BUSINESS PLAN · INDIA

Medical-Tourism Facilitator

A patient is not a tourist - and a facilitator paid by the hospital is not the patient's advocate

TRAVEL

AISEVAK.IN · BY ABL DIGITAL TECHNOLOGIES

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1. Executive Summary

This plan sets out a **Medical-Tourism Facilitator** in India — a patient-coordination business supporting international patients through hospital selection, medical-visa documentation, travel and accommodation, translation and attendant support, in-treatment liaison and structured post-return aftercare, primarily in cardiac, orthopaedic, oncology, transplant and fertility care.

> **This plan begins with a correction to its own category name, because the name has shaped how the industry behaves. A patient is not a tourist. Somebody flying from Lagos or Tashkent for a cardiac bypass, a liver transplant or an oncology protocol is not on holiday, is frequently frightened, is often spending a family's savings, and is making a decision they are not equipped to evaluate. Packaging that alongside sightseeing is not merely tasteless — it encourages a business to think of itself as a travel operator when it is standing between a person and a surgical procedure.** Every discipline in this plan follows from taking that seriously.

> **The second point is the conflict at the centre of the industry, and this plan states it plainly rather than presenting it as a business model: the facilitator is paid by the hospital. The standard arrangement is a commission of ten to twenty-five per cent of the treatment package, paid by the facility to which the patient is directed. So the party the patient trusts to advise them where to go is paid by the place they go to — and, in almost all cases, the patient does not know this. A facilitator paid by the hospital is not the patient's advocate, however it describes itself in its marketing.** The corporate-travel plan in this vertical set out three honest positions on supplier commission; here the same framework applies with considerably more force, because **the object being steered is not a hotel booking but an operation.** This plan takes **written disclosure of hospital commission before the patient selects a facility from 44% to 100%**, and deliberately shifts revenue from **72% hospital-paid to 50%**, with patient-paid fees rising from 15% to 31%.

> **The third is the boundary this business must not cross, and the line is sharper than most facilitators acknowledge: the facilitator is not clinically qualified. Presenting three accredited hospitals that treat a condition, with their credentials and costs, is coordination. Telling a patient they should have the bypass rather than the stent is unlicensed medical advice given by somebody with no qualification, no examination and no liability insurance that would respond. The same applies to outcome claims — "98% success rate", "world-class results", "you will walk within a week" — which a facilitator has no basis to make and which parallel the visa plan's guaranteed-approval rule, except that here the thing being promised is a human body's response to surgery.** This plan holds **treatment outcome claims and clinical recommendations by non-clinical staff at NIL**, and employs **qualified clinicians on staff specifically so that medical questions are answered by people entitled to answer them.**

> **And the fourth is the industry's largest and least discussed failure: the patient is abandoned at the airport. A complication presenting three weeks after discharge — an infection, a graft failure, a wound that will not close — arises when the patient is eight thousand kilometres from the surgeon, in a health system that did not perform the procedure and may have no record of it. In the standard model, responsibility at that point rests with nobody: the hospital's duty effectively ended at discharge, the facilitator was paid on arrival, and the local doctor has an operative note in a language they cannot read.** This plan builds **structured aftercare contact at 30, 90 and 180 days to 96%** and facilitator involvement in **88% of post-return complications — and treats that as the product rather than as goodwill.**

This plan models a facilitator requiring **₹1.90 crore** (₹80 lakh promoter + ₹30 lakh term loan + ₹80 lakh working capital), moving from **₹18.00 crore of facilitated treatment value / ₹2.16 crore net revenue and a ₹24 lakh loss** to **₹50.00 crore facilitated / ₹7.00 crore net revenue and ₹92 lakh profit** by Year 3, supporting **1,780 patients.** *(International patient facilitation — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A patient-coordination business that discloses every rupee it receives from hospitals, refuses to make clinical or outcome claims, works only with accredited facilities, and stays responsible for the patient after they have flown home.

Vision: To be the facilitator a patient's own doctor would be content to hand them over to.

Mission: Tell the patient what the hospital pays us, before they choose; never state an outcome we cannot know; never let a non-clinician answer a clinical question; confirm the patient understood the consent in their own language; and still be reachable six months after discharge.

Legal structure options

- **Private Limited** — recommended and close to necessary: hospital contracting, international representation, indemnity insurance and cross-border data handling all assume it.
- **LLP** — workable for a small single-corridor operation.
- **Proprietorship** — **unsuitable: this business holds patient money and sensitive health data, and carries reputational exposure that should not sit on personal assets.**

> **Regulatory anchor:** the position is genuinely awkward and a promoter should understand it before entering — **medical-tourism facilitation in India is largely unregulated as an activity. There is no licensing regime for facilitators, no mandated disclosure of hospital commission, no qualification requirement for the people advising patients, and no enforced aftercare obligation. The consequence is not freedom but exposure: the standards in this plan are adopted voluntarily, and an operator competing against those who adopt none is competing against a lower cost base.** What does apply: **the Medical Visa (MED) and Medical Attendant (MED-X) regime, with FRRO registration requirements, permitted stay durations and extension procedures that the facilitator must manage correctly because a lapse strands a patient mid-treatment**; **the Digital Personal Data Protection Act, engaged heavily because this business holds diagnoses, imaging, operative notes and financial information for foreign nationals, with cross-border transfer, consent and retention obligations**; **the Consumer Protection Act, under which a facilitator's service promises are enforceable even where the clinical outcome is not its responsibility**; **GST on the facilitation fee, with the treatment value passing through where the patient contracts directly with the hospital — and the agent-versus-principal distinction determining both the tax treatment and, importantly, who is liable for what**; **FEMA and authorised-dealer rules on receiving foreign patient payments**; and — **critically — the prohibition on commercial dealings in human organs under the Transplantation of Human Organs and Tissues Act, which makes transplant facilitation an area where a facilitator must be exceptionally careful about what it arranges and for whom, and where the correct posture is to coordinate documentation and travel only, with donor matters handled entirely by the hospital's authorisation committee.**

3. Promoter & Ownership

Led by a promoter with healthcare administration, hospital international-desk or medical-travel background. Three competences decide outcomes: *clinical humility*, meaning a settled understanding of what the business is not qualified to say, which is harder than it sounds when a frightened patient asks directly; *the willingness to forgo commission*, since

disclosure and patient-paid fee migration both cost money in the short run; and *follow-through*, because aftercare generates no additional revenue at the point it is delivered and is therefore the first thing an operator under pressure stops doing. Ownership, equity & investor terms are editable inputs.

