



BUSINESS PLAN · INDIA

Pathology / Diagnostic Lab

Where the person choosing for the patient is paid by the seller, refuse and say so

DIAGNOSTIC LABS & IMAGING

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This document is confidential and prepared for planning purposes. All financial figures are illustrative model assumptions for an Indian MSME context and must be validated against live quotes, local rates and professional advice before any investment or borrowing decision.

1. Executive Summary

This plan sets out a **Pathology / Diagnostic Lab** business in India — one main laboratory and three satellite labs by Year 3, running routine biochemistry and haematology, immunoassay and hormones, microbiology, histopathology and cytology, corporate testing contracts and reference testing for smaller labs, across roughly 1.61 million samples a year.

This plan opens the diagnostics vertical and sets the rules the other eight plans inherit. **It begins with the practice that determines almost everything else in Indian diagnostics, and that almost no patient knows exists.**

☐ **THE REFERRING DOCTOR IS PAID A COMMISSION ON EVERY TEST HE ORDERS. A share of the laboratory's fee — commonly twenty to forty per cent — is paid back to the physician, clinic or agent who sent the patient, and it is the single largest determinant both of WHICH lab a patient is sent to and of HOW MANY tests are ordered. The patient believes his doctor selected the laboratory on quality; the selection was made on the price paid to the doctor. And because the commission scales with the bill, THE INCENTIVE IS NOT MERELY TO PREFER ONE LAB OVER ANOTHER BUT TO ORDER MORE TESTS THAN THE PATIENT NEEDS — which produces unnecessary panels, incidental findings, cascades of follow-up investigation, and a bill the patient believes was clinical judgement. So this laboratory PAYS NIL REFERRAL COMMISSION TO ANY DOCTOR, CLINIC OR AGENT, PUBLISHES THAT POLICY AT EVERY COLLECTION POINT AND ON EVERY REPORT, and reports the consequence honestly: 604 REFERRERS STOPPED SENDING PATIENTS and ₹21.60 CRORE OF REVENUE WENT ELSEWHERE. WHERE THE PERSON CHOOSING FOR THE PATIENT IS PAID BY THE PERSON SELLING TO HIM, THE ONLY HONEST POSITION IS TO REFUSE TO PAY AND TO SAY SO.**

☐ **AND THE ARITHMETIC OF THE COMMISSION IS NOT WHAT PEOPLE ASSUME. Modelled at trade rates, paying it would take this laboratory to ₹117 crore of revenue and ₹8.57 crore of profit against our ₹72 crore and ₹6.48 crore — MORE PROFIT ON A LOWER NET MARGIN, because the commission consumes most of what it generates. THE COMMISSION DOES NOT MAKE THE LABORATORY MUCH RICHER. IT MAKES THE LABORATORY BIGGER AND THE PATIENT'S BILL 25% HIGHER. Patients paid ₹23.40 crore less this year than they would have at a commission-paying laboratory, which is the real output of the position.**

☐ **AND ACCREDITATION IS NOT EVIDENCE. A certificate says a laboratory passed an audit; the external quality assurance scores say whether it is getting the right answer this month. So INTERNAL QC AND EQA RESULTS ARE PUBLISHED RATHER THAN MERELY HELD, with 14 results outside acceptable limits and 4 ANALYTES WITHDRAWN pending investigation in Year 3.**

This plan models an operator requiring **₹26.00 crore** (₹11.20 crore investor + ₹8.40 crore term loan + ₹3.80 crore promoter + ₹2.60 crore working capital), moving from **₹14.00 crore revenue and a ₹5.05 crore loss** to **₹72.00 crore revenue and ₹6.48 crore profit** by Year 3 — a 9.0% net margin and 31.1% return on capital. (Diagnostic laboratory — figures illustrative.)

2. Business Description, Vision & Legal Structure

Concept: A laboratory that pays nobody to send it patients.

Vision: To make the referral question one a patient can ask and get a printed answer to.

Mission: Pay no commission and publish that we don't; publish the quality scores rather than the certificate; get a critical result to a named clinician in minutes; reject the sample that should be rejected; and query the panel that should not have been ordered.

Legal structure

- **Private Limited** — recommended. Clinical establishment registration, accreditation, corporate contracts and outside capital all assume it.
- **Partnership with a pathologist** — the trade's traditional form, and unsuited to a four-site network with published quality data.
- **Quality function reporting to the board, independent of operations and sales — because withdrawing an analyte stops revenue that somebody is measured on.**

Regulatory anchor: the Clinical Establishments (Registration and Regulation) Act 2010 and state rules where adopted, with registration and minimum standards; state Clinical Establishment and Nursing Home Acts where the central Act is not in force; the **National Medical Commission's professional conduct regulations, which PROHIBIT a registered medical practitioner from receiving any gift, commission or remuneration for referring a patient — a prohibition binding on the DOCTOR and, decisively, one that does not by itself make the LAB'S payment an offence, which is why the practice persists at scale**; the Prevention of Cutting-Practice legislation adopted in some states, which is narrow and unevenly enforced; NABL accreditation under ISO 15189, which is voluntary in most of the country; the PCPNDT Act where any prenatal diagnostic work is undertaken; the Bio-Medical Waste Management Rules; the Drugs and Cosmetics Act for diagnostic kits and reagents; the Digital Personal Data Protection Act 2023, under which a test result is sensitive personal data; the Atomic Energy Regulatory Board where radioisotope assays are used; GST; and shops and establishments, EPF/ESI and POSH. **The decisive structural fact is that the party paying the commission is generally outside the reach of the rule that forbids receiving it.**

3. Promoter & Ownership

Led by a promoter with pathology, diagnostics operations or healthcare background, with a registered pathologist as laboratory director. Three competences decide outcomes. *Analytical quality*, because a laboratory that publishes its EQA scores has removed its own hiding place and must actually be good. *Logistics and pre-analytical control*, since most diagnostic error happens outside the laboratory's walls and is nonetheless the laboratory's responsibility. And *the willingness to build demand without paying for it*, which is where this plan's proposition sits and which costs 604 referrers and three years of slower growth. Ownership, equity & investor terms are editable inputs; **the quality function reports to the board independently of operations and sales, and no employee's pay is linked to test volume from any individual referrer.**

4. Market Analysis — India

A very large market whose distribution channel is a payment nobody discloses.

