

HEALTHCARE PERFORMANCE IMPROVEMENT

Unlocking Value Creation Opportunities in Indian Hospitals



ALVAREZ & MARSAL



1.0

CONTEXT – THE NEED FOR

A STRUCTURED APPROACH

TOWARDS PERFORMANCE

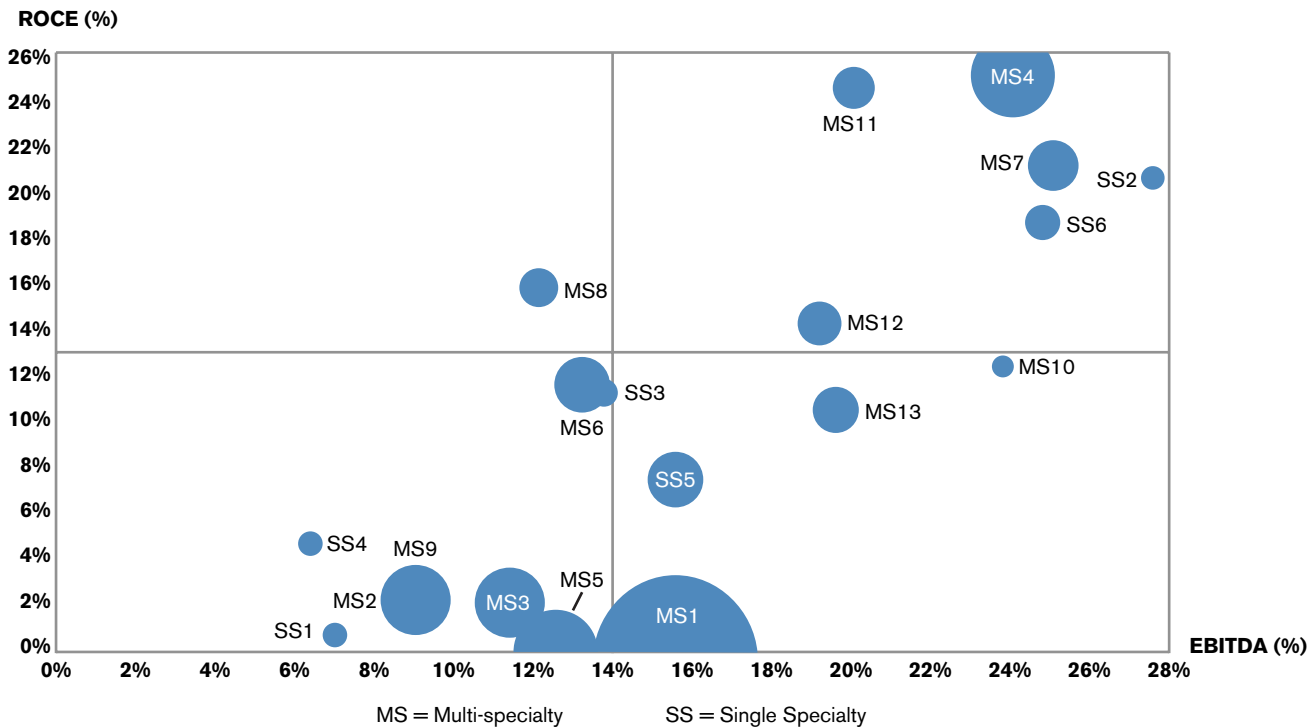
IMPROVEMENT



The private healthcare growth story in India has largely been an urban phenomenon, with the proliferation of private hospitals in top-tier towns. This, in many cities, has led to a healthy supply scenario or even an oversupply scenario – catering not only to the city in question but the larger catchment areas beyond the city as well. This dwindling demand-supply gap in urban clusters and increasing private competition is likely to impact the operational and financial performance of private players in the years to come. Managing optimal

performance in such a complex and dynamic competitive environment calls for a structured approach towards hospital performance management as opposed to the largely entrepreneurial, intuitive approach adopted by private operators over the last few decades.

