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NITI Aayog

Study on the

Not-for-Profit Hospital

Model in India

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Foreword

India's policies and programmes are aimed at achieving Universal Health Coverage by 2030. With a population of about 1.38 billion and counting, India has an ever-increasing need for healthcare services. Although multiple efforts across different areas spearheaded by the Government are meeting this vast need, statistics available in the public domain reveal a significant gap in the accessibility and availability of healthcare across all segments of the population. The private sector plays a significant role in bridging the gap in healthcare availability; however, it usually faces the challenge of providing affordable care to a large section of the population, while ensuring its own sustenance and efficiency.

The "Not-for-Profit" Hospital Sector has the reputation of providing affordable and accessible healthcare for many years. This sector has done yeoman service over the years with some institutions from even before Independence. Although various institutions have been established for different purposes, this sector provides not only curative healthcare, but also preventive healthcare, and links healthcare with social reform, community engagement, and education. They utilize the resources and grants provided to them by the Government to provide cost effective healthcare to the population without being overly concerned about profits. However, this sector remains largely understudied, with a lack of awareness about its services in the public domain.

The aim of this study is to understand the operating model of some of the prominent institutions across the country, including their premise of service, human resource availability, cost containment levers, and the challenges they face. This study will facilitate policymakers in deciding how they can assist this sector to sustain, grow, and in turn, help reach the unreached sections of society.

Dr. Vinod K Paul
Member, NITI Aayog

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9.	Mr. Joy Chakraborty	Chief Operating Officer	PD Hinduja Hospital, Mahim
10.	Dr R V Prabhakara Rao	Chief Executive Officer	Basavatarakam Indo-American Cancer Hospital, Hyderabad
11.	Mr. M Abdunnasir	General Manager	EMS Memorial Cooperative Hospital, Perinthalmanna

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Designed by yaap

List of Abbreviations

ABPMJAY	–	Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana
CAPEX	–	Capital Expenditure
CBC	–	Complete Blood Count
CGHS	–	Central Government Health Scheme
CMC	–	Christian Medical College
CMCHIS	–	Chief Minister's Comprehensive Health Insurance Scheme
ECG	–	Electrocardiogram
HACCP	–	Hazard Analysis Critical Control Point
ICU	–	Intensive Care Unit
IPD	–	In-patient Department
ISO	–	International Organization for Standardization
MGIMS	–	Mahatma Gandhi Institute of Medical Sciences
MJPJAY	–	Mahatma Jyotiba Phule Jan Arogya Yojana
NA	–	Not Applicable
NABH	–	National Accreditation Board for Hospitals and Healthcare Providers
NSS	–	National Sample Survey
OHSAS	–	Occupational Health and Safety Management Systems
OPD	–	Out-patient Department
OPEX	–	Operational Expenditure
ORIF	–	Open Reduction Internal Fixation
PNDT	–	Pre-Natal Diagnostic Techniques
PPP	–	Public Private Partnerships
PSUs	–	Public Sector Undertakings
TUV	–	TUVRheinland
USG	–	Ultrasonography

Contents

1 Background

In the recent past, the NITI Aayog has been endeavoring to study the Private Sector Healthcare Delivery landscape in India to ascertain the reach of quality healthcare, the health seeking behavior of the masses, and the healthcare expenditure borne by patients, through various studies. The studies revealed the lack of penetration of quality healthcare, especially among the economically weaker sections of society in both urban and rural areas. During these studies, the work done by the private not-for-profit hospitals came up for reckoning. There were many examples of commendable work being done to provide quality healthcare to the unreached at low cost; however, all these examples were in silos, and unknown to the larger section of the community. This prompted the need for a targeted study to gain a crisp and structured understanding about the not-for-profit hospital model in India.

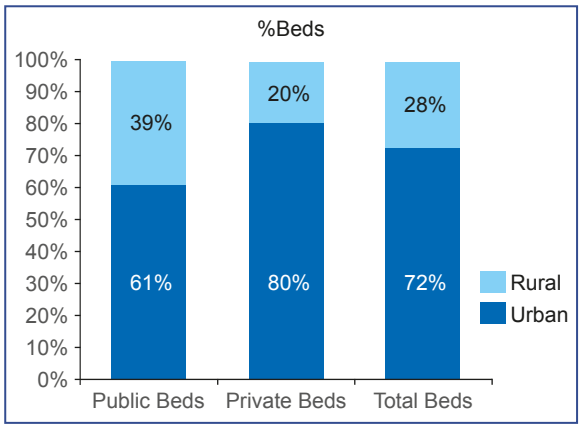


Fig.1: *Breakup of Hospital beds in India*

Source: *World Bank, NSS 75th round, NHRR, IMS study.*

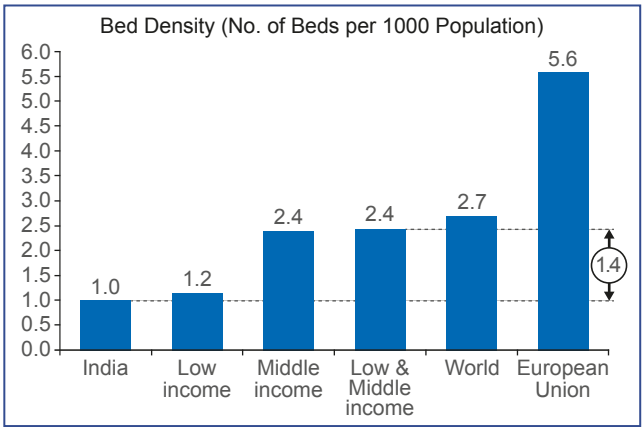


Fig.2: *Bed density (number of Hospital beds per 1000 population) in India compared to other parts of the world*

Source: *World Bank*

Despite economic growth and modernization, India continues to face significant challenges of unavailability and unaffordability in healthcare services. This is substantiated by the fact that India has a lower Bed Density than the rest of the world (Fig.2).

In addition, existing hospital beds (Fig.1) and hospitalization services have a high level of concentration in urban areas, which in turn impact the accessibility and affordability of hospitalization services.

The not-for-profit hospitals currently account for only a miniscule share of hospitalization cases (Fig.3).

Public hospitals that offer healthcare at negligible cost are overstretched. The burden of healthcare provision shifts to private hospitals, which generally offer healthcare at a higher cost to the patient, as they must sustain themselves.

Private hospitals are largely divided into "for-profit hospitals," which account for 23.3% of treated ailments and "not-for-profit hospitals," which account for only 1.1% of treated ailments, as of June 2018. (Fig.3). The disparity is further revealed in terms of hospitalization cases (Fig.4), wherein the for-profit hospitals account for 55.3% of in-patients, while the not-for-profit hospitals account for only 2.7% of in-patients in the country, according to the findings of the NSS 75th round survey on Health in India.

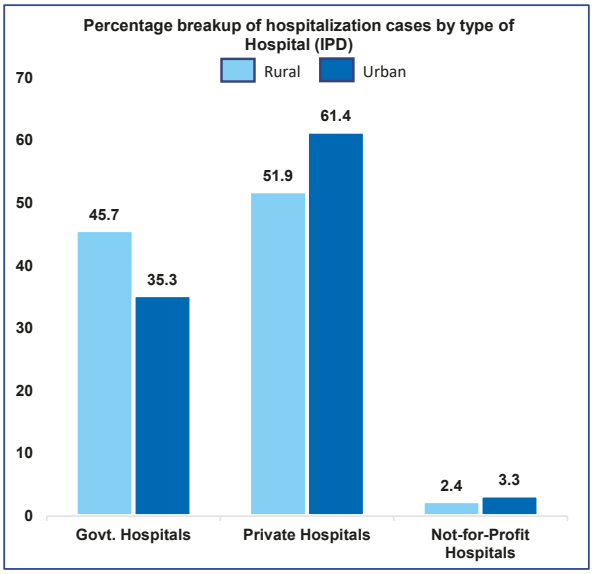


Fig.3: *Percentage of IPD Treatment*

Source: NSS 75th round survey

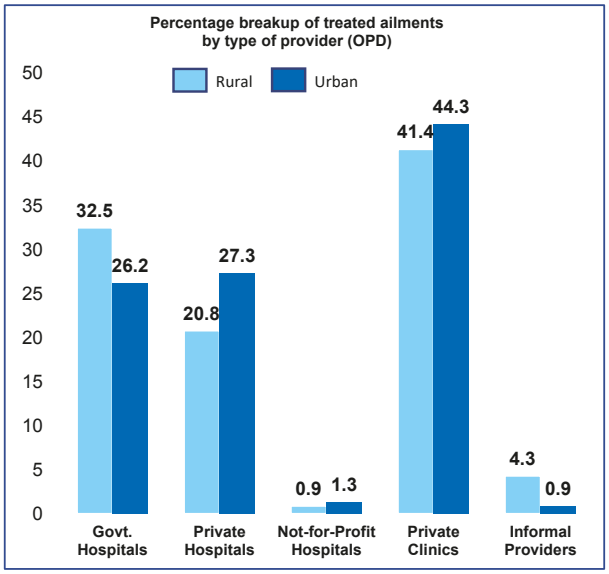


Fig.4: *Percentage of OPD Treatment*

Source: NSS 75th round survey

A not-for-profit hospital does not make profits for its owners from the funds collected for patient services. The owners of these hospitals are often charitable organizations or non-profit corporations. The fees for service at these hospitals are generally lower than for-profit hospitals and the income from fees (above the cost of service) are reinvested in the hospital. These hospitals are a potential remedy to the challenges of unavailability and unaffordability of healthcare in India. The infrastructure, services, and charges of these hospitals are positioned to cater to the unreached and underprivileged population of the country. In addition, these hospitals have managed to create a perception of goodwill in the country not only through selfless healthcare services with a social cause, but also through various community engagement programs for education, vocational training, hygiene, sanitation, women's empowerment and employment.

