BUSINESS PLAN · INDIA

Home Sample-Collection Service

Where the worker is alone and paid per visit, the visits-per-day number is the safety policy

DIAGNOSTIC LABS & IMAGING

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1. Executive Summary

This plan sets out a **Home Sample-Collection Service** in India — at-home phlebotomy across four cities with 240 employed phlebotomists by Year 3, serving own and partner laboratories, chronic-care and elderly subscription programmes, corporate at-home screening, and home ECG, vitals and nursing add-ons, across roughly 860,000 visits a year.

> This plan inherits the diagnostics anchor's rules from `pathology-lab` and the pre-analytical findings from `collection-centre-franchise`, and it removes the last protection those settings still had. **A collection centre at least has premises, a colleague and a queue that somebody can see. This service has a person, a bag and a door that closes behind them.**

> □□ **THE PHLEBOTOMIST IS ALONE IN A STRANGER'S HOME, UNSUPERVISED, WITH A NEEDLE, AND PAID PER VISIT. Everything the franchise plan said about blindness applies here — he still cannot see whether his sample was usable — and now there is NO PREMISES, NO COLLEAGUE, NO SUPERVISOR AND NO SECOND PAIR OF EYES, while the person being drawn from is frequently elderly, alone, frightened or unwell. A per-visit rate makes VISITS PER DAY the single variable the worker optimises, and that one number silently determines everything that matters: how long the tourniquet stays on, whether the sample reaches a centrifuge in time, whether hands are washed between homes, whether a nervous patient is reassured or hurried, and whether a difficult second attempt is offered or a poor draw is simply sent anyway. NOBODY DECIDES TO RUSH. THE RATE DECIDES. So this business CAPS VISITS AT FOURTEEN PER PHLEBOTOMIST PER DAY AND PUBLISHES THE CAP, PAYS FOR TIME INCLUDING TRAVEL AND WAITING RATHER THAN PER VISIT, EMPLOYS ITS PHLEBOTOMISTS RATHER THAN CONTRACTING THEM, and INVESTIGATES EVERY DAY THE CAP WAS EXCEEDED — 34 in Year 3, down from 218. WHERE THE WORKER IS ALONE, UNSUPERVISED AND PAID PER VISIT, THE VISITS-PER-DAY NUMBER IS THE SAFETY POLICY — SO PUBLISH IT AND CAP IT.**

> □□ **AND THE WORKER'S OWN SAFETY IS THE HALF OF THIS NOBODY MODELS. Phlebotomists in this trade are predominantly women entering strangers' homes alone, and the industry's standard answer is an application with a panic button. So EVERY PHLEBOTOMIST IS BACKGROUND-VERIFIED BEFORE A FIRST VISIT, EVERY VISIT IS START-AND-END LOGGED WITH LIVE LOCATION, LONE-WORKER CHECK-IN RUNS AT 99.6%, and EVERY INCIDENT IS REPORTED AND INVESTIGATED — 94 in Year 3, published.**

> □□ **AND THE DATA IS AN ADDRESS PLUS A CONDITION PLUS A HOUSEHOLD, HELD ON A FIELD WORKER'S PHONE. NIL patient data remains on the device after visit close, access is revoked at close, and per the online-pharmacy rule NIL medicine or test data is sold, shared or segmented — with seven approaches logged and published. NIL additional tests are sold at the doorstep by the person holding the needle.**

This plan models an operator requiring **₹14.00 crore** (₹5.80 crore investor + ₹4.40 crore term loan + ₹2.40 crore promoter + ₹1.40 crore working capital), moving from **₹8.00 crore revenue and a ₹3.13 crore loss** to **₹54.00 crore revenue and ₹4.05 crore profit** by Year 3 — *a 7.5% net margin and 34.7% return on capital. (Home collection — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A home phlebotomy service that publishes how many homes one person may enter in a day.

Vision: To make visits-per-day a published safety number rather than a hidden productivity target.

Mission: Employ our phlebotomists and pay them for time; cap the visits and publish the cap; verify, log and check in on every person we send alone into a stranger's home; get the sample to a centrifuge; and never let the person holding the needle sell anything.

Legal structure

- **Private Limited** — recommended. Laboratory linkage, partner contracts, employment obligations and outside capital all assume it.
- **Employment rather than gig contracting — a deliberate structural choice: a per-visit contractor cannot be capped, cannot be trained mandatorily, and cannot be paid for waiting.**
- **Field safety and quality function reporting to the board, independent of dispatch — because the cap costs completed visits somebody is measured on.**

> **Regulatory anchor:** the Clinical Establishments Act 2010 and state rules where adopted, under which **home collection is generally treated as an extension of a registered laboratory rather than as an establishment in itself — so the laboratory's registration and accreditation carry the obligation, and there is no separate licence whose conditions could govern the visit**; NABL accreditation under ISO 15189, which covers **pre-examination processes including collection performed on the laboratory's behalf, wherever it occurs**; Bio-Medical Waste Rules, under which **sharps generated inside a private home must be carried back and disposed of by the service, since the household is not a waste generator**; the Drugs and Cosmetics Act for consumables; the Digital Personal Data Protection Act 2023, under which name, address, condition and result together are sensitive personal data **held on a mobile device in a public place**; labour law — the Code on Wages, EPF/ESI, the Occupational Safety, Health and Working Conditions Code and, materially here, **POSH obligations for employees working alone at third-party premises, which is a setting the statute was not primarily written for**; motor vehicle and road-safety obligations for a two-wheeler field force; GST; and shops and establishments. **The decisive structural fact is that no regulation anywhere specifies how many homes one phlebotomist may enter in a day.**

3. Promoter & Ownership

Led by a promoter with diagnostics operations, field services or healthcare logistics background. Three competences decide outcomes. *Field workforce management*, because 240 people working alone across four cities is a supervision problem before it is a clinical one. *Route and time engineering*, since draw-to-centrifuge time is decided by dispatch design rather than by effort. And *the willingness to cap the day*, which is where this plan's proposition sits and which forgoes visits on a fixed cost base. Ownership, equity & investor terms are editable inputs; **the field safety and quality function reports to the board independently of dispatch, and no employee's pay is linked to visits completed or to test value.**

4. Market Analysis — India

The fastest-growing collection channel, built almost entirely on per-visit contracting.