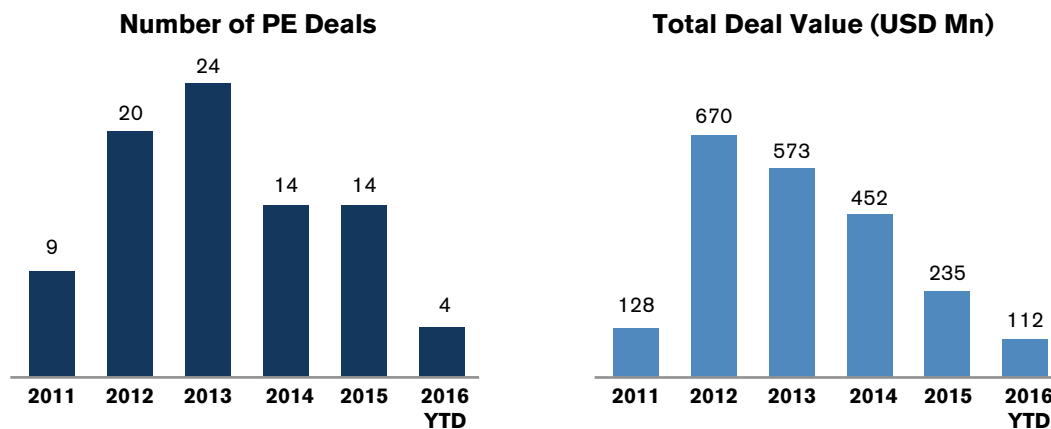
A look at the financial performance of leading healthcare organizations in India, both multi and single-specialty, helps underscore the need for more scientific performance management.



Source: Vccedge

As this illustration shows, the majority of the reputed players in the healthcare industry have found it difficult to replicate their success in key locations across their network, thereby pulling down overall group performance.

Add to this the fact that the healthcare sector has seen a profusion of private equity investment over the last five years, and many of these investors will push for attractive returns on their exits in the next few years. This, in many cases, will be an additional driver for exploration of more rational, structured means for improving hospital performance.



Source: Vccedge

Note: Deal value and number of deals could be higher as the value of some deals is undisclosed; Deals considered only in the healthcare delivery segment.