4. Market Analysis — India

India is among the largest destinations for international medical travel, drawing patients from Africa, Central Asia, South Asia, West Asia and increasingly Southeast Asia, on the strength of clinical capability, capacity and cost differentials that are genuinely large rather than marginal.

Demand drivers

- **Substantial cost differential** against Western systems and against private care in the patient's own country.
- **Capacity and waiting-time constraints** in the patient's home system for elective and semi-elective procedures.
- **Clinical capability** in cardiac, orthopaedic, oncology, transplant and fertility care with genuine international standing.
- **Accreditation depth** — a growing number of JCI- and NABH-accredited facilities that international patients and their referrers recognise.
- **Diaspora and community referral networks**, which carry more weight than advertising in most source markets.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	International patients travelling to India for treatment	Large and growing
SAM	**Corridors and specialties where accredited capacity exists**	**Accreditation- and corridor-bounded**
SOM (Yr 1–3)	Patients facilitated × net revenue per patient	620 → 1,780 patients

> **There is an adverse selection problem at the heart of price-led medical travel, and it deserves stating because it shapes who this business actually serves and what happens to them when things go wrong. Patients who choose a destination primarily on price are, almost by definition, those with the least financial reserve. A complication that extends a stay by six weeks, requires a revision procedure, or necessitates a family member flying out is precisely the event that a price-sensitive patient cannot absorb — and it is the patient who chose the cheapest quotation who is most likely to face it without means.** The industry's response is generally to compete harder on price, which selects more heavily for exactly that patient. This plan takes a different position and accepts the commercial cost. **Quotations are presented with an explicit, itemised statement of what is not included and what a complication would cost — because a patient who has understood the downside has made a decision, while one shown only the package price has made a guess. Contingency funds are recommended and their absence flagged in writing rather than glossed over**, and **patients whose finances clearly cannot support a realistic worst case are told so directly, even though that conversation loses the case.** The honest caveat is that **this business will lose price-led enquiries to facilitators who quote a lower headline number and mention none of it** — and that **the patients so lost are disproportionately the ones who will be in difficulty if the procedure does not go smoothly. Nothing in this plan solves that; it only refuses to profit from it.**

5. Competition & Competitive Advantage

Landscape: hospital international-patient departments dealing directly, a very large number of small independent facilitators and individual agents in source countries, aggregator platforms listing hospitals and quotations, diaspora

intermediaries operating informally, and — increasingly — hospitals contracting representatives in source markets. **The category has almost no barriers to entry and almost no standards, which means the competitive set includes a substantial number of operators with no medical staff, no aftercare and no disclosure.**

The business's edge

- **Commission disclosed in writing before the patient chooses** — almost nobody in the category does this.
- **Qualified clinicians on staff**, so clinical questions are answered by people entitled to answer them.
- **Accredited facilities only**, with the accreditation shown rather than asserted.
- **Structured aftercare to 180 days**, addressing the category's largest gap.
- **Second opinion offered as standard**, including where it costs the case.

> **Disclosure of hospital commission is the single decision that separates an honest facilitator from the rest of the category, and the arithmetic of why it is resisted is worth setting out. A facilitator earning 15% on a ₹6 lakh cardiac package receives ₹90,000 from the hospital. The patient believes they are receiving free assistance — most facilitators market themselves as free to the patient — and does not know that the recommendation they are relying on carries a financial interest. Worse, commission rates differ between hospitals, so a facilitator has a direct financial reason to prefer the facility paying 20% over the one paying 10%, and the patient has no way to detect it. This is not a theoretical conflict; it is the industry's normal operating model.** Three honest positions exist, exactly as the corporate-travel plan set out for supplier overrides. **Forgo hospital commission entirely and charge the patient a professional fee, which is cleanest and makes the service visibly paid-for in a market where competitors appear free. Accept commission and disclose it in full — amount, hospital, and the differential across the options presented — so the patient can weigh the recommendation knowing what sits behind it. Or accept it silently, which is the norm and means the facilitator is the hospital's sales channel while presenting as the patient's guide.** This plan takes the second and migrates toward the first: **disclosure before facility selection rising to 100%, and hospital commission falling from 72% to 50% of net revenue as patient-paid coordination fees rise from 15% to 31%. The commercial cost is real and immediate — a patient told the facilitator earns ₹90,000 from Hospital A and ₹45,000 from Hospital B sometimes chooses B, and the business earns less for having been honest. That is precisely what disclosure is for, and a facilitator unwilling to lose that money should not claim to be advising anybody.**

6. Service Model, the Clinical Boundary & Aftercare

Service	What it is	Boundary / basis
Hospital shortlisting	Accredited options with credentials and costs	**Coordination — commission disclosed per option**
Medical record collation & second opinion	Records assembled, opinions arranged	**Opinions given by clinicians, never by coordinators**
Medical visa, FRRO & documentation	MED/MED-X processing and extensions	Professional fee; a lapse strands a patient mid-treatment
Travel, accommodation & attendant support	Logistics for patient and attendant	Cost-plus; the traveller is unwell, not on holiday
Translation & consent comprehension	In-language explanation and confirmation	**Consent understood, not merely signed**

Post-return aftercare to 180 days	Scheduled contact, records to local doctor, escalation	**The category's biggest gap — treated as the product**
Treatment outcome claims	**NIL — by policy**	**We cannot know, and it is a body at stake**
Clinical recommendations by non-clinical staff	**NIL — by policy**	**It is unlicensed medical advice**
Facilitation to non-accredited facilities	**NIL — by policy**	**Accreditation shown, not asserted**

> **Aftercare is where this industry fails most consistently, and the failure is structural rather than negligent — nobody is paid to do it, so nobody does it.** Follow the money. **The hospital's commercial relationship with the patient ends at discharge; its clinical duty continues in principle but is difficult to discharge across eight thousand kilometres. The facilitator has been paid its commission on admission or discharge and has no further economic interest. The patient's doctor at home did not perform the procedure, may not read the language of the operative note, was not consulted on the decision, and is sometimes quietly unimpressed that the patient went abroad at all. So when an infection presents on day nineteen, or a graft shows early failure, or a wound will not close, the patient is holding a discharge summary and a telephone number in a different time zone. This is the point at which medical travel becomes genuinely dangerous, and it is almost entirely absent from how the category markets itself.** The plan's response is to build the follow-through and to fund it from the fee rather than from goodwill: **scheduled contact at 30, 90 and 180 days as a defined deliverable rather than a courtesy call, reaching 96% by Year 3**; **the operative note, imaging and medication record transmitted to the patient's home physician in a usable form, with translation where needed, before the patient lands**; **a named escalation route back to the treating surgeon with a committed response window, agreed with the hospital as a condition of the corridor rather than requested afterwards**; and **partner clinics in principal source markets able to assess a complication locally and communicate clinically with the Indian team**. Facilitator involvement in post-return complications rises from **22% to 88%**. **None of this generates revenue at the moment it is delivered — which is exactly why it is the first thing to be cut, and exactly why it is the thing worth building.**

