India’s Healthcare Industry

Innovation in Delivery, Financing, and Manufacturing

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To Lee, Alex, and Bud

with love

&

To God Almighty

with many thanks
Contents

List of Figures vii
Preface xv
Acknowledgments xix

SECTION I
Introduction: Lenses and Frameworks for Analyzing India’s Healthcare System

1. India’s Healthcare Industry: A System Perspective
   Lawton Robert Burns 3

2. Innovative Responses to the Healthcare Challenges Confronting India
   Stephen M. Sammut 38

3. India’s Healthcare Industry: An Overview of the Value Chain
   Lawton Robert Burns 59

SECTION II
Providers: Delivery of Healthcare Services

4. The Medical Profession in India
   Ajay Bakshi and Lawton Robert Burns 141

5. India’s Hospital Sector: The Journey from Public to Private Healthcare Delivery
   Lawton Robert Burns, Bhuvan Srinivasan and Mandar Vaidya 169

6. Medical Tourism: Opportunities and Challenges
   Lawton Robert Burns, Prashanth Jayaram and Richa Bansal 219

7. The Aravind Eye Care System
   R. Carter Clement, Arunavo Roy, Ravi Shah, James Calderwood and Lawton Robert Burns 290
Contents

8. The Real Deal at L V Prasad Eye Institute: Excellence and Equity in Healthcare 317
   Sashi Mohan Athota, Matthew Abel, Nessa Feller, Prasad Kilaru, Raghu Kodige,
   Vikram Lal, Meghna Shyam Varma, Richa Wilson and Rob Zwolinski

   Semi-Urban India
   Colleen Murphey

SECTION III
Payers: Financing of Healthcare Services

10. The Health Insurance Sector in India: History and Opportunities 361
    Aditi Sen, Jessica Pickett and Lawton Robert Burns

11. Providing Care to the Bottom of the Pyramid 400
    Neil Parikh and Vimala Raghavendran

12. Opportunities in Healthcare Private Equity in India 424
    Aman Kumar

SECTION IV
Producers: Manufacturers of Healthcare Technology

13. The Indian Pharmaceutical Sector: The Journey from Process Innovation 441
    to Product Innovation
    Vishwas Seshadri

