** • **Difficult to "blacklist" hospitals**	• **Not enough differentiation in tarriff** • **Lack of trained personnel at TPAs** • **Arbitrary deduction at time of claims settlement** • **Payment delays** • **Pre-auth process cumbersome and non-standard**

Elderly issue

In India there will be113 million people over the age of 60 by 2016,and they will be vulnerable due to lack of cover by health insurance. The breakdown of traditional joint family system and lack of employer cover post retirement. Another problem is that the high premiums may be difficult to fund post retirement.

Expense per person are likely to be more than 6 times that of 35 year old , this very fact

makes it unaffordable to large sections of the population. And also leads to anti-selection behaviour. Large proportion of the elderly likely to have existing chronic conditions.

LESSON FOR OTHER COUNTRIES:

Every country is unique and higher spends are not correlated to outcomes

No country can depend on the tried and tested model of any other country .Developed countries need all the more comprehensive plans for their health care needs. India is especially unique in all its needs so needs special plans. Health insurance is needed because in developing countries people mainly pay from their pockets and have to forego other important financial goals and aspirations

A word of caution

The pressure on insurance has to be decreased and expenditure in the more critical areas has to be increased. Usually no incentive is offered to people to take care of their health, speaker gave the example that 70% of the employees out of 5000 strength of his organisation had the family history of serious disorders like diabetes , hypertension and cancer.

Prepaid plans need redesign:

Issue	Cause
Over-utilization	• **Belief that more care is better** • **Consumer isolated from cost of healthcare as either insurance or govt. pays** • **Provider payouts not designed to manage the moral hazard of over-supply**
Lack of levers to manage demand for healthcare	• **Need to manage costs leads to focus on curative care and not preventive care** • **No "pricing for risk" reduces incentive for individual to manage health** • **Increasing lifestyle diseases**

Insurance:
Coverage for Unpredictable illness & injury .Premiums should be based on factors affecting the risk.

Savings:
It is meant for frequent, low value items .Chronic care as treatments, medicines are repetitive End-of-life and terminal illness care. Medisave account in Singapore, Health Savings Account in USA and South Africa are good examples of this system.

THE WAY AHEAD

Steps to improve coverage and to improve sustainability have to be taken .There definitely is light at the end of the tunnel , and the industry should continue with the efforts to bridge the gap between demand and supply.

TALK-4

PHARMACEUTICALS:Dr Chandrashekhar Potkar,Medical and Research Director,Pfizer

OUTLINE

1. A snapshot of pharmaceutical R & D
2. A case study of clinical research
3. Management lessons from R & D sector

A SNAPSHOT OF PHARMACEUTICAL R & D

The Scope of Pharmaceutical R & D lies in:

1. Drug Discovery
2. Biology
3. Chemistry
4. Preclinical – animal pharmacology & Toxicology
5. Clinical Research – human clinical trials
6. Registration
7. Post marketing research

Biopharmaceutical Companies' Investment in R&D is increasing steadily

In 2008, total industry spending on R&D was $65.2 billion

The main reasons of rising costs of Drug Development are –
Small Probability of Success
Drug Development Takes Longer -
Key Driver-Productivity Gap
Top Drivers for Outsourcing – To improve Speed, Cost, Market, Talent, Technology

- Clinical Research Process :
  1) Investigational new drug
  2) Study idea
  3) Investigators
  4) Regulatory approvals
  5) Ethics committee approvals
  6) Patient recruitment
  7) Trial management
  8) Data processing
  9) Medical writing

10)Regulatory

Clinical Research

Stakeholders – doctors, pharma, CRO, ethics committees, government, patients

Science, Society & Business

1) Healthcare interventions for unmet medical needs e.g. cancer, smoking cessation
2) Impact of process as well as outcome on healthcare
3) Execution, expertise based business

Evolution of clinical research:

- **Inception (Mid 1990s)**

1) Principle issue-availability of trained investigators, sponsors, ethics committees, regulatory agency
2) Onus on sponsors to train doctors, ethics committees and other stakeholders

- **Proof of concept (2000)**
  1) Conduct of international standard clinical trials in India
  2) ~ 50 clinical trial centers trained in GCP
  3) Data submitted to FDA, EMEA
  4) Ad hoc environment shaping
  5) *India Advantage for global development*

Evolution

- **Take off (2003)**
  1) Scale up in number of clinical trials and sponsors
  2) Potential-realization gap
  3) Explosion of CRO industry
  4) War for talent
  5) *Need to develop people (training in clinical research)*

- **Maturity (2008)**
  1) Execution as well as science
  2) India *vs.* China
  3) Industry-government partnerships
  4) Focus on tier 2 capacity building
  5) Perceptions management
  6) *India for India*

Management Lessons from Clinical research Industry

- **Inception**

- Entrepreneurship and new business opportunity
- Investments in environment shaping

India Advantage

- Strategy
  Industry competitiveness based on cost, quality & speed
- Execution
  Process
  Operations excellence

Take off

- Competition for people
  Focus on development, career paths, retention
- Service differentiation by CROs
  Niche services, end to end services