Despite their limited presence, which is seen disproportionately in Western, Southern and North East India (Fig.5), the not-for-profit hospitals have a disproportionate impact on the local communities they serve.

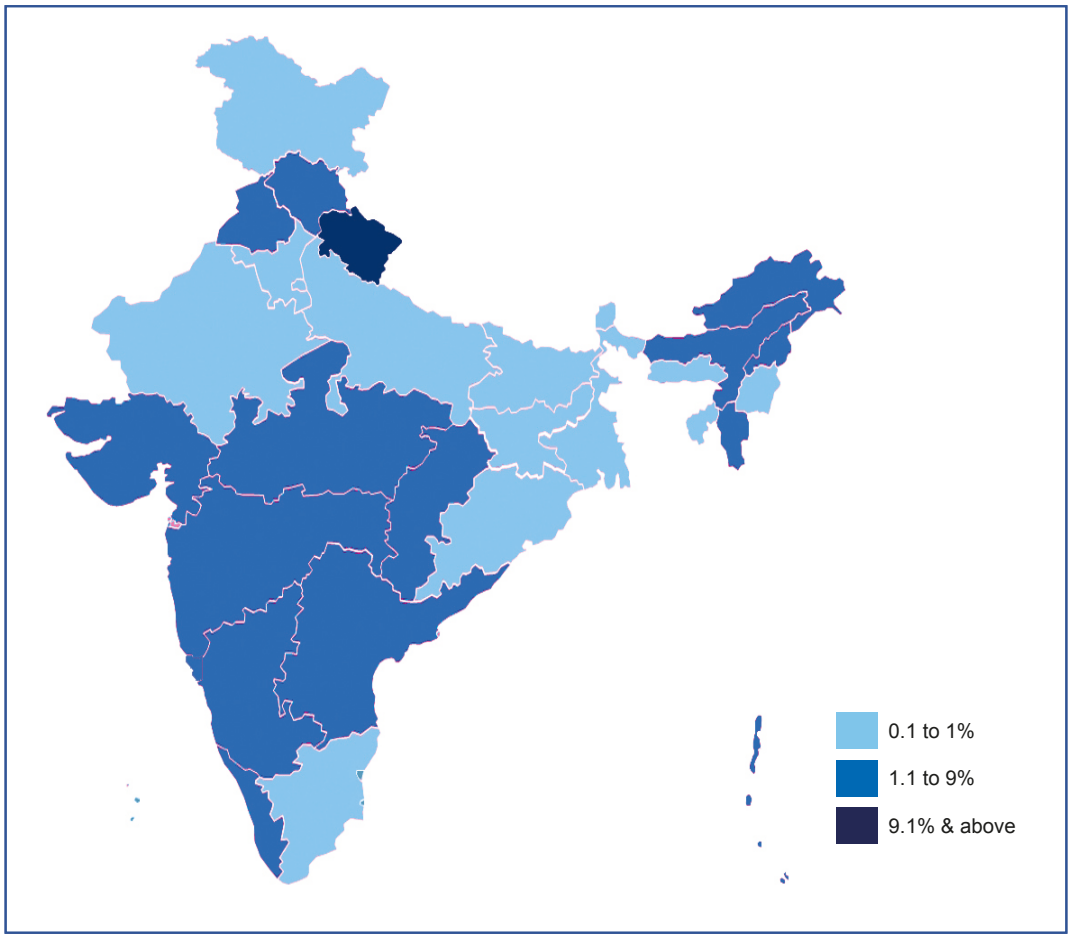


Fig.5: *Percentage of treated ailments (OPD) by Not-for-Profit Hospitals state-wise*

Source: *NSS 75th round survey*

2

Objectives

The not-for-profit Hospital sector remains a largely understudied sector in India with very less specific information available in public domain. Thus, this study aims to achieve the following objectives:

- To document the dynamics of operations of prominent not-for-profit hospitals in the country
  - Are these hospitals providing low cost care?
  - Are these Hospitals providing acceptable quality of care?
  - What are the various levers that help them offer low-cost, high-quality care?
  - What are the best practices of these Hospitals that can be replicated?
  - What are the challenges that these hospitals face?
- To suggest policy interventions to promote this sector
  - How can these hospitals become publicly more visible?
  - How can these hospitals become operationally more viable?
  - Can their expertise and network be leveraged to improve healthcare service delivery in Tier 2/ 3 cities and rural areas?
  - How can these hospitals associate in a better way with Government schemes?

3

Approach

The following approach was conceptualized to complete this study:

i. Categorization of the prominent not-for-profit hospitals based on the premise of services and their ownership

Detailed primary and secondary research on prominent hospitals was used to arrive at reasonably clear categories in which these hospitals could be classified. This categorization would be useful to understand the vision behind the establishment of these hospitals and the guiding force behind them.

ii. Understanding the business model of the hospitals

In addition to the basic understanding of these hospitals, the intent of this study is to understand the operating model of these hospitals, along with the financial viability, and their dependence on donations and grants for meeting their operational needs. This study also attempted to understand how these hospitals have managed to keep their costs lower than their peers and the focus on quality across these hospitals.

iii. Understanding the challenges faced by these hospitals

Another important objective of the study is to understand and classify the challenges faced by these hospitals in terms of criticality and universality on a day-to-day basis and the factors limiting the growth of this sector in the country

iv. Formulation of recommendations for policy interventions to promote the sector

Based on the information gained from the above-mentioned aspects, the intention is to ascertain and propose targeted interventions, which will not only mitigate the challenges faced operationally, but also provide insights for the overall growth of the sector from a strategic perspective.

4

Criteria for Classification of Hospitals

Using the above-mentioned approach and secondary research, the following four categories were defined for the not-for-profit hospitals (Table 1):

- Faith-based Hospitals
- Community-based Hospitals
- Cooperative Hospitals
- Private Trust Hospitals

a. Faith-based Hospitals

These hospitals work on the premise that selfless service to the society is done as service to God. A noteworthy feature of all major faiths has been their emphasis on charity and sharing wealth with others, especially the poor. Throughout the ancient and medieval periods, voluntary activity found its natural expression through religions institutions. This concept further accelerated with the advent of western influence and presence in India. Individual missionaries or religious trusts have founded many such hospitals based on the principles of religions or deities.

The salient features of the operations model of these hospitals are as follows:

i. Large number of general wards where underprivileged patients pay minimal costs and receive full/partial charity when required.

ii. Few private wards, where affording patients pay slightly more than basic costs.

iii. Some hospitals even provide free services to all patients.

iv. Most such hospitals provide Secondary-Tertiary level of care, while some even provide Quaternary care.

v. Economies of scale through high volumes allow low cost of care and internal cross-subsidization in services.

vi. Doctors and staff sacrificially volunteer to serve for salaries, which are about 50% or more lower than other hospitals.

vii. These majorly serve in remote areas, where there is negligible penetration of quality healthcare. They engage the local population through various projects focused on health and sanitation education, empowerment, vocational training, and so on.

viii. The capital expenditure, and at times, operational expenditure is funded by generous donations from devotees or from funds accumulated by the trusts.

b. Community-based Hospitals

These hospitals are not necessarily influenced by any faith but operate on the premise that selfless service to the underprivileged will result in all-round social reform. Highly motivated doctors, or a team of likeminded doctors, desiring to give back to society, have founded many such hospitals, often in the same community where they were born/raised.

The salient features of the operations model of these hospitals are as follows: -

i. Large number of general wards, where underprivileged patients pay minimal costs and receive full/partial charity when required.

ii. Few private wards where affording patients pay slightly more than basic costs.

iii. Economies of scale through high volumes allow low cost of care and internal cross-subsidization in services.

iv. These hospitals mainly provide secondary-tertiary level of care.

v. Doctors and staff volunteer to serve for salaries that are about 50% or more lower than other hospitals.

vi. These majorly serve in remote areas, where there is negligible penetration of quality healthcare. They engage the local population through various projects focused on health and sanitation education, empowerment, vocational training, and so on.

vii. The capital expenditure, and at times, operational expenditure is funded by generous donations from philanthropists or from Government grants.

c. Cooperative Hospitals

These hospitals are set up on the premise of self-sufficiency in healthcare by self-participation. They believe that quality healthcare at an affordable cost (commensurate to the locality of the hospital) is a right of all citizens and can result in the overall benefit of both the hospital and its patients.

Individual doctors or a likeminded team of doctors convinced of the same philosophy, have founded many such hospitals.