14. India’s Biotechnology Sector 477
    Sarah Frew

15. The Medical Device Sector in India 500
    Lawton Robert Burns, Tanmay Mishra, Kalyan Pamarthy and Arunavo Roy

16. Balancing Access and Innovation in Developing Countries 538
    Ashoke Bhattacharjya and Brian Corvino

Contributors 561

Index 569
List of Figures

1.1 The Iron Triangle of Health Care: Balancing Act among Intermediate Outcomes 4
1.2 India and US: Convergences in Healthcare Systems 8
1.3 India vs. US: Divergences in Healthcare Systems 10
1.4 The Millennium Preston Curve 11
1.5 Health Care Financing Structures in China and India in 2005 13
1.6 Age Distributions in China and India 14
1.7 Policy Levers, Intermediate Outcomes, and Ultimate Ends of a Health System 16
1.8 Government Initiatives to Drive Behavioral Change, from Disseminating Information to Prohibiting Behavior 18
1.9 The Health Care Value Chain 18
1.10 The Value Chain in India 19
1.11 The Health Care Quadrilemma 20
1.12 India States and Population Growth 22
1.13 Lifestyle and Chronic Diseases by Inpatient/Outpatient Treatment 26
1.14 Shimmering and Shivering India Households 27
1.15 Financial Allocations for Health Sectors in India Between 1951 and 1997 29
2.1 Intervventional Programs for Maternal and Child Health Over the Last 40 Years 46
2.2 National Policies for Chronic Diseases and Injuries in India 49
2.3 Intervention Strategies Categorized by Level of Health System and Cost Effectiveness 51
3.1 India’s Regulatory Body 62
3.2 Total Health Expenditure in India as a Percentage of GDP 65
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>Total Health Expenditure in India as a Percentage of GDP, Broken Out by Private versus Public Spend</td>
</tr>
<tr>
<td>3.4</td>
<td>Total Health Expenditure as a Share of GDP, 2009 (or Nearest Year)</td>
</tr>
<tr>
<td>3.5</td>
<td>Total Health Expenditure Per Capita, Public and Private, 2009 (or Nearest Year)</td>
</tr>
<tr>
<td>3.6</td>
<td>Projected Healthcare Spending in India ($US in Billions)</td>
</tr>
<tr>
<td>3.7</td>
<td>Five Year Plans (FYPs) Expenditures</td>
</tr>
<tr>
<td>3.8</td>
<td>Government Investment in Healthcare and Other Sectors</td>
</tr>
<tr>
<td>3.9</td>
<td>Private Sector Involvement in India's Growing Healthcare Market</td>
</tr>
<tr>
<td>3.10</td>
<td>Out-of-Pocket Spend on Various Categories</td>
</tr>
<tr>
<td>3.11</td>
<td>Public Health Expenditure in India</td>
</tr>
<tr>
<td>3.12</td>
<td>Sources of Funding for India's Healthcare System</td>
</tr>
<tr>
<td>3.13</td>
<td>Sources of National Health Expenditures: Direct + Indirect Financing (2001–02 Data)</td>
</tr>
<tr>
<td>3.14</td>
<td>Destinations of National Health Expenditures (2001–02 Data)</td>
</tr>
<tr>
<td>3.15</td>
<td>Destinations of Out-of-Pocket Household Spending</td>
</tr>
<tr>
<td>3.16</td>
<td>Traditional and Modern Indian Medicine</td>
</tr>
<tr>
<td>3.17</td>
<td>Hospital Beds Per 1000 Population, 2000 and 2009 (or Nearest Year)</td>
</tr>
<tr>
<td>3.18</td>
<td>Government Initiatives to Improve Healthcare Infrastructure</td>
</tr>
<tr>
<td>3.19</td>
<td>India's Healthcare Workforce</td>
</tr>
<tr>
<td>3.22</td>
<td>Ratio of Nurses to Physicians, 2009 (or Nearest Year)</td>
</tr>
<tr>
<td>3.23</td>
<td>Growth in Health Insurance Coverage</td>
</tr>
<tr>
<td>4.1</td>
<td>Current Architecture of India’s Health System</td>
</tr>
<tr>
<td>4.2</td>
<td>Details of Indian Public Health System Infrastructure</td>
</tr>
<tr>
<td>4.3</td>
<td>Indian Healthcare Providers Divided into Several Unique Segments</td>
</tr>
<tr>
<td>4.4</td>
<td>Trends in Medical Education, 1950–2004 (NISM – Allopathic)</td>
</tr>
<tr>
<td>4.5</td>
<td>Concentration of Medical Colleges in Southern States of India (2011)</td>
</tr>
<tr>
<td>4.6</td>
<td>The Long and Arduous Journey to Become a Doctor</td>
</tr>
<tr>
<td>4.7</td>
<td>Allopathic Physician’s Qualifications</td>
</tr>
<tr>
<td>4.8</td>
<td>Two Parallel Tracks for Medical Education in India</td>
</tr>
<tr>
<td>4.9</td>
<td>Doctor Engagement Models in India</td>
</tr>
<tr>
<td>4.10</td>
<td>Physicians can be Segmented by Their Goals and Practice Behavior</td>
</tr>
<tr>
<td>4.11</td>
<td>Physicians Vary Significantly in the Financial Value they Bring to a Hospital</td>
</tr>
<tr>
<td>4.12</td>
<td>Government Agencies Have Multiple Interactions with Physicians</td>
</tr>
<tr>
<td>4.13</td>
<td>Mobile Technologies That Can Disrupt the Healthcare Delivery Model</td>
</tr>
</tbody>
</table>
List of Figures