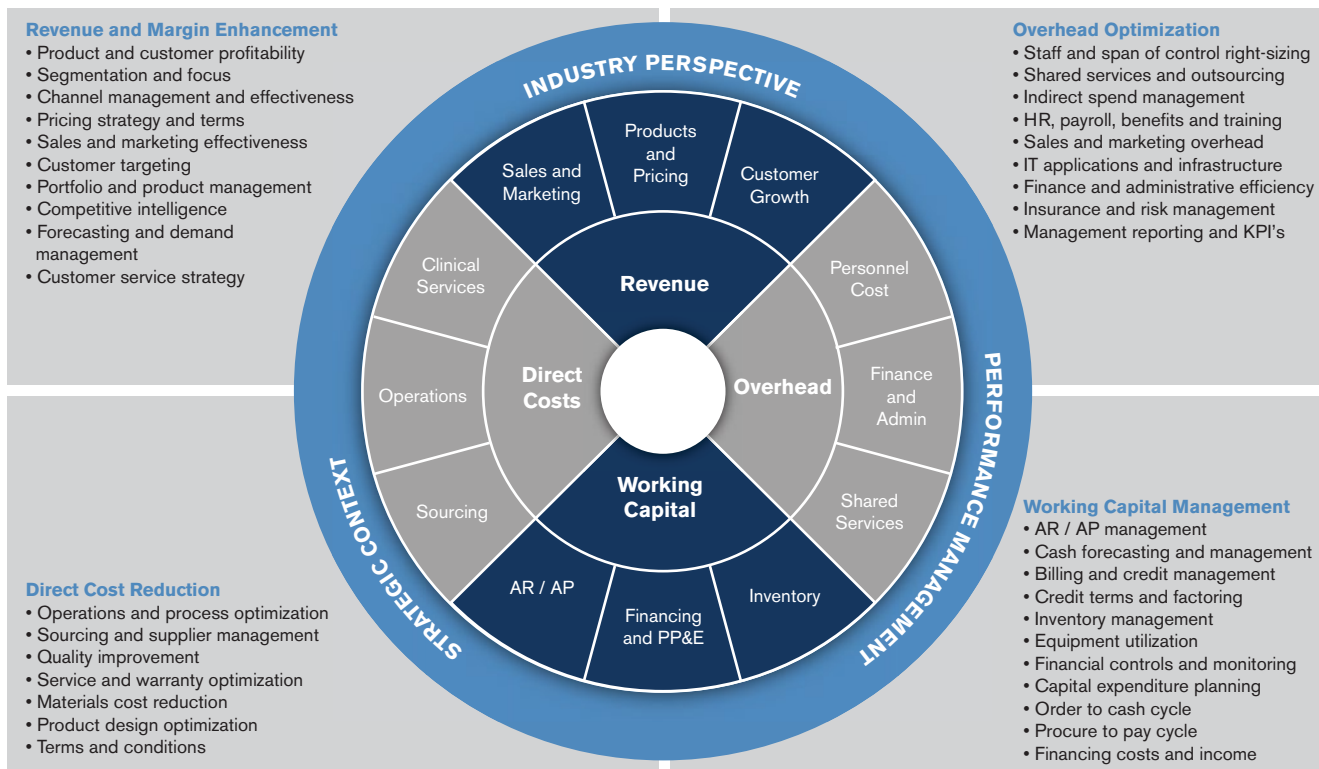




2.0

A HOLISTIC FRAMEWORK FOR

PERFORMANCE IMPROVEMENT



The healthcare industry in India needs a holistic approach towards performance improvement that addresses all the factors affecting revenue enhancement, direct cost reduction, overhead optimization and working capital management leading to improved operational and financial performance for the organization.

Revenue enhancement: Driving top-line growth is a challenge faced by the incumbent players as well as new entrants. In many cases, incumbent players are already burdened with high patient footfalls and are operating at near full capacity and hence, in order to improve revenue further, must evaluate opportunities for improving realization per patient and optimizing capacity utilization. New entrants face the challenge of driving footfalls to optimally utilise the built bed capacity and equipment installed. The key aspects that need to be analysed for revenue enhancement in such cases include patient volume enhancement, patient realization improvement and capacity optimization.

Cost optimization: Cost optimization measures focus on reduction of direct and indirect cost heads. Hospitals need to maintain a fine balance between cost rationalization and staff adequacy to maintain patient safety and quality standards. The key aspects that need to be analysed for cost optimization include medical and non-medical consumables cost, clinician cost, other employee cost, sales and marketing cost, and other overheads.

Working capital management: Working capital management must focus on optimizing channel mix, rationalizing inventory of medical and non-medical items, and reviewing credit terms for vendor payments. Capital expenditure on real estate and medical equipment needs to be optimized for the patient and service mix of the hospital in line with the market needs and the desired positioning of the hospital. Key focus areas for capex optimization include facility design, construction cost, and medical and non-medical capital expenditure.

2.1 | REVENUE ENHANCEMENT

Accelerated revenue enhancement is perhaps the biggest challenge facing healthcare organizations today, especially in view of new facility setups in new micro-markets. Returns on healthcare investments by private equity organizations are also contingent on how rapidly revenue and profitability can be maximized in new healthcare facilities by the investee organization.

Accelerated revenue enhancement in healthcare facilities has three strategic levers:

1. Footfalls or patient volume enhancement
2. Enhancement of revenue per footfall or revenue per patient
3. Capacity optimization (applicable in facilities constrained for capacity)

2.1.1 | FOOTFALLS OR PATIENT VOLUME ENHANCEMENT

Enhancing patient footfalls for hospitals has three strategic imperatives for operators:

1. Managing favourable patient profile by payment modes or channels viz. institutional / insurance / out of pocket and walk-ins / referrals
2. Managing the mix of repeat versus new patients
3. Aligning the service mix in tune with the catchment demand

Payment mode often has an impact on hospital profitability – given that corporate or insurance channels typically operate at a discount versus cash market rates. However, these institutional channels often contribute significant volumes of patients if managed well and hence compensate well for the

lower pricing levels. Leading private tertiary care hospitals in India typically have a 15-25 percent Inpatient (IP) volume contribution from Public Sector Unit (PSU) or corporate channels and 25-35 percent contribution from Insurance and Third Party Administrator (TPA) channels. This clearly has significant room for improvement. Some of the reasons that lead to a sub-optimal performance from insurance / TPA channels are limited empanelment with insurance / TPA network, limited corporate engagement initiatives such as corporate clinics or lifestyle disease management campaigns in corporate groups, lack of customized offerings and poor conversion management. For example, some of the leading players offer customized rehabilitation programs to corporates through leading TPAs, resulting in additional footfalls from the corporates empanelled with the TPAs.