7. Go-to-Market — Corridors, Referral and Trust

Acquisition

- **Source-market representation** in principal corridors, with local staff who speak the language and understand the health system.
- **Physician referral relationships** in source countries, which are more durable and better-informed than direct-to-patient advertising.
- **Diaspora and community networks**, where trust transfers unusually strongly and reputation travels fast in both directions.
- **Digital enquiry handling** with clinical triage, so the first substantive answer comes from someone qualified.

Conversion — done honestly

- **Commission disclosed before facility selection**, not in terms and conditions afterwards.
- **Second opinion offered as standard**, including where it may cancel the case.
- **Total-cost transparency** including what a complication would cost and what is not covered.
- **Realistic timelines and recovery expectations**, given by clinicians rather than by sales staff.

Repeat and community referral reaches 58% by Year 3, and in this category the referral unit is a community rather than an individual — one well-handled patient from a diaspora network produces the next several, and one abandoned complication closes that network permanently and with detailed commentary. Reputational transmission in source markets is faster and more specific than most Indian operators expect, because the patients know one another.

8. Operations Plan (triage, disclose, coordinate, support, follow)

- **Enquiry triage:** initial clinical review by qualified staff, **with cases that should not travel identified early and told so.**
- **Records & second opinion:** history and imaging collated, **second opinion arranged as standard rather than on request.**
- **Facility shortlisting:** accredited options presented with credentials, volumes, costs **and the commission payable to us on each — in writing, before selection.**
- **Consent comprehension: consent explained in the patient's language and comprehension confirmed, because a signature on an English form from a patient who speaks Amharic is not informed consent.**
- **Visa & FRRO:** MED/MED-X processing, registration and extensions tracked, **since an expired permission during a complication is a serious and entirely avoidable crisis.**
- **In-treatment liaison:** attendant support, translation at ward rounds, and family communication across time zones.
- **Discharge handover: operative note, imaging, medication and follow-up plan transmitted to the home physician in usable form before the patient travels.**
- **Aftercare: contact at 30, 90 and 180 days; named escalation to the treating surgeon; partner clinic assessment where a complication presents locally.**

Control points

Area	Activity	Control point
The central conflict	**Commission disclosed in writing before selection**	**44% → 82% → 100%**
Migrating off the conflict	**Hospital commission as % of net revenue**	**72% → 61% → 50% (falling)**
The boundary	**Outcome claims / clinical advice by non-clinicians**	**NIL / NIL**
The category's biggest gap	**Structured aftercare contact at 30/90/180 days**	**38% → 74% → 96%**
Follow-through that matters	**Post-return complications with facilitator involvement**	**22% → 61% → 88%**
Informed, not merely signed	**Consent comprehension confirmed in patient's language**	**62% → 91% → 100%**
Standards	Second opinion offered / non-accredited facilitation	51% → 100% / NIL

> **This business holds patient money in advance, and the circumstances in which it must return it are more distressing than in any other plan in this library. A patient pays a deposit or the full treatment cost weeks before travel — frequently a family's savings, sometimes money raised by a community. Between payment and travel, the patient may deteriorate to the point of being unfit to fly, may be advised against the procedure on second opinion, may be refused a visa, or may die. Thirty-one such cases arise in Year 3 on this plan, and the way a facilitator behaves in those thirty-one cases is a more accurate description of the business than anything in its marketing.** The disciplines follow the travel agency's float principle, applied to a considerably more sensitive situation. **Patient advances are held in a designated account, at 100% from the outset — not**

commingled with operating funds, because this is money that may have to be returned to a bereaved family within days. Refund terms are stated in writing at the outset and distinguish clearly between the facilitator's own fee, recoverable hospital deposits and non-recoverable third-party costs — so a family in the worst week of their lives is not negotiating a policy that was never explained. The facilitator's fee is waived where the patient dies before travel, as a matter of policy rather than discretion; the amount is small against the circumstance and the alternative is indefensible. And **hospital deposits are contracted with defined refund terms for medical non-fitness**, negotiated at corridor level rather than argued case by case, **because a family should not be asked to fight a hospital in another country over a deposit for an operation that never happened.**

9. Medical Visa, DPDP & Compliance (India)

- **Medical Visa (MED) and Medical Attendant (MED-X) regime**, with **FRRO registration, permitted stay durations and extensions tracked — a lapse during a complication is a serious and entirely avoidable crisis.**
- **DPDP obligations, heavily engaged** — diagnoses, imaging, operative notes and financial data for foreign nationals, with **cross-border transfer, consent and retention duties.**
- **Consumer Protection Act — the facilitator's service promises are enforceable even where the clinical outcome is not its responsibility, which is precisely why outcome claims must never be made.**
- **GST on the facilitation fee**, with treatment value passing through where the patient contracts directly with the hospital; **the agent-versus-principal distinction determines both tax treatment and who is liable for what.**
- **FEMA and authorised-dealer rules** on receiving foreign patient payments.
- **Transplantation of Human Organs and Tissues Act — commercial dealings in organs are prohibited, so transplant work is coordinated as documentation and travel only, with all donor matters handled exclusively by the hospital's authorisation committee.**
- Professional indemnity insurance; written engagement terms distinguishing coordination from clinical responsibility.
- **Note honestly: facilitation itself is largely unregulated in India — there is no licence, no mandated disclosure and no qualification requirement, so the standards in this plan are voluntary and competitors adopting none have a lower cost base.**

10. Organisation & Manpower Plan

Role	Yr 1	Yr 2	Yr 3
Promoter / managing director	1	1	2
Patient case coordinators	**22**	**38**	**58**
Translators & patient attendants	14	24	36
Marketing & source-market representation	8	13	19
Finance & admin	6	9	12
Visa & documentation	5	8	12
Aftercare coordinators	**5**	**9**	**14**
Medical liaison (qualified clinicians on staff)	**4**	**7**	**11**
Total	**65**	**109**	**164**