Demand drivers

- **Elderly and immobile patients** for whom travelling to a centre is the barrier.
- **Chronic-disease monitoring** generating predictable repeat collection at home.
- **Working households** unwilling to lose half a day to a blood test.
- **Post-pandemic normalisation** of clinical services delivered at home.
- **Laboratory competition** making collection reach a differentiator.
- **Corporate screening** delivered to employees at home rather than at a camp.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian at-home diagnostic collection	Large and growing fast; overwhelmingly gig-contracted
SAM	**Visits deliverable within a 14-per-day cap and draw-to-centrifuge limits**	**Bounded by ROUTE DENSITY, not by demand**
SOM (Yr 1–3)	Visits and patients across four cities	₹8cr → ₹54cr; 860,000 visits; 306,000 patients

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and what constrains it
Home collection for own and partner lab testing	**50.0%**	**46.0% — the base; every rejected sample is a full cost**
Collection service fee charged to partner laboratories	20.0%	62.0% — paid by labs, not patients
Chronic-care & elderly subscription programmes	**15.0%**	**52.0% — routable, predictable, and the retention engine**
Corporate at-home screening contracts	8.0%	44.0% — dense, scheduled, commission-free
Home ECG, vitals & nursing add-ons	5.0%	56.0% — ordered clinically, never sold at the door
Report delivery, teleconsult routing & records	2.0%	74.0% — no interpretation by the collector

> **The third row is the one that makes a capped model viable at all. A subscription chronic-care book is schedulable in advance, geographically clusterable and repeatable monthly, which means a phlebotomist can complete twelve or thirteen visits within the cap without hurrying anybody — whereas an on-demand book scattered across a city cannot reach eight without either speeding or extending the day. ROUTE DENSITY, NOT WILLINGNESS, IS WHAT MAKES A HUMANE VISIT RATE ECONOMIC, which is why subscriptions and corporate contracts are grown to 23% of revenue between them despite carrying lower margins than the fee line above. The fifth row carries an explicit prohibition rather than a margin note: ECG, vitals and nursing add-ons are ordered clinically in advance and NEVER offered at the door, because a person standing in your home with a needle is not in a position to make you a commercial offer you can comfortably decline.**

Constraints

- **Route density**, which decides whether the cap is affordable.
- **Draw-to-centrifuge time** from a home, the hardest pre-analytical problem in diagnostics.
- **Phlebotomist attrition**, which destroys quality faster than it destroys capacity.
- **Competitor pricing** built on per-visit contracting we have chosen not to use.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
National lab chains' home-collection arms	Brand, test menu, scale, existing patients	**Per-visit contracting; visits-per-day uncapped and unpublished**

Gig-model home phlebotomy platforms	Asset-light, fast to scale, low fixed cost	Cannot cap, cannot mandate training, cannot pay for waiting
Local lab collection boys	Cheap, familiar, flexible, personal	No verification, no logging, no waste return
Hospital home-care services	Clinical credibility, nursing capability	Small scale; expensive; limited geography
This plan	**Employed, time-paid, capped at 14, verified and logged, nil doorstep selling**	Higher fixed cost; slower to scale; 7.5% net

The positioning rests on two claims a customer can verify inside a single visit and a competitor cannot easily copy. The first: the person at your door is our employee, background-verified, and this is his eleventh visit today out of a published maximum of fourteen — a fact printed on the visit confirmation. The second: he will not offer to sell you anything, because he is paid for his time and has no idea what your tests are worth. Both are structural rather than aspirational, which matters because every competitor also says its phlebotomists are careful. The commercial handicap is real and permanent: a gig platform pays only for completed visits and carries no cost when demand is thin, while we carry 240 salaries whether the phones ring or not.

The cost of the honest position is stated in rupees rather than implied. Capping visits at fourteen a day and paying for time including travel and waiting rather than per visit cost ₹3.24 crore of Year-3 margin — the largest item, and the entire difference between this model and the category's. Field supervision, background verification and lone-worker check-in cost ₹1.62 crore. Field centrifugation and cold-chain equipment to hold draw-to-centrifuge times cost ₹86 lakh. Refusing doorstep upselling and refusing to link any pay to test value cost ₹68 lakh. Total ₹6.40 crore against ₹4.05 crore of profit — so an operator running the same four cities on gig contracting and uncapped visits would earn ₹10.45 crore.

6. The Rate Decides

This is the finding, and it operates without anybody making a decision.

What a rushed visit changes	Who would ever see it
Tourniquet left on past a minute	**Nobody — it alters the result, not the sample's appearance**
Poor draw sent rather than repeated	**Nobody — a repeat costs the worker a visit**
Hands not washed between homes	**Nobody**
Frightened patient hurried	The patient. Who rarely complains about a nurse.
Sample carried three more hours before centrifuge	**Nobody, until a potassium reads high**
Sharps carried home rather than returned	**Nobody, ever**

Every row in the right-hand column is an absence, and the absences are what make the per-visit rate so powerful. A phlebotomist paid per visit is not being asked to cut corners; he is being offered more money for going faster, in a job where GOING FASTER IS INVISIBLE AND ITS CONSEQUENCES ARRIVE SOMEWHERE ELSE, days later, as a number on a report nobody will trace back to him. He is also, very often, supporting a family on a rate that only works at high volume, which means the pressure is not greed but arithmetic. And the structure removes every ordinary correction: there is no colleague to notice, no supervisor to observe, no queue behind him to slow him down, and no patient who knows what a correct draw looks like. THE SINGLE NUMBER THAT DETERMINES ALL OF IT — VISITS PER DAY — IS SET BY THE COMPANY, EXPERIENCED BY THE

WORKER, PAID FOR BY THE PATIENT, AND PUBLISHED BY NOBODY.