The salient features of the operations model of these hospitals are as follows:

i. They invite patients and their families to pay a membership fee – either annual/ or lifetime/ or through purchase of hospital shares/ or as a hospital-run insurance scheme, through which the members obtain substantial discounts in out-patient/ in-patient treatment, investigations and medications.

ii. They give priority in non-emergency services to the patients enrolled as members.

iii. They engage the local population through various projects focused on health awareness and education, camps for senior citizens, and vulnerable citizens.

iv. They engage in marketing and fund-raising activities to increase the number of members.

v. These hospitals mainly provide secondary-tertiary level of care.

vi. They have a designated Indigent Patient Fund for treatment of non-affording patients based on documentary verification.

vii. Treatment for the members is cross subsidized by the treatment of non-members who are charged slightly lesser than the market rate but higher than the charges for the members.

viii. Their capital expenditure is funded by the corpus membership fees and by donations received from philanthropists.

d. Private Trust Hospitals

These hospitals operate with the premise of no profit and no loss and are primarily located in Tier 1/ Tier 2 cities. Famous businessmen/ philanthropists/ politicians, have founded many such hospitals in response to social causes based on individually observed needs.

The salient features of the operations model of these hospitals are as follows:

i. They have highly advanced infrastructure with the latest technology.

ii. They provide high-quality care at slightly less or at par with market rates to all patients.

iii. They have a designated indigent patient fund for the treatment of non-affording patients based on documentary verification.

iv. Most such hospitals provide Secondary-Tertiary level of care while some even provide Quaternary care.

v. The model involves a Robin-hood concept, wherein the affording patients cross-subsidize the non-affording patients.

vi. They have separate pricing structures for international patients and underprivileged patients.

vii. Their capital expenditure is funded by the revenue of the hospital and by donations received from philanthropists.

Table.1: Categorization of not-for-profit Hospitals

	Faith Based Hospitals	Community Based Hospitals	Cooperative Hospitals	Private Trust Hospitals
Premise	Selfless service to the society as service to God.	Selfless service to the underprivileged of the society, not necessarily influenced by faith.	Self-sufficiency in healthcare by self-participation	Service rendered on a no profit and no loss basis
Founders	Individual missionaries or religious trusts on the principles of religions or deities.	Individual doctors, or a team of likeminded doctors, who desire to give back to society, often in the same community where they were born/ raised.	Individual doctors who wish to harness the contributions of a wider population in the nearby areas sset up these institutions.	Eminent businessmen/ Philanthropists/ Politicians, in response to a social cause based on individually observed needs.
Interviewed Hospitals	Makunda Christian Leprosy & General Hospital, Karimganj CMC Vellore Amrita Institute of Medical Sciences, Kochi Sri Sathya Sai Central Trust Hospitals in Puttaparthi	Dr Hedgewar Rugnalaya, Aurangabad Sewa Rural, Jhagadia	Shushrusha Citizen's Cooperative Hospital MGIMS Kasturba Hospital, Sevagram EMS Memorial Cooperative Hospital & Research Centre, Perinthalmanna	Basavatarakam Indo-American Cancer Centre, Hyderabad PD Hinduja National Hospital & Medical Research Centre, Mumbai

5

Methodology

This study involves the following steps:

i. Secondary research for information about the sector

In addition to the information available on the websites of the hospitals, all available information was mined from Government authorized studies and statistical analysis, such as the websites of the Ministry of Corporate Affairs, Ministry of Statistics & Programme Implementation, and so on, to gain reliable and relevant information about these not-for-profit hospitals and the sector overall.

ii. Identification of prominent not-for-profit hospitals

Based on our secondary research, and the inputs from industry experts and consultations at NITI Aayog, we shortlisted 11 prominent not-for-profit hospitals were shortlisted (Fig.6) which was a good representation in terms of locations – Tier1/2/3/Rural, Bed size– 100 to 3000 bedded Hospitals, and level of care – Secondary, Tertiary & Quaternary. These Hospitals were contacted telephonically and after being informed adequately about the nature, purpose and scope of the study, they gave their consent to participate in the study

iii. Formal engagement of the top management members of these hospitals and scheduling of interviews at pre-decided times

A formal invitation to the key stakeholders of the shortlisted hospitals was sent from NITI Aayog, mentioning the nature, purpose, and scope of the study. After obtaining consent from these hospitals, a discussion was scheduled with the senior leadership to obtain specific insights about the operating model of the hospitals, and the challenges they faced continually.

iv. Formulation of a comprehensive questionnaire for interviewing the top management members of identified hospitals

A targeted questionnaire was designed for the hospitals being interviewed to obtain objective and subjective information from the senior leadership of these hospitals. The questions

were grouped under the sub-topics of General Information, Operations & Business, Human Resources, Quality and Community Impact, and were designed to provide adequate quantitative and qualitative information. The questionnaire is attached as **Annexure 1.**

v. Formulation of a list of specific data requirements from these hospitals

In addition to the qualitative and quantitative information gained from the questionnaire, an Information Request List (IRL) was designed to capture specific data points, which gave quantitative insights, such as Volumes, ALOS, Occupancy, OPD and IPD pricing, and so on, for the shortlisted hospitals. The hospitals were also requested to provide their recent financial statements. This is attached as **Annexure 2**.

vi. Collection and analysis of specific data

The data received from the hospitals during the interviews and as a response to the IRL was grouped, tabulated, and analyzed to provide meaningful insights about the above-mentioned objectives of the study.

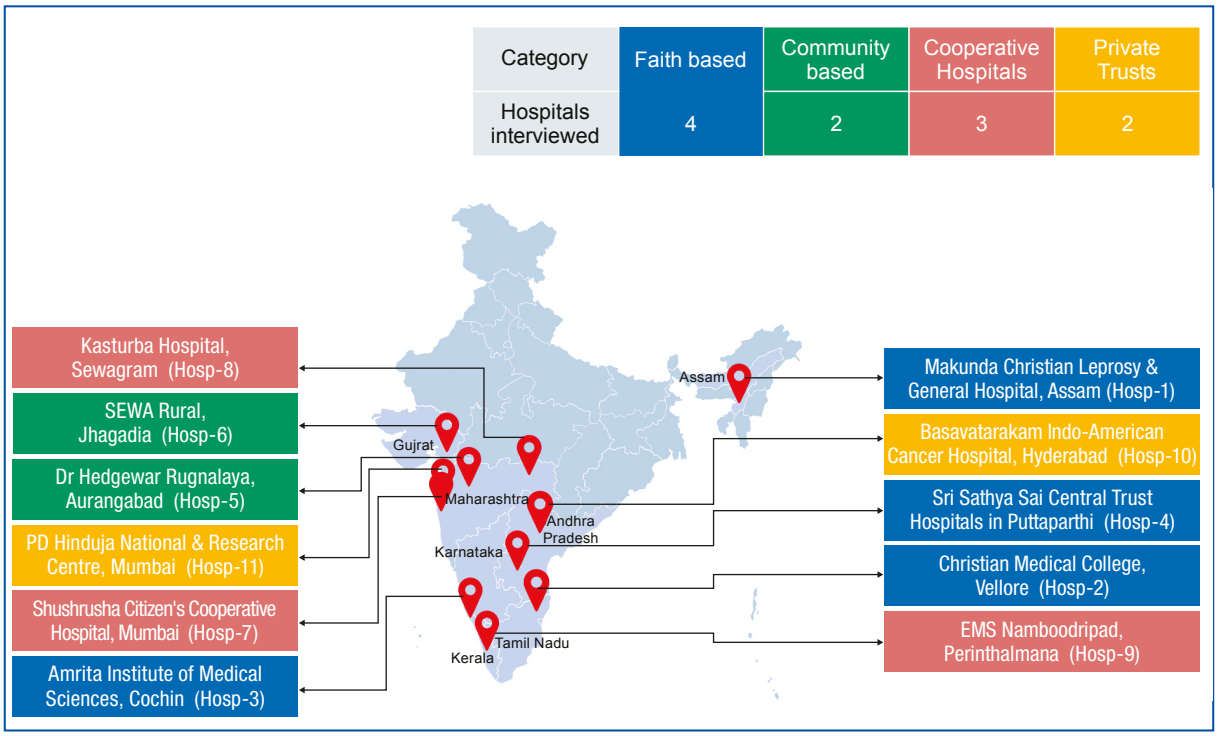


Fig.6: *The Hospitals identified under the defined categories*

This map is not to scale. It is an indicative outline intended for general reference use only.

The accuracy of this product is dependent upon the source data and therefore absolute accuracy for navigation or legal purposes cannot be guaranteed.

The above mentioned hospital numbering (Hosp-1, Hosp-2... Hosp-11) is kept consistent through the entire document.

6

Key Findings

Based on the detailed deliberations with the top management members of the selected hospitals between December 1, 2020 and December 22, 2020, and the analysis of the specific data provided by them, the following are the key findings:

i. Most of the not-for-profit hospitals charge lower than the for-profit hospitals

The cumulative cost of care at not-for-profit hospitals is lesser than for-profit hospitals by about one-fourth in the in-patient department. This is reckoned by the package component of cost, which is approximately 20% lower, the doctor's or surgeon's charges, which are approximately 36% lower and the major aspect being the bed charges, which are approximately 44% lower than the for-profit hospitals.