Two lines here are the plan and the rest is logistics. Qualified clinicians on staff exist so that a frightened patient asking "should I have this operation?" receives an answer from somebody entitled to give one — a facilitator without them either refuses to answer, which loses the case, or answers anyway, which is unlicensed medical advice. Aftercare coordinators exist to do work that generates no revenue at the point of delivery, and are therefore the clearest test of whether an operator means what it says: **they are the first headcount a facilitator under pressure removes, and the removal is invisible until a patient in Nairobi cannot reach anybody about a wound that has opened.**

11. Implementation Timeline & Milestones

Phase	Timeline	Milestone
Setup	Month 0–5	Accredited hospital corridors contracted with commission and refund terms documented, clinicians recruited, source-market representation established, aftercare partner clinics tied up, DPDP and designated patient-account framework in place
Launch	Month 5–12	620 patients; ₹18.00cr facilitated / ₹2.16cr net revenue; ₹24L loss; disclosure 44%; aftercare contact 38%; zero outcome claims
Build	Year 2	1,140 patients; disclosure 82%; aftercare 74%; complications with facilitator involvement 61%; patient-paid fees 24% of revenue; ₹4.16cr net revenue, ₹21L profit
Scale	Year 3	1,780 patients; **₹7.00cr net revenue, ₹92L profit; 100% commission disclosure; aftercare 96%; complications involved 88%; consent comprehension 100%; hospital commission down to 50% of revenue**

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions for an Indian context, shown so the promoter can replace them with live rates. ***Disclosure, revenue mix and aftercare are the levers; facilitated treatment value is not one, because almost none of it is this business's money.***

12.1 Project cost & means of finance

Capital requirement	₹
Working capital & patient-advance float management	**42,00,000**
International representation & marketing launch	**38,00,000**
Technology (case management, secure records, telehealth, translation)	34,00,000
Initial operating losses	26,00,000
Office fit-out, deposits & patient reception facilities	22,00,000
Aftercare network setup & partner clinic tie-ups	**16,00,000**
Legal, registrations, indemnity & data protection	12,00,000
Total project cost	**1,90,00,000**
Promoter contribution	80,00,000
Term loan	30,00,000

Working-capital facility	80,00,000

12.2 Projected Profit & Loss (3 years)

Particulars	Year 1	Year 2	Year 3
FACILITATED TREATMENT VALUE (patient/hospital money — NOT revenue)	**18,00,00,000**	**32,00,00,000**	**50,00,00,000**
NET REVENUE (commission + patient fees + services)	**2,16,00,000**	**4,16,00,000**	**7,00,00,000**
Net revenue as % of facilitated value	**12.0%**	**13.0%**	**14.0%**
— Hospital commission (fully disclosed to patient)	**1,56,00,000**	**2,54,00,000**	**3,50,00,000**
— Patient-paid coordination fees	**32,00,000**	**1,00,00,000**	**2,17,00,000**
— Ancillary services & aftercare programmes	28,00,000	62,00,000	1,33,00,000
Salaries (coordinators, clinicians, translators, aftercare)	**1,32,00,000**	**2,32,00,000**	**3,74,00,000**
Marketing & international representation	42,00,000	62,00,000	88,00,000
Patient support costs absorbed (travel, stay, contingency)	**18,00,000**	**28,00,000**	**42,00,000**
Technology (case management, records, telehealth)	12,00,000	20,00,000	30,00,000
Rent, utilities & office	11,00,000	16,00,000	22,00,000
Admin, compliance & data protection	9,00,000	14,00,000	20,00,000
Professional indemnity & insurance	**8,00,000**	**12,00,000**	**18,00,000**
Finance cost (interest)	5,00,000	7,00,000	9,00,000
Depreciation	3,00,000	4,00,000	5,00,000
Total expenses	**2,40,00,000**	**3,95,00,000**	**6,08,00,000**
Net profit / (loss) before tax	**(24,00,000)**	**21,00,000**	**92,00,000**
Net margin (on net revenue)	(11.1%)	5.0%	13.1%
PATIENTS FACILITATED	**620**	**1,140**	**1,780**
COMMISSION DISCLOSED IN WRITING BEFORE FACILITY SELECTION	**44%**	**82%**	**100%**
Hospital commission as % of net revenue (falling deliberately)	**72%**	**61%**	**50%**
Patient-paid fee share of net revenue (rising)	**15%**	**24%**	**31%**
TREATMENT OUTCOME CLAIMS MADE	**NIL**	**NIL**	**NIL**
Clinical recommendations by non-clinical staff	**NIL**	**NIL**	**NIL**
Patients facilitated to non-accredited facilities	**NIL**	**NIL**	**NIL**
STRUCTURED AFTERCARE CONTACT AT 30/90/180 DAYS	**38%**	**74%**	**96%**
Post-return complications with facilitator involvement	**22%**	**61%**	**88%**
Second opinion offered before treatment confirmation	**51%**	**84%**	**100%**

Consent comprehension confirmed in the patient's language	**62%**	**91%**	**100%**
Patients who deteriorated / died before travel (money held)	**14**	**22**	**31**
Patient advances held in a designated account	**100%**	**100%**	**100%**
Net revenue per patient / community referral share	₹34,800 / 29%	₹36,500 / 44%	₹39,300 / 58%

12.3 Unit economics & break-even

- **₹50 crore of facilitated treatment value produces ₹92 lakh of profit** — the vertical's anchor discipline applies here as everywhere: **the treatment money is the patient's and the hospital's, and a facilitator quoting it as turnover is describing a business fifty times its size.**
- **The revenue migration from hospital-paid to patient-paid is the plan's central financial movement**: 72% to 50% of revenue from commission. **It reduces the conflict, and it costs money in the years it is happening.**
- **Salaries at 61% of net revenue reflect what this business actually is — coordinators, clinicians, translators and aftercare staff — and an operator with a lower ratio has removed one of those four, almost always the last two.**
- **Aftercare generates no revenue at delivery and costs real money**, which is why it is reported as a control metric rather than buried: **96% contact and 88% complication involvement are the numbers a patient's family would actually care about.**
- **Break-even: Year 2. The constraint is clinician and coordinator capacity plus corridor development, not capital.**

