BUSINESS PLAN · INDIA

Preventive Health-Checkup Business

Where the customer is well, publish the PPV and drop what cannot clear it

DIAGNOSTIC LABS & IMAGING

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1. Executive Summary

This plan sets out a **Preventive Health-Checkup Business** in India — six screening centres and a mobile camp operation by Year 3, delivering corporate annual screening contracts, risk-stratified retail packages, follow-up and risk-management programmes, clinically justified comprehensive assessments, occupational and statutory screening, and aggregate population reporting to employers, across roughly 686,000 screenings a year.

> This plan inherits the diagnostics anchor's rules from `pathology-lab` and the actionability rule from `specialty-diagnostics`, and applies them to the one setting where the logic of testing inverts entirely. **Every other plan in this vertical tests people who are unwell. This one tests people who are fine.**

> □□ **A PREVENTIVE PACKAGE IS SOLD TO PEOPLE WITH NO SYMPTOMS, WHICH INVERTS THE ENTIRE LOGIC OF TESTING. In a symptomatic patient a positive result is usually true, because the pre-test probability is high. IN A WELL POPULATION WITH LOW PRE-TEST PROBABILITY, MOST POSITIVES ARE FALSE — and a sixty-test panel on a healthy forty-year-old is close to guaranteed to return something abnormal, because that is what sixty tests with ninety-five per cent reference intervals do. The package is then sold on precisely that property: "comprehensive", "everything checked", "peace of mind". THE FALSE POSITIVE IS NOT A DEFECT OF THE PACKAGE. IT IS ITS PRODUCT. It generates the follow-up consultation, the repeat test, the scan, the specialist referral, the months of worry, and — with remarkable reliability — next year's renewal. And nothing anywhere in the industry measures the downstream harm: NO OPERATOR IN INDIA PUBLISHES WHAT PROPORTION OF ITS ABNORMAL FINDINGS LED TO A REAL DIAGNOSIS RATHER THAN A CASCADE THAT ENDED IN NOTHING. So this business PUBLISHES POSITIVE PREDICTIVE VALUE PER TEST IN THE SCREENED POPULATION, DROPS TESTS WHOSE PPV FALLS BELOW A PUBLISHED THRESHOLD — 41 dropped in Year 3 — and TRACKS AND PUBLISHES THE CASCADE, following 96% of abnormal results to their outcome. WHERE THE CUSTOMER IS WELL, THE TEST'S VALUE IS NOT ITS ACCURACY BUT ITS PRE-TEST PROBABILITY — SO PUBLISH THE PPV AND DROP WHAT CANNOT CLEAR IT.**

> □□ **AND "COMPREHENSIVE" IS A HARM CLAIM DRESSED AS A BENEFIT. Bigger packages have lower yield and higher cascade cost, so panels here are STRATIFIED BY AGE, SEX AND RISK rather than by test count, NIL packages are marketed on the number of tests, and the AVERAGE PACKAGE FELL FROM 44 TESTS TO 29 while 48% of customers chose a smaller panel once shown the PPV data.**

> □□ **AND THE CORPORATE BUYER IS NOT THE PATIENT. NIL individual results reach the employer, aggregate reporting has a minimum group size of 25, and 100% of employees can decline a screening WITHOUT THE EMPLOYER KNOWING THEY DECLINED.**

This plan models an operator requiring **₹22.00 crore** (₹9.40 crore investor + ₹7.60 crore term loan + ₹3.20 crore promoter + ₹1.80 crore working capital), moving from **₹10.00 crore revenue and a ₹4.05 crore loss** to **₹62.00 crore revenue and ₹6.20 crore profit** by Year 3 — *a 10.0% net margin and 34.8% return on capital. (Preventive screening — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A screening business that measures what its findings led to.

Vision: To make positive predictive value the number a health package is sold on.

Mission: Publish the PPV of every test in the population we screen; drop what cannot clear the threshold; follow every abnormal result to its outcome and publish what we find; never give an employer an individual's result; and never sell a package on the number of tests in it.

Legal structure

- **Private Limited** — recommended. Corporate contracts, centre registration, accreditation and outside capital all assume it.
- **Clinical governance committee independent of corporate sales — because the panels a sales team can sell most easily are the ones with the worst yield.**
- **Employee data held under a contractual firewall from the paying employer — the buyer and the subject are different people, and the contract must say so before the first camp.**

> **Regulatory anchor:** the Clinical Establishments Act 2010 and state rules where adopted, with registration and minimum standards for screening centres; NABL accreditation for the laboratory component and AERB licensing for any X-ray or DEXA installation; the **Occupational Safety, Health and Working Conditions Code and the Factories Act, under which certain statutory examinations are MANDATORY for defined hazardous work — a genuinely different category from discretionary screening, and the only part of this business a regulator specifies at all**; the National Medical Commission's conduct regulations on referral commissions, binding on the doctor who receives; the **Digital Personal Data Protection Act 2023, under which an employee's health result is sensitive personal data and THE EMPLOYER IS NOT AUTOMATICALLY ENTITLED TO IT MERELY BECAUSE IT PAID FOR THE TEST**; consumer protection and ASCI rules on health claims in package advertising; Bio-Medical Waste Rules; GST; and EPF/ESI and POSH. **The decisive structural fact is that NOTHING REQUIRES A SCREENING BUSINESS TO KNOW, LET ALONE PUBLISH, WHETHER ITS TESTS FIND ANYTHING — a package may contain any test the operator wishes to sell, at any pre-test probability, with no obligation to measure what happened next.**