Demand drivers

- **Chronic disease burden** generating repeat monitoring across diabetes, thyroid, renal and cardiac care.
- **Preventive and corporate health screening** as an employer benefit.
- **Physician reliance on investigation** in short consultations.
- **Insurance and reimbursement** requiring documented diagnostics.
- **Specialty test availability** moving from metros outward.

- **Patient-direct demand**, small today and the only channel that is not intermediated.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian diagnostic laboratory testing	Very large; highly fragmented
SAM	Demand reachable WITHOUT paying a referral commission	Roughly 30% smaller than the commissioned market
SOM (Yr 1-3)	Samples processed across four laboratories	₹14cr → ₹72cr; 1.61m samples; 4 sites

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and how the demand arrives
Routine biochemistry, haematology & clinical pathology	40.0%	68.0% — the volume base, and the most commission-driven segment
Immunoassay, hormones & serology	22.0%	62.0% — where unnecessary panels concentrate
Microbiology, culture & sensitivity	12.0%	58.0% — slow, skilled, rarely over-ordered
Histopathology & cytology	10.0%	66.0% — consultant-led; reputation-driven
Corporate & institutional testing contracts	10.0%	52.0% — tendered, and structurally commission-free
Reference / referral testing for smaller labs	6.0%	46.0% — B2B; no patient relationship at all

The fifth and sixth rows carry the lowest margins in the table and are strategically the most valuable lines in the business, because they are the only two whose demand does not travel through a referring physician. Corporate contracts are tendered on price and turnaround; reference testing is bought by other laboratories on analytical capability. Neither channel has any place for a commission, which is why they are deliberately grown to 16% of revenue between them despite earning less per rupee than everything above. The second row is the mirror image: immunoassay and hormone panels carry good margins and are where unnecessary testing concentrates, because a thyroid or vitamin panel is easy to add, rarely questioned, and adds materially to a bill that somebody is taking a percentage of.

Constraints

- **Referral channel access**, which is the binding constraint and is purchased by everybody else.
- **Pathologist and technologist availability**, particularly in histopathology and microbiology.
- **Pre-analytical control** across collection points we do not staff directly.
- **Reagent cost and currency**, since most platforms are imported and closed-system.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
National diagnostic chains	Brand, scale, test menu, logistics, capital, price	Referral economics unpublished; EQA scores never disclosed

Local standalone laboratories	Physician relationships, speed, price, local trust	Commission is the whole distribution model; QC often unaudited
Hospital laboratories	Captive inpatient flow, clinician proximity	Outpatient reach limited; pricing captive
Collection-centre franchise networks	Footprint, low capital, convenience	Pre-analytical control weakest exactly where it matters most
This plan	Nil commission published, EQA scores published, critical-value callback measured, rejection rate rising	604 referrers lost; slower growth; 9.0% net

The positioning has to be built without the channel every competitor uses, which makes it slow and makes the first two years expensive. What replaces the commission is a set of things a patient or a physician can verify: the no-commission policy printed on every report and displayed at every collection point; the EQA scores published by analyte; the critical-value callback performance published; and a price that is roughly a quarter lower than a commission-paying laboratory charges for the same panel. The physicians who stay are the ones for whom that combination is the point, and there are fewer of them — 604 referrers stopped sending patients — but they are also the referrers least likely to be lost to somebody else's higher percentage next quarter.

The cost of the honest position is stated in rupees, and its shape is unusual enough to be worth stating carefully. Paying no referral commission cost ₹2.09 crore of Year-3 profit — not the ₹21.60 crore of revenue that went elsewhere, because a commission-paying laboratory must also PAY the commission, and the two largely cancel. Rejecting samples that should be rejected, with a rejection rate that rises rather than falls, cost ₹1.42 crore. Critical-value callback to a named clinician within minutes cost ₹96 lakh. Querying inappropriate panels back to the requisitioner cost ₹84 lakh. Publishing IQC and EQA scores and withdrawing analytes pending investigation cost ₹68 lakh. Total ₹4.99 crore against ₹6.48 crore of profit. And separately, the number that matters more: PATIENTS PAID ₹23.40 CRORE LESS THIS YEAR THAN THEY WOULD HAVE AT A COMMISSION-PAYING LABORATORY.

6. The Commission Nobody Discloses

This is the finding, and its arithmetic is more interesting than its morality.

What the patient believes	What is actually happening
My doctor chose this lab because it is good	It pays him 20-40% of the bill
These tests are the ones I need	The commission scales with the number ordered
The price is what the test costs	The price includes the referrer's share
A second opinion means a second doctor	Often the same referral network
This is illegal, surely	Illegal for the doctor to RECEIVE. Not, generally, for the lab to PAY.
Somebody must be checking	The prohibition binds the party who is not writing the cheque

The fifth row is why this survives at industrial scale. The National Medical Commission's conduct regulations forbid a registered practitioner from receiving a commission for a referral, and that prohibition is real — but it binds the DOCTOR, and it is enforced through a professional-conduct process that requires somebody to complain, name a practitioner, and prove a private payment. The laboratory writing the cheque is generally outside the reach of the rule that forbids receiving it, and the handful of state cutting-practice statutes are

narrow and unevenly enforced. So the entire distribution channel of Indian diagnostics rests on a payment that is prohibited for one party, unregulated for the other, invisible to the person paying for it, and universal. **NOBODY INVOLVED EXPERIENCES IT AS CORRUPTION:** the physician regards it as ordinary trade practice he did not invent, the laboratory as the price of access, and the patient as a bill. Per the anchor rules of this library, it is a commission-disclosure problem in its purest form — the adviser is paid by the seller, the advice determines the purchase, and the buyer is never told.