So the rate is removed and the number is published. PHLEBOTOMISTS ARE EMPLOYED RATHER THAN CONTRACTED, which is the structural precondition for everything else — a per-visit contractor cannot be capped, cannot be required to train, and cannot be paid for waiting outside a locked door. THEY ARE PAID FOR TIME INCLUDING TRAVEL AND WAITING, so an unproductive hour costs the company rather than the worker. VISITS ARE CAPPED AT FOURTEEN PER DAY AND THE CAP IS PUBLISHED — printed on the patient's visit confirmation along with the number of that visit in the phlebotomist's day, so a patient can see he is somebody's eleventh call and not somebody's twenty-second. EVERY DAY THE CAP WAS EXCEEDED IS INVESTIGATED: 34 in Year 3 against 218 in Year 1, published rather than corrected quietly. WHERE THE WORKER IS ALONE, UNSUPERVISED AND PAID PER VISIT, THE VISITS-PER-DAY NUMBER IS THE SAFETY POLICY — SO PUBLISH IT AND CAP IT.

7. The Centrifuge, the Lone Worker and the Phone

Three further rules, the first of which is the hardest pre-analytical problem in diagnostics.

DRAW-TO-CENTRIFUGE FROM A HOME IS THE HARDEST VERSION OF THE PROBLEM THE ANCHOR IDENTIFIED. A collection centre has a centrifuge on the counter; a home has a phlebotomist on a two-wheeler with eleven more addresses, and the clock on potassium, glucose and several other analytes starts the moment the tube fills. So DRAW-TO-CENTRIFUGE TIME IS MEASURED AND PUBLISHED WITH ITS 90TH PERCENTILE — 31 minutes median against 58 at the tail, from 46 and 88 — because a median conceals precisely the samples that sat too long. 89% OF SAMPLES ARE CENTRIFUGED IN THE FIELD in a vehicle-mounted unit rather than carried whole, and 4,600 SAMPLES WERE REJECTED FOR DELAY rather than run — because per the anchor rule, running a delayed sample produces a result that looks entirely normal and is wrong.

AND THE WORKER'S SAFETY IS THE HALF OF THIS NOBODY MODELS. Home phlebotomists are predominantly women entering the homes of strangers alone, several times a day, with an address list supplied by a company and no idea who is behind the door — and the trade's standard answer is a panic button in an application, which is a response to an incident rather than a system for preventing one. So EVERY PHLEBOTOMIST IS BACKGROUND-VERIFIED BEFORE A FIRST VISIT, EVERY VISIT IS START-AND-END LOGGED WITH LIVE LOCATION, LONE-WORKER CHECK-IN RUNS AT 99.6% with an escalation on any missed check-in, and EVERY INCIDENT — including verbal abuse and refusal to allow the visit to be logged — IS REPORTED AND INVESTIGATED, 94 in Year 3, published. A rising incident count is treated as improved reporting rather than deteriorating safety, per the library's rule on gates with no rejections.

AND THE DATA IS AN ADDRESS PLUS A CONDITION PLUS A HOUSEHOLD, HELD ON A PHONE IN THE STREET. An e-pharmacy holds an order history in a data centre; this business holds where you live, what you are being tested for, who else is in the house and when the house is empty — on a field worker's handset. So NIL PATIENT DATA REMAINS ON THE DEVICE AFTER VISIT CLOSE and access is revoked at close; the online-pharmacy rule is inherited unchanged with NIL data sold, shared, segmented on or targeted and SEVEN APPROACHES LOGGED AND PUBLISHED; and reports are never handed over in person, because a report delivered by the collector invites the question he must not answer.

> **AND THE PERSON HOLDING THE NEEDLE SELLS NOTHING. NIL additional tests are offered at the doorstep and NIL pay is linked to test value — because a patient with a tourniquet on his arm cannot comfortably decline anything, and consent obtained in that posture is not consent.**

8. Operations Plan (dispatch, draw, spin, return)

The day

- **Visits capped at 14 per phlebotomist per day**, published on the patient's confirmation.
- **Paid for time including travel and waiting**; nil per-visit pay anywhere.
- **Every day the cap was exceeded investigated** and published — 34 in Year 3.
- **Routes clustered by subscription and corporate blocks**, since density is what funds the cap.

Sample integrity

- **Draw-to-centrifuge measured and published with its 90th percentile.**
- **Field centrifugation in a vehicle-mounted unit** for 89% of samples.
- **Samples rejected for delay rather than run** — 4,600 in Year 3.
- **Chain of custody logged** from draw to laboratory receipt.

Worker safety

- **Background verification before a first visit**, without exception.
- **Visit start and end logged with live location**; lone-worker check-in at 99.6%.
- **Every incident reported and investigated**, including verbal abuse — 94 published.
- **Sharps carried back and disposed of by us**, since the household is not a waste generator.

Conduct and data

- **Nil additional tests offered at the doorstep; nil pay linked to test value.**
- **Nil results interpreted or discussed** by the collector; reports delivered digitally.
- **Nil patient data on the device after visit close**; access revoked at close.
- **Nil data sold, shared or segmented**; approaches logged and published.

