BUSINESS PLAN · INDIA

Hospital / In-house Pharmacy

Where the buyer cannot leave, the price is not a price

PHARMACY RETAIL & DISTRIBUTION

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1. Executive Summary

This plan sets out a **Hospital / In-house Pharmacy** business in India — a specialist operator running the in-house pharmacy across four partner hospitals, covering inpatient dispensing, ward satellites, surgical consumables and implants, critical-care injectables and discharge prescriptions, together with a managed-service line for hospitals that do not want to run their own.

> This plan inherits the pharmacy anchor's rules and applies them to the one customer in this entire library who cannot walk away. **Every other plan's buyer can leave the shop, close the app, or go to the chemist forty metres down the road. This one is admitted, cannulated, and physically unable to stand up.**

> □□ **WHERE THE BUYER CANNOT LEAVE, THE PRICE IS NOT A PRICE. A hospital pharmacy's customer cannot compare, cannot postpone, cannot negotiate and cannot source elsewhere — and the margin therefore migrates, precisely and predictably, TO WHERE PRICE CONTROL DOES NOT REACH. The DPCO caps scheduled formulations; it does not cap most consumables, devices, syringes, gloves, dressings, catheters or non-scheduled formulations — and on those the printed MRP is a number the manufacturer and the buying institution effectively choose together. So a ₹12 item can be billed at ₹140, no law is broken, no MRP is exceeded, and the patient sees a line on a four-hundred-line bill he is in no condition to audit. So this business CAPS ITS OWN MARGIN AT A PUBLISHED CEILING — 30% on consumables and devices, 22% on medicines — PRINTS THE CATEGORY MARGIN ON THE PATIENT'S BILL, and BILLS NIL ITEMS ABOVE THE CAP. The cap costs ₹6.84 crore a year against ₹4.70 crore of profit. WHERE THE BUYER CANNOT LEAVE, THE PRICE IS NOT A PRICE — IT IS A DECISION YOU MADE ABOUT SOMEBODY WHO COULD NOT ARGUE, SO PUBLISH IT AND CAP IT YOURSELF.**

> □□ **AND THE MOST COMMON OVERCHARGE IN INDIAN HOSPITAL BILLING IS THE ITEM THAT WAS NEVER GIVEN. Cancelled doses, unused vials, changed lines, a syringe opened and not used — all charged to the patient, and almost never refunded, because nobody reconciles what was administered against what was billed and the patient cannot audit a four-hundred-line statement from a ward bed. So EVERY ITEM IS RECONCILED ADMINISTERED-AGAINST-BILLED AND REFUNDED AUTOMATICALLY WITHOUT A COMPLAINT — ₹1.36 crore returned in Year 3, with NIL refunds requiring the patient to ask.**

> □□ **AND THE PRESCRIBER AND THE SELLER ARE THE SAME INSTITUTION. So the formulary is decided by a committee with NO P&L RESPONSIBILITY, minutes are published, and NIL clinician pay is linked to pharmacy revenue. Outside sourcing is permitted for non-urgent items without penalty, authorised in a median of nine minutes, and 31% of discharge patients buy elsewhere.**

This plan models an operator requiring **₹15.00 crore** (₹6.20 crore investor + ₹4.60 crore term loan + ₹2.60 crore promoter + ₹1.60 crore working capital), moving from **₹22.00 crore revenue and a ₹1.37 crore loss** to **₹94.00 crore revenue and ₹4.70 crore profit** by Year 3 — *a 5.0% net margin and 35.7% return on capital. (Hospital pharmacy — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A captive pharmacy that caps itself.

Vision: To make a hospital pharmacy bill a document the patient can check.

Mission: Print the margin on the bill and never exceed the published cap; refund what was billed and not given, before anybody asks; let the patient buy outside without penalty or delay; keep the formulary away from the profit and loss; and verify every prescription, including a consultant's.

Legal structure

- **Private Limited** — recommended. Hospital operating agreements, drug licences per site and institutional capital all assume it.
- **Hospital-owned department** — the usual arrangement, and the one in which the pharmacy's margin is a hospital budget line rather than a published number.
- **Pricing committee with a published cap, and a formulary committee carrying no P&L responsibility — because the person who chooses the brand must not be the person who benefits from the choice.**

> **Regulatory anchor:** the Drugs and Cosmetics Act 1940 and Rules 1945, with a **retail drug licence for each hospital pharmacy premises and each ward satellite from which dispensing occurs**; the Pharmacy Act 1948 and registered-pharmacist supervision, which applies inside a hospital exactly as it does in a shop; Schedules H, H1 and X, with Schedule X under NDPS storage, register and disposal conditions and controlled-substance reconciliation at ward level; **NPPA and DPCO ceiling prices on scheduled formulations — and the decisive structural fact, that MOST CONSUMABLES, DEVICES, IMPLANTS AND NON-SCHEDULED FORMULATIONS FALL OUTSIDE PRICE CONTROL ENTIRELY, so billing a ₹12 item at ₹140 exceeds no ceiling and violates nothing**; NPPA capping of selected devices such as stents and knee implants, which demonstrates both the problem and the narrowness of the remedy; the Clinical Establishments Act and state rules on rate display and billing transparency where adopted; the Consumer Protection Act, under which hospital billing disputes are routinely litigated after the fact; biomedical waste rules; and GST, EPF/ESI and POSH. **Nothing in any of it requires a hospital to reconcile what was administered against what was billed.**

3. Promoter & Ownership

Led by a promoter with hospital pharmacy, clinical or healthcare operations background. Three competences decide outcomes. *Ward-level operations*, because a hospital pharmacy is a distribution problem with a clinical safety layer, and the satellites are where both are won or lost. *Formulary and clinical relationships*, since the pharmacy's standing rests on interceptions rather than on service levels. And *the willingness to cap a margin nobody would question*, which is where this plan's proposition sits and which forgoes roughly twice the year's profit. Ownership, equity & investor terms are editable inputs; **the formulary committee carries no profit-and-loss responsibility, the pricing cap is published and cannot be varied by any commercial officer, and no clinician's pay is linked to pharmacy revenue.**

4. Market Analysis — India

A large and structurally protected market in which the customer has no alternatives at all.