5.1 Healthcare Spend by Government on a Steady Rise 170
5.2 India’s Healthcare Spend Likely to Become Much Higher than Peer Benchmarks 171
5.3 Primary, Secondary, and Tertiary Care Levels 171
5.4 Increase in Household Income 2010–20 172
5.5 India Shortfall in Beds, Physicians and Nurses 173
5.6 India Lags behind Most Other Countries in Immunization Rates, at Full Immunization Rate of around 61 percent 174
5.7 Multiple Gaps Lead to Demand Leakages 175
5.8 Right Siting is Critical to Ensure Demand–Supply 176
5.9 Structure of NRHM (11th Five-Year Plan) 179
5.10 Hospital Inpatient Market Shares, by Public–Private and Rural–Urban 180
5.11 Imbalance in Bed Supply and Utilization 181
5.12 Public Share of Outpatient Market, by Rural–Urban 181
5.13 All-India Shortfall in Health Infrastructure 182
5.14 State Variations in Government–provided Hospital Beds 182
5.15 73 Percent of Total Funds Allocated by Central to State Government Used 183
5.16 Hospital Projects Funded by the IFC in US $ Million 186
5.17 Vaatsalya Hospital Structure 188
5.18 Leading Hospital Players in India 193
5.19 Fortis Hospitals: Establishing Itself as a Multi-specialty National Chain 196
5.20 Fortis Hospitals: Escorts Acquisition Helped Fortis be EBITDA Positive 197
5.21 Fortis ARPOB Model 199
5.22 Fortis Combined Operations 204
5.23 Fortis Geographic and Business Diversification 205
5.24 Apollo Hospitals: Concentrated in South, Expanding to Other Regions 205
5.25 Apollo Hospitals: High Margins Despite Capacity and Regional Expansion 206
5.26 Apollo Hospitals: High Local Market Share to Drive Profitability 210
5.27 Max Healthcare: Regional Play – Underserved but Growing Locations 213
5.28 Max Healthcare: Turns EBITDA Positive FY08 214
5.29 Future Outlook for Private Hospital Sector 215

6.1 Medical Tourism: Historical Perspective 220
6.2 Cost Comparison by Procedure 221
6.3 Trade in the Health Sector 223
6.4 Definition of Medical Travel 228
6.5 Flow of Medical Tourists by Country 229
6.6 Balancing Price, Quality, and Service 230
6.7 Hypothesized Stages of Medical Tourism 232
6.8 Survey of Medical Travelers from around the World 234
6.9 Travel Costs in Medical Tourism 236
List of Figures

6.10 Flow Process for the Medical Tourist 239
6.11 The Medical Tourism System (MTS) 239
6.12 Physician Fees for Routine Office Visits: US, India, and Other Countries 241
6.13 MRI Imaging Fees: US, India, and Other Countries 241
6.14 JCI Accreditations by Country 242
6.15 US Medical Program Affiliations 244
6.16 Understanding the Payers in the US 245
6.17 Summary of Medical Tourism Offerings from Commercial Insurers 248
6.18 New AMA Guidelines on Medical Tourism 249
6.19 State Bills to Incentivize Medical Tourism 252
6.20 Stakeholder Perceptions Towards Medical Tourism 253
6.21 Patient Inflow to Indian Hospitals, by Country 260
6.22 Cost Comparison for CABG Between Three International Medical Tourism Providers 261
6.23 Top 10 Source Countries for Foreign Tourist Arrivals (FTAs) in India in 2009 262
6.24 JCI Accredited Organizations in India 263
6.25 Most Popular Treatments Sought in India by Medical Tourists 263
6.26 Broadening the List of Target Countries – for Indian Hospitals 265
6.27 Share of International Patients by Hospital 265
6.28 Essentials for Medical Tourism Success 267
6.29 Consumer Concerns 267

7.1 The Aravind Eye Care System, 2009 293
7.2 Aravind’s Financial Results 294
7.3 Total Volume for Surgeries and Lasers 295
7.4 Surgical Quality at Aravind 296
7.5 Surgeon Productivity Comparisons (Annual Procedure Volume) 298