And the arithmetic is not what people assume, which is worth stating because it changes the argument. Modelled at trade rates, paying the commission would take this laboratory to roughly **₹117 CRORE OF REVENUE AND ₹8.57 CRORE OF PROFIT**, against our ₹72 crore and ₹6.48 crore — **MORE PROFIT**, on a **LOWER** net margin of 7.3% against our 9.0%, because the commission consumes most of what it generates and the prices must rise about 25% to fund it. **THE COMMISSION DOES NOT MAKE THE LABORATORY MUCH RICHER. IT MAKES THE LABORATORY BIGGER, THE PHYSICIAN RICHER, AND THE PATIENT'S BILL 25% HIGHER.** That is the honest description: this is not primarily a transfer from laboratory to doctor, it is a transfer from **PATIENT** to doctor, with the laboratory as the collecting agent. So we pay **NIL** commission to any doctor, clinic or agent, **PUBLISH THE POLICY** at every collection point and on every report, and report that **604 referrers stopped sending patients and ₹21.60 crore of revenue went elsewhere — while PATIENTS PAID ₹23.40 CRORE LESS.** **WHERE THE PERSON CHOOSING FOR THE PATIENT IS PAID BY THE PERSON SELLING TO HIM, THE ONLY HONEST POSITION IS TO REFUSE TO PAY AND TO SAY SO.**

7. The Scores, the Callback and the Sample You Must Reject

Four further rules, which the remaining diagnostics plans inherit.

☐ **ACCREDITATION IS NOT EVIDENCE.** A NABL certificate on a wall records that a laboratory passed an assessment on a particular set of days; the external quality assurance scores record whether it is producing the right answer **THIS MONTH**, analyte by analyte. The two are routinely conflated, and only one of them is ever shown to anybody. So **INTERNAL QC IS RUN AND PUBLISHED** and **EQA RESULTS ARE PUBLISHED BY ANALYTE** rather than merely filed — including the failures: **14 results outside acceptable limits in Year 3, with 4 ANALYTES WITHDRAWN FROM THE MENU** pending investigation. Publishing the failures is the whole point, because a laboratory that published only its passes would be doing exactly what the certificate already does.

☐ **A CRITICAL RESULT THAT REACHES A PORTAL HAS NOT REACHED ANYBODY.** A potassium of 7.2 or a haemoglobin of 3 is a life-threatening finding that requires a clinician to act within the hour, and the trade's normal practice — publishing it to a report portal, or telephoning a number that goes unanswered — discharges a procedure without discharging the duty. So **CRITICAL-VALUE CALLBACK IS MEASURED AS REACHING A NAMED HUMAN CLINICIAN:** 99.4% in Year 3, median 9 minutes, **90TH PERCENTILE 26 MINUTES** per the library's tail rule, with 6 callbacks unclosed after four hours and each one investigated individually. The 90th percentile is reported because a median callback time conceals precisely the cases where the delay mattered.

☐ **THE SAMPLE REJECTION RATE MUST BE NON-ZERO, AND OURS IS RISING.** A haemolysed, clotted, insufficient or mislabelled sample produces a result that looks entirely normal and is wrong, and running it rather than rejecting it is the path of least resistance for everybody — the patient does not want a second needle, the collection point does not want the complaint, and the laboratory does not want the argument. So **SAMPLES ARE REJECTED RATHER THAN RUN — 54,800 in Year 3, a rejection rate RISING from 2.8% to 3.4% — and A COLLECTION POINT REPORTING A ZERO REJECTION RATE IS INVESTIGATED** rather than praised, per the

vertical-50 anchor's rule that a gate with no rejections is not a gate. It costs ₹1.42 crore.

☐ **AND MOST DIAGNOSTIC ERROR HAPPENS OUTSIDE THE LABORATORY.** Collection technique, tube selection, labelling at source, transport temperature and time-to-centrifuge account for the majority of wrong results, and almost nobody measures them because they occur where the laboratory has no staff — the commissary problem, in reverse. So **PRE-ANALYTICAL PERFORMANCE IS MEASURED BEYOND OUR OWN WALLS:** time-to-centrifuge within limit at 94%, transport temperature excursions recorded at 100%, and pre-analytical errors reported as 61% of all errors — a figure published precisely because it is embarrassing and because a laboratory claiming a low error rate while ignoring the pre-analytical phase is measuring the easy part.

☐ **AND A LABORATORY THAT NEVER QUESTIONS A REQUISITION IS NOT A LABORATORY.** 11,200 inappropriate or duplicated panels were queried back to the requisitioner in Year 3 — a repeat vitamin D at three weeks, a full thyroid profile on a stable patient, a tumour marker used as a screening test — at a cost of ₹84 lakh in tests not performed.

8. Operations Plan (collect, run, check, call)

Referral and pricing

- **Nil commission to any doctor, clinic, agent or collection intermediary,** in any form.
- **Policy printed on every report and displayed at every collection point.**
- **Price list published,** single-tier, with no referrer-specific rate cards.
- **Nil employee pay linked to volume from any individual referrer.**

Analytical quality

- **Internal QC run per shift per analyte,** with Westgard rules and documented action.
- **EQA participation on 100% of analytes,** with scores published by analyte.
- **Analytes withdrawn pending investigation** on an EQA failure — 4 in Year 3.
- **Quality function reporting to the board,** independent of operations and sales.

Pre-analytical and sample integrity

- **Samples rejected rather than run** when haemolysed, clotted, insufficient or mislabelled.
- **Rejection rate published per collection point;** zero readings investigated.
- **Time-to-centrifuge and transport temperature measured** outside our own walls.
- **Pre-analytical error share published** as a proportion of all error.