Demand drivers

- **Private hospital bed growth** across tier-1 and tier-2 cities.
- **Surgical and procedural volume**, which drives consumables and implants.
- **Critical care and oncology**, with high-value injectables and cold-chain needs.
- **Insurance and TPA scrutiny** of itemised billing, which rewards defensible pricing.
- **Hospitals outsourcing pharmacy** to specialists for working capital and compliance reasons.
- **Regulatory and public attention** to hospital billing, which is rising rather than falling.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian hospital pharmacy and consumables spend	Very large; mostly in-house and unpublished
SAM	**Hospitals willing to operate under a PUBLISHED margin cap**	**Bounded by the hospital's own economics, not the patient's**
SOM (Yr 1–3)	Partner hospitals operated	₹22cr → ₹94cr; 4 hospitals; 18% of hospital revenue

Revenue mix and share (Year 3)

Stream	Share of revenue	Capped gross margin — and what it would otherwise be
Inpatient medicines — scheduled & non-scheduled	**40.0%**	**19.0% — DPCO binds much of it; the honest part**
Surgical consumables, devices & implants	**24.0%**	**30.0% CAPPED — where price control does not reach**
Discharge & outpatient prescriptions	18.0%	20.0% — and the outside price is shown
Critical care, oncology & high-value injectables	10.0%	17.0% — deliberately the lowest cap in the book
OTC, nutrition & patient-comfort items	5.0%	34.0% — the only genuinely discretionary purchase
Managed-pharmacy service fees from hospitals	3.0%	62.0% — paid by the hospital, not the patient

> **The second row is the whole finding rendered as a business line. Surgical consumables, devices and implants are 24% of revenue and sit almost entirely outside price control, which is exactly why the trade's margins on them are measured in multiples rather than percentages — and capping ourselves at 30% forgoes more money than every other commitment in this plan combined. The fourth row is the one to read next: critical care and oncology injectables carry the LOWEST cap in the book at 17%, deliberately, because those are the patients with the least capacity to question anything and the largest bills, and a pricing policy that is generous everywhere except where the patient is sickest is not a pricing policy. The sixth row is the structural answer: managed-service fees are paid by the HOSPITAL rather than by the patient, so growing that line is the only way this business can grow its margin without taking more from somebody in a bed.**

Constraints

- **Hospital willingness** to accept a published cap, which is the binding constraint on growth.
- **Registered pharmacist availability** for round-the-clock ward cover.
- **Working capital** in high-value injectables and implants.
- **Insurance and TPA payment cycles** on the institutional share of billing.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits

Hospital-owned in-house pharmacies	Total control, captive flow, margin as a budget line	**Uncapped consumables margin; no administered-vs-billed reconciliation**
Retail chains operating hospital counters	Buying power, systems, brand, staffing depth	Retail category-mix habits imported into a ward
Distributors managing hospital stores	Supply strength, working capital, logistics	No clinical layer; formulary influenced by supply economics
External chemists outside the hospital gate	Price, choice, no captivity at all	No ward access, no emergency supply, no clinical record
This plan	**Published margin cap, margin printed on the bill, automatic refunds, outside sourcing permitted**	5.0% net; forgoes roughly twice its profit

> **The positioning is aimed at two buyers with opposite interests, which is unusual and is the reason it can work at all. The patient gets a bill on which the margin is printed, items never administered are refunded before he notices, and he may buy anything non-urgent outside without penalty. The hospital gets something it increasingly needs: a pharmacy whose billing survives a TPA audit, a consumer complaint, a regulator's inspection and a viral social-media post about a ₹140 syringe — because insurance scrutiny and public attention to hospital billing are both rising, and an uncapped consumables margin is a liability accumulating quietly on somebody's balance sheet. Every claim is checkable by the patient within one admission, which is this library's standing test.**

> **The cost of the honest position is stated in rupees, and here it is roughly twice the profit. Capping category margins at 30% on consumables and devices and 22% on medicines, rather than charging what an unconstrained captive market permits, cost ₹6.84 crore of Year-3 margin — by a wide distance the largest commitment in this vertical. Refunding items billed but not administered, automatically and without a complaint, cost ₹1.36 crore. Permitting outside sourcing without penalty or delay, with 31% of discharge patients buying elsewhere, cost ₹1.24 crore. Keeping the formulary committee free of profit-and-loss responsibility, and no clinician's pay linked to pharmacy revenue, cost ₹92 lakh in forgone brand-mix margin. Total ₹9.36 crore against ₹4.70 crore of profit — so an operator running the same four hospitals on ordinary captive-market terms would earn ₹14.06 crore, roughly three times as much.**

6. The Buyer Who Cannot Leave

This is the finding, and it is a structural fact rather than a behaviour.

What a normal buyer can do	What this buyer can do
Compare the price elsewhere	**Nothing — he is in a bed**
Postpone the purchase	**Nothing — it is going into a cannula**
Walk out	**Nothing — he is admitted**
Ask what it costs before agreeing	**Nothing — he is often unconscious**
Check the bill line by line	**Four hundred lines, at discharge, while unwell**
Complain afterwards	Yes — and almost nobody does
Choose the brand	**No — the institution that sells it also prescribes it**

Read that table and the pricing behaviour of Indian hospital pharmacy stops being a scandal and becomes a prediction. A market with no exit, no comparison, no postponement and no informed consent at the point of purchase will produce whatever margin the seller chooses, and the only real constraint is price control — which is why THE MARGIN MIGRATES WITH SUCH PRECISION TO EXACTLY WHERE PRICE CONTROL DOES NOT REACH. Scheduled formulations are capped and earn 19%; consumables, devices and non-scheduled formulations are not capped, and there the printed MRP is a number the manufacturer and the buying institution effectively choose together, because the manufacturer's customer is the hospital rather than the patient and a higher printed MRP is a feature both parties want. The stent and knee-implant caps prove the mechanism precisely: the moment a device was capped, the behaviour on that device changed and continued unchanged everywhere else — which tells you the pricing was never about cost and always about the absence of a constraint. NOBODY IN THE HOSPITAL FEELS LIKE A PROFITEER, because each individual price is just the MRP.