> **The operational hinge is a Monday morning in monsoon with 22% of the field force absent, a booking book already accepted, and a dispatch system that can clear the day by pushing eight phlebotomists to nineteen visits each — which nobody would ever see, which the patients would each experience as a normal visit, and which the workers themselves would mostly accept because a long day is better than a cancelled one. So the DISPATCH SYSTEM CANNOT ASSIGN A FIFTEENTH VISIT: the cap is a hard constraint in the routing engine with no per-day, per-city or per-supervisor override, and the alternative is to CANCEL AND REBOOK, which is what happens. The system refuses rather than warns. Cancellations are published alongside the cap breaches, because a company that caps visits and hides the resulting cancellations has only moved the number it is embarrassed by, and NO DISPATCH OR SUPERVISORY PAY IS AFFECTED BY VISITS COMPLETED.**

9. Registration, Labour & Operating Compliance (India)

- **Clinical Establishments Act 2010 and state rules — home collection is generally an extension of a registered laboratory rather than an establishment in itself, so there is no separate licence whose conditions could govern the visit.**
- **NABL accreditation under ISO 15189** — covers pre-examination processes **including collection performed on the laboratory's behalf, wherever it occurs.**
- **Bio-Medical Waste Rules — sharps generated inside a private home must be carried back and disposed of by the service, since the household is not a waste generator.**
- **Digital Personal Data Protection Act 2023** — name, address, condition and result together are sensitive personal data, **held here on a mobile device in a public place.**
- **Labour** — Code on Wages, EPF/ESI, the Occupational Safety, Health and Working Conditions Code, and **POSH obligations for employees working alone at third-party premises, a setting the statute was not primarily written for.**
- **Motor vehicle and road-safety obligations** for a two-wheeler field force, including insurance and rider training.
- **Drugs and Cosmetics Act** for consumables; NMC conduct regulations on referral commissions, per the vertical anchor.
- **GST and shops and establishments. No regulation anywhere specifies how many homes one phlebotomist may enter in a day.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owns the visit cap
Phlebotomists — employed, paid for time	62	240	**Capped at 14 visits; nil per-visit pay**
Customer care & scheduling	12	42	Cancels and rebooks rather than overloading
Dispatch & routing	10	34	**Pay unaffected by visits completed**
Field supervision & safety	8	32	**One per 7.5 phlebotomists; board-reporting**
Technology, records & chain of custody	8	20	Device wiped at visit close
Training, certification & verification	4	12	Background check before a first visit
Finance, legal, compliance & admin	9	25	Publishes cap breaches and incidents
Total	**114**	**406**	Phlebotomists at 59% of headcount

> **The phlebotomist salary line is COST TO COMPANY and is materially above take-home, because employing rather than contracting means carrying provident fund, insurance and paid leave — which is most of why a gig operator's cost per visit looks lower and is the honest explanation for the gap. Median phlebotomist take-home rises from ₹24,600 to ₹32,200 a month while ATTRITION FALLS FROM 46% TO 19%, and that second figure is the one that matters: a service losing half its field force annually is retraining continuously, and a phlebotomist in his third month is measurably worse than one in his second year. One supervisor per 7.5 phlebotomists is roughly triple the category norm, and the function reports to the board independently of dispatch — because the cap costs completed visits, and the people whose day it disrupts must not be the people who can relax it.**

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & first city	Month 0–7	Incorporation, lab linkage, 62 phlebotomists employed and certified
Cap in the routing engine	Month 2–7	**14-visit hard constraint; no override; cancellations published**
Field centrifugation rollout	Month 5–16	Vehicle-mounted units; draw-to-centrifuge 46 → 38 minutes
Safety system	Month 6–14	Verification, live-location logging, lone-worker check-in
Cities two to four & subscriptions	Month 12–28	Route density from chronic-care blocks; attrition 46% → 31%
Scale & publication	Month 26–36	860,000 visits; 34 cap breaches; 94 incidents published

Training and competence

- **Phlebotomy certification** — tourniquet time, order of draw, haemolysis avoidance, difficult veins.
- **The elderly and the frightened patient**, who take longer and are the reason the cap exists.
- **Declining the question and the sale** at the door, warmly and without embarrassment.
- **Personal safety** — entry assessment, check-in discipline, and when to leave without drawing.

12. Financial Plan (Illustrative)

> **All figures are illustrative model assumptions, not forecasts or guarantees.** They exist to show the drivers of a home-collection P&L under an employed, time-paid, capped model. Every input is editable. **The defining economics are that 240 salaries are fixed and 860,000 visits are not — so route density rather than demand decides whether the cap is affordable, and the gig counterfactual is modelled honestly rather than dismissed.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Technology — routing, dispatch, chain of custody & records	**336**	**The cap is a hard constraint here, not a policy**
Phlebotomist kit, mobile centrifuges & cold-chain boxes	**280**	**Field spinning for 89% of samples**
Working capital — partner lab settlement & receivables	238	Partner labs settle monthly
Training academy, certification & background verification	182	No first visit without verification
Fleet & field logistics	168	Two-wheeler field force across four cities
City hubs & sample drop points	126	Shortens the last leg to the laboratory
Licences, deposits & pre-operative	70	Lab linkage and city registrations
Total project cost	**1,400**	₹580L investor + ₹440L term loan + ₹240L promoter + ₹140L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
VISITS PER PHLEBOTOMIST PER DAY — capped at 14 and PUBLISHED on the patient's confirmation / **phlebotomists paid PER VISIT** / paid for TIME including travel and waiting / **days on which the cap was exceeded, each investigated**	14 / NIL / 100% / 218	14 / NIL / 100% / 96	**14 / NIL / 100% / 34**
DRAW-TO-CENTRIFUGE median (90th percentile) / samples centrifuged IN THE FIELD within limit / **samples REJECTED FOR DELAY rather than run**	46 min (88) / 62% / 8,400	38 min (72) / 78% / 6,200	**31 min (58) / 89% / 4,600**
PHLEBOTOMIST BACKGROUND-VERIFIED before a first visit / visit start and end logged with live location / **lone-worker check-in completed** / **incidents reported AND investigated**	100% / 100% / 96.2% / 42	100% / 100% / 98.4% / 68	**100% / 100% / 99.6% / 94**
PATIENT DATA remaining on the device after visit close / access revoked at close / **data sold, shared, segmented on or targeted** / **approaches logged and published**	NIL / 100% / NIL / 2	NIL / 100% / NIL / 4	**NIL / 100% / NIL / 7**
ADDITIONAL TESTS SOLD AT THE DOORSTEP by the phlebotomist / **phlebotomist pay linked to test value** / consent for additions taken by the LAB rather than the collector / results interpreted by the collector	NIL / NIL / 100% / NIL	NIL / NIL / 100% / NIL	**NIL / NIL / 100% / NIL**
Visits / phlebotomists / subscription retention / **median phlebotomist take-home** / **phlebotomist attrition**	0.14m / 62 / 54% / ₹24,600 / 46%	0.42m / 132 / 68% / ₹28,400 / 31%	**0.86m / 240 / 79% / ₹32,200 / 19%**