Reporting and clinical interface

- **Critical-value callback to a named clinician,** measured to the 90th percentile.
- **Inappropriate and duplicated panels queried** back to the requisitioner.
- **Turnaround published with its 90th percentile,** not the median alone.
- **Contribution per test category,** never blended into a single laboratory margin.

The operational hinge is a consultant who sends roughly ₹40 lakh of work a year, is genuinely competent, and asks — reasonably, in his own view — for the arrangement every other laboratory offers him, framed not as a commission but as a "professional coordination fee" for the time his staff spend on sample handling. The

framing is not cynical: his staff do spend that time, other laboratories do pay for it, and refusing costs a fifth of one laboratory's referred volume in a single conversation. So the answer is no, **WITH THE OFFER TO FUND A TRAINED PHLEBOTOMIST AT HIS CLINIC AT OUR COST AND UNDER OUR SUPERVISION** — because the underlying need is real even where the payment would not be, and refusing without addressing the need is not integrity, it is just refusal. The system refuses rather than warns: there is no vendor category, cost centre or payment type in the finance system through which a referrer can be paid, so the arrangement cannot be created by a manager acting alone, and **NO EMPLOYEE'S PAY IS AFFECTED BY VOLUME FROM ANY INDIVIDUAL REFERRER.**

9. Registration, Accreditation & Operating Compliance (India)

- **Clinical Establishments Act 2010 and state rules** where adopted, with registration and minimum standards; state Clinical Establishment and Nursing Home Acts elsewhere.
- **National Medical Commission conduct regulations** — **PROHIBIT a registered practitioner from RECEIVING a commission for a referral; the prohibition binds the DOCTOR and does not by itself make the laboratory's PAYMENT an offence, which is why the practice persists at scale.**
- **State cutting-practice legislation** where enacted — narrow in scope and unevenly enforced.
- **NABL accreditation under ISO 15189** — **voluntary in most of the country, and an assessment of days rather than a statement about this month's results.**
- **PCPNDT Act** where any prenatal diagnostic work is undertaken, with registration, record and reporting duties.
- **Bio-Medical Waste Management Rules;** the Drugs and Cosmetics Act for diagnostic kits and reagents; AERB where radioisotope assays are used.
- **Digital Personal Data Protection Act 2023** — a test result is sensitive personal data, with consent, purpose limitation and erasure duties.
- **GST, shops and establishments, EPF/ESI and POSH.** The decisive fact remains that the party paying the commission is generally outside the reach of the rule that forbids receiving it.

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owens the no-commission rule
Laboratory technologists & technicians	46	148	Four sites, three shifts
Phlebotomy & collection network	34	112	Pre-analytical is measured here
Logistics & cold-chain transport	14	42	Time-to-centrifuge and temperature logged
Pathologists & consultants	8	26	Histopathology, microbiology, sign-out
Quality — IQC, EQA, audit & callback	6	22	Reports to board; can withdraw an analyte
LIS, IT & reporting	5	14	Critical-value callback tracking
Admin, finance, marketing & corporate sales	12	33	Patient-direct and corporate, not referrer-paid
Total	126	398	Quality and pathology at 12% of headcount

Twenty-two people in quality for a four-site laboratory is roughly double trade practice, and the reason is that this business has published its scores and therefore cannot afford to discover a problem the way everybody

else does — from an external assessor, a year late. The function reports to the board rather than to laboratory operations, and holds authority to **WITHDRAW AN ANALYTE FROM THE MENU** on an EQA failure, which stops revenue immediately and is exactly why the decision cannot sit with the people whose numbers it damages. The 112-strong phlebotomy and collection team is the other unusual line: most laboratories treat collection as a low-cost outsourced function, which is precisely why 61% of all diagnostic error originates there, and staffing it properly is cheaper than explaining a wrong result.

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & main laboratory	Month 0–8	Incorporation, registration, analysers commissioned, LIS live
No-commission policy published	Month 2–6	On every report and at every collection point; no payment path exists
Quality programme & EQA publication	Month 4–14	IQC per shift; EQA on all analytes; scores published by analyte
Critical-value callback	Month 6–16	Named-clinician contact measured to the 90th percentile
Satellite labs & corporate book	Month 12–28	Three satellites; corporate and reference lines to 16% of revenue
Scale & publication	Month 26–36	1.61m samples; rejection rate published per collection point

Training and competence

- **Declining the coordination fee** — the script, the alternative offered, and why it is offered.
- **Phlebotomy and pre-analytical discipline**, taught as the largest single error source.
- **Critical-value escalation**, including what to do when the named clinician cannot be reached.
- **Querying a requisition** without appearing to second-guess a physician's judgement.

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions, not forecasts or guarantees. They exist to show the drivers of a diagnostic laboratory P&L and how the referral, quality and rejection disciplines move them. Every input is editable. **The defining economics are a 62.4% gross margin against heavy fixed analytical and staffing cost, producing 9.0% net — and a demand channel that competitors purchase and this laboratory does not, which is why the first two years are loss-making.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Analysers, immunoassay platforms & microbiology systems	962	Mostly imported, closed-system reagents
Laboratory build-out — main lab plus three satellites	546	Four registered sites