So the constraint is supplied voluntarily, because it will not arrive any other way. A PUBLISHED MARGIN CEILING — 30% ON CONSUMABLES AND DEVICES, 22% ON MEDICINES, 17% ON CRITICAL-CARE AND ONCOLOGY INJECTABLES — WITH NIL ITEMS BILLED ABOVE IT and the CATEGORY MARGIN PRINTED ON THE PATIENT'S OWN BILL, so he can see what the hospital made on him rather than inferring it. The cap CANNOT BE VARIED BY ANY COMMERCIAL OFFICER; it moves only by a published decision of the pricing committee, which is the difference between a cap and a guideline. And OUTSIDE SOURCING IS PERMITTED FOR ANY NON-URGENT ITEM WITHOUT PENALTY, AUTHORISED IN A MEDIAN OF NINE MINUTES AND WITH NIL HANDLING FEE — because a hospital that permits outside purchase in policy while making it take two hours has not permitted it. WHERE THE BUYER CANNOT LEAVE, THE PRICE IS NOT A PRICE — IT IS A DECISION YOU MADE ABOUT SOMEBODY WHO COULD NOT ARGUE, SO PUBLISH IT AND CAP IT YOURSELF.

7. The Item That Was Never Given, and the Formulary

Four further rules, the first of which costs a hospital almost nothing to fix and is almost universally unfixed.

□□ THE MOST COMMON OVERCHARGE IN INDIAN HOSPITAL BILLING IS THE ITEM THAT WAS NEVER GIVEN. A dose cancelled after the round, a vial drawn and not used, a line changed, a catheter opened for a procedure that was abandoned, an antibiotic stopped when the culture came back — every one of them is issued from the pharmacy, charged to the patient, and never reconciled against what the nurse actually administered. It is not a fraud; it is an ABSENCE OF A RECONCILIATION, and it survives because the only person with an interest in performing it is lying down and cannot audit four hundred lines. So EVERY ITEM IS RECONCILED ADMINISTERED-AGAINST-BILLED through barcode administration at the bedside, and the difference is REFUNDED AUTOMATICALLY BEFORE THE PATIENT ASKS — ₹1.36 crore in Year 3, with NIL refunds requiring a complaint. The refund value is published, because a hospital claiming to refund unadministered items without stating the amount has claimed nothing — and a reconciliation returning zero would be investigated as a measurement failure, per the anchor's rule.

□□ AND THE PRESCRIBER AND THE SELLER ARE THE SAME INSTITUTION. A salaried clinician prescribes from a formulary his employer profits from, and the formulary is generally set with procurement and margin sitting in the room — which quietly converts a clinical instrument into a commercial one without anybody proposing anything improper. So THE FORMULARY COMMITTEE CARRIES NO PROFIT-AND-LOSS RESPONSIBILITY AND SEES NO MARGIN DATA, its MINUTES ARE PUBLISHED, NIL CLINICIAN PAY IS LINKED TO PHARMACY REVENUE, and selecting a brand over a cheaper therapeutic equivalent requires A RECORDED CLINICAL REASON — nil selections without one. Per the anchor's control-independence rule, the person who chooses must not be the

person who benefits.

AND DISCHARGE IS THE MOMENT OF MAXIMUM CAPTURE. A patient leaving with a month's supply is steered to the counter he is already standing beside, for medicines he could buy anywhere at leisure — the one purchase in the whole admission where he genuinely has a choice, made at the moment he is least inclined to exercise it. So THE OUTSIDE PRICE IS SHOWN ALONGSIDE OURS ON EVERY DISCHARGE PRESCRIPTION, and 31% OF PATIENTS BUY ELSEWHERE — with the discharge capture rate FALLING from 79% to 69%, which is reported as a success rather than as attrition.

AND THE ANCHOR'S REFUSAL RULE APPLIES INSIDE A HOSPITAL TOO. Every prescription is verified by a registered pharmacist, 21,400 were queried or refused in Year 3 INCLUDING CONSULTANTS', and 3,180 medication errors were intercepted — because a pharmacy that never questions a senior clinician is not performing verification, it is performing deference.

8. Operations Plan (verify, dispense, reconcile, refund)

Pricing

- **Published margin ceiling per category** — 30% consumables and devices, 22% medicines, 17% critical care.
- **Category margin printed on the patient's bill**, not disclosed on request.
- **Cap not variable by any commercial officer**; moves only by published pricing-committee decision.
- **Outside sourcing permitted for any non-urgent item**, nil handling fee, nine-minute median authorisation.

Clinical verification

- **Every prescription verified by a registered pharmacist**, consultants' included.
- **Queries and refusals logged**; a verifier with a zero query rate is audited.
- **Medication errors intercepted and published** — 3,180 in Year 3.
- **Registered-pharmacist cover round the clock** across main pharmacy and ward satellites.

Reconciliation and refunds

- **Barcode administration at the bedside**, so administered is captured rather than assumed.
- **Every item reconciled administered-against-billed** before the bill is finalised.
- **Refund issued automatically**, without a complaint, before discharge where possible.
- **Refund value published**; a zero reconciliation is investigated as a measurement failure.

Formulary and supply

- **Formulary committee with no P&L responsibility**, seeing no margin data, minutes published.
- **Brand over cheaper equivalent requires a recorded clinical reason.**
- **Cold chain and controlled substances reconciled at ward level** under Schedule X conditions.
- **Near-expiry destroyed, not returned**; suppliers de-listed on a substandard batch, per the anchor.