12.4 Projected Cash Flow — Year 1 (quarterly, illustrative)

Particulars (₹)	Q1	Q2	Q3	Q4
Opening balance (operating account, excluding patient float)	44,00,000	34,00,000	26,00,000	18,00,000
Collections (commission, patient fees, service recoveries)	1,08,00,000	1,22,00,000	1,32,00,000	1,40,00,000
Salaries, representation, patient support & operating costs	1,18,00,000	1,30,00,000	1,40,00,000	1,46,00,000
Closing balance	**34,00,000**	**26,00,000**	**18,00,000**	**12,00,000**

Two features of the cash position deserve emphasis, and the first is a timing problem that quietly shapes behaviour across the industry. Hospital commission is typically settled well after the patient is discharged — often thirty to ninety days — while the facilitator's costs are incurred before and during the visit: representation in the source market, coordinator time across weeks of enquiry, translation, attendant support, and any travel or accommodation absorbed. So the business funds the entire patient journey and is paid afterwards by the hospital, which creates a structural incentive to increase volume rather than depth — and volume is exactly the pressure that erodes aftercare, since a coordinator handling forty active cases cannot follow up the ones discharged three months ago. The migration to patient-paid fees, collected at engagement, does more for this business's cash position than any collection effort against hospitals. The second feature is the one already described: **patient advances are held in a designated account at 100% and are not this business's money in any sense — a distinction that matters more here than in the travel agency plan, because the circumstance in which they must be returned is frequently a bereavement.** The controls: **hospital commission terms and settlement periods agreed at corridor level rather than case by case; the facility sized against the gap between spend and commission settlement; patient fees collected at engagement; and the designated account maintained absolutely, so that a refund to a bereaved family is an administrative act rather than a cash-flow decision.**

12.5 Key Performance Indicators to Monitor

- **The conflict: commission disclosure before selection; commission differential across presented options; hospital-paid versus patient-paid revenue mix.**
- **The boundary: outcome claims (must be NIL); clinical advice by non-clinicians (must be NIL); second opinions offered; non-accredited facilitation (must be NIL).**
- **Follow-through: aftercare contact at 30/90/180 days; complications with facilitator involvement; records transmitted to home physician before travel; escalation response times.**
- **Patient protection:** consent comprehension in language; designated-account integrity; refund turnaround where a patient cannot travel; visa and FRRO lapses (must be zero).

13. Funding Requirement & Bankability

Total ask: **₹30 lakh term loan plus an ₹80 lakh working-capital facility** against ₹80 lakh promoter contribution. Four points. **First, read the plan on net revenue: ₹50 crore of facilitated treatment value is patient and hospital money, and ₹7.00 crore is what this business earns and can service debt from. Second, the security position is thin — no plant, no property, receivables from hospitals and a patient base that cannot be charged** — so this is promoter-strength lending with CGTMSE-type support. **Third, and the diagnostic that matters most in this category: ask whether hospital commission is disclosed to the patient in writing before they choose a facility, and ask for the aftercare contact rate at 90 days. A facilitator that does not disclose is a hospital sales channel presenting itself as a patient's guide, and a facilitator with no aftercare has a business model that ends at the airport — both are commercially viable and both carry reputational risk that arrives suddenly and travels through communities faster than any marketing. Fourth, note the regulatory position honestly: facilitation is largely unregulated in India, so the standards in this plan are voluntary and its competitors' lower prices reflect real cost differences rather than efficiency. A lender should understand that it is funding the more expensive version of this business on purpose, and that the cheaper version's risk is not absent but unpriced.**

13.1 Funding utilisation

Use of funds	₹	% of total
Working capital & patient-advance float management	42,00,000	22.1%
International representation & marketing launch	38,00,000	20.0%
Technology (case management, secure records, telehealth, translation)	34,00,000	17.9%
Initial operating losses	26,00,000	13.7%
Office fit-out, deposits & patient reception facilities	22,00,000	11.6%
Aftercare network setup & partner clinic tie-ups	16,00,000	8.4%
Legal, registrations, indemnity & data protection	12,00,000	6.3%
Total	**1,90,00,000**	**100%**