Table 2: Average Medical Expenditure (for Hospitalization Cases) in INR

Hospital Type ➡ Cost item ⬇	Government Settings*	For-Profit Settings	Not-for-profit Settings	All
Package component	557	10060	7959	6012
Doctor's/Surgeons Fee	179	5710	3674	3332
Medicines	2184	6903	5680	4888
Diagnostic Tests	791	3038	2658	2084
Bed Charges	128	3690	2062	2150
Others	612	2444	2201	1668
Total	4452	31845	24233	20134

Source: *NSS 75th round survey*

**Cost considered for Government settings is only Out-of-pocket expenditure by patients, in addition to this, Doctor's salaries, consumable costs etc., are borne directly by the Government.*

The above charge structure is not specific to any ailment as studied in the NSS 75th round survey.

The cumulative cost of OPD care (Table .3) in not-for-profit hospitals is about one-third lesser than private for-profit hospitals. The NSS 75th round data revealed that the not-for-profit hospitals provide medicines to patients at about 26% lesser than the for-profit hospitals, while the doctor's fees are approximately 18% lower in not-for-profit hospitals.

Table.3: Cumulative Price comparison with other types of Hospitals (OPD)

Hospital Type ➡ Cost item ⬇	Government Settings*	For-Profit Settings	Not-for-profit Settings	All
Medicines	272	683	396	447
Diagnostic Tests	36	167	211	80
Doctor's Fee	8	151	105	85
Other	15	52	20	24
Total	331	1062	732	636

Source: NSS 75th round survey

**Cost considered for Government settings is only Out-of-pocket expenditure by patients, in addition to this, Doctor's salaries, consumable costs etc., are borne directly by the Government.*

The above charge structure is for one treatment episode on OPD basis as studied in the NSS 75th round survey.

A glance at the basic price comparison (Fig.7) of the different categories of not-for-profit hospitals against a for-profit hospital shows that Faith-based Hospitals and the Community-Based Hospital charge lower OPD consultation charges than the for-profit hospital. The General Ward Charges of the Faith-based Hospitals, Community-based Hospital, and the Cooperative Hospital, are lower than the for-profit hospital. The ICU charges of the Faith-based Hospitals, Community-Based hospital, and the Cooperative Hospital are lower than the for-profit hospital.

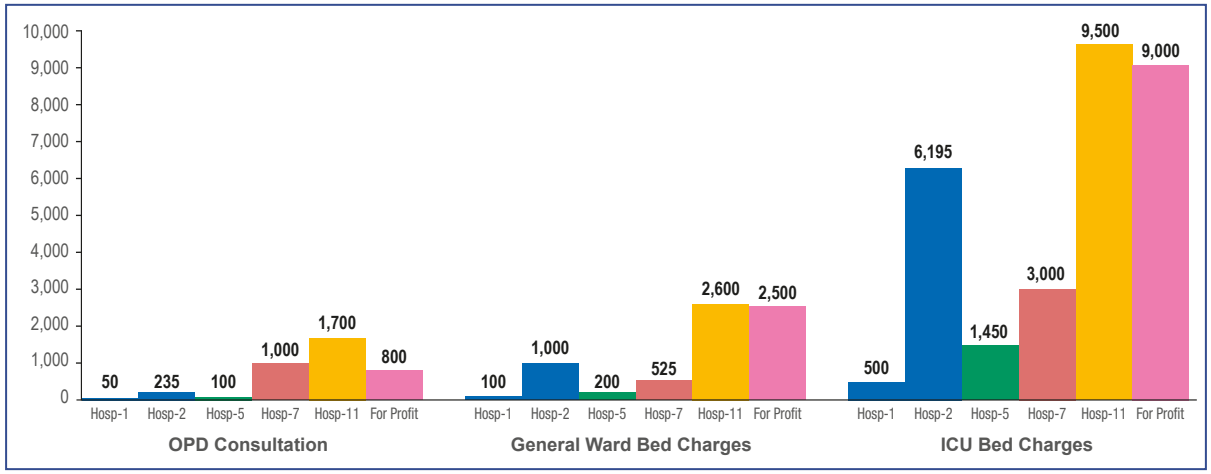


Fig.7: *Basic Price comparison with a for-profit Hospital*

Source: Primary discussions with stakeholders

Hospital Number is taken from Fig.6

ii. OPD prices of Rural Community Based Hospital are lower, while Rural Cooperative Hospital prices are comparable with CGHS Delhi rates (Fig.8)

The OPD and Diagnostic charges of pathology and radiology for routine investigations such as Complete Blood Count, X-ray Chest, Lipid Profile, Fasting Blood Sugar, Ultrasonography of Abdomen, Electrocardiogram and OPD Consultation (General Medicine) was compared for the hospitals under the study. A Price Index was calculated with the CGHS Delhi NCR rates as the base rate and the other hospital's price index was mapped accordingly.

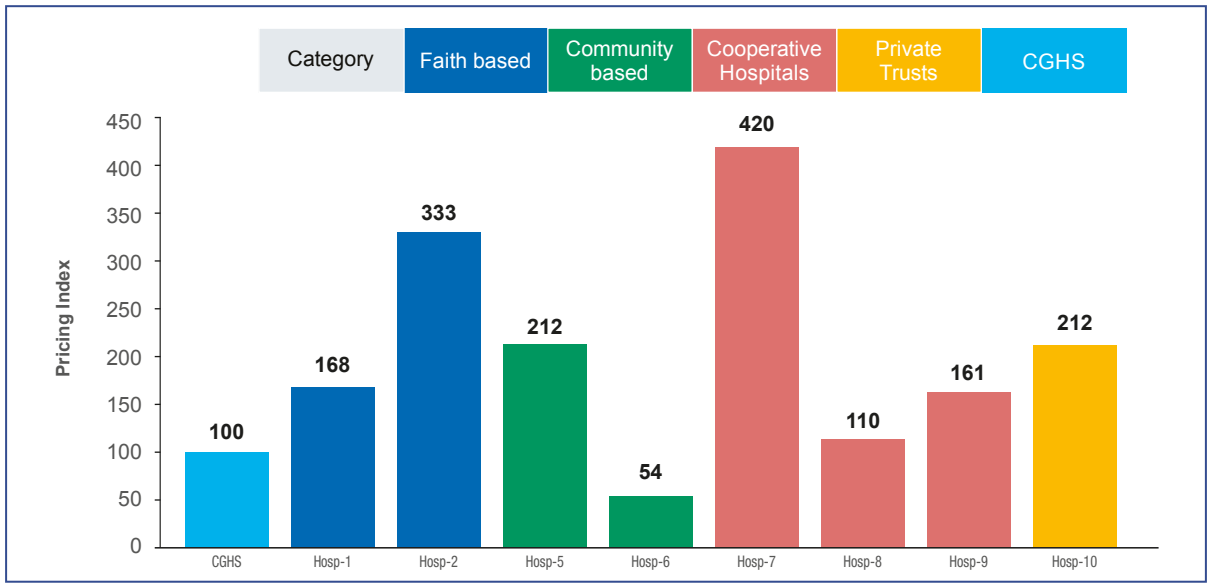


Fig.8: *Specific OPD Investigation price index comparison with CGHS Delhi Rates.*

Source: Primary discussions with stakeholders
Hospital Number is taken from Fig.6.

When compared to the CGHS Delhi rates, the overall price indexing shows that the Out-patient Department price index of Rural Community-based Hospital (54) is lower, while the Rural Cooperative Hospital price index (110) is comparable with CGHS Delhi rates. The prices of the Faith-based Hospitals – Rural (168) and Tier 2 (333), Tier 2 Community-Based Hospital (212), Tier 2 Cooperative Hospital (161), Tier 1 Cooperative Hospital (420), and the Private Trust Hospital (212), are higher than the CGHS Delhi price index.