Histopathology & cytology setup	286	Consultant-led, reputation-critical
Working capital — corporate receivables & reagents	260	Corporate contracts pay slowly
LIS, reporting, critical-value callback & integration	234	Callback tracked to a named human, not a portal
Collection-centre network & cold-chain logistics	208	Where 61% of error originates
Licences, accreditation, deposits & pre-operative	104	Registration, NABL, PCPNDT where applicable
Total project cost	2,600	₹1,120L investor + ₹840L term loan + ₹380L promoter + ₹260L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
REFERRAL COMMISSION paid to any doctor, clinic or agent / policy published at every collection point and on every report / referrers who STOPPED sending patients / revenue gone elsewhere (₹cr)	NIL / 100% / 218 / 4.3	NIL / 100% / 416 / 11.4	NIL / 100% / 604 / 21.6
INTERNAL QC run and EQA scores PUBLISHED BY ANALYTE (not merely accredited) / EQA participation across analytes / EQA results outside acceptable limits / ANALYTES WITHDRAWN pending investigation	100% / 100% / 34 / 9	100% / 100% / 21 / 6	100% / 100% / 14 / 4
CRITICAL VALUES reaching a NAMED HUMAN CLINICIAN (not a portal or an unanswered number) / median callback / 90th-percentile callback / callbacks unclosed after 4 hours	94.2% / 22 min / 68 min / 41	97.6% / 14 min / 41 min / 18	99.4% / 9 min / 26 min / 6
SAMPLE REJECTION RATE — must be NON-ZERO and is RISING / samples rejected as haemolysed, clotted, insufficient or mislabelled / collection points reporting a ZERO rejection rate and investigated	2.8% / 8,600 / 100%	3.1% / 26,400 / 100%	3.4% / 54,800 / 100%
PRE-ANALYTICAL measured BEYOND OUR OWN WALLS — time-to-centrifuge within limit / transport temperature excursions recorded / pre-analytical errors as % of ALL error (published because it is embarrassing)	78% / 100% / 68%	88% / 100% / 64%	94% / 100% / 61%
Turnaround median (90th percentile) / repeat or rerun rate / inappropriate or duplicated panels QUERIED back to the requisitioner / samples processed	6.2h (22h) / 1.9% / 1,840 / 312k	5.1h (16h) / 1.4% / 5,600 / 848k	4.4h (12h) / 1.1% / 11,200 / 1,610k

Row one reports the cost of the position rather than claiming the position is free: 604 referrers stopped sending patients and ₹21.60 crore went elsewhere, both published. Row two publishes the FAILURES — 14 EQA results outside limits and 4 analytes withdrawn — because a laboratory publishing only its passes would be doing exactly what the certificate already does, and the falling series from 34 is the evidence the programme works. Row four is the vertical-50 anchor's rule applied to specimens, and its direction is deliberately counterintuitive: the rejection rate RISES from 2.8% to 3.4%, because rising means the gate is being enforced harder and a zero reading at any collection point means somebody is running samples that should have been rejected. Row five publishes an unflattering number — 61% of all error is pre-analytical — because a laboratory reporting a low error rate while ignoring the phase where most error occurs is measuring the easy part. Rows three and six carry their 90TH PERCENTILES per the library's tail rule, since a median callback time conceals precisely the cases where the delay mattered.

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Routine biochemistry, haematology & clinical pathology	560	1,520	2,880	68.0%
Immunoassay, hormones & serology	308	836	1,584	62.0%
Microbiology, culture & sensitivity	168	456	864	58.0%
Histopathology & cytology	140	380	720	66.0%
Corporate & institutional testing contracts	140	380	720	52.0%
Reference / referral testing for smaller labs	84	228	432	46.0%
Total revenue	1,400	3,800	7,200	62.4% blended

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	1,400	3,800	7,200
Cost of testing — reagents, consumables, outsourced and rejected samples	(527)	(1,430)	(2,710)
Gross profit	873	2,370	4,490
Laboratory staff — pathologists, technologists, phlebotomists	(496)	(908)	(1,440)
Laboratory premises, utilities & cold chain	(186)	(268)	(388)
Logistics — sample transport & collection network	(126)	(212)	(324)
Quality — IQC, EQA, proficiency testing & audit	(112)	(186)	(288)
Technology, LIS, callback & reporting	(118)	(164)	(216)
Marketing — patient-direct and corporate, NO referral commission	(142)	(196)	(288)
Admin, legal, compliance & other	(148)	(212)	(306)
EBITDA	(455)	224	1,240
Depreciation & amortisation	(212)	(328)	(432)
Finance cost	(78)	(112)	(144)
Other income — reference-testing incentives and equipment placement terms (<i>disclosed</i>)	72	148	200
PBT	(673)	(68)	864
Tax	168	17	(216)
PAT	(505)	(51)	648
Net margin	(36.1%)	(1.3%)	9.0%
ROCE	(25.7%)	(4.0%)	31.1%

The marketing line at ₹2.88 crore is the whole strategic difference expressed as a cost: it buys patient-direct awareness and corporate tendering, and it does NOT buy referrals, which is why it is a quarter the size of the

referral spend a comparable laboratory carries and why the first two years lose money. Quality at ₹2.88 crore — the same figure — is the second unusual line, spending 4.0% of revenue on IQC, EQA and audit in a trade where the equivalent is often a fraction of that. Other income of ₹2.00 crore is reference-testing incentives and equipment placement terms, disclosed as a line because equipment placement in particular ties a laboratory to a manufacturer's reagents and is a commercial relationship the customer never sees. Commitments of ₹4.99 crore against ₹6.48 crore of profit; and the number that matters more sits outside the P&L entirely — patients paid ₹23.40 crore less than they would have at a commission-paying laboratory.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹72.0cr	₹6.48cr	As modelled, 9.0% net
Referral commission paid at trade rates	₹117.0cr	₹8.57cr	More profit, LOWER margin (7.3%), patient pays 25% more
Corporate contract book doubles	₹79.2cr	₹8.38cr	The channel with no commission in it
Reagent cost +12%	₹72.0cr	₹4.04cr	Closed-system platforms, imported
Pathologist wage inflation +20%	₹72.0cr	₹5.55cr	26 consultants is the fixed exposure
A published EQA failure on a major analyte	₹66.2cr	₹3.79cr	The cost of having published in the first place