Maturity

- Country competitiveness:India vs China
- Growth opportunities - India specific development
  - Newer models
- Managing risks - Stakeholder partnerships

growth rate in CIS adoption in India

1. Explained how the chances of errors are much higher with paper documentation as compared to those with CIS and the criticality of such errors in Health Care Sector

   - Huge amount of data collected in last 3years which is the combined figure of 40,000 year
   - Large number of patients die in US hospitals every year due to medical errors which could be prevented through the use of CIS
   - Very less number of federal US hospitals use comprehensive electronic health record system

2. Explained how CIS can improve the value of care plotting a self explanatory graph with “RIGHT CLINICAL KNOWLEDGE” on X-AXIS and “ACCESS TO RELEVANT PATIENT CARE” on Y-AXIS and how the combinations of increasing levels of both result in “TRIAL & ERROR”, “EVIDENCE BASED”, and “PERSONALISED” forms of medicine in that order

3. Showed (pictures) the hospital set ups and record management systems that existed in earlier times (way back in 1935) and emphasized on why these should not exist now especially when there are all the technical advances available at our discretion

4. Brought to attention the prevailing inequality in per capita Dollar spending on health throughout the world and the comparatively miniscule spending in India(50 cents) and how CIS can help in utilizing these 50 cents smartly

5. Made aware of the per capita Dollar spending Emphasised on benefits of CPOE (which is a computer program to generate physician orders) and order sets in improving quality of care and drastically reducing the average length of stay(ALOS) and mortality- leap frog group

6. Shed light on how success of insurance in India (pay for performance model),which is also a rapidly growing industry, depends on the success of CIS

7. “India’s strength in Healthcare is growing” –beautifully explained and exemplified by the success story of our country’s telecom and railway industry

8. Compared the human efficiency levels of doctors with and without CIS-value of clinical decision support

9. Compared the local products with International ones in terms of features and usability and how OHUMVISTA is comparable with the best products available globally.

10. Clarified on what is the difference between EMR (encompasses: LABORATORY – IMAGES – PHARMACEUTICAL – LONGITUDINAL EMR) and a fully functional CIS which is much more than just EMR (encompasses: CPOE – CDSS – ORDER SETS – BCMA – CLINICAL WORK FLOWS – CLINICAL TRANSFORMATION) and how is it essential in increasing quality of care and patient safety levels

11. In the wake of several problems for adoption of CIS in India, at provider and institutional levels, strategies applied to solve these through OHUMVISTA were shared with the keen audience

12. The various drivers for CIS adoption:

    - Business drivers
    - CEO’s POV
    - Clinical transformation-outline of the clinical transformation plan and priorities for action related to the same

13. Various levels of CIS implementation: STAGE 0 TO STAGE 7

- STAGE 0: All three ancillaries not installed
- STAGE 1: Ancillaries—Lab, Radiology, Pharmacy
- STAGE 2: CDR, CMV, CDSS inference engine,
- STAGE 3: Nursing Clinical documentation (flow sheets),
  CDSS (error checking) PACS (Radiology)
- STAGE 4: Computerized Provider Order Entry
- STAGE 5: Closed loop medication administration
- STAGE 6: Physician documentation (structured templates),
  full CDSS (variance & compliance),Full PACS
- STAGE 7: Medical record fully electronic:
  Data interoperability

14. Briefly explained the role of VISTAOHUM as a solution to all the problems relating to the data building, preservation, retrieval and management

15. Apart from the very informative session, what students (of SIHS) acknowledged the most was the appreciation from Dr.Mullick for the talent that he got from this institute's pioneer batch (second year students of MBA-HHC 2007-09 batch, who will start working very soon on the project of **OUR COUNTRY'S FIRST REAL CIS APPLICATION)**

He also introduced the first year students who will join OHUM shortly as internees for their summer training

TALK -6

Manufacturing Industry – Mr Anjan Bose ,Senior Director & Business Head ,Philips Healthcare India, Sri Lanka, Bangladesh and Nepal & Philips Electronics India Ltd.

The talk was delivered in 2 parts- first one dealing with the Strategies acquired by Philips; the other one involving a case study.

Part 1 : Key Points:-

1) Healthcare is a people's business. To be sustainable, health organizations must communicate and connect with their customers through innovative approaches and fresh perspectives Customers & patients are becoming increasingly aware of their rights and choices.
2) Meaningful innovation & research- a must and is a double edged sword.
3) There exists a need to gain a deeper understanding of how people interact with and benefit from technology(interactive technology).
4) Manufacturing companies should try & provide the technology as well as make the ambience less intimidating in hospitals, which would make patients more comfortable and less anxious.
5) Clinical IT needs to emphasize on the need of Clinical Decision Support System with a deep understanding of disease pathways and user insights.
6) Post- operative care, emergency systems, remote monitoring systems, home treatment, chronic disease management to be improved upon.
7) Cost effective, simple, all pervasive & user friendly technology to be developed.
8) Responsibility of ownership – holistic consideration of patient needs.
9) Certain challenges encountered in healthcare:-
    a) Increasing prevalence of chronic diseases.
    b) Shortage of manpower (doctors , nurses to cope with the need).
    c) Increasing burden of lifestyle diseases.