The CGHS Delhi applicable prices are as of 2014 and are pending revision.

iii. IPD prices of the Rural Community-based Hospital are 40–60% lower, while Rural Cooperative Hospital prices are on par with CGHS Delhi prices and ABPMJAY prices (Fig.9)

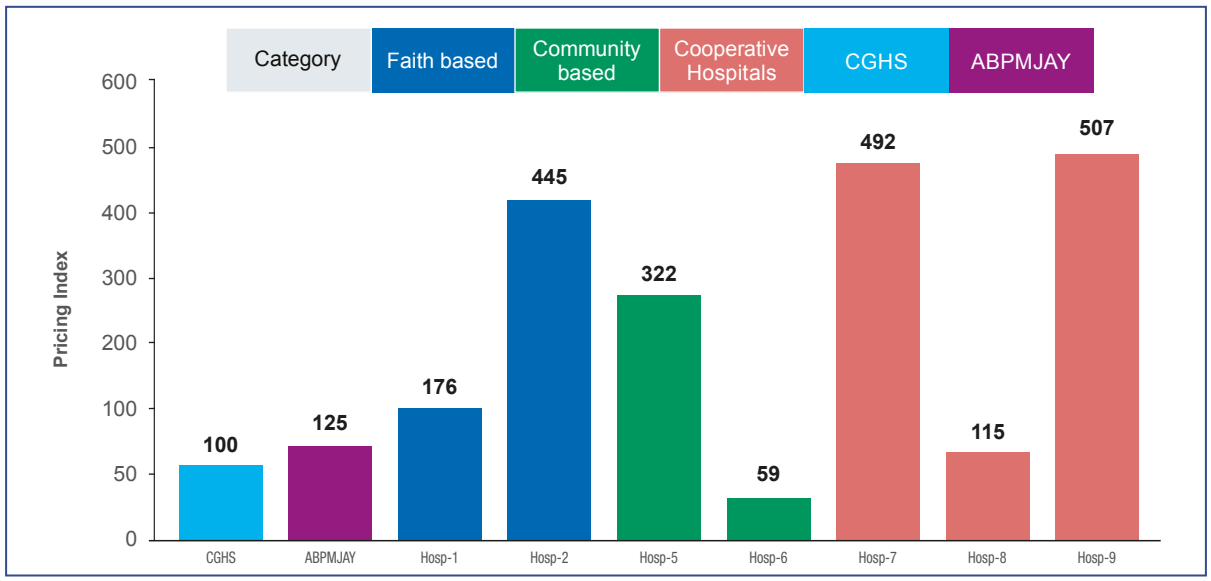


Fig.9: *Specific IPD (end bill to patient) price index comparison with CGHS Delhi and ABPMJAY Rates.*

Source: Primary discussions with stakeholders
Hospital Number is taken from Fig.6.

The end price to the patient for common IPD procedures such as Normal and Cesarean Deliveries, Hysterectomy, Appendectomy, Cataract, ORIF, Laparotomy and Cholecystectomy was compared for the not-for-profit hospitals under the study. A Pricing Index was calculated with the CGHS Delhi rates as the base rate and the same was benchmarked against the ABPMJAY rates.

The comparison revealed that the Rural Community-based Hospital charges are approximately 40–60% lower than the CGHS Delhi NCR rates and the ABPMJAY rates. The prices of the Faith-based Hospitals – Rural (176) and Tier 2 (445), Tier 2 Community-based Hospital (322), Tier 2 Cooperative Hospital (507), Tier 1 Cooperative Hospital (492).

iv. Most of the Not-for-profit Hospitals are empaneled with State or Central Government Healthcare schemes (Table.4)

Table.4: Empanelment status with State and Central Government Health Schemes

	Faith Based				Community Based		Cooperative Hospitals			Private Trusts	
	Hosp-1	Hosp-2	Hosp-3	Hosp-4	Hosp-5	Hosp-6	Hosp-7	Hosp-8	Hosp-9	Hosp-10	Hosp-11
State Schemese	Assam Arogya Nidhi	CMCHIS	None	NA (Free to all)	MJPJAY	Mukhyamantri Amruta, Chiranjeevi Bal Sabha	MJPJAY applied	MJPJAY	Karunya	Arogyasri	None
ABMJAY	■	■		NA (Free to all)	None	■	None	■		■	None
CGHS/ ECHS			■						■	■	
ESI			■						■		

■ Service provided

Almost all of the identified not-for-profit hospitals are empanelled either with the State Health Schemes of their respective State, or with the Central Government Health Schemes such as the Central Government Health Scheme (CGHS), Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (ABPMJAY), Ex-servicemen Contributory Health Scheme (ECHS), and Employees State Insurance (ESI).

v. The not-for-profit hospitals use various levers to facilitate their low cost of clinical care and reduced operational expenditure

a. Human resource levers

Human resource costs make up a significant amount of the operational expenses in hospitals. The discussions with the selected hospitals showed the following levers, which they used to keep the human resource cost as low as possible:

- **Salaries of doctors are 50–75% lower than market benchmarks:**

  The Faith-based Hospitals and Community-based Hospitals had set a conscious ceiling limit of salaries for their senior doctors who are unanimously likeminded to serve humanity. In contrast, doctors at for-profit corporate hospitals earn a much higher salary,

which also increases with the doctor's seniority and growth in position. For example, in a Rural Faith-based Hospital, a Pediatric Surgeon with over 30 years of work experience receives a meager salary of INR 1 lakh per month, which would be approximately 20–30% of the salary that a consultant with comparable experience would expect to get in a for-profit hospital.

- **Salaries of staff are ~20–30% lower than market benchmarks:**

  The staff at Faith-based and Community-based Hospitals and Tier 2 Cooperative Hospitals was working at lower salaries than what they would earn at a for-profit hospital.

- **Multitasking workforce reduces the number of total staff required:**

  The doctors and staff of the Faith-based and Community-based Hospitals (in three hospitals in the study) were undertaking more activities than their routine job description. Doctors were performing managerial functions, which reduces the need for administrative staff.

b. Infrastructure and equipment levers

The discussions with the selected hospitals also revealed that as most of them depended on external funding for capital expenditure; they made judicious use of the resources provided to them to achieve cost optimization and customization of services, according to the needs of the target population in the following manner:

- **90–95% general ward beds:**

  Some of the Faith-based and Community-based Hospitals had a greater number of general ward beds and negligible number of private ward beds. This was in line with their purpose of low-cost care and it helped in reducing infrastructural costs.

- **Energy-efficient construction and judicial installation of air conditioning:**

  Some of the Faith-based and Community-based Hospitals especially had their majority of beds without air conditioning and their in-patient rooms had windows to the outside of the building. This allowed natural light in the rooms and ambient ventilation.

- **In-house manufacturing of equipment, such as beds, dental chairs:**

  One of the Faith-based Hospitals has ventured into in-house manufacturing of equipment, which helps them reduce purchase costs from external vendors.

- **Using high cost equipment beyond the recommended lifespan:**

  Most of the Faith-based and Community-based Hospitals use their diagnostic and other equipment for much longer than the recommended lifespan. They could ensure quality and efficiency because of highly competent biomedical engineers and robust maintenance regimes.

- **Scavenging for usable parts from condemned equipment:**

  Some of the Faith-based Hospitals were salvaging usable parts from condemned equipment and using them as spare parts for existing equipment, with the help of highly competent biomedical engineers.

c. *Hospital operations levers*

The qualitative and quantitative analysis of the selected hospitals revealed their use of the following lean operations based on the analysis of their volumes, health seeking behavior, and paying capacity of their target population:

- Cross-subsidization – This was commonly found across all the categories of nor-for-profit hospitals, as follows:
  - Across patients – The revenue from patients who paid full charges were used to cross-subsidize the bills of the patients who could not pay the full charges.
  - Across departments based on volumes – In one of the Faith-based Hospitals, the revenue from departments that had high volumes and a significant margin of revenue above the cost price was used to cross-subsidize the services of other departments.
- Most of the Tier 2 and rural not-for-profit hospitals used generic low-cost medicines and engaged in direct procurement from the manufacturers at lower prices.
- Most of the Tier 2 and rural not-for-profit hospitals spent only a minimal amount on marketing activities. They also had a no-referral commission policy.
- Most of the not-for-profit hospitals could break even and be self-sustaining at low costs because of the high volume of patients utilizing their services.
- One Faith-based Hospital and one Private Trust Hospital had highly competent Anesthesia teams, which enabled them to perform many day care surgeries. This helped them increase productivity in the utilization of their services.

d. *Operational expense levers*

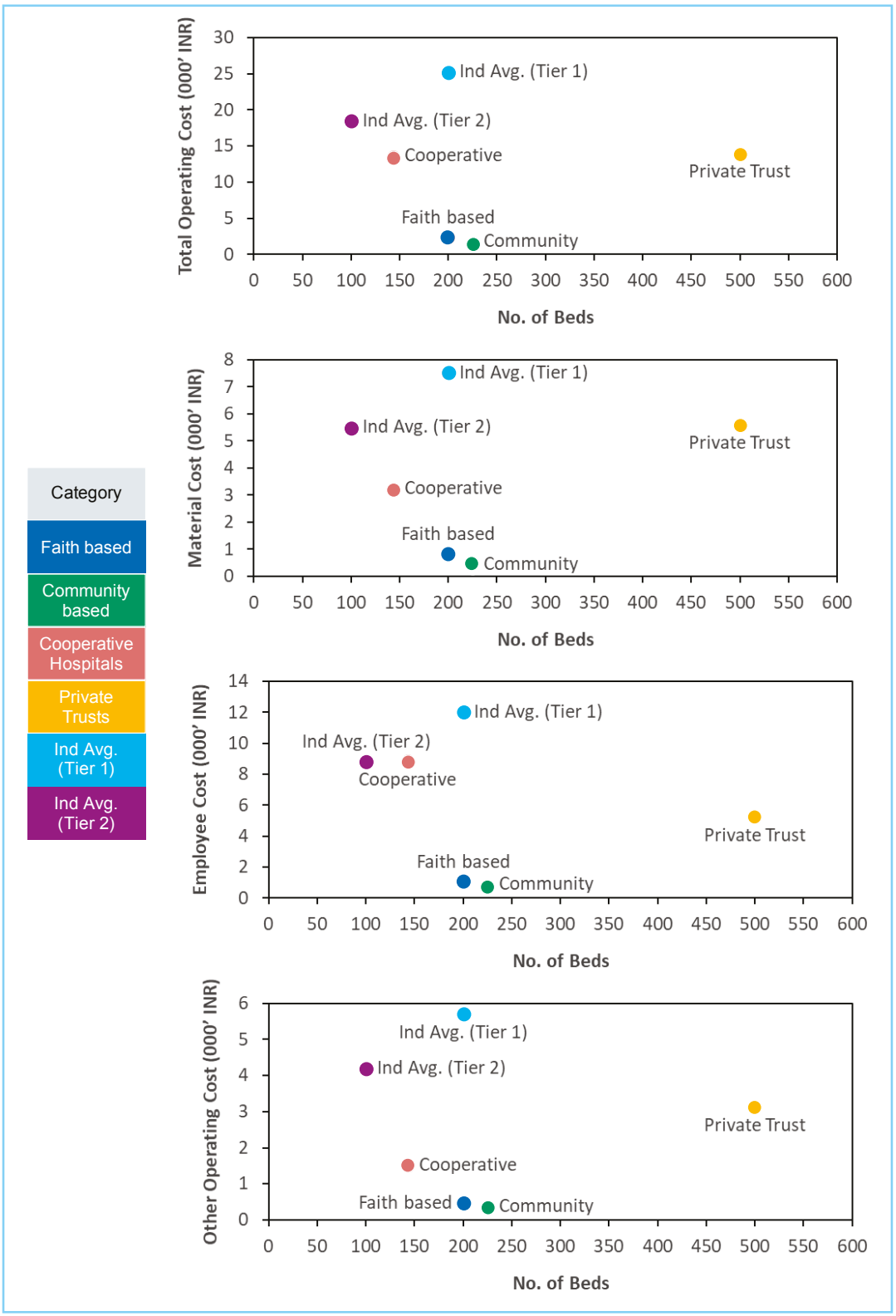
One of the indicators for cost-efficient operations is the management of operational expenses. Despite the relatively low pricing of services, a significant number of patients are unable to pay their bills, which potentially affect operational cash flows. The qualitative and quantitative analysis of the interviewed hospitals revealed the following practices to manage operational expenses:

- Some of the not-for-profit hospitals could engage in a mutual understanding with corporates, non-governmental organizations, and other willing donors, for funding the dues of certain non-affording patients.
- Almost all hospitals have no debt, as the capital expenses are mostly funded by Government grants or by donations from philanthropists. Thus, they can re-use their revenue on operational expenses

vi. Not for profit Hospitals have lower operating costs as compared to For-Profit Hospitals (Fig.10)

The recent financial statements of certain Not-for-Profit Hospitals were analysed in detail. The cost categories were grouped under Employee costs, Material Costs, Repair & maintenance Costs, Electricity & fuel costs and even other miscellaneous operating costs. In comparison to the industry benchmarks (which is an average of professionally run Hospitals in Tier 1 cities which are 200 beds or above and in Tier 2 cities which are 100 beds or above), it was found that the interviewed

Not-for-Profit Hospitals spent lesser amounts on the above mentioned cost heads. The operating cost per bed was also significantly lower than the industry average of operating costs in Tier 1 & Tier 2 cities.



*Industry average is an average of professional run greater than 100 bed hospital; Tier 2 being for 100 bedded and Tier 1 being for 200 bedded Hospitals. All costs shown as per bed per day.

Source: Discussions with stakeholders and PwC analysis.
Hospital Number is taken from Fig.6.

Fig.10: *Breakup of Operational Costs of Not-for-Profit Hospitals*

vii. Focus on Quality practices

This study found a strong focus on quality care across all categories of not-for-profit hospitals, as most of them had some form of accreditation for their services (Table 3). They also had strong Internal Quality Assurance teams, which performed clinical audits and utilization audits regularly. Additional Accreditations include ISO 270001:2015, TÜV (OHSAS), College of American Pathologists, HACCP, and so on.

Table.5: Accreditation status of the not-for-profit Hospital categories

	ISO 9001	NABH (Entry Level complete)	Additional Accrediations*
Faith Based	Not Accredited	Accredited	Not Accredited
Community Based	Not Accredited	Accredited	Not Accredited
Cooperative Hospitals	Not Accredited	Accredited	Not Accredited
Private Trusts	Accredited	Accredited	Accredited

**Additional Accreditations include ISO 270001:2015, TÜV (OHSAS), College of American Pathologists, HACCP etc.*

7

Challenges Faced by the Not-for-Profit Hospitals

In the interviews, the top management of the selected hospitals reported various challenges that were critical to their operations and sustenance. Using the Mini-Delphi method, we arranged the challenges in the decreasing order of criticality and applicability to all interviewed hospitals, as follows:

i. Recruitment and retention of doctors & staff

Most of the hospitals find it difficult to recruit and retain doctors and staff because of the following reasons:

- Two of the Faith-based and two of the Community-based Hospitals stated that the lower salaries offered than the for-profit hospitals form a hindrance, especially, for recruiting specialist and super-specialist consultants.
- Five of the interviewed hospitals stated the remoteness of location of the hospitals, especially those in rural areas, as a challenge. Although these hospitals provide on-campus accommodation, as they lack many basic facilities for living in rural areas, not many doctors and staff would join them or continue for a long time.
- Owing to the above-mentioned reasons, one of the Rural Cooperative Hospitals has a high volume of patients with cardiac ailments; however, they have been unable to recruit a full-time cardiologist. They depend on a cardiologist visiting from the nearest available Tier 2 City thrice a week to perform cardiac procedures.

ii. Reimbursements for treatment of Government health scheme beneficiaries

As Table.4 shows, most of these hospitals are empaneled with State or Central Government Health schemes, and they offer treatment to a significant number of beneficiaries.

- Most of the interviewed hospitals have cited perennially delayed reimbursements and long-pending amounts, despite their persistence, causing strain in their cash flows, and in turn, burdening their operations.

- Two of the Private Trust Hospitals also have reported that for some of the procedures, especially, where there are added procedures due to perioperative complications, there are no set codes, and thus, the hospitals must absorb the additional cost. This is also a challenge that other stakeholders in the Healthcare industry face, such as the for-profit hospitals.

iii. Infrastructure and equipment expansions

Many of these hospitals are dependent on external funding in the form of philanthropy and grants for capital expenditure components, such as infrastructural expansion, purchase of new technology, and advanced equipment. Some hospitals could contribute only a small amount of their operational revenue toward the purchase of much-needed new equipment, and hence, can only purchase/expand with the help of external funding.

- Three of the Faith-based and one of the Community-based Hospitals reported instances of delay in expansion project approvals from regulatory bodies.
- One Faith-based Hospital reported an overall time frame of five years for the regulatory permission to operationalize a newly constructed additional wing.

iv. Regulatory challenges

Some of the hospitals, especially those in remote areas, reported challenges because of the high compliance burden of staffing requirements of the Regulations for running a blood bank, Clinical Establishments Act, PNDT Act, and Quality standards.

- The Rural Faith-based Hospital and the rural Community Hospital have difficulty in recruiting a full-time pathologist for the manufacture of blood products/ plasma in a blood bank; hence, they are dependent on an external blood bank far away, which causes inconvenience to patients' relatives and donors.
- Some of the hospitals in rural areas also reported a high burden of paperwork and record keeping in addition to the challenges with periodic online submission of reports for certain regulatory compliances.

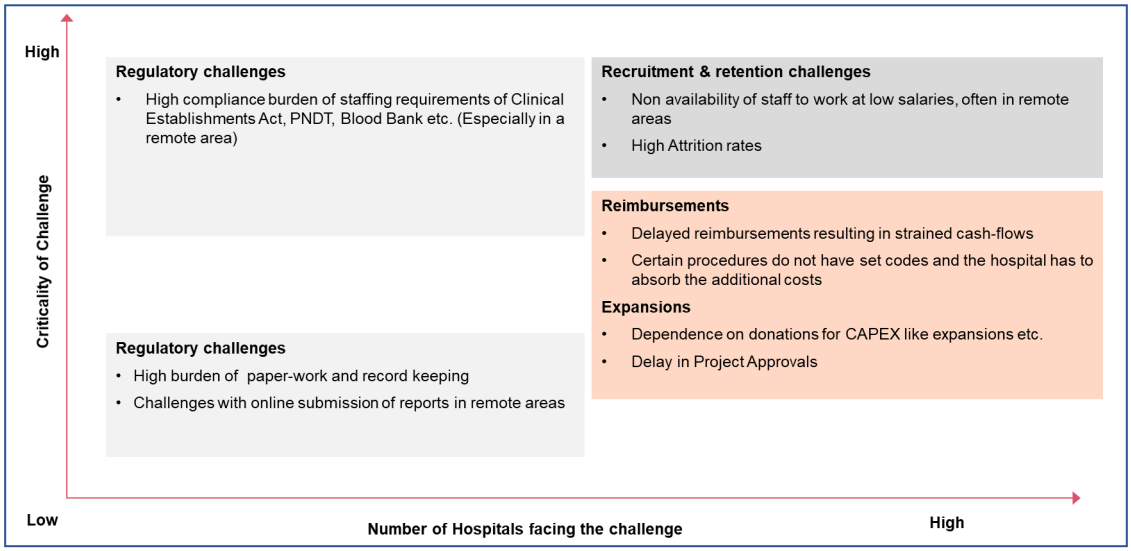


Fig.11 *Challenges faced by the Not-for-Profit Hospitals in a Criticality vs Count matrix*

Source: Discussions with stakeholders

8 Proposed Policy Interventions to Promote the Not-for-Profit Hospital Sector

The proposed policy interventions have been classified into four broad categories: Identification and Promotion, Leveraging Expertise, Human Resources, and Finance based on the nature of recommendations. In addition, they have been classified into Short Term and Long Term.