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	1,120	Laboratory build and network; no-commission covenant
Term loan	840	Analysers, build-out and LIS; 6–7 years
Promoter contribution	380	Cash and pathology leadership
Working capital facility	260	Corporate receivables and reagent stock
Total	2,600	Illustrative structure

A lender should read the referrer series, the corporate book and the EQA record, and should understand that two loss-making years are the direct and predictable cost of not buying distribution. The 604 lost referrers are the risk stated honestly; the corporate and reference lines growing to 16% of revenue are the answer, because they are the only channels where the commission has no purchase. Reagent cost is the sharpest operating sensitivity — a 12% rise takes profit from ₹6.48 crore to ₹4.04 crore — because closed-system imported platforms leave no substitution option once installed, which is a procurement decision made years earlier. The EQA-failure scenario is worth reading twice: publishing quality scores means a failure is public, and the ₹3.79 crore outcome is the price of having published — a price this plan accepts deliberately, because a laboratory that publishes only when the news is good has published nothing.

- **Use of funds** — 37% analysers and platforms, 21% laboratory build-out, 11% histopathology setup, 10% working capital, 9% LIS and callback systems, 8% collection network, 4% licences and accreditation.

- **Repayment** — term loan from Year 3 cash flow; working capital revolving against corporate receivables.
 - **Investor exit** — sale to a national diagnostics chain, a hospital group or a healthcare platform; or promoter buyback.
- The no-commission commitment survives change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation
The commission nobody discloses	A share of the laboratory's fee — commonly 20-40% — IS PAID BACK TO THE PHYSICIAN, CLINIC OR AGENT WHO SENT THE PATIENT, and it is the single largest determinant BOTH of which lab a patient is sent to AND of how many tests are ordered. The patient believes his doctor selected the laboratory ON QUALITY; the selection was made ON THE PRICE PAID TO THE DOCTOR. And because the commission SCALES WITH THE BILL, THE INCENTIVE IS NOT MERELY TO PREFER ONE LAB BUT TO ORDER MORE TESTS THAN THE PATIENT NEEDS — producing unnecessary panels, incidental findings, CASCADES OF FOLLOW-UP INVESTIGATION, and a bill the patient believes was clinical judgement. It survives at industrial scale because THE NMC PROHIBITION BINDS THE DOCTOR WHO RECEIVES, NOT THE LABORATORY THAT PAYS — the party writing the cheque is generally outside the reach of the rule — and state cutting-practice statutes are narrow and unevenly enforced. NOBODY INVOLVED EXPERIENCES IT AS CORRUPTION: the physician regards it as ordinary trade practice HE DID NOT INVENT, the laboratory as THE PRICE OF ACCESS, and the patient as A BILL	PAY NIL COMMISSION TO ANY DOCTOR, CLINIC, AGENT OR COLLECTION INTERMEDIARY IN ANY FORM; PUBLISH THE POLICY AT EVERY COLLECTION POINT AND ON EVERY REPORT; single-tier published price list with NO REFERRER-SPECIFIC RATE CARDS; and REPORT THE CONSEQUENCE HONESTLY — 604 REFERRERS STOPPED SENDING PATIENTS AND ₹21.60cr WENT ELSEWHERE. There is NO VENDOR CATEGORY, COST CENTRE OR PAYMENT TYPE IN THE FINANCE SYSTEM THROUGH WHICH A REFERRER CAN BE PAID, so the arrangement CANNOT BE CREATED BY A MANAGER ACTING ALONE; and NO EMPLOYEE'S PAY IS LINKED TO VOLUME FROM ANY INDIVIDUAL REFERRER. GENERAL RULE: WHERE THE PERSON CHOOSING FOR THE PATIENT IS PAID BY THE PERSON SELLING TO HIM, THE ONLY HONEST POSITION IS TO REFUSE TO PAY AND TO SAY SO
The arithmetic is not what people assume	Modelled at trade rates, paying the commission takes this laboratory to ₹117cr of revenue and ₹8.57cr of profit against ₹72cr and ₹6.48cr — MORE PROFIT ON A LOWER NET MARGIN (7.3% vs 9.0%), because THE COMMISSION CONSUMES MOST OF WHAT IT GENERATES AND PRICES MUST RISE ABOUT 25% TO FUND IT	THE COMMISSION DOES NOT MAKE THE LABORATORY MUCH RICHER — IT MAKES THE LABORATORY BIGGER, THE PHYSICIAN RICHER, AND THE PATIENT'S BILL 25% HIGHER. THIS IS NOT PRIMARILY A TRANSFER FROM LABORATORY TO DOCTOR; IT IS A TRANSFER FROM PATIENT TO DOCTOR, WITH THE LABORATORY AS THE COLLECTING AGENT — which is stated plainly because it changes the argument from a moral appeal into an arithmetic one. PATIENTS PAID ₹23.40cr LESS THIS YEAR than they would have at a commission-paying laboratory, published as the real output of the position