> **Row one publishes a number no competitor discloses and prints it where the patient will see it: the cap, and which visit of the day this one is. The 34 cap breaches are published rather than corrected quietly, because a cap whose exceptions are invisible is a target. Row two carries the 90th percentile per the library's tail rule — 58 minutes against a 31-minute median — since a median draw-to-centrifuge conceals exactly the samples that sat too long. Row three's rising incident count from 42 to 94 is read as IMPROVED REPORTING rather than deteriorating safety, on the same logic the vertical anchor applies to rejection rates: a service recording no incidents among 240 people entering strangers' homes is not safe, it is not listening. Row six's attrition falling from 46% to 19% is the operating figure that matters most, because a phlebotomist in his third month is measurably worse than one in his second year.**

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Home collection for own & partner lab testing	400	1,300	2,700	**46.0%**
Collection service fee charged to partner laboratories	160	520	1,080	62.0%
Chronic-care & elderly subscription programmes	120	390	810	**52.0%**
Corporate at-home screening contracts	64	208	432	44.0%
Home ECG, vitals & nursing add-ons	40	130	270	56.0%
Report delivery, teleconsult routing & records	16	52	108	74.0%
Total revenue	**800**	**2,600**	**5,400**	**51.0% blended**

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	800	2,600	5,400
Cost of services — lab share, consumables & samples rejected for delay	(392)	(1,274)	(2,646)
Gross profit	**408**	**1,326**	**2,754**
Phlebotomist salaries — employed, paid for time (cost to company)	**(268)**	**(546)**	**(972)**
Field supervision, safety & verification	**(96)**	**(162)**	**(270)**
Logistics, cold chain & mobile centrifuge running	(98)	(164)	(270)
Technology, routing, dispatch & records	(82)	(118)	(162)
Training & certification	(48)	(68)	(108)
Marketing & customer acquisition	(72)	(96)	(135)
Admin, legal, compliance & other	(64)	(92)	(135)
EBITDA	**(320)**	**80**	**702**
Depreciation & amortisation	(98)	(156)	(216)
Finance cost	(48)	(76)	(108)
Other income — partner platform fees and corporate incentives *(disclosed)*	48	104	162
PBT	**(418)**	**(48)**	**540**
Tax	105	12	(135)
PAT	**(313)**	**(36)**	**405**
Net margin	**(39.1%)**	**(1.4%)**	**7.5%**
ROCE	**(29.9%)**	**(5.4%)**	**34.7%**

The phlebotomist salary line at ₹9.72 crore is 18.0% of revenue and is the whole argument expressed as a cost — a gig operator converts it into a variable per-visit payment, saves roughly ₹3.24 crore, and carries nothing when demand is thin. The sensitivity below models that counterfactual honestly at ₹5.58 crore of profit rather than dismissing it, because a plan that refuses to compute the alternative it rejects has not made an argument. Field supervision at ₹2.70 crore — one supervisor per 7.5 phlebotomists — is the second unusual line and exists because nobody else is present when the work is done. Other income of ₹1.62 crore is partner platform fees and corporate incentives, disclosed as a line and never conditional on test volume from any laboratory. Commitments of ₹6.40 crore against ₹4.05 crore of profit mean an operator running the same four cities on gig contracting and uncapped visits would earn ₹10.45 crore.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹54.0cr	₹4.05cr	As modelled, employed and capped at 14

Gig contracting, uncapped visits	₹58.9cr	₹10.45cr	**The category's model, computed rather than dismissed**
Cap raised to 22 visits per day	₹62.6cr	₹6.89cr	Same people, longer days, invisible to everyone
Per-visit contracting only (cap retained)	₹54.0cr	₹5.58cr	Saves salary; loses training and check-in
Attrition doubles to 38%	₹49.7cr	₹1.68cr	**Retraining plus productivity; the real risk**
Subscription retention falls to 65%	₹52.9cr	₹3.61cr	Route density collapses with the book

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	580	City rollout; visit-cap and employment covenants
Term loan	440	Technology, kit, centrifuges and fleet; 5 years
Promoter contribution	240	Cash and field operations experience
Working capital facility	140	Partner settlement and receivables
Total	**1,400**	Illustrative structure

> **A lender should read attrition, subscription retention and route density, in that order, and should understand that the fixed salary base is the deliberate design rather than an inefficiency to be optimised away. Attrition doubling to 38% takes profit from ₹4.05 crore to ₹1.68 crore, and the mechanism is not wage cost but capability — a service losing half its field force annually is permanently staffed by beginners, and a beginner draws worse blood. Subscription retention is the second exposure because it is what creates the geographic clustering that makes a 14-visit cap affordable at all: at 65% retention the book scatters, route density falls, and the same cap that was comfortable becomes expensive. The visit cap and the employment model both deserve covenants, because relaxing either would lift reported profit within one quarter and would be entirely invisible to any patient, any laboratory and any regulator.**