The other key factor affecting patient footfalls is how hospitals execute on their market outreach for impacting direct patient footfalls as well as referrals. Direct patient footfalls are typically only 15–25 percent in most corporate hospitals in India. This is in stark contrast to diagnostic setups where there is clear evidence of increasing consumer awareness of branded diagnostic chains. Leading diagnostic chains in India have 50–60 percent “retail” patient footfalls that are not referred by any stakeholder; this metric used to be at a low 15-20 percent only five to six years back. Are hospitals likely to follow the diagnostics story with increased instances of consumers independently choosing their care provider instead of being referred or directed by doctors? There are already green shoots of that revolution visible in select cases where 30–60 percent of total patient inquiries are being routed through hospital portals or call centres. Also, independent patient-doctor connect portals are increasingly aiding in such independent decision-making. Currently, the poor direct footfall contributions, even in urban setups, is a reflection of the inability of the corporate hospital sector to effectively manage their initiative and spend mix for promotions across various channels. Most importantly, the majority of



healthcare organizations including leading ones are yet to execute on a coherent, focused digital outreach and new media strategy.

The flip side of the story is how hospitals manage their referral channels. For all practical purposes, at least in the foreseeable future, referral channels will continue to contribute a large proportion of IP cases to hospitals. Hence, one cannot over-emphasize the need to manage such referral channels in a structured manner. However, there are many gaps in the way hospitals plan and execute their market outreach for referrals in terms of market connect and new product mix not being in alignment with catchment needs. Hospitals must design customized initiatives such as associate centre programs with feeder hospitals, general practitioners (GPs) and specialist clinics to address the referral requirements for specialties or micro-specialties. For example, leading hospitals develop ST-segment elevation MI (STEMI) networks for cardiac specialties, where the cardiologist trains the local clinician and paramedics on protocols to be followed to stabilize the patient in case of emergency and then refer to the hospital for further treatment. A similar approach can be extended to other specialties such as oncology and gastroenterology as well, where chemotherapy and endoscopy procedures would be performed at the associate centre and the complex surgical procedures would be referred to the main hub hospital.

The second key facet of footfall volumes and profile management is related to the fact that hospitals in India still take an episodic view of events rather than a lifecycle view. The “footfalls” approach is myopic and helps build only for the short term. Leading healthcare groups globally typically have 50–70 percent of their cases contributed to by repeat patients. It is an advertisement of customer loyalty as much as it is an indication of the hospitals’ ability to treat the patient as a “lifetime customer” and not just as another footfall. In India, even leading hospital groups often do not have a clear sense of new versus repeat patients. As a corollary, they do not have any understanding of follow-on opportunities for such patients. This impacts both the revenue basket per patient as well as the overall contribution of repeat patients. Leading hospitals rely on data mining, customer relationship management (CRM) and clearly defined clinical care pathways for lifetime patients to determine follow-up opportunities.

The third aspect of footfall management is related to providing the right service mix in alignment with the catchment demand and gaps unaddressed by competition. For example, a hospital on a highway will typically have an emergency, ambulatory care and trauma care setup. It needs to go beyond immediate patient care opportunities and provide the entire gamut of services such as rehabilitation services, orthopaedics and cosmetic care that will be essential for such patients.



2.1.2 | ENHANCEMENT OF REVENUE PER FOOTFALL OR REVENUE PER PATIENT

Enhancing revenue per footfall or patient is achieved by focusing on three key areas:

1. Cross-sell or up-sell initiatives
2. Pricing optimization
3. Conversion management

The ability to up-sell and cross-sell services is contingent on whether the hospital has thought through the service offerings that can enable such opportunities as well as the ability to use data analytics for identifying potential clinical and non-clinical service requirements that can be proactively promoted to the patient. For example, the use of data analytics will alert the organization that a patient undergoing joint replacement surgeries will often require rehabilitation services and hence, the hospital can promote home healthcare services to the patient. Similarly, building interdepartmental capabilities enables the hospital to perform high-end, complex surgeries and improve quality outcomes. For example, neurosurgery and plastic surgery departments could collaborate to perform 3D-enabled surgeries for skull and spine.

The second aspect relates to optimizing the pricing of services rendered. Pricing optimization is a complex and evolved analytical science that Indian healthcare organizations have yet to adopt. Leading healthcare organizations in India largely rely on historical trends, market benchmarking and cost-plus models to decide pricing. Ideally, pricing has to be decided based on models that would take into account a myriad of factors including the hospital's brand, the relevant department or clinician's brand vis-à-vis competition, pricing benchmarks in the market, bottom-up costing, channel, desired positioning and package definition among others. Using such analytical models will ensure two outcomes – potential pricing upsides

leading to margin expansion and a favourable outcome on enhancing patient footfalls. The area of pricing also offers “easy wins” and revenue upsides that many hospitals often overlook, for example, an initial assessment charge for an inpatient that is commensurate with the effort by the clinicians and paramedical staff, which is not widely followed in leading hospitals.