8.1 Causes of Blindness and Visual Impairment 320
8.2 LVPEI Eye Health Pyramid 321
8.3 Historical Patient Statistics at LVPEI 324
8.4 LVPEI Organization Structure 326

9.1 Purchasing Hydrochloride at Jaisalmer Pharmacy 336
9.2 Streets of Jaisalmer 337
9.3 Generic Injectable Adrenaline and Methylprednisone, Jaisalmer Pharmacy 339
9.4 Price List Posted by Physician Organization in Mandya Hospital Waiting Room 343
9.5 Mysore Hospital Nursing Station 345
9.6 Sample Profit and Loss (P&L) Exhibit A: Revenues 349
9.7 Sample Hospital Utilization Report (October 2011) 351
9.8 Prototype Electric Wheelchair 352
List of Figures

9.9 Designation of Separate Waste Bags Posted Above Scrub Sink in the OR 353
9.10 Questions Asked on Patient Feedback Call 354

10.1 Out-of-Pocket Spending is the Primary Source of Healthcare Spending in India 362
10.2 Indian General [Non-Life] Insurance Companies 363
10.3 The Fundamental Role of Health Plans is to Insure Members against Unexpected Financial Burdens of Medical Care 366
10.4 Historical Timeline of Health Insurance in India 369
10.5 Public Sector Insurance Companies Continue to Comprise about 60 percent of the Market but Stand-alone Insurers are Gaining Share 370
10.6 Emergence of Private Insurance Firms 373
10.7 Growth in Indian Insurance Market 2002–08 374
10.8 Organized Workforce in India is Historically Small, but Growing 375
10.9 Indian Insurance Value Chain 375
10.10 TPAs Primarily Administer Claims and Contract Provider Network Management for Insurers 376
10.11 National and State Health Insurance Coverage 2010 378
10.12 Population Covered by Health Insurance 379
10.13 Source of Revenue under Insurance Schemes 379
10.14 Ecosystem of Indian Insurance (Private Intermediation in the Indian Health Care Sector) 380
10.15 Three Types of Insurance Policies 381
10.16 Characteristics of Health Insurance Policies 382
10.17 Future Growth of the Health Insurance Industry 392

11.1 Estimates of Number Living Below Poverty Line (Millions) 402
11.2 Inequities in Health Status and Utilization 405
11.3 Public Health Care Facilities Run by the Municipality versus the Maharashtra State in Mumbai 406
11.4 Prahalad’s Principles of Innovation for BOP 412
11.5 Business Models that Work 412
11.6 Yeshasvini Identity Card (RSBY) 413
11.7 Yeshasvini Enrollees (100,000), 2003–10 414
11.8 Premiums and Subsidy Per Yeshasvini Enrollee (Rs.), 2004–08 415
11.9 Surgical Volume Per Physician in Selected Cardiac Programs 417
11.10 Acumen Fund Equity Investments in India 2011 418
11.11 Acumen Investments 419
11.12 Acumen Fund’s Portfolio ($M under Management) 419