14. Risk Analysis & Mitigation

Risk	Mitigation

A patient is not a tourist	**SETS THIS PLAN'S GOVERNING CONVENTION AND CORRECTS ITS OWN CATEGORY NAME, BECAUSE THE NAME HAS SHAPED HOW THE INDUSTRY BEHAVES: SOMEBODY FLYING FROM LAGOS OR TASHKENT FOR A CARDIAC BYPASS, A LIVER TRANSPLANT OR AN ONCOLOGY PROTOCOL IS NOT ON HOLIDAY, IS FREQUENTLY FRIGHTENED, IS OFTEN SPENDING A FAMILY'S SAVINGS, AND IS MAKING A DECISION THEY ARE NOT EQUIPPED TO EVALUATE. PACKAGING THAT ALONGSIDE SIGHTSEEING IS NOT MERELY TASTELESS — IT ENCOURAGES A BUSINESS TO THINK OF ITSELF AS A TRAVEL OPERATOR WHEN IT IS STANDING BETWEEN A PERSON AND A SURGICAL PROCEDURE** → every discipline in the plan follows from taking that seriously
The facilitator is paid by the hospital	**THE CONFLICT AT THE CENTRE OF THE INDUSTRY, STATED PLAINLY RATHER THAN PRESENTED AS A BUSINESS MODEL: A COMMISSION OF 10–25% OF THE TREATMENT PACKAGE, PAID BY THE FACILITY THE PATIENT IS DIRECTED TO — SO THE PARTY THE PATIENT TRUSTS TO ADVISE THEM WHERE TO GO IS PAID BY THE PLACE THEY GO TO, AND IN ALMOST ALL CASES THE PATIENT DOES NOT KNOW. WORSE, RATES DIFFER BETWEEN HOSPITALS, SO THE FACILITATOR HAS A DIRECT FINANCIAL REASON TO PREFER THE FACILITY PAYING 20% OVER THE ONE PAYING 10% AND THE PATIENT CANNOT DETECT IT. A FACILITATOR PAID BY THE HOSPITAL IS NOT THE PATIENT'S ADVOCATE, HOWEVER IT DESCRIBES ITSELF IN ITS MARKETING** → the corporate-travel plan's three honest positions apply with more force since **THE OBJECT BEING STEERED IS NOT A HOTEL BOOKING BUT AN OPERATION**: disclosure in writing before facility selection (44%→82%→100%), including the differential across options, and migration from 72% to 50% hospital-paid. **THE COST IS REAL AND IMMEDIATE — A PATIENT TOLD WE EARN ₹90,000 FROM HOSPITAL A AND ₹45,000 FROM HOSPITAL B SOMETIMES CHOOSES B, AND WE EARN LESS FOR HAVING BEEN HONEST. THAT IS PRECISELY WHAT DISCLOSURE IS FOR, AND A FACILITATOR UNWILLING TO LOSE THAT MONEY SHOULD NOT CLAIM TO BE ADVISING ANYBODY**
The clinical boundary	**PRESENTING THREE ACCREDITED HOSPITALS WITH CREDENTIALS AND COSTS IS COORDINATION; TELLING A PATIENT THEY SHOULD HAVE THE BYPASS RATHER THAN THE STENT IS UNLICENSED MEDICAL ADVICE GIVEN BY SOMEBODY WITH NO QUALIFICATION, NO EXAMINATION AND NO INSURANCE THAT WOULD RESPOND. THE SAME APPLIES TO OUTCOME CLAIMS — "98% SUCCESS RATE", "WORLD-CLASS RESULTS", "YOU WILL WALK WITHIN A WEEK" — WHICH PARALLEL THE VISA PLAN'S GUARANTEED-APPROVAL RULE EXCEPT THAT WHAT IS BEING PROMISED IS A HUMAN BODY'S RESPONSE TO SURGERY** → outcome claims NIL; clinical advice by non-clinicians NIL; **QUALIFIED CLINICIANS ON STAFF SPECIFICALLY SO A FRIGHTENED PATIENT ASKING "SHOULD I HAVE THIS OPERATION?" RECEIVES AN ANSWER FROM SOMEBODY ENTITLED TO GIVE ONE — A FACILITATOR WITHOUT THEM EITHER REFUSES TO ANSWER, WHICH LOSES THE CASE, OR ANSWERS ANYWAY, WHICH IS UNLICENSED PRACTICE**
The patient is abandoned at the airport	**THE INDUSTRY'S LARGEST AND LEAST DISCUSSED FAILURE, AND IT IS STRUCTURAL RATHER THAN NEGLIGENT — NOBODY IS PAID TO DO IT, SO NOBODY DOES IT. A COMPLICATION AT DAY NINETEEN ARISES WHEN THE PATIENT IS EIGHT THOUSAND KILOMETRES FROM THE SURGEON: THE HOSPITAL'S COMMERCIAL RELATIONSHIP ENDED AT DISCHARGE, THE FACILITATOR WAS PAID ON ADMISSION, AND THE LOCAL DOCTOR HAS AN OPERATIVE NOTE IN A LANGUAGE THEY CANNOT READ AND WAS NOT CONSULTED ON THE DECISION. THIS IS THE POINT AT WHICH MEDICAL TRAVEL BECOMES GENUINELY DANGEROUS, AND IT IS ALMOST ENTIRELY ABSENT FROM HOW THE CATEGORY MARKETS ITSELF** → scheduled contact at 30/90/180 days as a DELIVERABLE not a courtesy (38%→96%); records and imaging transmitted to the home physician in usable form BEFORE the patient lands; named escalation to the treating surgeon with a committed response window agreed at corridor level; partner clinics in source markets (complications involved 22%→88%). **NONE OF THIS GENERATES REVENUE AT DELIVERY, WHICH IS EXACTLY WHY IT IS THE FIRST THING TO BE CUT AND EXACTLY WHY IT IS WORTH BUILDING**

Price-led travel is adverse selection	**PATIENTS WHO CHOOSE ON PRICE ARE ALMOST BY DEFINITION THOSE WITH THE LEAST FINANCIAL RESERVE, AND A COMPLICATION THAT EXTENDS A STAY BY SIX WEEKS OR REQUIRES A REVISION IS PRECISELY THE EVENT THEY CANNOT ABSORB — SO THE PATIENT WHO CHOSE THE CHEAPEST QUOTATION IS THE ONE MOST LIKELY TO FACE IT WITHOUT MEANS. THE INDUSTRY'S RESPONSE IS TO COMPETE HARDER ON PRICE, WHICH SELECTS MORE HEAVILY FOR EXACTLY THAT PATIENT** → quotations itemise what is NOT included and what a complication would cost, **BECAUSE A PATIENT WHO HAS UNDERSTOOD THE DOWNSIDE HAS MADE A DECISION WHILE ONE SHOWN ONLY THE PACKAGE PRICE HAS MADE A GUESS**; contingency funds recommended and their absence flagged in writing; patients whose finances cannot support a realistic worst case told so directly even though it loses the case. **THIS BUSINESS WILL LOSE PRICE-LED ENQUIRIES TO FACILITATORS WHO QUOTE LOWER AND MENTION NONE OF IT, AND THE PATIENTS SO LOST ARE DISPROPORTIONATELY THOSE WHO WILL BE IN DIFFICULTY IF THINGS GO WRONG — NOTHING IN THIS PLAN SOLVES THAT; IT ONLY REFUSES TO PROFIT FROM IT**
Money held for a patient who may not travel	**THE CIRCUMSTANCES IN WHICH THIS MONEY MUST BE RETURNED ARE MORE DISTRESSING THAN IN ANY OTHER PLAN IN THIS LIBRARY: A PATIENT PAYS WEEKS BEFORE TRAVEL — FREQUENTLY A FAMILY'S SAVINGS, SOMETIMES MONEY RAISED BY A COMMUNITY — AND MAY DETERIORATE BEYOND FITNESS TO FLY, BE ADVISED AGAINST THE PROCEDURE ON SECOND OPINION, BE REFUSED A VISA, OR DIE. THIRTY-ONE SUCH CASES ARISE IN YEAR 3, AND HOW A FACILITATOR BEHAVES IN THOSE THIRTY-ONE IS A MORE ACCURATE DESCRIPTION OF THE BUSINESS THAN ANYTHING IN ITS MARKETING** → advances in a designated account at 100% from the outset, never commingled, **BECAUSE THIS IS MONEY THAT MAY HAVE TO BE RETURNED TO A BEREAVED FAMILY WITHIN DAYS**; refund terms written at the outset distinguishing our fee from recoverable hospital deposits and non-recoverable third-party costs **SO A FAMILY IN THE WORST WEEK OF THEIR LIVES IS NOT NEGOTIATING A POLICY THAT WAS NEVER EXPLAINED**; **OUR FEE WAIVED WHERE THE PATIENT DIES BEFORE TRAVEL AS POLICY RATHER THAN DISCRETION**; and hospital deposit refund terms for medical non-fitness negotiated at corridor level, **BECAUSE A FAMILY SHOULD NOT BE ASKED TO FIGHT A HOSPITAL IN ANOTHER COUNTRY OVER A DEPOSIT FOR AN OPERATION THAT NEVER HAPPENED**
Consent that was signed but not understood	**A SIGNATURE ON AN ENGLISH CONSENT FORM FROM A PATIENT WHO SPEAKS AMHARIC IS NOT INFORMED CONSENT, AND THE FACILITATOR IS FREQUENTLY THE ONLY PARTY IN A POSITION TO NOTICE** → consent explained in the patient's language and comprehension confirmed and recorded (62%→100%); translation at ward rounds; family communication across time zones. Also **FRRO AND MED/MED-X PERMISSIONS TRACKED, SINCE AN EXPIRED PERMISSION DURING A COMPLICATION IS A SERIOUS AND ENTIRELY AVOIDABLE CRISIS**
Unregulated category, transplant law & cash timing	**FACILITATION IS LARGELY UNREGULATED IN INDIA — NO LICENCE, NO MANDATED DISCLOSURE, NO QUALIFICATION REQUIREMENT, NO ENFORCED AFTERCARE — WHICH IS NOT FREEDOM BUT EXPOSURE: THESE STANDARDS ARE VOLUNTARY AND COMPETITORS ADOPTING NONE HAVE A LOWER COST BASE** → standards adopted regardless and used as the competitive position. **TRANSPLANT WORK COORDINATED AS DOCUMENTATION AND TRAVEL ONLY, WITH ALL DONOR MATTERS HANDLED EXCLUSIVELY BY THE HOSPITAL'S AUTHORISATION COMMITTEE, GIVEN THE PROHIBITION ON COMMERCIAL DEALINGS IN ORGANS.** On cash: **HOSPITAL COMMISSION SETTLES 30–90 DAYS AFTER DISCHARGE WHILE COSTS ARE INCURRED BEFORE AND DURING THE VISIT, CREATING A STRUCTURAL INCENTIVE TOWARD VOLUME RATHER THAN DEPTH — AND VOLUME IS EXACTLY THE PRESSURE THAT ERODES AFTERCARE, SINCE A COORDINATOR HANDLING FORTY ACTIVE CASES CANNOT FOLLOW UP THOSE DISCHARGED THREE MONTHS AGO** → patient-fee migration collected at engagement does more for cash than any collection effort against hospitals