10)The Philips care cycle approach provides significant business, organizational and personal benefits.

To name a few;

- Improved efficiency and productivity
- Patient Safety
- Improved Outcomes
- Better utilization of equipment
- Increase competitive position for your hospital

- Improved customer and staff satisfaction

Part 2 : Key Points (Case Study):-

1) Philips has had two acquisitions in recent past in India.
2) Steps involved in the acquisition comprise of three phases & areas of consideration.

Phase 1 – Information collection and synthesis

a) Economics outlook, Demographic shift, Shift in end-user demand pattern
b) Competitive landscape analysis along with analysis of the target company, intentions to acquire the company is the prime need.
c) Market analysis & segmentation of utmost importance.

Phase 2 – Strategizing and decision marking

a) Portfolio gap analysis: Current Vs. Future with a detailed evaluation of alternatives to target.
b) Option generation and evaluation- Due diligence important to identify the risks & assess the valuation & strategic fit.

Phase 3 – Execution

a) Implementation, Monitoring and feedback.

3) The gap between death rate (0.73%) and birth rate (2.6%) in India as well as the demand supply gap should be taken as an opportunity.
4) Ample scope for significant growth in value segment.
5) There is a need to make excellence a habit .

TALK -7

CONSULTANCY :DR. RAKESH KAPUR, Manager, Ernst & Young Consultancy Services

Dr.Kapur described the healthcare market with the help of the 3P model which E&Y has developed with FICCI. The 3p model attempts to describe the healthcare market with the help of 3 important components i.e Provider, Prevalence and Propensity. The following are the important points regarding the 3p model:

Prevalence:

High prevalence, likely to be higher than reported

Change in disease profile likely to drive the prevalence higher

Significant disparity between states & socio-economic classes in prevalence

Propensity:

3% of population slips below poverty line every year due to healthcare costs

Average cost of single hospitalization equal to > 6 months of average household income

Only 10-12% of Indian population is insured though growing at more than 35%

Provider:

Although India has 20% of global disease burden, we have 6% of beds, 8% of doctors, 8% of nurses & 1% of paramedics

Of the 13 Lakh private providers, 37% are unregistered providing little quality assurance

Next Dr.Kapur went on to describe the healthcare scenario in india with the help of this 3A model from the view point of the consumer. The 3A Model like the 3P Model describes the consumer needs for healthcare by following 3 points:

Accessibility:

Inadequate infrastructure

Regional disparity in India

Shortage of manpower

Assurance:

Unregulated and fragmented market

Lack of data or information systems

Affordability:

Inability to afford quality healthcare

Inadequate insurance penetration

Emergence of new diseases

Then with the help of statistical figures Dr. Kapur went on to show that there is a gross discrepancy between supply and demand for healthcare in india. The is a sizeable gap and this provides a good opportunity for healthcare providers in the country.

However in spite of an existing un tapped market both in urban and rural india, hospitals are unable to expand in a profitable manner. The hospitals provide an profitability of only 18% whereas the hospitality industry has a profitability of more than 22%. This makes investment in hospitality a better option than healthcare. Unless the profitability is more than 45% in any business then investment in that sector in not advisable.

Next Dr. Kapur explained that profitability of a hospital will depend on its business model. And the business model consists of the functional mix, the specialty mix, the service level, the service mix and the growth model.

The 5 elements of the business model were explained with the help of a flow chart.

Then the discussion went on to state that now days many small primary care units catering to niche markets are more profitable than large hospitals. Examples include Diabetic clinics and pain management clinics.

Dr. Kapur went on to state that the success of a hospital depend on its business model as well as its service positioning and choice of market segment. He explained that E & Y has developed a model to divide the healthcare market into different segments like cost leaders, lean differentiators, differentiators and Niche: Super specialty hospitals. This model has segmented the market based on value (Y axis) and cost/ price (on X axis). Based on this model the hospital must decide where they want to position themselves and which strategy they want to follow.

Examples included Arvind hospital catering to ophthatmology only, SPARSH hospital specializing in orthpaedics only.

Even though there is so much gap in demand - supply hospitals are still not able to maintain profitability when expanding: why?- it is because they are not able to replicate their mother hospital model in the new setting.

To explain this Dr. Kapur described a case study in which two hospital groups though has very profitable initial hospitals , they failed to generate profit when they expanded and built an identical hospital elsewhere as a part of their expansion plan.

These were actual hospitals who had approached E&Y for help.

E&Y had conducted their research and pointed out how the groups had failed to replicate the business model and functioning of their mother hospital in their new hospital and thereby had failed to create a profitable model.

Dr. Kapur pointed out the following points for evaluating the functioning of a hospital in relation to the parent hospital: business model, doctor engagement model, patient experience, brand management, growth plans.

If a hospital is expanding and building a new hospital under its brand then the patient must have identical experience in all hospital under the same brand.