12.1 Recent Trends in PEVC Investments 427
12.2 Recent Notable Healthcare PEVC Deals 427
List of Figures

12.3 Pharmaceutical and Healthcare Deal-Making 2006–10 435
12.4 PEVC as a Cyclical Business 435
13.1 Evolution of the Indian Pharmaceutical Sector 443
13.2 Indian Pharmaceutical Domestic Market Sales Forecast 444
13.3 Sales and Sales Growth by Therapeutic Area in India 445
13.4 Domestic Market Share of Top 10 Competitors 446
13.5 USFDA ANDAs Filed by Top 10 Indian Pharmaceutical Firms 448
13.6 Total US FDA ANDAs Filed and Approved for Each Company till FY12 449
13.7 Recent Collaborative Deals Between Indian Companies and Foreign MNCs 451
13.8 Leading Eight Indian Pharmaceutical Companies Net Sales in Rupees Million by Rank, 2009–11. 453
13.9 Profit after Tax (Rs. Million) 454
13.10 Indian Pharmaceutical Companies Sales Rankings FY12 454
13.11 Ranbaxy's Top 10 Brands 455
13.12 Geographic Split of Ranbaxy's FY12 Global Sales 456
13.13 Geographic Split of Global Revenues FY12 – Dr Reddy's Laboratories 457
13.14 Sun Pharmaceuticals and Taro Revenue Mix FY11 460
13.15 Lupin's FY12 Revenue Mix 462
13.16 Lupin's FY12 Therapeutic Segments 463
13.17 Cipla Revenues by Therapeutic Area 465
13.18 Recent Acquisitions of Indian Companies by MNCs 467
13.19 A Comparison of Unit Manufacturing Cost of Formulated Chemical Drug Product Between US-based and Indian Formulation Plants 468
13.20 Traditional Bulk Drug and Formulation Clusters in India 469
13.21 G-CSF Price Trend after Entry of Biosimilars 472
13.22 G-CSF Market Expansion after Entry of Biosimilars 473
14.1 India Biotech Industry 2005–10 ($MM) 479
14.2 Biotech Industry Exports vs. Domestic 2009–10 ($MM) 479
14.3 Top Biotech Clusters (2009–10) 480
14.5 BioPharma Revenues by Sub-Segment (2009–10) 482
14.6 India’s Top 10 Domestic Biotech Companies (2009–10) – $MM 482
14.7 Biocon Revenues by Segment (FY2006–10) 485
14.8 Biocon Financials FY2006–10 ($MM) 486
14.9 Biocon Pipeline 487
14.10 Serum Institute of India’s Exported Products 489
14.11 FY2009–10 Panacea Financial Performance Summary ($MM) 491
15.1 Global Medical Device Market 2004–11 502
15.2 Projected Medical Device Market 2011–18 503
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.3</td>
<td>Geographical Distribution 2011</td>
</tr>
<tr>
<td>15.5</td>
<td>Global Market Share by Segment, 2011</td>
</tr>
<tr>
<td>15.6</td>
<td>Largest Medical Device Companies and Their Sales 2010 and 2011</td>
</tr>
<tr>
<td>15.7</td>
<td>Indian Medical Device Market 2004–11</td>
</tr>
<tr>
<td>15.8</td>
<td>Medical Device Innovation Timeline</td>
</tr>
<tr>
<td>15.9</td>
<td>The American Multinational Approach to Emerging Markets (EM)</td>
</tr>
<tr>
<td>15.10</td>
<td>Funding Models for Medical Device Innovations</td>
</tr>
<tr>
<td>15.11</td>
<td>Growth in the Number of VC/PE Investors in Different Regions</td>
</tr>
<tr>
<td>15.12</td>
<td>Regulatory Process for Medical Devices</td>
</tr>
<tr>
<td>16.1</td>
<td>Projected Global Distribution of Chronic Disease Deaths</td>
</tr>
<tr>
<td>16.2</td>
<td>Projected Deaths by Major Cause</td>
</tr>
<tr>
<td>16.3</td>
<td>Estimated Proportions of Total Deaths and DALYs Lost by Cause</td>
</tr>
<tr>
<td>16.4</td>
<td>Classifications Based on Global Medical Device Nomenclature</td>
</tr>
<tr>
<td>16.5</td>
<td>Medical Device Revenue by Country</td>
</tr>
<tr>
<td>16.6</td>
<td>Top 30 Medical Device Companies by Sales Revenue</td>
</tr>
<tr>
<td>16.7</td>
<td>Comparison of Urban Population Concentration and GNI Per Capita</td>
</tr>
<tr>
<td>16.8</td>
<td>History of Improved Health Outcomes in Acute Myocardial Infarction</td>
</tr>
<tr>
<td>16.9</td>
<td>Reductions in Utilization in Acute Myocardial Infarction</td>
</tr>
<tr>
<td>16.10</td>
<td>WHO Perspective on Medical Device Market Access</td>
</tr>
</tbody>
</table>
This volume grew out of an experiment at the Wharton School's MBA program: to have Wharton faculty teach global modular courses (GMCs) to Wharton students on specific topics all around the world. The idea of the GMCs is to provide students with a unique combination of local immersion, course concepts, and understanding of emerging business issues. The topics and locations of these courses are chosen to give students first-hand exposure to business challenges and opportunities in regions undergoing rapid change – for example, energy and infrastructure in Brazil, global supply chain management in China, and marketing in emerging economies such as India and China.1