The operational hinge is a request from a partner hospital's finance director: raise the consumables cap from 30% to 45% for one quarter to cover a shortfall, on items nobody outside the hospital can price, for patients who will never know a cap existed. It is lawful, it exceeds no MRP, it is invisible in every external document, and it would add about ₹85 lakh in that quarter — and he is not proposing anything unusual, because 45%

would still be well below what the market bears. So THE CAP IS PUBLISHED, WHICH IS WHAT MAKES IT REAL: a number stated to patients cannot be varied for a quarter without stating that too. The system refuses rather than warns — the billing engine will not accept a line above the published ceiling and there is no override role, so raising the cap requires a published pricing-committee decision rather than an instruction. And NO EMPLOYEE'S PAY IS AFFECTED BY PHARMACY MARGIN, which is why the answer can be no without anybody being brave.

9. Licensing, Pricing & Operating Compliance (India)

- **Drugs and Cosmetics Act 1940 and Rules 1945** — retail drug licence for each hospital pharmacy premises **and each ward satellite** from which dispensing occurs.
- **Pharmacy Act 1948** — registered-pharmacist supervision, which applies inside a hospital exactly as it does in a shop.
- **Schedules H, H1 and X** — registers maintained; Schedule X under NDPS storage, register and disposal conditions with ward-level reconciliation.
- **NPPA and DPCO** — ceiling prices on scheduled formulations; **and the decisive gap: MOST CONSUMABLES, DEVICES, IMPLANTS AND NON-SCHEDULED FORMULATIONS FALL OUTSIDE PRICE CONTROL, so billing a ₹12 item at ₹140 exceeds no ceiling and violates nothing.**
- **Selective device capping** — stents, knee implants and similar, which demonstrate both the problem and the narrowness of the remedy.
- **Clinical Establishments Act and state rules** on rate display and billing transparency, where adopted.
- **Consumer Protection Act** — under which hospital billing disputes are routinely litigated, always after the fact.
- **Cold chain, biomedical waste, GST, EPF/ESI and POSH. Nothing in any of the above requires a hospital to reconcile what was administered against what was billed.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owns the published cap
Pharmacy technicians & ward liaison	32	128	Bedside barcode administration capture
Registered pharmacists — verification & ward cover	24	86	**Round the clock; query consultants too**
Inventory, cold chain & controlled substances	8	26	Ward-level Schedule X reconciliation
Billing reconciliation & administration audit	6	22	**Administered against billed, every item**
Refund processing & patient billing helpdesk	4	14	**Refunds issued before anybody asks**
Finance, legal, compliance & admin	5	17	Publishes the cap and the refund value
Total	**80**	**294**	Reconciliation and refunds at 12% of headcount

Thirty-six people on billing reconciliation and refunds is a function that does not exist in most hospitals, because the work it performs has no revenue attached to it — it exclusively finds money the institution should give back. That is precisely why it must be staffed rather than automated into a monthly exception report: an administered-versus-billed reconciliation performed by the billing team would find what the billing team wanted to find. Eighty-six registered pharmacists across four hospitals provide round-the-clock verification

including ward satellites, and their standing instruction is that a consultant's prescription is verified on the same terms as anybody else's — because A PHARMACY THAT NEVER QUESTIONS A SENIOR CLINICIAN IS NOT PERFORMING VERIFICATION, IT IS PERFORMING DEFERENCE. No employee's pay is affected by pharmacy margin, at any level.

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & first hospital	Month 0–7	Incorporation, drug licences per site, first operating agreement
Published cap & margin-on-bill	Month 2–8	**Billing engine rejects lines above ceiling; no override role exists**
Barcode administration & reconciliation	Month 5–15	Bedside capture; first automatic refunds issued
Formulary governance	Month 8–16	Committee without P&L responsibility; minutes published
Hospitals two to four	Month 12–28	Ward satellites licensed; outside-sourcing authorisation under 10 minutes
Scale & publication	Month 26–36	₹1.36cr refunded; discharge capture down to 69%

Training and competence

- **Querying a consultant** — the single hardest skill in hospital pharmacy, taught explicitly.
- **Bedside administration capture** for nursing staff, since reconciliation depends on it.
- **Explaining a printed margin** to a patient who has never seen one on a bill.
- **Authorising outside purchase quickly**, because delay is how permission is withdrawn in practice.

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions, not forecasts or guarantees. They exist to show the drivers of a hospital pharmacy P&L under a self-imposed margin cap. Every input is editable. **The defining economics are that a 23.7% blended gross margin is a CHOICE rather than a market outcome — an uncapped operator in the same four hospitals would earn a multiple of it, which is why the cost of the honest position here is roughly twice the profit rather than a fraction of it.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Working capital — inventory across four hospital sites	486	High-value injectables and implants
Pharmacy fit-out, storage, cold rooms & ward satellites	384	Licensed premises at each satellite
Technology — billing engine & administered-vs-billed reconciliation	**268**	**Rejects lines above the cap; no override role**
Automated dispensing cabinets & bedside barcode administration	**186**	**Without this, reconciliation is not possible**
Licences, deposits & pre-operative	98	Per-premises drug licensing including satellites

Refund processing & patient helpdesk infrastructure	**48**	**A function that only ever gives money back**
Launch & mobilisation	30	Hospital-by-hospital transition
Total project cost	**1,500**	₹620L investor + ₹460L term loan + ₹260L promoter + ₹160L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
CATEGORY MARGIN PRINTED ON THE PATIENT'S OWN BILL / capped at a PUBLISHED ceiling (30% consumables & devices, 22% medicines, 17% critical care) / items billed ABOVE the cap / cap variable by a commercial officer	100% / 100% / NIL / NIL	100% / 100% / NIL / NIL	**100% / 100% / NIL / NIL**
ADMINISTERED RECONCILED AGAINST BILLED for every item / billed-but-not-administered REFUNDED AUTOMATICALLY without a complaint / refund value published (₹L) / refunds requiring the patient to ask	100% / 100% / 34 / NIL	100% / 100% / 78 / NIL	**100% / 100% / 136 / NIL**
OUTSIDE SOURCING permitted for non-urgent items without penalty / requests granted / **median time to authorise** / handling fee charged on outside items	100% / 100% / 22 min / NIL	100% / 100% / 14 min / NIL	**100% / 100% / 9 min / NIL**
FORMULARY decided by a committee with NO P&L RESPONSIBILITY and seeing no margin data / minutes published / **clinician pay linked to pharmacy revenue** / brand chosen over cheaper equivalent without a recorded clinical reason	100% / 100% / NIL / NIL	100% / 100% / NIL / NIL	**100% / 100% / NIL / NIL**
Outside price shown alongside ours on every discharge prescription / patients who bought outside / **discharge capture rate (reported as a success when it FALLS)**	100% / 21% / 79%	100% / 26% / 74%	**100% / 31% / 69%**
Prescriptions verified by a registered pharmacist / **queried or refused INCLUDING CONSULTANTS'** / medication errors intercepted / **pharmacy as % of hospital revenue (a HIGH figure is a warning, not an achievement)**	100% / 4,180 / 640 / 22%	100% / 11,600 / 1,720 / 20%	**100% / 21,400 / 3,180 / 18%**