Lastly Dr. Kapur went on to explain how the services of E&Y can help any help any hospital to grow and what all services are provided by the healthcare consultancy wing of E&Y.

Question Answer session followed by conclusion

Dr. Narottam Puri the anchor of the pre-conference symposium asked the speakers to join him on the dais and opened the session for questions from the audience.

The questions and their answers are as follows –

1. Addressed to Mr. B. K. Agarwala - The general perception is if you don't fall ill what happens to your premium. With ICICI's new health saver plan premium is still high so what about the affordability aspect?

   Mr. B.K. Agarwala said that we need to understand that health insurance is based on risk premium. This means that out of 1000 people if 50 fall ill then the rest 950 premiums are used to pay for those 50 people and vice versa. He also stated that the premiums are the lowest that an insurance company can afford to provide the services.

2. Addressed to Dr. Rakesh Kapur – For bench marking and brand building models, is it better to have a full time hospital Consultant Model?

Dr. Rakesh Kapur said that unfortunately this is not a one size fits all model as the individual needs of every hospital are different. But the model you will choose will depend on the following

a. Life cycle or maturity of the institutions
b. Maturity of the paying public in that area
c. Maturity of the consultant, you cannot compare a fresh pass out Dr to a Dr. Practising for 25 yrs.
d. Maturity of the speciality, this means that getting a skilled Neurosurgeon is more difficult than getting a skilled General surgeon.

Dr. Narrotam Puri said that the best option is having a variable fee model with riders.

3. Addressed to Dr. Narrotam Puri – According to the statistics mentioned by Dr. Puri in his slide 80% of the Dr's are in the private sector and in another slide it was said that 37% of medical practioners in rural areas were not registered medical practioners. So what are the steps taken by the private sector so that the patient reaches directly to a private sector or Registered Medical Practioner?

   Dr. Narrotam Puri said that the statistics stated were based on the results stated by government and private agencies. He added that it is not the responsibility of the private sector to educate against the non registered practioners. As far as the law is concerned the Unregistered medical practioners are illegal. Why government is not doing anything is their issue, one explanation could be that the government probably believes that some service is better than no service at all.

4. Addressed to Dr. Rakesh Kapur and Mr. Anjan Bose – The focus in hospitals is to reduce the average length of stay. The question is if the home healthcare industry is ready for the patients to be treated at home and what can the private industry do about it?

   Mr. Anjan Bose said that the number of hospitals and the number of beds per patient is very less. Simply put Home healthcare in India is unprepared. Philips recently acquired Respironics a company working in sleep disorders like sleep apnoea. Philips has chosen India as the key market and this service was launched in Goa. What needs to be done is to create market awareness and innovative programs like Sleep laboratories.

   Dr. Rakesh Kapur added that while home healthcare market has great potential the challenges are Technology, distribution and marketing.

   Dr. Narrotam Puri added that sanitation and hygiene will be a major challenge.

5. Addressed to Dr. Rakesh Kapur – While doing the assignment required for PGDHHM, it was noticed that there was a lag in designing of services and in the way the services are actually delivered which has resulted in patient being unsatisfied. Why this dissatisfaction?

   Dr. Rakesh Kapur said that patient satisfaction is the core of any hospital. Patient satisfaction is depended many factors right from admission till post discharge. The key is to find out the gap and address it.

   Mr. Anjan Bose added that the gaps need to be checked before implementation. Also in his view the gaps will be narrowed by accredations.

6. Addressed to Dr. Chandrashekhar Potdar – According to a survey conducted on the physicians in U.K. the results stated that only 23% of the medicines available are effective in treatment. Therefore logically 77% are not useful, so is there any way in which drug utility can be tested?

   Dr. Chandrashekhar Potdar said that Health technological assessment is necessary. He said that it was not enough for the drug to be safe and effective but it should also have pharmaco effectiveness. Unfortunately India is not implementing this. There is a need for development of Reimbursement Competency.

7. Addressed to all the members – Why Indian medical degrees are not recognised globally? What steps are to be taken to increase the credibility of Indian medical degrees?

   Dr. Narrotam Puri said that this was not the correct forum to discuss this issue. He said that India reciprocally had derecognised foreign degrees. However recently a MOU has been signed with 6 countries recognising their UG and Pg degrees.

8. Addressed to Dr. Rakesh Kapur –It is noted that Star hospitals in tier 1 cities are not replicated in tier 2 cities as star dr's do not want to shift. In this case how do we retain the quality of Dr's?

   Dr. Rakesh Kapur said that there is a need to build the star Dr's in tier 2 cities. Tier 1 Dr's can come and train the Dr'd in tier 2 cities. There after the trained Dr's have to perform well.

   Dr. Narrotam Puri added that while there are multiple elements to retaining star Dr's important are

   a. First to identify the problem

b. Good monetary compensation

c. Facilities for education of children

d. Entertainment and lifestyle

There has to be a work social balance.

Dr. Krishna Reddy added that we have to think beyond star performers. Changing the training guidelines for the staff. We have to face and treat the constraints.