The professional coordination fee	A consultant sending ~₹40L of work a year, GENUINELY COMPETENT, asks for the arrangement every other laboratory offers — framed not as a commission but as A FEE FOR THE TIME HIS STAFF SPEND ON SAMPLE HANDLING. THE FRAMING IS NOT CYNICAL: HIS STAFF DO SPEND THAT TIME, OTHER LABORATORIES DO PAY FOR IT, and refusing costs a fifth of one laboratory's referred volume IN A SINGLE CONVERSATION	THE ANSWER IS NO, WITH THE OFFER TO FUND A TRAINED PHLEBOTOMIST AT HIS CLINIC AT OUR COST AND UNDER OUR SUPERVISION — BECAUSE THE UNDERLYING NEED IS REAL EVEN WHERE THE PAYMENT WOULD NOT BE, AND REFUSING WITHOUT ADDRESSING THE NEED IS NOT INTEGRITY, IT IS JUST REFUSAL. THE SYSTEM REFUSES RATHER THAN WARNS: no payment path to a referrer exists in the finance system at all, so the question cannot be settled by a manager under pressure at the end of a quarter
Accreditation is not evidence	A certificate records that a laboratory PASSED AN ASSESSMENT ON PARTICULAR DAYS; the EQA scores record whether it is producing THE RIGHT ANSWER THIS MONTH, analyte by analyte. THE TWO ARE ROUTINELY CONFLATED AND ONLY ONE IS EVER SHOWN TO ANYBODY. And publishing means a failure is public — the sensitivity shows ₹3.79cr	IQC PER SHIFT PER ANALYTE; EQA ON 100% OF ANALYTES WITH SCORES PUBLISHED BY ANALYTE — INCLUDING THE FAILURES: 14 outside limits and 4 ANALYTES WITHDRAWN pending investigation, falling from 34 and 9. PUBLISHING THE FAILURES IS THE WHOLE POINT, BECAUSE A LABORATORY THAT PUBLISHED ONLY ITS PASSES WOULD BE DOING EXACTLY WHAT THE CERTIFICATE ALREADY DOES. Quality reports TO THE BOARD and can WITHDRAW AN ANALYTE, which stops revenue immediately — WHICH IS WHY THE DECISION CANNOT SIT WITH THE PEOPLE WHOSE NUMBERS IT DAMAGES (₹68L)
A critical result that reaches a portal has not reached anybody	A potassium of 7.2 or a haemoglobin of 3 REQUIRES A CLINICIAN TO ACT WITHIN THE HOUR, and the trade's normal practice — publishing to a report portal, or telephoning a number that goes unanswered — DISCHARGES A PROCEDURE WITHOUT DISCHARGING THE DUTY	CALLBACK MEASURED AS REACHING A NAMED HUMAN CLINICIAN: 99.4%, median 9 min, 90TH PERCENTILE 26 MIN, with 6 unclosed after four hours EACH INVESTIGATED INDIVIDUALLY. THE 90TH PERCENTILE IS REPORTED BECAUSE A MEDIAN CALLBACK TIME CONCEALS PRECISELY THE CASES WHERE THE DELAY MATTERED (library tail rule); escalation defined for when the named clinician cannot be reached (₹96L)
The sample you must reject	A haemolysed, clotted, insufficient or mislabelled sample PRODUCES A RESULT THAT LOOKS ENTIRELY NORMAL AND IS WRONG, and running it is THE PATH OF LEAST RESISTANCE FOR EVERYBODY — the patient does not want a second needle, the collection point does not want the complaint, and the laboratory does not want the argument	REJECTED RATHER THAN RUN — 54,800 in Yr3, rate RISING 2.8% → 3.4% BECAUSE RISING MEANS THE GATE IS BEING ENFORCED HARDER; PUBLISHED PER COLLECTION POINT with A ZERO READING INVESTIGATED rather than praised; and 11,200 INAPPROPRIATE OR DUPLICATED PANELS QUERIED BACK TO THE REQUISITIONER — a repeat vitamin D at three weeks, a tumour marker used as a screening test — BECAUSE A LABORATORY THAT NEVER QUESTIONS A REQUISITION IS NOT A LABORATORY (₹1.42cr + ₹84L)

Most error happens outside the laboratory	Collection technique, tube selection, labelling at source, transport temperature and time-to-centrifuge account for the MAJORITY of wrong results, and almost nobody measures them BECAUSE THEY OCCUR WHERE THE LABORATORY HAS NO STAFF	PRE-ANALYTICAL MEASURED BEYOND OUR OWN WALLS — time-to-centrifuge within limit 78%→94%, transport excursions recorded at 100%, and PRE-ANALYTICAL ERRORS PUBLISHED AS 61% OF ALL ERROR PRECISELY BECAUSE IT IS EMBARRASSING, since a laboratory claiming a low error rate while ignoring that phase IS MEASURING THE EASY PART; 112 phlebotomy staff EMPLOYED RATHER THAN OUTSOURCED
Reagent, consultant and channel exposure	Reagent cost +12% takes profit to ₹4.04cr on closed-system imported platforms with no substitution once installed; 26 consultants at +20% takes it to ₹5.55cr; and the referral channel remains purchased by every competitor	Multi-vendor platform strategy at replacement rather than lock-in; reagent contracts with volume and currency terms; CORPORATE AND REFERENCE LINES GROWN TO 16% OF REVENUE AS COMMISSION-FREE CHANNELS; contribution reported PER TEST CATEGORY, never blended; and equipment-placement terms disclosed BECAUSE THEY TIE THE LABORATORY TO A MANUFACTURER'S REAGENTS IN A WAY THE CUSTOMER NEVER SEES

15. SWOT Analysis

Strengths • Nil referral commission, published everywhere • EQA scores published by analyte, failures included • 99.4% critical values reaching a named clinician • Rejection rate rising to 3.4%; zero readings investigated • Patients paid ₹23.40cr less than at a commission lab	Weaknesses • 604 referrers lost; ₹21.60cr of revenue gone elsewhere • Two loss-making years by design • ₹4.99cr of commitments against ₹6.48cr of profit • A published EQA failure is a public event
Opportunities • Corporate and reference channels with no commission in them • Patient-direct demand on published price and quality • Physicians who want a lab they can defend • Any enforcement of cutting-practice law favours us • Reference testing for labs without our menu	Threats • Competitors buying the referral channel outright • Reagent cost and currency on closed systems • Pathologist and technologist scarcity • A public EQA failure on a major analyte

16. Recommended AiSevak Tools for This Business

- **No-payment-path finance control** — no vendor category or payment type through which a referrer can be paid.
- **EQA publication board** — scores by analyte, failures included, with withdrawal status.
- **Critical-value callback tracker** — named clinician, median and 90th percentile, unclosed escalations.
- **Rejection register** — per collection point, with zero-rate auto-investigation.
- **Pre-analytical monitor** — time-to-centrifuge, transport temperature, labelling errors at source.
- **Requisition query engine** — duplicate and inappropriate panels flagged back to the requisitioner.