3. Promoter & Ownership

Led by a promoter with preventive health, corporate wellness or diagnostics background, with a physician as clinical director. Three competences decide outcomes. *Corporate contracting*, because 40% of revenue comes from employers buying on price per head and coverage breadth. *Camp and throughput operations*, since a thousand employees screened in three days is a logistics problem with a clinical layer. And *the willingness to shrink the package*, which is where this plan's proposition sits and which removes tests the market believes it is buying. Ownership, equity & investor terms are editable inputs; **the clinical governance committee is independent of corporate sales, holds authority to drop a test on PPV, and no employee's pay is linked to package size or test count.**

4. Market Analysis — India

A large and fast-growing market that has never been asked to show its results.

Demand drivers

- **Corporate wellness budgets** as an employee benefit and retention instrument.
- **Rising lifestyle-disease awareness** across urban middle-income households.
- **Insurance-linked screening** and pre-policy medical requirements.
- **Statutory occupational examinations** for defined hazardous work.
- **Ageing population** seeking reassurance and early detection.
- **Falling test cost** making broader packages affordable and therefore marketable.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian preventive and corporate health screening	Large and growing fast
SAM	**Tests whose PPV in a well population clears a published threshold**	**A smaller package than the market expects to buy**
SOM (Yr 1–3)	Screenings across six centres and camps	₹10cr → ₹62cr; 686,000 screenings; 74% repeat

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and who the customer actually is
Corporate annual screening contracts	**40.0%**	**44.0% — the employer pays; the employee is screened**
Retail packages, age/sex/risk-stratified	**25.0%**	**58.0% — sold on stratification, never on test count**
Follow-up consultation & risk-management programmes	13.0%	66.0% — where a finding becomes a plan, or is closed
Executive / comprehensive assessments	10.0%	52.0% — offered only where clinically justified
Occupational & statutory screening	8.0%	48.0% — mandated by law; the only prescribed testing here
Employer aggregate reporting & population analytics	4.0%	78.0% — aggregate only, minimum group size 25

> **The third row is the one that makes this model work rather than merely virtuous. Follow-up consultation at 66% margin is where an abnormal result becomes either a genuine care plan or an explicit closure — "this was a false positive, here is why, no further action" — and it is the only line in the business that pays us to CLOSE a cascade rather than extend one. Most operators leave the follow-up to somebody else, which is precisely why nobody knows what happens next. The fifth row is worth distinguishing carefully: statutory occupational examinations are MANDATED for defined hazardous work, have a clear regulatory purpose, and are the only testing in this book somebody other than us decided was necessary — so they are delivered to the letter and never bundled with discretionary tests, because mixing the two would let a commercial package ride on a legal obligation.**

Constraints

- **Corporate price-per-head competition**, where breadth is the visible differentiator.
- **Cascade tracking**, which requires following people who have left our care.
- **Camp throughput** against clinical quality on a three-day corporate screening.
- **Customer expectation** that more tests mean better value.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
National diagnostics chains' package businesses	Scale, price, brand, reach, aggressive package marketing	**Packages sold on test count; PPV never measured or published**
Hospital preventive health departments	Clinical credibility, specialist access, follow-up capability	Cascade drives hospital revenue; no incentive to close it

Corporate wellness platforms	Employer relationships, engagement tooling, aggregation	Test menu outsourced; data boundary with employer often blurred
Standalone screening centres	Price, convenience, local relationships	No governance; package composed by what sells
This plan	**PPV published, low-yield tests dropped, cascade tracked, employer firewall**	Sells a visibly smaller package than everyone else

The positioning has a specific commercial difficulty: we are selling less of a thing customers measure by volume. A corporate buyer comparing a 29-test package against a competitor's 62-test package at a similar price has an obvious conclusion available to him, and "our tests find things and theirs mostly do not" is a harder sentence than "sixty-two tests included". What makes it land is the published data: PPV per test in a screened population, the cascade outcome record showing what our abnormal findings actually led to, and the count of tests we dropped. 48% of retail customers choose a smaller panel once shown the PPV figures, which is the number that proves the disclosure works — and also concedes that 52% do not.

The cost of the honest position is stated in rupees rather than implied. Dropping 41 tests whose PPV fell below the published threshold, and shrinking the average package from 44 tests to 29, cost ₹4.28 crore of Year-3 revenue — the largest item, and the entire difference between this package and the market's. Paying no referral commission and permitting no package upselling at the collection point cost ₹1.42 crore. Tracking the cascade to outcome on 96% of abnormal results cost ₹1.24 crore. Giving employers nil individual results and making opt-out invisible to them cost ₹68 lakh in lost corporate contracts. Total ₹7.62 crore against ₹6.20 crore of profit — so an operator with the same six centres running trade-standard practice would earn ₹13.82 crore.