- **Use of funds** — 24% technology and routing, 20% kit and mobile centrifuges, 17% working capital, 13% training and verification, 12% fleet, 9% city hubs, 5% licences and deposits.
- **Repayment** — term loan from Year 3 cash flow; working capital revolving against partner settlement.
- **Investor exit** — sale to a diagnostics chain, a home-healthcare group or a laboratory network; or promoter buyback. **Visit-cap and employment commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation

The rate decides	THE PHLEBOTOMIST IS ALONE IN A STRANGER'S HOME, UNSUPERVISED, WITH A NEEDLE, AND PAID PER VISIT. He still cannot see whether his sample was usable, AND NOW THERE IS NO PREMISES, NO COLLEAGUE, NO SUPERVISOR AND NO SECOND PAIR OF EYES, while the patient is frequently ELDERLY, ALONE, FRIGHTENED OR UNWELL. A per-visit rate makes VISITS PER DAY the single variable he optimises, and that ONE NUMBER SILENTLY DETERMINES how long the tourniquet stays on, whether the sample reaches a centrifuge in time, whether hands are washed between homes, whether a nervous patient is reassured or hurried, and WHETHER A DIFFICULT SECOND ATTEMPT IS OFFERED OR A POOR DRAW IS SIMPLY SENT ANYWAY. HE IS NOT BEING ASKED TO CUT CORNERS — HE IS BEING OFFERED MORE MONEY FOR GOING FASTER, IN A JOB WHERE GOING FASTER IS INVISIBLE AND ITS CONSEQUENCES ARRIVE SOMEWHERE ELSE, DAYS LATER, AS A NUMBER ON A REPORT NOBODY WILL TRACE BACK TO HIM. He is also often supporting a family on a rate that only works at high volume, SO THE PRESSURE IS NOT GREED BUT ARITHMETIC. And the structure removes every ordinary correction: no colleague to notice, no supervisor to observe, no queue to slow him, AND NO PATIENT WHO KNOWS WHAT A CORRECT DRAW LOOKS LIKE. THE SINGLE NUMBER THAT DETERMINES ALL OF IT IS SET BY THE COMPANY, EXPERIENCED BY THE WORKER, PAID FOR BY THE PATIENT, AND PUBLISHED BY NOBODY	**REMOVE THE RATE AND PUBLISH THE NUMBER. PHLEBOTOMISTS EMPLOYED RATHER THAN CONTRACTED — THE STRUCTURAL PRECONDITION FOR EVERYTHING ELSE, SINCE A PER-VISIT CONTRACTOR CANNOT BE CAPPED, CANNOT BE REQUIRED TO TRAIN, AND CANNOT BE PAID FOR WAITING OUTSIDE A LOCKED DOOR. PAID FOR TIME INCLUDING TRAVEL AND WAITING, SO AN UNPRODUCTIVE HOUR COSTS THE COMPANY RATHER THAN THE WORKER. VISITS CAPPED AT 14 AND THE CAP PUBLISHED — PRINTED ON THE PATIENT'S CONFIRMATION ALONG WITH WHICH VISIT OF THE DAY THIS IS, SO A PATIENT CAN SEE HE IS SOMEBODY'S ELEVENTH CALL AND NOT SOMEBODY'S TWENTY-SECOND. EVERY DAY THE CAP WAS EXCEEDED INVESTIGATED AND PUBLISHED — 34 against 218 (₹3.24cr). GENERAL RULE: WHERE THE WORKER IS ALONE, UNSUPERVISED AND PAID PER VISIT, THE VISITS-PER-DAY NUMBER IS THE SAFETY POLICY — SO PUBLISH IT AND CAP IT**
Monsoon Monday	22% of the field force absent, a booking book ALREADY ACCEPTED, and a dispatch system that can clear the day by pushing eight phlebotomists to NINETEEN VISITS EACH — WHICH NOBODY WOULD EVER SEE, which each patient would experience as a normal visit, and WHICH THE WORKERS THEMSELVES WOULD MOSTLY ACCEPT, BECAUSE A LONG DAY IS BETTER THAN A CANCELLED ONE	**THE DISPATCH SYSTEM CANNOT ASSIGN A FIFTEENTH VISIT: the cap is A HARD CONSTRAINT IN THE ROUTING ENGINE WITH NO PER-DAY, PER-CITY OR PER-SUPERVISOR OVERRIDE, and the alternative is TO CANCEL AND REBOOK. THE SYSTEM REFUSES RATHER THAN WARNS. CANCELLATIONS ARE PUBLISHED ALONGSIDE CAP BREACHES, BECAUSE A COMPANY THAT CAPS VISITS AND HIDES THE RESULTING CANCELLATIONS HAS ONLY MOVED THE NUMBER IT IS EMBARRASSED BY; and NO DISPATCH OR SUPERVISORY PAY IS AFFECTED BY VISITS COMPLETED**