Row one is the row this plan exists to report, and its last two figures are what make the first two real: NIL items billed above the cap, and NIL ability for any commercial officer to vary it — because a ceiling that can be lifted by a decision nobody publishes is a guideline. Row two's ₹1.36 crore is money returned to patients who did not ask and mostly never knew, and a reconciliation returning zero would be investigated as a measurement failure per the anchor's rule. Row five reports a FALLING discharge capture rate — 79% to 69% — as a success, which inverts the metric every hospital pharmacy in the country optimises, because capture at discharge measures how effectively a patient was prevented from exercising the one real choice in his admission. Row six's last figure does the same: pharmacy at 18% of hospital revenue and falling, stated with the explicit note that a HIGH figure is a warning rather than an achievement — a hospital earning a quarter of its revenue from the pharmacy is telling you something about its pricing, not its clinical volume.

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Capped margin
Inpatient medicines — scheduled & non-scheduled	880	2,080	3,760	**19.0%**
Surgical consumables, devices & implants	528	1,248	2,256	**30.0% cap**
Discharge & outpatient prescriptions	396	936	1,692	20.0%

Critical care, oncology & high-value injectables	220	520	940	17.0% cap
OTC, nutrition & patient-comfort items	110	260	470	34.0%
Managed-pharmacy service fees from hospitals	66	156	282	62.0%
Total revenue	**2,200**	**5,200**	**9,400**	**23.7% blended**

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	2,200	5,200	9,400
Cost of goods — incl. expiry and destroyed stock	(1,679)	(3,970)	(7,176)
Gross profit	**521**	**1,230**	**2,224**
Pharmacy staff — pharmacists, technicians & ward liaison	**(264)**	**(428)**	**(682)**
Space, utilities & hospital facility charge	(118)	(186)	(296)
Technology, billing reconciliation & administration audit	**(96)**	**(142)**	**(184)**
Inventory management, cold chain & expiry	(64)	(96)	(148)
Refund processing & patient billing helpdesk	**(32)**	**(48)**	**(76)**
Admin, legal, compliance & other	(82)	(112)	(155)
EBITDA	**(135)**	**218**	**683**
Depreciation & amortisation	(74)	(112)	(148)
Finance cost	(46)	(72)	(96)
Other income — managed-service incentives and supplier terms *(disclosed)*	72	116	188
PBT	**(183)**	**150**	**627**
Tax	46	(38)	(157)
PAT	**(137)**	**112**	**470**
Net margin	**(6.2%)**	**2.2%**	**5.0%**
ROCE	**(13.9%)**	**7.1%**	**35.7%**

The gross margin of 23.7% is the only number in this vertical that is a CHOICE rather than a market outcome, and everything else in the P&L follows from it. Refund processing at ₹76 lakh and reconciliation technology at ₹1.84 crore are costs incurred entirely to give ₹1.36 crore back, which is a combination no ordinary commercial logic produces — the function exists because the alternative is keeping money the patient was charged for something he never received. Other income of ₹1.88 crore is managed-service incentives and supplier terms, disclosed as a line and never conditional on the volume of a specific brand, per the anchor's rule. Commitments of ₹9.36 crore against ₹4.70 crore of profit mean an operator running the same four hospitals on ordinary captive-market terms would earn ₹14.06 crore — roughly three times as much, from the same beds, the same patients and the same clinical work.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹94.0cr	₹4.70cr	As modelled, capped at 5.0% net
Uncapped captive-market pricing	₹104.4cr	₹14.06cr	**Same beds, same patients, same clinical work**
Consumables cap raised to 45%	₹97.4cr	₹7.24cr	**The request that must be refused**
Fifth hospital added	₹114.7cr	₹6.10cr	Operating leverage sits in verification
Discharge capture falls to 60%	₹91.8cr	₹4.37cr	Reported as success, costed honestly
Pharmacist wage inflation +20%	₹94.0cr	₹4.12cr	86 pharmacists is the fixed exposure

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	620	Hospital rollout; published-cap covenant
Term loan	460	Fit-out, cabinets and systems; 5–6 years
Promoter contribution	260	Cash and hospital relationships
Working capital facility	160	Inventory across four sites
Total	**1,500**	Illustrative structure

> **A lender should read the operating-agreement tenure, the pharmacy's share of hospital revenue, and the refund line — and should understand that the last of these is an asset rather than a leakage. The binding commercial risk is contract renewal: this business's revenue sits inside somebody else's building under agreements that end, and a hospital that decides to take the pharmacy back in-house removes a quarter of the revenue in one notice period. That is why the managed-service line and the published cap matter commercially: the cap is what makes the operating agreement defensible to a TPA, a regulator and a court, and it becomes harder for a hospital to terminate the arrangement the more publicly the cap has been stated. The published cap deserves a covenant precisely because lifting it would improve every financial line simultaneously and would be invisible outside the billing engine.**

- **Use of funds** — 32% working capital, 26% fit-out and satellites, 18% billing and reconciliation technology, 12% dispensing cabinets and barcode administration, 7% licences and deposits, 5% refund and helpdesk infrastructure.
- **Repayment** — term loan from Year 2–3 cash flow; working capital revolving against inventory and institutional receivables.
- **Investor exit** — sale to a hospital group, a pharmacy chain building institutional capability, or a healthcare platform; or promoter buyback. **The published cap survives change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation

The buyer who cannot leave	The customer is admitted, cannulated and PHYSICALLY UNABLE TO COMPARE A PRICE, POSTPONE A PURCHASE, WALK OUT OR OFTEN EVEN BE CONSCIOUS AT THE POINT OF SALE. This is the purest case in this library of A MARKET WITH NO EXIT — every other plan's customer can leave, and this one cannot stand up. A market with no exit, no comparison, no postponement and no informed consent WILL PRODUCE WHATEVER MARGIN THE SELLER CHOOSES, and the only real constraint is price control — WHICH IS WHY THE MARGIN MIGRATES WITH SUCH PRECISION TO EXACTLY WHERE PRICE CONTROL DOES NOT REACH. DPCO caps scheduled formulations; IT DOES NOT CAP MOST CONSUMABLES, DEVICES, IMPLANTS OR NON-SCHEDULED FORMULATIONS, and there the printed MRP is a number THE MANUFACTURER AND THE BUYING INSTITUTION EFFECTIVELY CHOOSE TOGETHER, because the manufacturer's customer is the hospital rather than the patient AND A HIGHER PRINTED MRP IS A FEATURE BOTH PARTIES WANT. A ₹12 item bills at ₹140, no ceiling is exceeded and nothing is violated. THE STENT AND KNEE-IMPLANT CAPS PROVE THE MECHANISM: THE MOMENT A DEVICE WAS CAPPED THE BEHAVIOUR ON THAT DEVICE CHANGED AND CONTINUED UNCHANGED EVERYWHERE ELSE, WHICH TELLS YOU THE PRICING WAS NEVER ABOUT COST AND ALWAYS ABOUT THE ABSENCE OF A CONSTRAINT. And NOBODY IN THE HOSPITAL FEELS LIKE A PROFITEER, BECAUSE EACH INDIVIDUAL PRICE IS JUST THE MRP	**SUPPLY THE CONSTRAINT VOLUNTARILY, BECAUSE IT WILL NOT ARRIVE ANY OTHER WAY: a PUBLISHED MARGIN CEILING — 30% consumables and devices, 22% medicines, 17% CRITICAL CARE AND ONCOLOGY (deliberately the LOWEST cap in the book, because those patients have the least capacity to question anything and the largest bills, and A PRICING POLICY THAT IS GENEROUS EVERYWHERE EXCEPT WHERE THE PATIENT IS SICKEST IS NOT A PRICING POLICY) — with NIL items billed above it and THE CATEGORY MARGIN PRINTED ON THE PATIENT'S OWN BILL so he can SEE what was made on him rather than infer it. THE CAP CANNOT BE VARIED BY ANY COMMERCIAL OFFICER and moves only by a PUBLISHED pricing-committee decision, WHICH IS THE DIFFERENCE BETWEEN A CAP AND A GUIDELINE (₹6.84cr). GENERAL RULE: WHERE THE BUYER CANNOT LEAVE, THE PRICE IS NOT A PRICE — IT IS A DECISION YOU MADE ABOUT SOMEBODY WHO COULD NOT ARGUE, SO PUBLISH IT AND CAP IT YOURSELF**
The finance director's request	Raise the consumables cap from 30% to 45% FOR ONE QUARTER to cover a shortfall, ON ITEMS NOBODY OUTSIDE THE HOSPITAL CAN PRICE, FOR PATIENTS WHO WILL NEVER KNOW A CAP EXISTED. It is lawful, exceeds no MRP, is INVISIBLE IN EVERY EXTERNAL DOCUMENT, adds about ₹85L in that quarter — and HE IS NOT PROPOSING ANYTHING UNUSUAL, BECAUSE 45% WOULD STILL BE WELL BELOW WHAT THE MARKET BEARS	**THE CAP IS PUBLISHED, WHICH IS WHAT MAKES IT REAL: A NUMBER STATED TO PATIENTS CANNOT BE VARIED FOR A QUARTER WITHOUT STATING THAT TOO. THE SYSTEM REFUSES RATHER THAN WARNS — the billing engine WILL NOT ACCEPT A LINE ABOVE THE PUBLISHED CEILING AND THERE IS NO OVERRIDE ROLE, so raising the cap requires a published pricing-committee decision rather than an instruction. And NO EMPLOYEE'S PAY IS AFFECTED BY PHARMACY MARGIN AT ANY LEVEL, WHICH IS WHY THE ANSWER CAN BE NO WITHOUT ANYBODY BEING BRAVE**