9. Addressed to the panel – On Indian roads even a 1 lakh car has to be insured before it runs on the road but in India more than 85% of the population is not insured. Can we do anything about it?

   It was said that there should be greater awareness of trauma clause. Insurance companies per say are not responsible. However government needs to be more stringent. Government responsibility of health for all should be converted to cover for all.

10. Addressed to Mr. B.K. Agarwala – Why 24 hour prior admission required for insurance claims?

    This time clause has been removed by majority of the insurance companies. The intent behind the time clause was to not cover the opd procedures.

11. Adddressed to Mr. B.K. Agarwala – Has the addition of TPA's raised cost of insurance premiums?

    Mr. B.K. Agarwala said that TPA's are only the outsourced arm. It is cheaper for the insurance companies to get their work done through TPA's. So there is no effect on premium rates.

Summary and Conclusion by Dr. Narottam Puri

1. On Dr. B. Soma Raju and Dr. Krishna Reddy

   They explained what healthcare is all about. The core elements are Affordability, Accessibility and Reliability.

   Care works on passion a quality that does not appeal to equity shareholders. For care the patient comes first.

2. On Mr. B.K. Agarwala

He spoke about the way forward in health insurance The problem areas in Indian scenario are

a. Large aging population
b. Increase in lifestyle diseases
c. Lack of standardisation
d. Tussle between payer and provider
e. Lack of data

3. On Dr. Chandrashekhar Potdar

   Clinical research has huge potential in India. Speed,cost. Market, talent and technology in India contribute to a good outsourced industry for clinical research.

   Difficulties are that the cost of developing a new drug are increasing considerably.1.75 billion dollars required for 1 drug development.

4. On Dr. Aloke C Mullick

   It is very important that Indian healthcare brace IT. The quantity of space saved will be huge. CPOE is the biggest tool available to reduce prescription errors.

5. Mr. Anjan Bose

   Philips is an innovator. There has to be a change in relationship from vendors to partners.

6. Dr. Rakesh Kapur

   There is a huge opportunity for healthcare consultancy in India. He was impressed with the explanation of why hospitals are not profitable and if profitable why not replicable and where they are going wrong and what needs to be done.

TALK 8:

Future of Hospital Designing: Dr.Vivek Desai MD, Hosmac & Ms. Nandini Shah

Speaking on the hospitals of future, Dr Vivek Desai said that hospitals will be technologically intensive, sensitive to energy needs. There should be patient friendly environment. Today India has large public and private sector which are very diverse in their needs and functioning, therefore the infrastructure demands are varied. Accreditations focus on patient safety and hence these should be kept in mind while designing hospitals. These factors overall increase the cost of infrastructure and hence the project will require sound financial planning.

On the need for careful planning, he said that the investments would be a long term and at present there are no standards for hospital engineering in India. The growing sector of medical tourism will necessitate emulating global benchmarks. Hospitals are highly engineered and doctors are not too conversant with the various architectural integrities. The construction of a hospital constitutes more than 50% cost of the entire hospital projects.

Hospital concept and development

- Project conceptualization starts with a very important aspect of market research. There should be a selection of appropriate facility and bed mix. There should be scope for phased growths and future expansions and the whole process should have realistic cost estimates, expenses etc. Sensitivity analysis also a “what if” analysis should be undertaken to understand risk factors. These should be compared with industry benchmarks. This was explained by taking an example of a Project for 200 bedded Children’s Hospital where by conducting the sensitivity analysis they could conclude that Capex Requirement: Rs. 40 Cr. for Phase I(150 beds) & Rs. 20 Cr (50 beds). for Phase II, Revenue from built up capacity in the initial years is not enough to cover the operating costs. This is natural for such projects. Sensitivity is moderately high for volume of charity. Sensitivity is high for the utilisation factor. Sensitivity is also high for incidence of interest bearing funding

Designing for future

Functions change so rapidly that designers should no longer aim for an optimum fit between building and function. The real requirement is to design a building that will inhibit change of function least, and not one that will fit specific function best. He said there has been a shift of the process of healing from “treating illness” to “creating wellness”.

Talking about the diverse needs of various establishments he gave an example explaining that a medical college campus needs almost 25 acres of land while corporate

hospitals would require approximately 1000 sqft / bed, highly engineered and centralized AC etc.

While planning the architecture, due importance should be given to sunlight, wind directions, rain beating, peak temperature etc. one should understand the ‘ law of the land’ for building regulations. The plan should cater for flexibility in the building design for any future alterations. He discussed the pros and cons of flat slab Vs grid slab like though a flat slab give enormous convenience in planning the layout very limited modifications can be made later on, span of the grid, use of steel structures and importance of interstitial spaces. Further expanding into Air conditioning planning, he talked of maintaining quality, type of system, location of units and high recurrent costs. Electrical systems, their backups, CCTV surveillance, PACS, access control systems and tele-medicine all were highlighted as having immense futuristic potential.

With regards to plumbing system of the future, he mentioned the requirement of water and sewage treatment plants, reverse osmosis for dialysis, water harvesting etc.