The nature of the healthcare business in India demands that hospitals frequently discount or write-off services to the patient. Hospitals follow an authorization matrix to keep the discounts under control; however, this mechanism is often not properly followed, resulting in higher discounts. Typically, leading hospitals keep the discounts under control at 1–2 percent of the revenue for cash patients, whereas the discount for under-performing hospitals could become as high as 8–10 percent of revenue.

The third driver to maximizing revenue per footfall is effective conversion management. Mapping the journey of a patient from entry to exit helps management to identify revenue leakages at the hospital. Leading hospitals meticulously track conversion indicators such as Outpatient (OP)/ Emergency (ER) to Inpatient (IP), Outpatient (OP) / Emergency (ER) to Pharmacy, OP / ER- diagnostics, amongst others, to measure performance by departments and doctors. Moreover, hospitals offering allied services such as home healthcare, tele-consultation, etc. have to focus on follow-ups and track conversion for these services. Some of the reasons for sub-optimal performance by the hospitals in conversion management include lack of inter-departmental coordination, incentive structure for clinicians as well as the operations team. For example, a doctor connected with a neighbouring diagnostic centre or pharmacy may refer patients to such centres, thereby resulting in revenue leakage for the hospital. Again, focused analytics can help hospitals identify anomalies in conversion and utilization metrics by doctors or departments and identify root causes for sub-optimal performance.

2.1.3 | CAPACITY OPTIMIZATION

Capacity optimization is significant especially in cases where the hospital is constrained for capacity and is already operating at high levels of occupancy or utilization.

The key levers to optimize capacity are:

1. Average length of stay (ALOS) optimization
2. Outpatient department (OPD), occupational therapy (OT), intensive care unit (ICU) and equipment utilization

A key lever to improve throughput is reduction in the length of stay of the patient while not compromising on outcomes or the quality of care. Mature hospital facilities operating at high utilization levels face lost sales due to bed capacity constraints. Globally, hospitals have been able to reduce the length of inpatient stay by the adoption of monitoring mechanisms and follow-up care initiatives such as home healthcare services, remote monitoring through e-ICU and telemedicine, amongst others. For example, a knee bilateral package in India typically has an ALOS of six to seven days, whereas a similar procedure in developed countries would have an ALOS of five to 5.5 days due to better post-discharge rehabilitation techniques and other predefined methods. The other reason why hospitals in India have struggled to reduce ALOS is because they have only had limited success in standardizing discharge process, identifying and eliminating redundant processes in inpatient care, improving inter-departmental coordination in a multi-specialty approach, and improving rehabilitation and monitoring services. For example, there is typically a time lag between receiving clearance from a doctor and the patient exit, and often, doctor unavailability is the bottleneck in this process. Again, technology and data analytics can play a key role in improving the whole inpatient treatment and discharge process.



OT and equipment utilization is also a key factor in solving for optimal capacity utilization in a hospital. While providers aim for a higher proportion of surgical-medical mix to drive better patient realization, availability of OT often becomes a constraint on the number of surgeries that can be performed. Standardization of processes, clinician management and support staff can act as key enablers for improving capacity utilization of OTs. Similarly, equipment utilization is a function of the hospital's ability to manage conversions from OP / IP, marketing outreach activities and the incentive structure for clinicians at the hospital. For example, the incentive structure including the revenue generated from diagnostics often leads to higher usage of diagnostics at the hospitals and fewer instances of revenue leakages to neighbouring centres.

2.2 | COST OPTIMIZATION

Rationalization of operating costs has a direct impact on the earnings and cash of the organization. This lever is of paramount importance for new as well as established hospitals. Cost optimization has two key focus areas:

1. Direct costs reduction
2. Overheads optimization

2.2.1 | DIRECT COSTS REDUCTION

The key enablers for reducing direct costs in a hospital include:

1. Package standardization
2. Optimizing consumption efficiency
3. Enhancing procurement efficiency

Depending on the typical consumption of consumables and the number and type of diagnostic tests performed, hospitals offer standardized packages for procedures. Hospitals have limited influence on the overall package price offered by government schemes and PSUs or corporates, as they are often pegged to schemes or are market-linked. In view of this, it becomes imperative for hospitals to look at initiatives such as value-capping, bottom-up costing and competitive benchmarking for each package and arrive at an appropriate set of exclusions and inclusions including classification of drugs (branded versus generic) and type of consumables that impact the input costs for the package. For example, the composition of an angioplasty package offered against a scheme versus a package offered to a cash or insurance patient will vary in the type and make of stent and medicines offered. An analytical approach towards defining package composition will help optimize input costs and manage optimal margins by specialties, procedures and channels.