The item that was never given	A dose cancelled after the round, a vial drawn and not used, a line changed, a catheter opened for an abandoned procedure, an antibiotic stopped when the culture returned — EVERY ONE ISSUED FROM THE PHARMACY, CHARGED TO THE PATIENT, AND NEVER RECONCILED AGAINST WHAT THE NURSE ACTUALLY ADMINISTERED. IT IS NOT A FRAUD; IT IS AN ABSENCE OF A RECONCILIATION, AND IT SURVIVES BECAUSE THE ONLY PERSON WITH AN INTEREST IN PERFORMING IT IS LYING DOWN AND CANNOT AUDIT FOUR HUNDRED LINES	**RECONCILE ADMINISTERED AGAINST BILLED FOR EVERY ITEM through BEDSIDE BARCODE ADMINISTRATION, and REFUND THE DIFFERENCE AUTOMATICALLY BEFORE THE PATIENT ASKS — ₹1.36cr in Yr3, NIL refunds requiring a complaint. THE REFUND VALUE IS PUBLISHED, BECAUSE A HOSPITAL CLAIMING TO REFUND UNADMINISTERED ITEMS WITHOUT STATING THE AMOUNT HAS CLAIMED NOTHING, and A RECONCILIATION RETURNING ZERO WOULD BE INVESTIGATED AS A MEASUREMENT FAILURE (anchor rule). 36 staff on reconciliation and refunds — A FUNCTION THAT EXCLUSIVELY FINDS MONEY THE INSTITUTION SHOULD GIVE BACK, WHICH IS WHY IT CANNOT SIT INSIDE THE BILLING TEAM: AN ADMINISTERED-VERSUS-BILLED RECONCILIATION PERFORMED BY THE BILLING TEAM WOULD FIND WHAT THE BILLING TEAM WANTED TO FIND**
The prescriber and the seller are the same institution	A salaried clinician prescribes from a formulary HIS EMPLOYER PROFITS FROM, and the formulary is generally set WITH PROCUREMENT AND MARGIN SITTING IN THE ROOM — which quietly converts a clinical instrument into a commercial one WITHOUT ANYBODY PROPOSING ANYTHING IMPROPER	**THE FORMULARY COMMITTEE CARRIES NO P&L RESPONSIBILITY AND SEES NO MARGIN DATA; MINUTES PUBLISHED; NIL CLINICIAN PAY LINKED TO PHARMACY REVENUE; and selecting a brand over a cheaper therapeutic equivalent REQUIRES A RECORDED CLINICAL REASON, with nil selections lacking one — the anchor's control-independence rule: THE PERSON WHO CHOOSES MUST NOT BE THE PERSON WHO BENEFITS (₹92L)**
Discharge is the moment of maximum capture	A patient leaving with a month's supply is steered to the counter HE IS ALREADY STANDING BESIDE, for medicines he could buy anywhere at leisure — THE ONE PURCHASE IN THE WHOLE ADMISSION WHERE HE GENUINELY HAS A CHOICE, MADE AT THE MOMENT HE IS LEAST INCLINED TO EXERCISE IT	**THE OUTSIDE PRICE IS SHOWN ALONGSIDE OURS ON EVERY DISCHARGE PRESCRIPTION and 31% BUY ELSEWHERE, with DISCHARGE CAPTURE FALLING 79% → 69% AND REPORTED AS A SUCCESS — WHICH INVERTS THE METRIC EVERY HOSPITAL PHARMACY IN THE COUNTRY OPTIMISES, BECAUSE CAPTURE AT DISCHARGE MEASURES HOW EFFECTIVELY A PATIENT WAS PREVENTED FROM EXERCISING THE ONE REAL CHOICE IN HIS ADMISSION. Outside sourcing permitted for ANY non-urgent item, NIL handling fee, NINE-MINUTE MEDIAN AUTHORISATION — BECAUSE A HOSPITAL THAT PERMITS OUTSIDE PURCHASE IN POLICY WHILE MAKING IT TAKE TWO HOURS HAS NOT PERMITTED IT (₹1.24cr)**

Verification inside a hierarchy	The anchor's refusal rule is harder here than in a shop, because the prescriber is a senior consultant standing in the same building and the pharmacist is junior to him in every way that matters	21,400 prescriptions QUERIED OR REFUSED IN YEAR 3 INCLUDING CONSULTANTS' and 3,180 medication errors intercepted; a verifier with a ZERO query rate is audited; querying a consultant is TAUGHT EXPLICITLY — because A PHARMACY THAT NEVER QUESTIONS A SENIOR CLINICIAN IS NOT PERFORMING VERIFICATION, IT IS PERFORMING DEFERENCE
Contract renewal and hospital concentration	Revenue sits INSIDE SOMEBODY ELSE'S BUILDING under agreements that end; a hospital taking the pharmacy back in-house removes a quarter of revenue in one notice period, and four sites is genuine concentration	The published cap makes the operating agreement DEFENSIBLE TO A TPA, A REGULATOR AND A COURT, which makes termination harder the more publicly it has been stated; managed-service fees grown as a HOSPITAL-PAID rather than patient-paid line; staggered tenures and further sites to dilute concentration; and clinical interception statistics reported to each hospital board as value a purely commercial operator cannot show
Working capital, wages and expiry	High-value injectables and implants tie up ₹4.86cr; 86 pharmacists are a fixed cost and 20% wage inflation takes profit to ₹4.12cr; expiry on slow oncology lines is expensive and cold-chain failure is invisible on arrival	Consignment terms on implants and high-value injectables where possible; near-expiry DESTROYED not returned and suppliers DE-LISTED per the anchor; cold chain excursion-logged to ward level; Schedule X reconciled at ward level daily; and pharmacist rostering shared across sites rather than duplicated

15. SWOT Analysis

Strengths

- Published margin cap; nil items billed above it
- Category margin printed on the patient's own bill
- ₹1.36cr refunded automatically, nil complaints required
- Outside sourcing in nine minutes, nil handling fee
- 21,400 prescriptions queried, consultants' included

Weaknesses

- ₹9.36cr forgone against ₹4.70cr of profit
- 5.0% net where the market permits far more
- Revenue sits inside somebody else's building
- Four-hospital concentration

Opportunities

- Rising TPA and regulatory scrutiny of hospital billing
- Managed-service fees paid by hospitals, not patients
- Clinical interception as demonstrable board-level value
- Hospitals wanting billing that survives an audit
- Any future consumables price control favours us

Threats

- Hospitals taking the pharmacy back in-house
- Competitors whose economics assume no cap
- Pharmacist scarcity for round-the-clock cover
- Working capital in implants and oncology

16. Recommended AiSevak Tools for This Business

- **Capped billing engine** — rejects any line above the published ceiling; no override role exists.
- **Margin-on-bill printer** — category margin shown to the patient as a bill line, not on request.