Draw-to-centrifuge from a home	A collection centre has a centrifuge ON THE COUNTER; a home has a phlebotomist ON A TWO-WHEELER WITH ELEVEN MORE ADDRESSES, and the clock on potassium, glucose and several other analytes STARTS THE MOMENT THE TUBE FILLS — the hardest version of the anchor's pre-analytical problem	**DRAW-TO-CENTRIFUGE MEASURED AND PUBLISHED WITH ITS 90TH PERCENTILE — 31 min median against 58 at the tail, from 46 and 88 — BECAUSE A MEDIAN CONCEALS PRECISELY THE SAMPLES THAT SAT TOO LONG; 89% CENTRIFUGED IN THE FIELD in a vehicle-mounted unit rather than carried whole; and 4,600 SAMPLES REJECTED FOR DELAY RATHER THAN RUN, because a delayed sample PRODUCES A RESULT THAT LOOKS ENTIRELY NORMAL AND IS WRONG (₹86L)**
The worker's own safety	Home phlebotomists are PREDOMINANTLY WOMEN ENTERING THE HOMES OF STRANGERS ALONE, SEVERAL TIMES A DAY, with an address list supplied by a company AND NO IDEA WHO IS BEHIND THE DOOR — and the trade's standard answer is A PANIC BUTTON IN AN APPLICATION, WHICH IS A RESPONSE TO AN INCIDENT RATHER THAN A SYSTEM FOR PREVENTING ONE	**BACKGROUND VERIFICATION BEFORE A FIRST VISIT WITHOUT EXCEPTION; VISIT START AND END LOGGED WITH LIVE LOCATION; LONE-WORKER CHECK-IN AT 99.6% WITH ESCALATION ON ANY MISSED CHECK-IN; EVERY INCIDENT INCLUDING VERBAL ABUSE AND REFUSAL TO ALLOW LOGGING REPORTED AND INVESTIGATED — 94 published; AND A RISING INCIDENT COUNT TREATED AS IMPROVED REPORTING RATHER THAN DETERIORATING SAFETY, because A SERVICE RECORDING NO INCIDENTS AMONG 240 PEOPLE ENTERING STRANGERS' HOMES IS NOT SAFE, IT IS NOT LISTENING (₹1.62cr with supervision)**
An address plus a condition plus a household, on a phone	An e-pharmacy holds an order history IN A DATA CENTRE; this business holds WHERE YOU LIVE, WHAT YOU ARE BEING TESTED FOR, WHO ELSE IS IN THE HOUSE AND WHEN THE HOUSE IS EMPTY — ON A FIELD WORKER'S HANDSET, IN THE STREET	**NIL PATIENT DATA REMAINING ON THE DEVICE AFTER VISIT CLOSE and access REVOKED AT CLOSE; the online-pharmacy rule inherited unchanged with NIL data sold, shared, segmented on or targeted and SEVEN APPROACHES LOGGED AND PUBLISHED; and reports NEVER handed over in person, BECAUSE A REPORT DELIVERED BY THE COLLECTOR INVITES THE QUESTION HE MUST NOT ANSWER**
The sale at the door	A patient WITH A TOURNIQUET ON HIS ARM CANNOT COMFORTABLY DECLINE ANYTHING, and consent obtained in that posture IS NOT CONSENT	NIL additional tests offered at the doorstep and NIL pay linked to test value; consent for any addition taken BY THE LABORATORY, NOT THE PERSON HOLDING THE NEEDLE; NIL results interpreted or discussed by the collector; and add-on services such as ECG and vitals ORDERED CLINICALLY IN ADVANCE rather than offered on arrival

Attrition and capability	Attrition doubling to 38% takes profit to ₹1.68cr, and THE MECHANISM IS NOT WAGE COST BUT CAPABILITY — a service losing half its field force annually is PERMANENTLY STAFFED BY BEGINNERS, AND A BEGINNER DRAWS WORSE BLOOD	Employment with provident fund, insurance and paid leave rather than contracting; median take-home grown ₹24,600 → ₹32,200 and published; attrition driven 46% → 19% and reported as an operating metric; one supervisor per 7.5 phlebotomists; and training and certification funded as a standing function rather than an onboarding event
Route density and fixed cost	240 salaries are fixed and 860,000 visits are not; at 65% subscription retention THE BOOK SCATTERS, ROUTE DENSITY FALLS, AND THE SAME CAP THAT WAS COMFORTABLE BECOMES EXPENSIVE, taking profit to ₹3.61cr	Subscription and corporate blocks grown to 23% of revenue as the schedulable, clusterable base that FUNDS THE CAP; routing optimised for density rather than for individual visit time; city hubs shortening the last leg; capacity added city by city rather than nationally; and contribution reported PER STREAM so a scattering book is visible early

15. SWOT Analysis

Strengths • Visits capped at 14 and published on the confirmation • Employed and paid for time; nil per-visit pay • Draw-to-centrifuge 31 min median, 58 at the 90th • Verified, logged, checked in; 94 incidents published • Nil doorstep selling; nil data on the device at close	**Weaknesses** • ₹6.40cr forgone against ₹4.05cr of profit • 240 fixed salaries against variable demand • Slower to scale than a gig platform • Cap forces cancellations on a bad day
Opportunities • Elderly and chronic subscribers who value the same face • Partner laboratories wanting pre-analytical reliability • Corporate at-home screening with dense routing • Any regulation of field-worker load favours us • Phlebotomists who want employment rather than gigs	**Threats** • Gig platforms pricing below our cost base • Attrition destroying capability faster than capacity • Subscription churn collapsing route density • Fuel and field cost inflation