Table.6: Proposed policy interventions to promote the Not-for-Profit Hospital Sector with the proposed timeline

	Identification & Promotion	Leveraging expertise	Human Resources	Financial
Short Term	◆ Develop criteria to identify these Hospitals ◆ Develop Mechanisms to rank these Hospitals on a performance Index ◆ Create a national level portal/ directory of these Hospitals	Representatives of high-performing not-for-profit Hospitals across different geographical locations can be invited to share experiences in relevant policy making committees	Posting of Government Medical College students for their mandatory internships in these hospitals *(To be explored in accordance with Medical Education laws)*	◆ 100% exemption for donations (Section 80G) (Currently 50%) ◆ Extension of a low-cost credit line (Esp. Working Capital Loans) ◆ Income Tax exemption for membership fees paid at Cooperative Trust Hospitals ◆ Single window clearance for Govt. reimbursements
Long Term	Promote the top hospitals for facilitating philanthropy, investments and patient flows	Involving high performing Hospitals in PPP models for managing PHCs, operations of Government Facilities, PSU Hospitals	◆ Develop a mechanism to incentivize super-specialists to work in remote areas. ◆ Revisiting of the compliance requirements of regulations like CEA, PNDT, Blood Bank	◆ Grant in Aid scheme (Similar to Gujarat Model) ◆ Timely allocation of unencumbered land

SHORT TERM

a. Identification and promotion

Develop criteria to identify these hospitals

Formulation of objective criteria such as type, size, location, level of care offered and their ownership, infrastructure and equipment expansion initiatives, community engagement initiatives along with their latest photographs/videos, and so on.

Develop mechanisms to rank these hospitals on a performance index

Creation of a rating scale based on the volume of services utilized annually, the extent of charity work done, impact on the community health indicators of the location, operational efficiency, and self-sufficiency, to rank the top few hospitals (e.g., Top 50, which can be determined later based on the details received from the hospitals).

Create a national level portal/directory of these hospitals

Creation of a national portal/directory in the public domain, wherein all the not-for-profit hospitals can be listed to highlight the hospital and its functions in the public domain.

b. Leveraging expertise

Representatives of high-performing not-for-profit hospitals across different geographical locations can be invited to share their experiences in relevant policymaking committees

The not-for-profit hospitals have vast experience in providing low-cost high-quality care to the unreached sections of society, some of them existing since before India's Independence, yet, they remain largely unknown and understudied. To obtain a comprehensive understanding of the sector, and to tap into this vast expertise, the representatives of high-performing not-for-profit hospitals across different geographical locations can be invited to relevant policymaking committees.

c. Human resources

Representatives of high-performing not-for-profit hospitals across different geographical locations can be invited to share their experiences in relevant policymaking committees

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d. Financial

100% exemption for donations under section 80G

Income-tax exemption could be increased from the current 50% exemption to 100% exemption for philanthropy toward the identified not-for-profit hospitals. This could be a catalyst in channelizing the much-needed funds to deserving hospitals.

Extension of a low-cost credit line (esp. working capital loans)

The Government can consider the provision of working capital loans with lower interest rates, which would be more financially viable for the not-for-profit hospitals and would assist in adequate cash flows during times of need.

Income-tax exemption for membership fees paid at Cooperative Trust Hospitals

To enable higher membership at Cooperative Trust Hospitals, enabling them to achieve their goal of self-sufficiency in healthcare through self-participation, Income-tax exemption can be given for membership fees paid at Cooperative Trust Hospitals.

Single window clearance for Government reimbursements

Most of the not-for-profit hospitals reported long-pending reimbursements for the treatments of Government scheme beneficiaries, which remain uncleared despite persistent follow-ups. The timely release of these funds can be a substantial boost to their working capital for operations.

LONG TERM

a. Identification & Promotion

Promote the top hospitals for facilitating philanthropy, investments and patient flows

The Top 50 hospitals should be prominently displayed along with the amount of funding received over a specific timeline, the amount of funding needed for capital expenditure, and the appropriate channel for philanthropy and investment, clearly and transparently. These could be listed on philanthropy-based portals, after adequately verifying the credentials of such hospitals.

b. Leveraging of expertise

Involving high performing Hospitals in PPP models for managing PHCs, operations of Government Facilities, PSU Hospitals

One Faith-based, one Community-based, and one Private Trust Hospital mentioned that they are interested in using expertise in provision of cost-efficient high-quality healthcare to the unreached and underprivileged in association with the Government by professionally managing PHCs, PSU Hospitals, and other Government facilities. They perceive that they can use the available infrastructure of the existing Government facilities and achieve efficient utilization to promote Health for All. The National Health Mission guidelines on Public Private Partnership can be used for such endeavors.

c. Human resources

Revisiting the compliance requirements of regulations such as CEA, PNDT, Blood Bank

It is necessary to customize the mandatory manpower requirements of the above-mentioned regulations to make them more relevant to the realities of the remote areas, making them less cumbersome for these hospitals, who genuinely wish to serve the unreached and underprivileged with the available low resources. Provision can be made for the representation of top management members of these not-for-profit hospitals in decision-making committees to understand their perspectives and practical challenges.

Develop a mechanism to incentivize super-specialists to work in remote areas

To mitigate the manpower scarcity challenge, super-specialist doctors should be given some incentives and motivation to engage with hospitals in remote areas where there is a dire need for their services. These identified hospitals can be granted a certain amount of remuneration per full-time super-specialist associated with them.

The current e-Sanjeevni program can be integrated and the benefits of this program should be extended to not-for-profit hospitals.

In addition, to foster learning, associations of Trust Hospital super-specialists in various specialties can be created and linked virtually.

The penetration of telemedicine can be increased to facilitate e-consultation in unreached areas.

d. Operations & Financial

Grant-in-Aid scheme

Other States can consider the implementation of a Grant-in-Aid scheme similar to the Gujarat Model, wherein the Government funds up to 75% of admissible costs of the not-for-profit hospitals. The Grant is provided to various hospitals and dispensaries, run by voluntary organizations and charitable trusts. The norms of allocation are as per Government Resolution dated December 19, 1991, Health & Family Welfare Department, Gandhinagar. This would enable better cash flows for operational expenses and can possibly help in creating a fund for future expansions in terms of infrastructure or equipment.

Timely allocation of unencumbered land

This will help many not-for-profit hospitals who face operational delays in their expansion plan because of permissions and regulatory clearances.

9 Annexures

9.1 ANNEXURE 1–QUESTIONNAIRE

General

1. In the evolving mindset of hospital operations towards profitability, what is the inspiration behind the current model of your Hospital's operations?
2. What is the current size (beds) of your Hospital? What is the average volume (OPD Footfalls and IPD Occupancy & Daily/monthly surgery count)?
3. How has your Hospital grown over the last 5 years (infrastructure/equipment etc.)
4. What are the currently functioning branches / subcenters of the Hospital ?
5. What are the key focus areas of the Hospital services and why?
6. What is your catchment area & target population within it?
7. What is the management structure & governance mechanism of your Hospital?

Operations & Business

1. Can you please provide the list of Top 10 surgeries/procedures by volume?
2. We understand that you charge a miniscule amount from patients, what would be the average end to end cost for these top 10 surgeries/procedures?
3. What is the approximate CAPEX and OPEX?
4. We understand your charging method which is considerably low as compared to the private Healthcare providers, are you able to breakeven?
5. What do you do to keep the costs so low? Do you have to depend on external funding sources like Gap funding/donations etc?
6. What are the government schemes which you Hospital is empaneled with? E.g. AB-PMJAY, CHGS, ESI, State Programmes etc.

7. What are the top 5 challenges which the Hospital faces?
8. What are the innovative strategies practiced by your Hospital?

Human resources

1. What is the approximate number of clinical and non-clinical staff at your Hospital?
2. What is the engagement model (full time/fixed salaries/ honorarium etc.) for the doctors?
3. Are your payouts to the manpower in line with the market standards?
4. Do you have any employee engagement activities? How do you keep them motivated in a challenging environment?
5. What are the charges for treatment of staff at your Hospital?

Quality

1. Is your Hospital Accredited by any of the existing quality accreditation systems?
2. What is your perception of Quality and the way it should be measured?

Community Impact

1. What is the measured impact of the Hospital's services on community Health indicators like MMR, IMR etc? (optional)
2. What have been the initiatives to develop trust and goodwill in the community you serve?
3. What in your opinion would be 3 major interventions with which the government can help you?