- **Administered-vs-billed reconciler** — bedside barcode capture against every charged item.
- **Automatic refund engine** — issues before discharge without a complaint; refund value published.
- **Outside-sourcing authoriser** — nine-minute median, nil handling fee, fully logged.
- **Formulary governance register** — committee without margin data, published minutes, recorded clinical reasons.
- **Verification & interception log** — queries and refusals by prescriber seniority; zero-rate verifiers audited.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, hospital count, capped category margins, refund values and capture rates are editable inputs; actual outcomes depend on operating agreements, case mix, pharmacist availability and any future price control. Figures are in Indian rupees. **This plan inherits the pharmacy vertical anchor's rules from `retail-pharmacy`.**
- **The central integrity finding is that where the buyer cannot leave, the price is not a price.** A hospital pharmacy's customer is admitted, cannulated and physically unable to compare, postpone, walk out or often even be conscious at the point of sale — the purest case in this library of a market with no exit, since every other plan's customer can leave and this one cannot stand up. **A market with no exit, no comparison, no postponement and no informed consent will produce whatever margin the seller chooses, and the only real constraint is price control — which is why the margin migrates with such precision to exactly where price control does not reach. The DPCO caps scheduled formulations; it does not cap most consumables, devices, implants or non-scheduled formulations, and there the printed MRP is a number the manufacturer and the buying institution effectively choose together, because the manufacturer's customer is the hospital rather than the patient and a higher printed MRP is a feature both parties want. A ₹12 item bills at ₹140, no ceiling is exceeded, and nothing is violated. The stent and knee-implant caps prove the mechanism exactly: the moment a device was capped the behaviour on that device changed and continued unchanged everywhere else — which tells you the pricing was never about cost and always about the absence of a constraint. And nobody in the hospital feels like a profiteer, because each individual price is just the MRP.**
- **So the constraint is supplied voluntarily, because it will not arrive any other way.** A published margin ceiling of 30% on consumables and devices, 22% on medicines and 17% on critical care and oncology injectables — deliberately the lowest cap in the book, because those patients have the least capacity to question anything and the largest bills, and a pricing policy that is generous everywhere except where the patient is sickest is not a pricing policy. Nil items are billed above it, the category margin is printed on the patient's own bill so he can see what was made on him rather than infer it, and the cap cannot be varied by any commercial officer — it moves only by a published pricing-committee decision, which is the difference between a cap and a guideline. **The cap costs ₹6.84 crore against ₹4.70 crore of profit. WHERE THE BUYER CANNOT LEAVE, THE PRICE IS NOT A PRICE — IT IS A DECISION YOU MADE ABOUT SOMEBODY WHO COULD NOT ARGUE, SO PUBLISH IT AND CAP IT YOURSELF.**
- **The most common overcharge in Indian hospital billing is the item that was never given.** A dose cancelled after the round, a vial drawn and not used, a line changed, a catheter opened for an abandoned procedure, an antibiotic stopped when the culture returned — every one issued from the pharmacy, charged to the patient, and never reconciled against what the nurse actually administered. **It is not a fraud; it is an absence of a reconciliation, and it survives because the only person with an interest in performing it is lying down and cannot audit four hundred lines. So every item is reconciled administered-against-billed through bedside barcode administration and refunded automatically before the patient asks — ₹1.36 crore in Year 3, with nil refunds requiring a complaint, the value published, and a reconciliation returning zero investigated as a measurement failure.** The thirty-six staff who do this work exclusively find money the institution should give back, which is why the function cannot sit inside the billing team.

- **The prescriber and the seller are the same institution, and discharge is the moment of maximum capture.** A salaried clinician prescribes from a formulary his employer profits from, generally set with procurement and margin in the room — so the formulary committee carries no profit-and-loss responsibility and sees no margin data, minutes are published, nil clinician pay is linked to pharmacy revenue, and a brand chosen over a cheaper therapeutic equivalent requires a recorded clinical reason. **And the outside price is shown alongside ours on every discharge prescription, with 31% of patients buying elsewhere and the discharge capture rate falling from 79% to 69% — reported as a success, which inverts the metric every hospital pharmacy in the country optimises, because capture at discharge measures how effectively a patient was prevented from exercising the one real choice in his admission.** Outside sourcing is permitted for any non-urgent item with nil handling fee and a nine-minute median authorisation, because a hospital that permits outside purchase in policy while making it take two hours has not permitted it.
- **The anchor's refusal rule is harder inside a hospital than in a shop.** The prescriber is a senior consultant in the same building and the pharmacist is junior to him in every way that matters — so 21,400 prescriptions were queried or refused in Year 3 including consultants', 3,180 medication errors were intercepted, a verifier with a zero query rate is audited, and querying a consultant is taught explicitly as the hardest skill in hospital pharmacy. **A pharmacy that never questions a senior clinician is not performing verification, it is performing deference.**
- **The economics are a choice rather than a market outcome, which is unusual and is the point.** A 23.7% blended gross margin producing 5.0% net exists because it was capped; an uncapped operator in the same four hospitals would earn ₹14.06 crore against our ₹4.70 crore, from the same beds, the same patients and the same clinical work. **Commitments total ₹9.36 crore, roughly twice the profit — the largest ratio anywhere in this vertical.** Pharmacy at 18% of hospital revenue and falling is stated with the explicit note that a high figure is a warning rather than an achievement, since a hospital earning a quarter of its revenue from the pharmacy is telling you something about its pricing rather than its clinical volume. The binding commercial risk is contract renewal, because this revenue sits inside somebody else's building — and the published cap is what makes the operating agreement defensible to a TPA, a regulator and a court.
- **Compliance and professional advice.** The Drugs and Cosmetics Act 1940 and Rules 1945, with a retail drug licence for each pharmacy premises and each ward satellite; the Pharmacy Act 1948 and registered-pharmacist supervision, which applies inside a hospital exactly as in a shop; Schedules H, H1 and X with ward-level reconciliation and Schedule X under NDPS conditions; NPPA and DPCO ceiling prices on scheduled formulations, **with the decisive gap that most consumables, devices, implants and non-scheduled formulations fall outside price control entirely**; selective device capping such as stents and knee implants; the Clinical Establishments Act and state rules on rate display and billing transparency where adopted; the Consumer Protection Act, under which hospital billing disputes are litigated after the fact; cold chain, biomedical waste, GST, EPF/ESI and POSH. **Nothing in any of it requires a hospital to reconcile what was administered against what was billed, which is why that commitment is a business decision rather than a compliance one.** Professional advice should be taken on premises licensing including satellites, operating-agreement terms, price-control applicability by item and billing-disclosure obligations by state.

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