16. Recommended AiSevak Tools for This Business

- **Hard visit cap in routing** — a fifteenth visit cannot be assigned; no override role exists.
- **Cap-breach & cancellation register** — both published, so neither number can be hidden behind the other.
- **Draw-to-centrifuge clock** — median and 90th percentile per city, with delay rejection.
- **Lone-worker check-in** — live-location visit logging with escalation on a missed check-in.
- **Device wipe at visit close** — patient data removed and access revoked automatically.
- **No-sell interface** — the collector's application has no facility to add a test or take payment for one.
- **Route density planner** — subscription and corporate blocks clustered so the cap stays affordable.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, visit volumes, phlebotomist headcount, attrition and retention are editable inputs; actual outcomes depend on route density, city geography, wage levels and partner terms. Figures are in Indian rupees. **This plan inherits the diagnostics anchor's rules from `pathology-lab`, the pre-analytical findings from `collection-centre-franchise`, and the data rule from `online-pharmacy`.**
- **The central integrity finding is that the phlebotomist is alone in a stranger's home, unsupervised, with a needle, and paid per visit.** He still cannot see whether his sample was usable, and now there is no premises, no colleague, no supervisor and no second pair of eyes, while the patient is frequently elderly, alone, frightened or unwell. A per-visit rate makes visits per day the single variable he optimises, and that one number silently determines how long the tourniquet stays on, whether the sample reaches a centrifuge in time, whether hands are washed between homes, whether a nervous patient is reassured or hurried, and whether a difficult second attempt is offered or a poor draw is simply sent anyway. **He is not being asked to cut corners — he is being offered more money for going faster, in a job where going faster is invisible and its consequences arrive somewhere else, days later, as a number on a report nobody will trace back to him. He is also often supporting a family on a rate that only works at high volume, so the pressure is not greed but arithmetic. And the structure removes every ordinary correction: no colleague to notice, no supervisor to observe, no queue to slow him, and no patient who knows what a correct draw looks like. The single number that determines all of it is set by the company, experienced by the worker, paid for by the patient, and published by nobody.**
- **So the rate is removed and the number is published.** Phlebotomists are employed rather than contracted, which is the structural precondition for everything else — a per-visit contractor cannot be capped, cannot be required to train, and cannot be paid for waiting outside a locked door. They are paid for time including travel and waiting, so an unproductive hour costs the company rather than the worker. Visits are capped at fourteen a day and the cap is published, printed on the patient's confirmation along with which visit of the day this one is, so a patient can see he is somebody's eleventh call and not somebody's twenty-second. Every day the cap was exceeded is investigated and published — 34 against 218 in Year 1. **It costs ₹3.24 crore. WHERE THE WORKER IS ALONE, UNSUPERVISED AND PAID PER VISIT, THE VISITS-PER-DAY NUMBER IS THE SAFETY POLICY — SO PUBLISH IT AND CAP IT.**
- **The hardest moment is a monsoon Monday rather than a dilemma.** With 22% of the field force absent and a booking book already accepted, dispatch can clear the day by pushing eight phlebotomists to nineteen visits each — invisible to everyone, experienced by each patient as a normal visit, and accepted by most workers because a long day is better than a cancelled one. **So the cap is a hard constraint in the routing engine with no per-day, per-city or per-supervisor override, the alternative is to cancel and rebook, and cancellations are published alongside cap breaches — because a company that caps visits and hides the resulting cancellations has only moved the number it is embarrassed by.** No dispatch or supervisory pay is affected by visits completed.
- **Draw-to-centrifuge from a home is the hardest version of the anchor's pre-analytical problem, and the worker's own safety is the half nobody models.** A centre has a centrifuge on the counter; a home has a phlebotomist on a two-wheeler with eleven more addresses, so the time is published with its 90th percentile — 31 minutes median against 58 at the tail — with 89% centrifuged in the field and 4,600 samples rejected for delay rather than run. **And because home phlebotomists are predominantly women entering strangers' homes alone with no idea who is behind the door, every one is background-verified before a first visit, every visit is start-and-end logged with live location, lone-worker check-in runs at 99.6% with escalation on a miss, and every incident including verbal abuse is reported and investigated — 94 published, with a rising count read as improved reporting rather than deteriorating safety, because a service recording no incidents among 240 people entering strangers' homes is not safe, it is not listening.**

- **The data is an address plus a condition plus a household, held on a phone in the street, and the person holding the needle sells nothing.** Nil patient data remains on the device after visit close and access is revoked at close; nil data is sold, shared, segmented on or targeted, with seven approaches logged and published; and reports are never handed over in person, because a report delivered by the collector invites the question he must not answer. **Nil additional tests are offered at the doorstep and nil pay is linked to test value, because a patient with a tourniquet on his arm cannot comfortably decline anything, and consent obtained in that posture is not consent.**
- **The economics are a fixed salary base against variable demand, and the counterfactual is computed rather than dismissed.** The phlebotomist salary line at ₹9.72 crore is 18.0% of revenue and is cost to company — materially above take-home, because employing rather than contracting means carrying provident fund, insurance and paid leave, which is most of why a gig operator's cost per visit looks lower. **A gig operator with uncapped visits in the same four cities would earn ₹10.45 crore against our ₹4.05 crore, and the plan states that figure rather than avoiding it, because a plan that refuses to compute the alternative it rejects has not made an argument.** Attrition is the real risk — doubling it takes profit to ₹1.68 crore, and the mechanism is capability rather than wage cost, since a service losing half its field force annually is permanently staffed by beginners. Route density from subscription and corporate blocks is what makes a humane visit rate economic at all.
- **Compliance and professional advice.** The Clinical Establishments Act 2010 and state rules, under which home collection is generally an extension of a registered laboratory rather than an establishment in itself; NABL accreditation under ISO 15189, covering pre-examination processes including collection performed on the laboratory's behalf wherever it occurs; **the Bio-Medical Waste Rules, under which sharps generated inside a private home must be carried back and disposed of by the service, since the household is not a waste generator**; the Digital Personal Data Protection Act 2023, under which name, address, condition and result together are sensitive personal data held on a mobile device in a public place; labour law including the Code on Wages, EPF/ESI, the Occupational Safety, Health and Working Conditions Code and **POSH obligations for employees working alone at third-party premises, a setting the statute was not primarily written for**; motor vehicle and road-safety obligations for a two-wheeler field force; the Drugs and Cosmetics Act for consumables; NMC conduct regulations on referral commissions; GST and shops and establishments. **No regulation anywhere specifies how many homes one phlebotomist may enter in a day, which is why the cap is a business decision rather than a compliance one.** Professional advice should be taken on laboratory linkage by state, waste return obligations, lone-worker safety duties and data handling on field devices.

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