9.2 ANNEXURE 2 – INFORMATION REQUEST LIST

1. Tariffs or the following OPD services:	**Prices**
a) OPD Consultation (Internal Medicine)	
b) CBC	
c) Urine Routine	
d) X-ray Chest	
e) Lipid Profile	
f) Fasting Blood Sugar	
g) USGAbdomen	
h) CTBrain Plain	
i) MRI Brain Plain	
j) ECG	
2. Total Bill Amountfor the following IPDservices:	
a) Normal Delivery	
b) Caesarean Section	
c) Coronary Angiography	
d) Coronary Angioplasty	
e) Total Knee Replacement (Unilateral)	
f) Cataract charges without lens	
g) Open Reduction Internal Fixation	
h) Laparotomy	
i) Image Guided Radiotherapy	
j) Hysterectomy	
k) Appendectomy	
1) Laminectomy	
m) Cholecystectomy	
(In case theabove list has some procedures which are not applicable to your Hospital, please substitute with any of the Top 5 procedures done at your Hospital)	
3. Average volumes (2019-2020)	
a) OPD Footfalls	
b) IPD Occupancy	
c) Monthly surgery Count	
4. Bed Charges	
a) General Ward	
b) Private Ward	
c) ICU	
5. Latest Financial Report (as a separate attachment)	

9.3 ANNEXURE 3 – BRIEF HOSPITAL PROFILES

	About the Hospital	Operating Model	Key Community Engagement activities
Makunda Christian Leprosy & General Hospital	Year of inception – 1993 Level of care – Secondary Geographic presence – Karimganj District, Assam; Small Branch in Tripura No of Units / Beds – 2/200 Governance – Makunda Christian Leprosy & General Hospital Society, Emmanuel Hospital Association	The Hospital is self- reliant for OPEX and CAPEX. Cross subsidization from revenues of high-volume departments Separate charging structure for non-affording patients and affording patients	The Hospital engaged and trained the local ASHAs to increase institutional deliveries and reduce the MMR & IMR at Karimganj District by almost 50% The Hospital has conducted detailed research into its target population to customize the services and tariffs.
Christian Medical College, Vellore	Year of inception - 1900 Level of care – Tertiary to Quaternary Geographic presence – Vellore, Tamil Nadu; units in different locations No of Units/Beds – 7/3000 No of beds – 3000 Governance - CMC Vellore Association - the apex body, a Governing council, an Executive Committee	The Hospital is self- reliant for OPEX. Depends on Grants for CAPEX Cross subsidization from revenues of high-volume departments Separate charging structure for non-affording patients and affording patients	The Community health and development (CHAD) program under the Community Health Department of CMC, Vellore covers approximately 200,000 in the rural, urban and tribal community areas of Vellore Districts.
Amrita Institute of Medical Sciences, Kochi	Year of inception - 1998 Level of care – Tertiary to Quaternary Geographic presence – Kochi, Kerala; upcoming unit in Faridabad No of Units /Beds- 1/1350 Governance - Board of Trustees (devotees from the Math), a Medical Director and a Chief Medical Superintendent.	The Hospital is self-reliant for OPEX & CAPEX. Depends on Grants for CAPEX Separate charging structure across units for non-affording patients and affording patients	Regular Health camps in neighboring tribal areas Vocational Training for Tribals Priority in recruitment for trained tribals in level 3 staff.

	About the Hospital	Operating Model	Key Community Engagement activities
Sri Sathya Sai Central Trust Hospitals, Puttaparthi (Sri Sathya Sai General Hospital, Prasanthi Nilayam, Puttaparthi & Sri Sathya Sai Institute of Higher Medical Sciences, Prasanthigram, Puttaparthi)	Year of inception – 1956 & 1991 Level of care – Secondary & Tertiary Geographic presence – Puttaparthi, Andhra Pradesh No of Units / beds – 2/570 Governance – Board of Trustees of the Sri Sathya Sai Central Trust	The Hospital gives free treatment to all patients irrespective of caste, creed, religion, socio-economic condition.	Mobile Hospital operates from the 1st to 12th day of every month at 12 nodal points (base villages) drawn from 6 mandals from Anantapur District. Serves patients from 63 target villages along with the patients visiting from about 400 villages in the region free of cost. Diagnostic bus has Pathology, X-ray, USG & Color Doppler, ECG, EEG etc. which serves remote areas free of cost
Dr Hedgewar Rugnalaya, Aurangabad	Year of inception - 1989 Level of care – Tertiary Geographic presence – Aurangabad, Maharashtra; Unit in Nasik and Shib Sagar, Assam No of Units / beds – 1/300 Governance – Dr. Babasaheb Ambedkar Vaidyakiya Pratishthan Charitable Trust	The Hospital is self- reliant for OPEX. Depends on Grants for CAPEX 80% of the patients (General ward category) pay ~5% more than the basic cost price of services, the remaining 20% of affording patients (private ward category) pay ~25% more than the basic cost price of services.	Reached out for medical care and social transformation to ~270 villages. Annually ~300000 patients in Aurangabad and ~100000 patients are reached out in Nashik through outreach camps. 40 slums have a full-time resident doctor staying in the slum areas and 8 rural centers are being run at negligible costs
Sewa Rural Kasturba Hospital, Jhagadia	Year of inception – 1980 Level of care – Secondary Geographic presence – Jhagadia, Gujarat No of Units / beds – 1/225 Governance – Board of Trustees along with a core management group	The Hospital is self- reliant for OPEX. Depends on Grants for CAPEX 95% general rooms and only 3 private rooms Annual expenses of ~Rs 10 Cr of which ~2Cr comes from its own revenue, 3 Cr from reimbursement of Government schemes, and ~3.5 Cr as grants/ donations	Took up the Jhagadia block having 6 PHCs and ~1.8 lakh population and showed improvement in the community health indicators

	About the Hospital	Operating Model	Key Community Engagement activities
Shushrusha Citizens Cooperative Hospital	Year of inception – 1966 Level of care – Tertiary Geographic presence – Dadar, Mumbai; unit in Vikhroli, Mumbai No of Units – 1/143 Governance – Board.	The Hospital is self- reliant for OPEX. Depends on Grants for CAPEX Members pay Rs 10,000 as lifetime fees, are entitled to the following benefits of Lifetime discount of 25% for OPD Consultation and IPD admission, 10% discount on Investigations and medicines.	The Hospital runs a Senior Citizens health education and awareness group which meets every alternate week. The Hospital collaborates with neighboring colleges for Anemia detection in girls (in line with the National Anemia programme. The Hospital regularly conducts CPR training for public.
MGIMS Kasturba Hospital	Year of inception – 1944 Level of care – Tertiary Geographic presence – Sevagram, Maharashtra No of Units / beds -1/ 1000 Governance – Board of Trustees of Kasturba Health Society	Grant-in-aid organization wherein Government of India, Maharashtra Government and the Kasturba Health society share the expenditure of the Hospital & Medical College in the proportion of 50:25:25 Annual Health Assurance Membership Card for Rs 100/- per person per year and give 50% concession in OPD & IPD services.	Achieved the formation of 3-4 Self Help Groups per village, totally ~170 such groups in all the villages of its field practice area; viz. PHC Anji, Gaul and Talegaon for women empowerment and health empowerment Kisan Vikas Manch (Farmers' club) provides learning for the members to improve their agricultural yield improve their economic status
EMS Memorial Cooperative Hospital	Year of inception – 1998 Level of care – Tertiary Geographic presence – Perinthalmanna, Kerala No of Units / beds – 1/500 Governance – Board of Directors elected from the shareholders	Membership can be availed by purchasing shares of Rs 250/- per share. If a person buys 400 shares @Rs 1 Lakh, he is given free treatment at the Hospital for himself and immediate family for the same amount for that year Charges for non-members are ~30-35% lesser than similar for-profit Hospitals	Dialysis unit with 6 Hemodialysis machines, is performing 550 free dialysis per month Started a Tribal Health and social transformation project at Atapadi which serves ~40000 tribal patients.

	About the Hospital	Operating Model	Key Community Engagement activities
Basavatarakam Indo-American Cancer Hospital, Hyderabad	Year of inception – 2000 Level of care – Tertiary Geographic presence – Hyderabad, Telangana No of Units / beds – 1/500 Governance – Board of Trustees of Nandamuri Basavatarakam Ramarao Memorial Cancer Foundation (NBTRCF)	The Hospital is self- reliant for OPEX. Depends on Grants for CAPEX Separate charge structure for underprivileged patients and for affording/international patients Hospital compares the market rate of Private Hospitals and intentionally positions its own charges ~ 10-20% lower	Cancer awareness and services to the poor people in avail free cancer diagnosis through CSP where more than 165000 people were screened in the last 15 years, 80 camps are done in a year and CSP screens 15000 poor people Cancer Screening Programs at a regular periodicity
PD Hinduja Memorial National Hospital	Year of inception – 1951 Level of care – Quaternary Geographic presence – Mumbai, Maharashtra No of Units / beds – 1/300 Governance – Board of Trustees, Governing Council, an Executive Council and a professional management tire having the CEO, COO	The Hospital is self- reliant for OPEX. Cross subsidize the treatment of the underprivileged by the revenue generated by treating the affording patients Hospital treats 10% of extremely underprivileged patients free of cost and 10% of underprivileged patients with 50% concession, Does additional charity also.	Runs 12 mobile health clinics in the rural area of Palghar having residential staff which cater to ~100000 patients annually

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