Consumption efficiency is a lever that has not been well analyzed by many healthcare organizations. Need for quicker volume ramp-up in low demand-density and price-sensitive catchments in smaller towns is driving many hospitals towards banking on government schemes and offering pricing discounts to cash patients. However, the challenge is with the pricing of procedures, which is typically at a discount of 50–60 percent to that at a comparable hospital in a city. In order to achieve profitability, hospitals should leverage data analytics on consumption patterns for widely used procedures to look at reusability of some of the consumables such as catheters, gauges and dialyzers, amongst others.

Most organized healthcare operators have focused on procurement efficiency for improving gross margins. Typically, the approach is to drive procurement efficiency through bulk purchasing, maintaining a judicious mix of branded versus generic drugs, vendor and brand consolidation, and central rate contracts with strategic vendors. However, the focus has usually been on the medical consumables while non-clinical and outsourced services such as outsourced test pricing, food, beverages, etc. are often ignored for analysis.

2.2.2 | OVERHEADS OPTIMIZATION

While many leading hospital chains in India have worked on improving consumption and procurement efficiency, very few have systematically tackled costs related to physicians, other personnel costs and other overheads. Optimizing overhead costs would entail improvement initiatives in three key areas:

1. Clinician engagement model
2. Other personnel cost
3. Other major overhead costs – administrative, shared services, power and utility

While corporatization has gathered pace in Indian healthcare over the last few decades, driving high patient volumes, at least at the inception of a new facility, is often dependent on the seniority of consultants and their visibility in a micro-market. In such a scenario, hospitals have to arrive at the right balance between senior and junior clinicians and also work out remuneration models for the clinicians that are in tune with the economic needs and maturity of the hospital facility. Hospitals have been trying to innovate on the consultant engagement model, and there is a clear shift towards performance linked models, especially for senior clinicians. In order to achieve the dual objective of attracting the best clinical talent and improving profitability, hospitals have embarked on innovative methods such as

providing equity stakes and financial performance-linked incentives. Linking a significant proportion of clinician remuneration to operating profit, instead of revenues, can lead to better operational and financial performance for the facility.

Medical personnel such as nurses and paramedical staff are a vital cog in the functioning of a hospital and are often the differentiating factors in services provided. Typically, hospitals carry out a competitive benchmarking exercise for determining the adequacy and remuneration for this category of staff. However, many times staffing and service delivery models are designed by hospitals without giving due attention to the hospital layout, workflow, specialties offered and bed mix, resulting in a sub-optimal quality of care and higher costs of delivery. The other factor that leads to higher costs for this category of staff is the inordinately high attrition rate, especially for the nursing cadre. To solve for high attrition and to prevent service outages, many hospitals create redundant layers of staffing, thereby leading to high staff costs apart from higher recruitment and training expenses.