- **Patient savings statement** — published price against commission-inclusive market rate.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, sample volumes, category margins, rejection rates and callback times are editable inputs; actual outcomes depend on referral access, reagent cost, consultant availability and corporate contracting. Figures are in Indian rupees. **This is the anchor plan for the diagnostics vertical, and the eight plans that follow inherit the rules set out here.**
- **The central integrity finding is that the referring doctor is paid a commission on every test he orders.** A share of the laboratory's fee, commonly twenty to forty per cent, goes back to the physician, clinic or agent who sent the patient, and it determines both which laboratory a patient is sent to and how many tests are ordered. The patient believes his doctor selected the laboratory on quality; the selection was made on the price paid to the doctor. **And because the commission scales with the bill, the incentive is not merely to prefer one laboratory but to order more tests than the patient needs — producing unnecessary panels, incidental findings, cascades of follow-up investigation, and a bill the patient believes was clinical judgement. It survives at industrial scale because the National Medical Commission's prohibition binds the doctor who RECEIVES, not the laboratory that PAYS: the party writing the cheque is generally outside the reach of the rule that forbids receiving it, and the state cutting-practice statutes are narrow and unevenly enforced. Nobody involved experiences it as corruption — the physician regards it as ordinary trade practice he did not invent, the laboratory as the price of access, and the patient as a bill.**
- **So we pay nil commission to any doctor, clinic, agent or intermediary in any form, publish the policy at every collection point and on every report, and report the consequence honestly: 604 referrers stopped sending patients and ₹21.60 crore of revenue went elsewhere.** There is no vendor category, cost centre or payment type in the finance system through which a referrer could be paid, so the arrangement cannot be created by a manager acting alone, and no employee's pay is linked to volume from any individual referrer. **WHERE THE PERSON CHOOSING FOR THE PATIENT IS PAID BY THE PERSON SELLING TO HIM, THE ONLY HONEST POSITION IS TO REFUSE TO PAY AND TO SAY SO.**
- **The arithmetic is not what people assume, and stating it changes the argument.** Modelled at trade rates, paying the commission would take this laboratory to ₹117 crore of revenue and ₹8.57 crore of profit against our ₹72 crore and ₹6.48 crore — more profit, on a lower net margin of 7.3% against 9.0%, because the commission consumes most of what it generates and prices must rise about 25% to fund it. **The commission does not make the laboratory much richer. It makes the laboratory bigger, the physician richer, and the patient's bill 25% higher — so this is not primarily a transfer from laboratory to doctor, it is a transfer from patient to doctor, with the laboratory as the collecting agent. Patients paid ₹23.40 crore less this year than they would have at a commission-paying laboratory, and that figure, rather than our profit, is the real output of the position.**
- **Accreditation is not evidence, and a critical result that reaches a portal has not reached anybody.** A certificate records that a laboratory passed an assessment on particular days; the external quality assurance scores record whether it is producing the right answer this month, analyte by analyte — so IQC is run per shift and EQA results are published by analyte including the failures, with 14 results outside limits and 4 analytes withdrawn from the menu pending investigation, falling from 34 and 9. **Publishing the failures is the whole point, because a laboratory publishing only its passes would be doing exactly what the certificate already does.** And critical-value callback is measured as reaching a named human clinician — 99.4%, median 9 minutes, 90th percentile 26 minutes, 6 unclosed after four hours — with the 90th percentile reported because a median conceals precisely the cases where the delay mattered.
- **The sample rejection rate must be non-zero, and ours rises.** A haemolysed, clotted, insufficient or mislabelled sample produces a result that looks entirely normal and is wrong, and running it is the path of least resistance for

everybody — the patient does not want a second needle, the collection point does not want the complaint, and the laboratory does not want the argument. **54,800 samples were rejected in Year 3 with the rate rising from 2.8% to 3.4%, published per collection point, and a zero reading anywhere is investigated rather than praised.** 11,200 inappropriate or duplicated panels were queried back to the requisitioner, because a laboratory that never questions a requisition is not a laboratory.

- **Most diagnostic error happens outside the laboratory, and almost nobody measures it.** Collection technique, tube selection, labelling at source, transport temperature and time-to-centrifuge account for the majority of wrong results, and they occur where the laboratory has no staff. Time-to-centrifuge within limit rose from 78% to 94%, transport excursions are recorded at 100%, and pre-analytical errors are published as 61% of all error — precisely because the figure is embarrassing, since a laboratory reporting a low error rate while ignoring that phase is measuring the easy part. **112 phlebotomy staff are employed rather than outsourced, because staffing collection properly is cheaper than explaining a wrong result.** Commitments total ₹4.99 crore against ₹6.48 crore of profit, and the two loss-making years are the direct, predictable cost of not buying distribution.
- **Compliance and professional advice.** The Clinical Establishments Act 2010 and state rules were adopted, or state Clinical Establishment and Nursing Home Acts elsewhere; **the National Medical Commission's professional conduct regulations, which prohibit a registered practitioner from receiving a commission for a referral — a prohibition binding on the doctor that does not by itself make the laboratory's payment an offence**; state cutting-practice legislation where enacted; NABL accreditation under ISO 15189, voluntary in most of the country; the PCPNDT Act where prenatal diagnostic work is undertaken; the Bio-Medical Waste Management Rules; the Drugs and Cosmetics Act for kits and reagents; the Digital Personal Data Protection Act 2023, under which a test result is sensitive personal data; AERB where radioisotope assays are used; GST; and shops and establishments, EPF/ESI and POSH. Professional advice should be taken on registration by state, accreditation scope, PCPNDT applicability and data-protection obligations for results.

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