The Planning grid – Importance for flexibility

The demand of QUALITY healthcare is on the increase. High QUALITY health infrastructure is the enabler for a modern and efficient healthcare system. A modern healthcare system is not only beneficial to the individual citizen and their quality of life, but also one of the building blocks for economic development of the region and country as a whole

Impact of Grid design in the future - Compact design solutions is the need of the hour owing to the rising scarcity of land. Planning Grids are the best possible solutions as they provide optimal space within and also avoids wanton use of spaces. It provides with ample flexibility for future expansion. It allows the vertical and horizontal circulations to work in tandem which is important in any healthcare facility. Planning grids also form the base for structural grids which then relates to service routing. A proper planning grid will help the structure function efficiently.

This was explained by many floor designs, the design constraints affecting layout and flexibility, and various innovative ideas incorporated.

Talking about green building concept the challenge was to reach a point where green architecture is indistinguishable from good architecture. A Green building is one that is environmentally responsible, profitable and a healthy place to live and work

The major benefits that any Hospital can achieve by making the hospital building Green are:

1. Resource conservation
2. Energy optimization
3. Water conservation

4. Renewable energy
5. Effective waste management and recycling techniques

These were explained with examples like solar heaters for hot water, solar power for garden lights, waste management and recycling, integration of natural light and artificial light. Use of energy conversation methods like reducing ingress of heat and by allowing good penetration of daylight. Energy savings were said to be approx 35%-40%. The use of recycled material like fly-ash bricks etc were pointed out.

Planning for Operational Efficiency & Technology Interface

The present day hospitals should have provisions for the physically challenged, some features were elaborated upon like

- Provision for railings easily defined for the use by the physically challenged
- Ramp provision to the entry / exit of the structures.
- Assisted toilets for use by the physically challenged.
- Inpatient rooms with toilet and bath areas with grab rails and spaces for wheelchair movement.
- Alcoves for provisions of wheelchairs for easy use.

The use of aesthetics and colors are an integral part of hospital designing. Some practical points like warm or cool colors in lighter hues and tones and their smoothening effects were told. The importance of outside view to avoid ICU Psychosis, visibility from nurse station, hand washing facilities etc was elaborated. Creating a patient friendly environment by allowing easy movement of bed, remote controlled operations, pediatric play area, foot light at night and day spaces for relatives were mentioned.

Due points were also raised regarding safety in healthcare, their importance in JCI and NABH accreditation were pointed out.

Intelligent building

The current scenario in futuristic hospital design includes

1) Use of BMS like managing air conditioning systems, intelligent elevators, controlling lighting systems and automatic water pumps
2) Use of PACS which will facilitate ease of clinical information relay, filmless/paperless hospitals, minimizing time for reports, superior image quality, helps in clinical research, telemedicine made easy and easier data management.

The architects role in this are:

- To maintain an empathy with the user of the space and to design spaces accordingly. The human factor with core clinical functionality.
- Patient care is paramount. Design will always be subject to this basic parameter.
- Design to be modular if possible for areas that require duplications of functionality.
- The overall scheme should always be flexible with scopes of future requirements thought about at the basic design level.

In conclusion both the speakers said “Growth is inevitable”. Rising requirements will imply similar rise in space constraints. Hospitals should be designed with the future as a vision. Technology will always improvise and hospital design should keep pace with it. Compact well planned hospitals are the need of the world.

TALK -9

MEDICAL VERSUS NON MEDICAL MANAGERS

Dr Narottam Puri
President-Medical Strategy and Quality Fortis Healthcare Limited

Flow of Presentation

1) Highlighted the disconnect between CEOS and physician leaders.
2) Equated the conflict between hospital administrators and their medical staff with actual battles for the soul of the hospital.
3) Established the fact that the conflict was seen mostly in 'FOR PROFIT' institutions.
4) Explained how doctors view administrators as being slow in decision making whereas administrators view doctors as impatient, too direct and impractical.
5) Talked about Doctors'/Clinicians' perspective- Administrators are responsible only to their employers with no obligation to serve the public good. Their attempts to deliver ideal care is strained by paperwork that they view as intrusive and valueless and by the need to seek permission to use resources.
6) Administrators' perspective- Physicians don't understand and don't want to understand costs, cost-quality and value for money imperatives. Their quest for " best patient care" might not always be most profitable.
7) Explained reasons for this conflict- Development of attitudes as a result of training the physicians undergo
   a) Medicine encourages individual accomplishment above teamwork.
   b) Physicians think in terms of individual success.
   c) Physicians are often trusted more than other professionals.
   d) Nurses, doctors and other professionals rarely have an opportunity to practice together as a team.
   e) Aptitude for teamwork is never emphasised upon them.
   f) Medical education prepares graduates to make challenging, time sensitive decisions which are often irreversible with no clear favourable outcomes.
8) Had a word over physicians expectations
   a) Availability of finance to purchase equipment and hire trained manpower.
   b) Ability of to get competitive market rates.
   c) Opportunity to make money.
   d) Need for greater time for research and education and less time for administrative hassles.
   e) Sense of belonging and collegiality in Department and Institution.
   f) Better work life balance.
   g) Stake/Say in running the institute.
9) Talked about the things that administrators look forward to
   a) Name, talent and ability.
   b) Time and capacity to do the amount of work required.

c) Commitment to quality.
d) Leadership qualities.
e) Alignment with the vision of the institution.
f) Understanding financial constraints.