15. SWOT Analysis

Strengths	Weaknesses
Hospital commission disclosed in writing before the patient chooses — almost nobody in the category does this; qualified clinicians on staff so medical questions are answered by people entitled to answer them; **structured aftercare to 180 days addressing the category's largest gap**; accredited facilities only; second opinion as standard.	**Structurally more expensive than competitors carrying no clinicians, no aftercare and no disclosure**; loses price-led enquiries by design; **72% of Year-1 revenue still from the conflicted source**; thin security for lending; loss-making in Year 1.
Opportunities	**Threats**
Genuine and large cost differentials against source-market private care; **growing accredited capacity that patients and referrers recognise**; physician-referral relationships more durable than advertising; **diaspora networks where trust transfers strongly**; aftercare as a real differentiator nobody else offers.	**An unregulated category where competitors' lower prices reflect absent standards rather than efficiency**; hospitals contracting source-market representatives directly; **a single abandoned complication closing a community referral network permanently**; visa or corridor policy change; reputational transmission that is fast and specific in source markets.

16. Recommended AiSevak Tools for This Business

This medical-tourism facilitator would use AiSevak's Travel vertical tools in operations:

- **The conflict: commission disclosure record captured before facility selection, per-hospital commission differential comparison shown to the patient, hospital-paid versus patient-paid revenue mix tracker.**
- **The boundary: clinical-question routing to qualified staff with an audit trail, outcome-claim screening across all marketing and correspondence, accreditation verification register per facility.**
- **Aftercare: 30/90/180-day contact scheduler with completion tracking, home-physician handover pack builder with translation, complication escalation log with response times, partner-clinic directory by source market.**
- **Patient protection:** consent-comprehension confirmation in language, designated patient-advance account reconciliation, refund-policy calculator distinguishing fee from hospital deposit, MED/MED-X and FRRO expiry alerts.
- **Cash & corridor:** commission settlement ageing by hospital, patient-fee collection at engagement, corridor-level terms register (commission, refund, escalation), net-revenue-per-patient reporting.

17. Key Assumptions & Notes

- Medical-tourism facilitator: international patient coordination covering hospital selection, medical-visa documentation, travel and accommodation, translation and attendant support, in-treatment liaison and structured post-return aftercare, across cardiac, orthopaedic, oncology, transplant and fertility care. **EIGHTH PLAN IN THE TRAVEL VERTICAL — AGENCY/INTERMEDIARY SUB-MODEL, AND THE ETHICALLY HEAVIEST PLAN IN THIS VERTICAL.**
- ⚠ **GOVERNING CONVENTION FOR THE MEDICAL-TRAVEL SUB-MODEL, SET HERE: (a) A PATIENT IS NOT A TOURIST, AND THE CATEGORY NAME HAS SHAPED HOW THE INDUSTRY BEHAVES. (b) THE FACILITATOR IS PAID BY THE HOSPITAL, SO A FACILITATOR PAID BY THE HOSPITAL IS NOT THE PATIENT'S ADVOCATE HOWEVER IT DESCRIBES ITSELF — DISCLOSE IN FULL OR FORGO THE COMMISSION. (c) THE FACILITATOR IS NOT CLINICALLY QUALIFIED: PRESENTING OPTIONS IS COORDINATION, RECOMMENDING A PROCEDURE IS**

UNLICENSED MEDICAL ADVICE, AND OUTCOME CLAIMS ARE NEVER PERMISSIBLE BECAUSE WHAT IS BEING PROMISED IS A HUMAN BODY'S RESPONSE TO SURGERY. (d) THE PATIENT IS ABANDONED AT THE AIRPORT — THE INDUSTRY'S LARGEST FAILURE, STRUCTURAL RATHER THAN NEGLIGENT, BECAUSE NOBODY IS PAID FOR AFTERCARE. (e) PRICE-LED MEDICAL TRAVEL IS ADVERSE SELECTION: THE PATIENT WHO CHOSE THE CHEAPEST QUOTATION HAS THE LEAST RESERVE FOR A COMPLICATION.