The first such course offered was HCMG 890, “Innovation in the Indian Healthcare Industry.” Wharton faculty and students developed the content for the course in collaboration with industry experts from across India. Their collective effort is presented here. This volume seeks to describe the current state of India’s healthcare system ranging from the parties that pay for healthcare (individuals who pay out of pocket, insurance companies, community insurance schemes, government ministries), the parties that provide healthcare (hospitals, physicians, and diagnostic laboratories), and the parties that produce the products used in healthcare delivery (pharmaceuticals, biotechnology, and medical devices). The volume also includes discussion of innovative efforts to raise capital for the development of these sectors (e.g., private equity and venture capital), to deliver care to those at the “bottom of the pyramid,” to balance the population’s ability to pay with their desire for access to modern care and technology, and to deliver care to foreign tourists. As such, this represents an effort to capture the components of the “value chain” of healthcare in India. In prior works, Wharton faculty have captured portions of the US healthcare value chain; this represents our first effort to go global.2

At first, it seems daunting (and perhaps presumptuous) to attempt to describe the healthcare system of a foreign country that one has never lived in. I have spent over 30 years studying and conducting research on my own country’s healthcare system, beginning during my doctoral student days in the late 1970s. I have taught an introductory course on the US healthcare system since the early 1980s, and taught the required first-year core course to all entering MBA
Preface

healthcare majors at Wharton since the late 1990s. In that course, we explicitly cover the pay-
ers, providers, and producers of healthcare – from a domestic angle as well as an international angle – all, by necessity, in 14 weeks. The Wharton students are increasingly drawn from a global pool, are the brightest and most demanding students I have ever had the privilege to teach, and historically have been more interested in the product side of the industry (pharmaceuticals, biotechnology, medical devices) than the payer and provider side (where most faculty like myself trained and have field experience). After more than 30 years of considerable effort, I feel I am beginning to understand how it all works (or doesn’t) and just how “systemic” it really is.

Thus, despite my lack of sustained exposure to and formal training in other healthcare contexts, I have had to confront how other countries finance and deliver healthcare to their populations. I have also had the privilege of training (and working on research projects with) an increasingly international student body, and learning from them as I go. When the Wharton School asked me to travel to the Indian School of Business (ISB) to teach a course on India’s healthcare system to ISB and Wharton students, I suspected that some (though not all) of the learning gathered on how systems work in the US might be transferable, but that I might also be able to discern important differences. After all, India has many states and a central federal government that split financial responsibility for healthcare, as in the US. India also has an entrepreneurial class of physicians (many of them western trained) and for-profit hospital executives who are pursuing many of the innovative strategies observed in the US system. At the same time, India has historically lacked the wealth of the US and has thus developed innovative financing and delivery systems that balance cost and access better than their counterparts in the US.

After several visits to India and other Asian countries (such as China, where I now teach a second GMC on their healthcare system at Guanghua School of Management at Peking University) to study their healthcare systems and talk with academics and industry experts, I have confirmed that the similarities outweigh the differences. I have concluded that governments around the world grapple with a similar set of issues in financing and delivering healthcare: how to balance the ultimate goals of improving health status, financial risk protection, and consumer satisfaction (the WHO model) or improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare (the “triple aim” pursued in US healthcare reform). The frameworks used to analyze national healthcare systems and engineer their goals (policy levers and intermediate outcomes) are also broadly applicable (e.g., to countries like India and China). Finally, I have concluded that these countries face many of the same concerns and problems, utilize many of the same strategies to address these issues, and possess many of the same dynamics between major players on the financing, delivery, and product development sides.