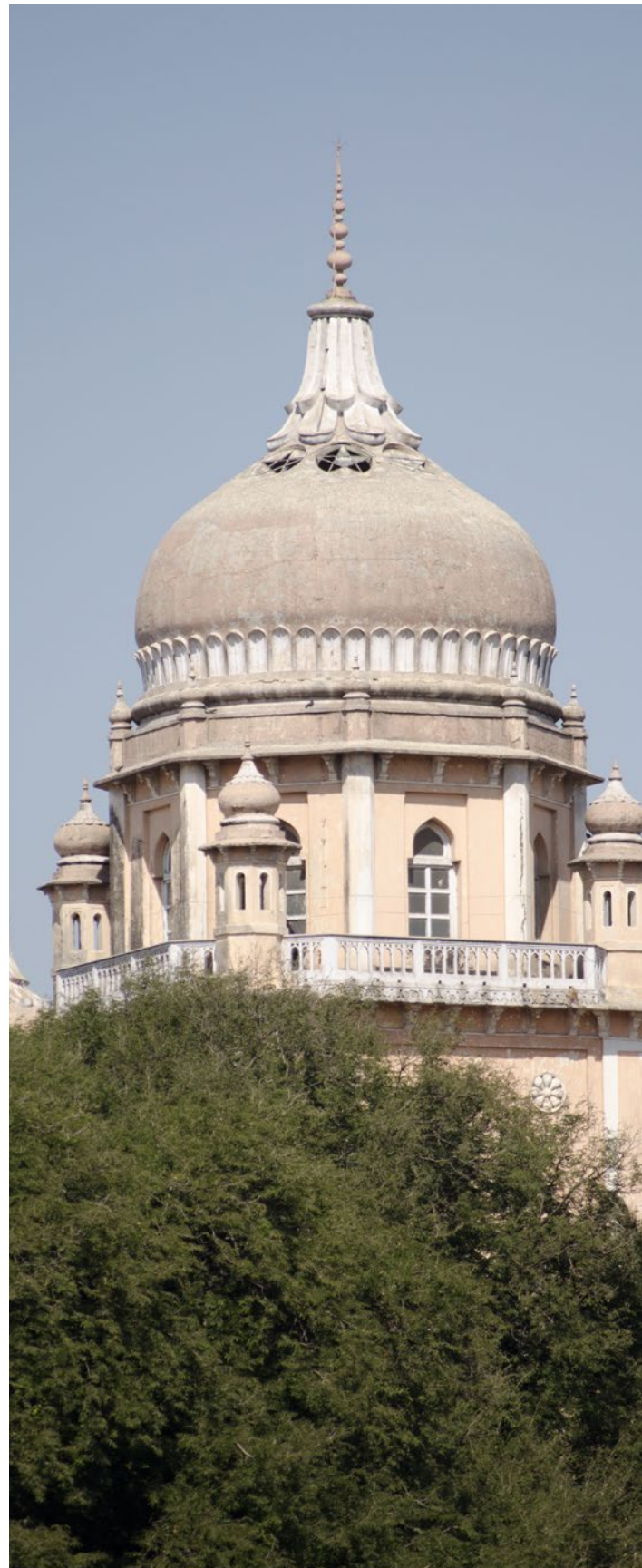
The other major overhead costs for a hospital include sales and marketing expenses, repair and maintenance and utilities cost. Data analytics can play an extremely important role in understanding the relative efficacy of channels and devising targeted marketing campaigns, thereby optimizing marketing costs and channel spends. The one area that presents a significant opportunity to hospitals, especially in urban clusters, and in which most Indian hospitals have yet to create and execute on an effective plan is digital marketing. An effective digital media strategy would maximize positive buzz for the hospital and its doctors, identify prospective targets for proactive promotions and offer a measurable mechanism to drive greater patient footfalls and conversions, all at costs that are directly linked to the revenue outcome. Repairs and maintenance expenses are usually dependent on the service contract and warranty terms negotiated during the purchase of medical equipment. As hospital groups in India expand through a mix of organic and inorganic means, they generally have a diverse medical equipment portfolio,

thereby leading to limitations on potential synergies in service contracts and burgeoning service costs. From a strategic perspective, therefore, hospitals must evaluate cost-effective options, including lease options for upgrades, for standardizing their medical equipment portfolio that can help them drive down their repair and maintenance costs significantly. A cost-benefit analysis of outsourced versus in-house capabilities for servicing and capital expenditure versus lease model will help hospitals arrive at appropriate strategic choices. Finally, power and fuel overheads are often over-looked by hospitals but can again be a source of easy wins in terms of cost savings through initiatives such as a shift to energy-efficient lighting, motion-activated lighting, HVAC optimization, alternative energy sources and building design, amongst others.

2.3 | WORKING CAPITAL MANAGEMENT

The key focus areas for working capital management include account receivables, vendor payments and inventory management. Account receivables management is to a major extent dependent on the patient mix, collection team and follow-up mechanisms at the hospital. For example, cash, insurance and government scheme patients may have account receivables of 0–1 days, 30 days and 180 days, respectively. Hospitals need to conduct a cost-benefit analysis to arrive at the purchasing decisions and the credit terms with suppliers which have a bearing on the payable days and inventory cost. For example, hospitals going for the bulk purchase of frequently used consumables may receive scale discounts but may then have to settle for higher inventory days thereby affecting working capital. Adopting techniques used in other industries such as data analytics and supply chain optimization can help optimize inventory costs. Some leading hospitals in developed economies have started using pharmacy robots that not only manage just-in-time supply but look at expiry and reduce human error in stock management and reorder.