10) Through each other's eyes –Physicians' view
a) Administrators are insulated from the real pressure of patient care.
b) Administrators don't understand how hard the doctors are working
c) Administrators are paid for non-productive work, like sitting around in meetings
d) Cost is the primary concern
e) Administrators focus only on problems rather the solutions
f) Administrators don't get out from behind their desks often enough to see what's really going on.

11) Through each other's eyes –Administrators' view
a) Physicians fail to see the broader picture laying too much importance over what they see from their own perspective.
b) Physicians don't attach a sense of urgency to accomplish administrative tasks.
c) Physicians are unwilling or uncomfortable when it comes to peer confrontations.
d) Physicians in the front line often have hard time coming to a group decision.
e) Physicians function as if other healthcare workers are less valuable

12) Had a look into the possibility of physicians as Executives / Administrators- Leadership traits like honesty, passion and compassion are inherent in physicians but at the same time only a few possess technical competencies like strategic planning, financial/economic knowledge and organizational principles.

13) Talked about the major roles & areas of physician executive

a) Technical Advice
b) Strategic Director
c) Tactics for Success
d) Negotiating Conflict
e) Bridge between Medical & Business

14) Gave his idea of prerequisites to be a good physician executive
a) Clinically Competent
b) Maturity
c) Good People Skills
d) Leadership Skills
e) Status

15)Suggested his idea of a recipe for success

a) Credibility
b) Communication
c) Maintenance of skills in both words

16) Possible reasons of failure/Hinderances

a) Job descriptions are not well crafted.
b) Expectations not clear.

17) Had an interactive session with the audience over
Should there be a medical CEO and if yes
What should the qualifications of the medical CEO be:

- Pure medical
- Medical + MBA (or equivalent)
- Medical + Experience in running a hospital

18) Summed up the basic differences between a physician leader and a business leader and compared the pros and cons of each

PHYSICIAN LEADER	BUSINESS LEADER
Intellectually analytical	Intellectually empirical
Autonomous Working	Team Oriented
Emotional Detachment	Emotional Engagement
Think & Act Quickly	Move slower, thoughtfully, deliberating, considering options

OVERVIEW OF LAWS RELATING TO HEALTHCARE

Chairperson of the session – Adv. Ram Jethmalani

Speakers – Dr.Nikhil Datar, Dr. Sanjay Gupte.

According to both the doctors the objective of the talk was to make a fruitful discussion on making a change in the existing legal system of India towards trying to make it

--more safe.

--more transparent .

--better in quality.

PROBLEMS IN THE INDIAN MEDICO –LEGAL SYSTEM:

-our laws are mainly made a kneejerk reaction without any retrospective thoughts.

- before creating and attempting to implement a new law it is not ensured that the people implementing it are serious and efficient.

-less than required use of common sense to round off angularities of laws and rules, both before and after their formation.

SOLUTION:

Organized profession and constant vision [farsight] over the entire legal system.

-consorted effort is needed.

The main body for medical doctors in India is the MCI, which is autonomous body

There are some voluntary organizations such as the IMA, FOGSI.

SOME OF THE LAWS WITH WHICH SOME DOCTORS HAVE ISSUES:

PCPNDT ACT:

-some doctors find this law uselessly bothering them a large number of times. for example at times even issues such as not filling forms properly according to the strict guidelines of the law lead to imprisonment of the concerned doctors.

-the solution to these issues was provided by Sir RAM JETH MALANI [the chairman of the session] was that the doctors should provide the lawmakers with a list of the minor and unimportant issues which they want to be dealt with in a linient way.

-insignificant irregularities should be identified .

-though the doctors agreed that the misuse of the various laws was also very rampant.

LAWS RELATED TO EUTHANASIA:

-it should be clearly mentioned as to who and when should it be decided to put off the ventilator.

GENERAL VIEW OF MEDICAL FRATERNITY TOWARDS THE LAWS RELATED TO MEDICAL PROFESSION:

-most doctors say that the laws have a paternalistic attitude .i.e almost all the responsibility is put on the doctors and later on all the blame also comes on the doctors shoulders .

-doctors find this practice regressive because in medicine guarantee is not always possible.

-the laws should be made more rational ,with more practical applications.

-build proper and good public opinion about the various laws from the time these laws are being considered to be formed .

-laws against attacks on doctors should be implemented all over India.

-laws about cross –speciality practice should be put in place properly.

-there should be clear cut guidelines about various types of consent ,especially implied consent.