This volume represents my effort to demonstrate these contentions. More importantly, it is intended to educate practitioners and executives who operate and/or do business in India in order to provide them with a “system view.” I have learned through several decades of experience studying the US system that parties occupying one part of the value chain (payers, providers, producers – and the intermediaries who separate them) rarely understand the motivations and strategies of the others, which leads to enormous conflicts and misalignment of incentives.
Such a value chain (or system) view is not presented in other recent texts on India's healthcare industry. This volume is designed to educate all parties about one another.

Notes

Acknowledgments

This book is the serendipitous result of interest on the part of individuals at both Wharton and the Indian School of Business in studying the vibrant healthcare industry in India. At Wharton, Harbir Singh, Vice Dean for Wharton's Global Initiatives, encouraged me to teach the Global Modular Course (GMC) on India’s healthcare industry. Anjani Jain and Ziv Katalan, both on Wharton’s faculty, were deeply involved in the Global Initiatives and spurred me to develop a course in tandem with ISB. Anjani and Ziv handled much of the logistics involved in putting on a course such as this. I am so grateful they accompanied me to Hyderabad during its first iteration at ISB as I became acclimated to “The Indian Way.” As the healthcare program in Mohali took off, Jagmohan Raju lent invaluable help in navigating the interstices between Wharton and ISB.

To develop the content for such a course was a daunting task for someone unfamiliar with the country and its healthcare system. In fashioning the course curriculum and lecture material, I necessarily relied on a lot of people who had studied the topic for some time. These included my Wharton teaching assistants, most of whom were Indian and had worked in the industry, or had studied various sectors in India: (in alphabetical order) Sarah Frew, Prashanth Jayaram, Kalyan Pamarthy, Neil Parikh, Vimala Raghavendran Aditi Sen, Vishwas Seshadri, and Bhuvan Srinivasan. They also included my Wharton colleagues, like Jitendra Singh who gave me the book he coauthored on *The India Way* just as I set off to teach in India for the first time. I have also learned a considerable amount from the healthcare industry executives who came to speak to my ISB class or sent me a considerable amount of background reading material (again, in alphabetical order): Pervez Ahmed, Ashok Alexander, Ajay Bakshi, Sofi Bergkvist, Ashoke Bhattacharjya, Shefali Chhachhi, Amita Chebbi, Deepanwita Chattopadhyay, Krishna Ella, Zeena Johar, Ashok Kakkar, Deepa Krishnan, Preetha Reddy, Suneeta Reddy, Varaprasad Reddy, Varun Sahni, Devi Shetty, Shivender Singh, A. Vaideesh, and Vishal Vasisht, and the CEOs of LV Prasad Eye Institute and Gandhi Government Hospital in Hyderabad. Finally, I wish to thank some of my friends in the consulting and investment communities who shared with me presentations on India’s healthcare industry: Jay Desai, Karl Kellner, Paul Mango, and Ajit Singh.
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I gratefully acknowledge the support of Analjit Singh, Founder and Chairman of Max India Limited, who spearheaded the development of a healthcare management program at ISB’s new campus in Mohali. It was Analjit who catalyzed my decision first to teach at the campus in Hyderabad, and later to serve as the program’s first area leader. Analjit’s generosity has made all of the above possible.

Every author knows the singular importance of a good editor and editorial help. Many thanks to Chris Harrison at Cambridge University Press for adroitly seeing the potential of a volume like this, and to Suvadip Bhattacharjee and Ranjini Majumdar for seeing it through with alacrity. My administrative assistant, Holly Cronin, did excellent work in editing this entire volume. I hired her almost entirely for this task and she has exceeded all of my expectations.

Finally, I want to thank my wife, Alexandra, who initially suggested to me that I ought to get more “global” in my research and consider countries like India. Like many husbands, I heeded her suggestion a bit later than I should have, but here I am at last.