Optimization of capital expenditure is another lever that hospitals are targeting to ensure more attractive returns to their shareholders. 50–60 percent of capital expenditure (excluding land) in a hospital is towards interiors and medical equipment. New hospitals and renovation of existing hospitals are designed with a strategy to target international patients, thereby increasing spend towards state-of-the-art infrastructure and interior design. However, hospitals do not always have a clear understanding of what patients and their families truly value and hence end up overspending on infrastructure elements that have little or no bearing on patient decision-making and satisfaction. For example, discussions with international medical tourists indicate that they value language and cultural support, rehabilitation support, and the quality of care and outcome more than opulent interior design on which hospitals often end up spending. As healthcare organizations go into more price-conscious lower town tier markets, it is even more imperative for them to have a pragmatic, data-driven view on what equipment and capabilities are truly required for addressing catchment demand – rather than be influenced solely by doctor demands and supposed positioning requirements. Strategic choices on each piece of medical equipment in a planned hospital should be analyzed holistically at a portfolio level as well as in isolation – laying bare the stand-alone economic feasibility of investment in all medical equipment.



3.0

THE MAGIC BULLETS



In summary, what are the magic bullets for hospital performance improvement? As is evident from the preceding section, actual improvement in performance is about doing many small things right – each of which incrementally leads to an impact that is bigger than the sum of those individual steps. However, there are some key themes that are central to any high-performance healthcare organization. Here is a summary of these themes:

- 1. Know thy customer first; build and offer accordingly:** Over the previous few decades, many private healthcare organizations have built facilities and offering baskets first and expected demand to follow supply. This has largely panned out well for the health providers, especially in the backdrop of the inordinate demand-supply gap in these markets. Now, the demand-supply equation has changed – especially in the top urban clusters. Gone are the days when one can just build a general mix of specialties, throw in a few famous doctor names and have their facility teeming with patients within a short period of the operationalization of a new facility. The situation is even more critical in smaller towns. Building fully built-out tertiary care models at high costs for small towns which lack appropriate demand-density and paying power may not always be the most prudent strategy. Hence, the imperative is for providers to know what their micro-market and the drainage catchment truly require and the affordability economics in that market. That will help them build the right facility for the right mix of services and with the right mix of doctors that are commensurate with the market needs.
- 2. Put in the hard work on branding and focused promotions:** Historically, hospitals have predominantly relied only on star doctor power for bringing in patients. While that is still a reality, just having good doctors in an ultra-competitive environment is not enough anymore. It is important to back the doctors and infrastructure investments with structured and focused market outreach and promotions in the relevant markets – especially if the hospital's brand is new to such markets. This approach would not only help a new facility ramp up faster, but it would also make new customer acquisition more economical in the long run with greater brand identity for the facility in the markets.
- 3. Think beyond referrals; think digital:** Urban India is at an inflection point in terms of how it can use digital platforms to connect with providers and choose between the various options. In this context, healthcare organizations that are smarter in the use of digital models for connecting with consumers will have lower customer acquisition costs, higher value per consumer and more “sticky” customers. Referral models will not vanish in a hurry – but social and digital platforms will emerge as new, cost-effective conduits for acquiring and retaining customers.
- 4. Leverage analytics – the new game-changer:** Collecting relevant data and mining it to drive decision-making has to become a cultural theme in the organization. Cutting-edge data analytics can impact decisions and outcomes related to positioning, market outreach, promotions, customer retention, pricing, cost optimization, redesign of clinician engagement models, staff optimization and productivity improvement. Healthcare organizations that use the right context for analytics will make fewer mistakes than others and will eventually emerge winners.

- 5. To control costs, know them first:** Most healthcare organizations do not know their true costs of delivering different services, of serving different channels or of using certain doctors versus others. Good Indian healthcare organizations understand factors impacting gross margins but have relatively lower visibility on key activities or elements impacting profitability below gross margins. However, it is imperative to have this visibility by specialties, procedures, doctors, channels and patient types – as it will help organizations prioritize services, patient types, channels and doctors that are more remunerative to them and will assist them in identifying and redesigning key elements that affect profitability.
- 6. Embrace “accountable care,” the Indian way:** Health organizations in India need to breed a culture of accountability in their staff – doctors, nurses, Allied Healthcare Professionals (AHPs), service teams, and sales and marketing. Staff appraisal and remuneration models have to reflect the status, maturity and the strategic need of the organization in question and drive ownership and accountability for faster ramp-up and profit expansion. Change in engagement models can be enabled by an open culture of sharing relevant data and perspective with the staff – thus bringing out the need for accountability and ownership.

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