The topics discussed were as follows –

1. The problems faced due to the lacunae in laws governing healthcare.
2. How healthcare related laws are framed?
3. Why Dr's are fragmented and why there is no single opinion making body for healthcare providers?
4. PCPNDT act, its loop holes, how it is used to trouble Dr's and why FOGSI is opposing it.
5. Changes needed in the Maharashtra Medical Council act over nominated members.
6. Who decides to take the patient off the ventilator? The role of Human rights commission in the same.
7. MTP and the amendments needed especially in cases of congenital anomalies detected in later stages of pregnancy.
8. EMS and laws related to it.
9. How to deal with rioting relatives?
10. Consent and its santity.
11. Specialist and super specialist and cross speciality practice

12. Need for MCI recognised courses for additional skills like endoscopy, laparoscopy etc .
13. Medical Negligence and Medical autopsy, who is the right person to comment.
14. Consent and importance of written consent.
15. Audience opinion on Consent, rioting patient relatives and medical autopsy.

There was a healthy discussion on the above mentioned topics where in the following important points were noted –

1. There should be more transparency in healthcare procedures.
2. Laws related to healthcare should not be based on a knee jerk reaction without proper introspection. Experienced people are required for intelligent implementation of the law.
3. MCI is the main governing body for Dr's. But it hardly does anything worthwhile for the Dr's. There is apathy on part of Dr's to register in voluntary organisations like FOGSI and IMC. There is no consorted effort which has resulted in fragmentation and no supporting forum.
4. PCPNDT act should not be imposed by dictatorship. The Dr's should not be harassed unnecessarily and the forms to be filled should not be time consuming. The law should not be misused or abused against the Dr's.
5. The attending Dr should have the right to decide if the patient should be taken off the ventilator.
6. If there is a danger to a woman's life and injury to public interest MTP should be allowed in later stages of pregnancy also. The FOGSI should fight for such clauses to be included in the MTP act.
7. In India EMS is the weakest and we need to strengthen the role of paramedics and the emergency medical services network available.
8. Maharashtra Ordinance law which was recently passed to protect Dr's and hospitals against rioting relatives is a law made to please the Dr's as by law trespassing is a criminal, non bail able offence. There is a need for social resistance against these activities.
9. Written consent is necessary to protect Dr's interest but in case of life saving procedure such as tracheostomy or intubation implied consent can also be taken to reduce waste of time.
10. Regarding Medical autopsies, the MBBS Dr's are trained to find out immediate cause of death.

OUTSOURCING OF HEALTHCARE- Emerging trends & opportunities

Dr Pradeep Bhardwaj, COO; Ojjus Medicare Group of Hospitals, Delhi

He emphasized that Healthcare Management is the toughest and the most challenging.

- **WHY TO OUTSOURCE?**

- To maximize your revenues
- Concentrate on the core area
- To save money
- To save time
- Reduce operating costs
- Make capital finds available
- Share risks
- Cash infusion

- The punch line was when he explained the dynamics of Outsourcing with the movie Sholay, where Thakur outsourced killing Gabbar Singh to Jay and Veeru.

- **OUTSOURCING**

- Is big business and is the sunrise sector in healthcare

- India is a good ground for outsourcing because it is the skill capital of the world with high quality at low cost. It has favourable government policies for healthcare.

- Outsourcing helps in

- Saving cost
- Bringing new and faster solution to customer
- Surpassing competitors
- Entering new markets
- Focusing on core competencies
- Improving quality

- **ABCD** of Outsourcing

A- Alignment: is it the right move?
B- Business Case: taken all costs into consideration?
C- Culture: can you bridge the differences between your company and outsourcer?
D- Delivery: how to define success?

- **TYPES OF OUTSOURCING**

- Business Process Outsourcing (BPO)

- Knowledge Process Outsourcing (KPO)
- Legal Process Outsourcing (LPO)
- Research Process Outsourcing (RPO)
- Human Resource Outsourcing (HRO)
- Medical BPO (MBPO)

➢ The most common industries where outsourcing is useful and prominent are;

- Diagnostics
- Billing
- Housekeeping
- Biomedical Waste
- Security
- Kitchen
- Pharmacy
- Medical Tourism
- HR

➢ **SUCCESS OF OUTSOURCING DEPENDS ON**

- Understanding of company goals and objectives
- The right vendor selection
- Structured contract
- Two way communication with the affected groups
- Senior executive support and involvement
- Financial justification

➢ **ADVANTAGES**

- Better cost management
- Reduce expenses
- Focus on core strength
- Save time
- Stability of services
- Share business risk

➢ **DISADVANTAGES**

- Dependency
- Lack of control
- Risk of exposing confidential data
- Lack of customer focus

➢ **OUTSOURCING IN HR**

It is important because

- Deadlines are missed
- Recruiting needs more focus
- HR staffers are angry
- Employee relations are suffering
- Everyone is on the same page about what to outsource

Some other points of consideration are

- **QUALITY CONTROL**
  Maintenance of quality is important.
- **OPPORTUNITY**
- Develop skills to anticipate opportunities and be prepared to
  The staff should be rewarded and respected for their contribution in the success of the organization.
- **NEVER SHOW ALL YOUR CARDS**
  This is a strategy to ensure that the top management stays interested in your work.