- **ON DISCLOSURE, WHICH IS THE SINGLE DECISION SEPARATING AN HONEST FACILITATOR FROM THE REST OF THE CATEGORY: A FACILITATOR EARNING 15% ON A ₹6 LAKH CARDIAC PACKAGE RECEIVES ₹90,000 FROM THE HOSPITAL WHILE THE PATIENT BELIEVES THE ASSISTANCE IS FREE — AND BECAUSE RATES DIFFER BETWEEN HOSPITALS, THERE IS A DIRECT FINANCIAL REASON TO PREFER THE FACILITY PAYING 20% OVER THE ONE PAYING 10%, UNDETECTABLE BY THE PATIENT. THREE HONEST POSITIONS EXIST, EXACTLY AS THE CORPORATE-TRAVEL PLAN SET OUT FOR SUPPLIER OVERRIDES: FORGO AND CHARGE THE PATIENT; ACCEPT AND DISCLOSE IN FULL INCLUDING THE DIFFERENTIAL; OR ACCEPT SILENTLY, WHICH IS THE NORM AND MEANS THE FACILITATOR IS THE HOSPITAL'S SALES CHANNEL WHILE PRESENTING AS THE PATIENT'S GUIDE** → this plan takes the second and migrates toward the first (disclosure 44%→100%; commission 72%→50% of revenue; patient-paid 15%→31%).
- **ON AFTERCARE: FOLLOW THE MONEY AND THE FAILURE EXPLAINS ITSELF — THE HOSPITAL'S COMMERCIAL RELATIONSHIP ENDS AT DISCHARGE; THE FACILITATOR HAS BEEN PAID; THE HOME DOCTOR DID NOT PERFORM THE PROCEDURE, MAY NOT READ THE OPERATIVE NOTE'S LANGUAGE, AND IS SOMETIMES QUIETLY UNIMPRESSED THAT THE PATIENT WENT ABROAD. SO A DAY-NINETEEN INFECTION FINDS THE PATIENT HOLDING A DISCHARGE SUMMARY AND A TELEPHONE NUMBER IN A DIFFERENT TIME ZONE** → contact at 30/90/180 days as a deliverable (38%→74%→96%), handover pack transmitted before the patient lands, named surgeon escalation with committed response window agreed at corridor level, partner clinics in source markets (complications with facilitator involvement 22%→61%→88%).
- Economics & cash — **₹50 CRORE OF FACILITATED TREATMENT VALUE PRODUCES ₹92 LAKH OF PROFIT; THE TREATMENT MONEY IS THE PATIENT'S AND THE HOSPITAL'S, AND A FACILITATOR QUOTING IT AS TURNOVER IS DESCRIBING A BUSINESS FIFTY TIMES ITS SIZE. HOSPITAL COMMISSION SETTLES 30–90 DAYS AFTER DISCHARGE WHILE COSTS ARE INCURRED BEFORE AND DURING THE VISIT, WHICH CREATES A STRUCTURAL INCENTIVE TOWARD VOLUME RATHER THAN DEPTH — AND VOLUME IS EXACTLY THE PRESSURE THAT ERODES AFTERCARE. PATIENT ADVANCES ARE HELD IN A DESIGNATED ACCOUNT AT 100% AND ARE NOT THIS BUSINESS'S MONEY IN ANY SENSE, A DISTINCTION THAT MATTERS MORE HERE THAN IN THE TRAVEL AGENCY PLAN BECAUSE THE CIRCUMSTANCE IN WHICH THEY MUST BE RETURNED IS FREQUENTLY A BEREAVEMENT** (Y1 −₹24L → Y3 ₹92L; net margin −11.1%→5.0%→13.1%; 620→1,780 patients; net revenue per patient ₹34,800→₹39,300; salaries 61% of net revenue; break-even Year 2; **THE CONSTRAINT IS CLINICIAN AND COORDINATOR CAPACITY PLUS CORRIDOR DEVELOPMENT, NOT CAPITAL**). Regulatory: MED/MED-X and FRRO tracking; DPDP with cross-border transfer, consent and retention duties over diagnoses, imaging and operative notes; Consumer Protection Act, under which **SERVICE PROMISES ARE ENFORCEABLE EVEN WHERE THE CLINICAL OUTCOME IS NOT THE FACILITATOR'S RESPONSIBILITY — WHICH IS PRECISELY WHY OUTCOME CLAIMS MUST NEVER BE MADE**; GST on the facilitation fee with agent-versus-principal determining liability; FEMA on foreign patient receipts; **TRANSPLANTATION OF HUMAN ORGANS AND TISSUES ACT — DONOR MATTERS HANDLED EXCLUSIVELY BY THE HOSPITAL'S AUTHORISATION COMMITTEE**; professional indemnity. **AND THE HONEST NOTE THAT FACILITATION ITSELF IS LARGELY UNREGULATED — NO LICENCE, NO MANDATED DISCLOSURE, NO QUALIFICATION REQUIREMENT — SO THESE STANDARDS ARE VOLUNTARY AND COMPETITORS ADOPTING NONE HAVE A LOWER COST BASE.** Lender note: **READ ON NET REVENUE — ₹50CR FACILITATED IS PATIENT AND HOSPITAL MONEY, ₹7.00CR SERVICES DEBT**; security is thin, so promoter-strength lending with CGTMSE-type support; **ASK WHETHER HOSPITAL COMMISSION IS DISCLOSED IN WRITING BEFORE THE PATIENT CHOOSES A FACILITY, AND ASK FOR THE 90-DAY AFTERCARE CONTACT RATE — A**

FACILITATOR THAT DOES NOT DISCLOSE IS A HOSPITAL SALES CHANNEL PRESENTING ITSELF AS A PATIENT'S GUIDE, AND ONE WITH NO AFTERCARE HAS A BUSINESS MODEL THAT ENDS AT THE AIRPORT; BOTH ARE COMMERCIALLY VIABLE AND BOTH CARRY REPUTATIONAL RISK THAT ARRIVES SUDDENLY AND TRAVELS THROUGH COMMUNITIES FASTER THAN ANY MARKETING; and **UNDERSTAND THAT YOU ARE FUNDING THE MORE EXPENSIVE VERSION OF THIS BUSINESS ON PURPOSE, AND THAT THE CHEAPER VERSION'S RISK IS NOT ABSENT BUT UNPRICED.** ₹1.90cr, facilitated value 18.00→50.00cr, net revenue 2.16→7.00cr, 620→1,780 patients, 65→164 staff. Figures illustrative, exclude GST.

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