6. The Package Whose Product Is the False Positive

This is the finding, and it is a statistical property rather than a deception.

Tests in the panel	Chance at least one result falls outside the reference interval in a healthy person
1 test	~5%
10 tests	~40%
20 tests	~64%
40 tests	**~87%**
60 tests	**~95%**
What the package is marketed on	**The number in the left-hand column**

A reference interval is constructed to contain ninety-five per cent of a healthy population, which means one healthy person in twenty falls outside it on any single test BY DEFINITION AND BY DESIGN. Run sixty independent tests on a well forty-year-old and the arithmetic is not close: something will be abnormal, almost certainly, and the person will be told so. The package is then marketed on the very property that guarantees this — more tests, more comprehensive, better value — so THE THING BEING SOLD AND THE THING CAUSING THE HARM ARE THE SAME FEATURE. What follows is a cascade: a repeat test, a consultation, an ultrasound, a specialist opinion, occasionally a biopsy, and for most people several months of low-grade fear, ending in the

words "it's nothing". NOBODY LIES AT ANY POINT — every result was accurate, every reference interval correct, every follow-up recommendation defensible. And the commercial loop closes neatly: the cascade generates revenue for somebody, the relief of the eventual all-clear is experienced as value received, and the customer renews next year with the same package or a larger one. THE INDUSTRY HAS NEVER BEEN ASKED WHAT PROPORTION OF ITS ABNORMAL FINDINGS LED ANYWHERE, AND HAS THEREFORE NEVER FOUND OUT.

So the missing measurement is made and published. POSITIVE PREDICTIVE VALUE IS MEASURED PER TEST IN THE POPULATION WE ACTUALLY SCREEN — not the manufacturer's figure from a diseased cohort, which is a different number entirely — and PUBLISHED test by test. ANY TEST WHOSE PPV FALLS BELOW THE PUBLISHED THRESHOLD FOR ITS AGE AND RISK GROUP IS DROPPED FROM THE PANEL: 41 dropped by Year 3, and NIL tests are sold whose PPV we have not measured. THE CASCADE IS TRACKED AND PUBLISHED — 96% of abnormal results followed to outcome, with 31.2% leading to a real diagnosis and 68.8% ending in nothing after further testing, at a median null-cascade cost of ₹5,400 borne by the customer. That 68.8% is an uncomfortable number to print and is printed anyway, because a screening business that will not say how often it frightened somebody for nothing has not measured its own product. WHERE THE CUSTOMER IS WELL, THE TEST'S VALUE IS NOT ITS ACCURACY BUT ITS PRE-TEST PROBABILITY — SO PUBLISH THE PPV AND DROP WHAT CANNOT CLEAR IT.

7. Comprehensiveness, the Employer and the Incidental Finding

Three further rules, the first of which inverts the category's principal sales claim.

"COMPREHENSIVE" IS A HARM CLAIM DRESSED AS A BENEFIT. Every additional test in a well population adds a small probability of a true finding and a much larger probability of a false one, so a bigger package is not a better package — IT IS A PACKAGE WITH LOWER YIELD AND HIGHER CASCADE COST, sold at a higher price on the strength of the word. So PANELS ARE STRATIFIED BY AGE, SEX AND RISK rather than assembled by test count, NIL PACKAGES ARE MARKETED ON THE NUMBER OF TESTS THEY CONTAIN, and the AVERAGE PACKAGE FELL FROM 44 TESTS TO 29 across three years while yield per package rose. 48% of retail customers choose a smaller panel once shown the PPV data — and the honest reading of that figure is that a majority still do not, which is why the stratification is built into the product rather than left to the customer's choice.

AND THE CORPORATE BUYER IS NOT THE PATIENT. Per the corporate-canteen rule, an employer pays for the screening, receives the invoice, negotiates the package and quite reasonably expects to know what it bought — while the person on the table is an employee whose blood pressure, liver function, HIV status and mental-health screen are nobody's business but his own. So NIL INDIVIDUAL RESULTS ARE SHARED WITH AN EMPLOYER in any form, aggregate reporting carries a MINIMUM GROUP SIZE OF 25 so no individual can be inferred from a small department, and 100% OF EMPLOYEES CAN DECLINE A SCREENING WITHOUT THE EMPLOYER LEARNING THAT THEY DECLINED — which is the part that costs contracts, because attendance data is exactly what a wellness manager wants. Statutory occupational examinations are the sole exception and are handled under their own legal basis, separately and explicitly.

AND A BUNDLED SCAN FINDS THINGS NOBODY WAS LOOKING FOR. Per the imaging-centre rule, an incidental finding reported without guidance generates its own momentum — so reports state explicitly "NO FURTHER IMAGING INDICATED" where that is true, "NO CLINICAL ACTION IS INDICATED BY THIS RESULT" per the specialty-diagnostics rule, and EVERY ABNORMAL RESULT CARRIES A NAMED NEXT STEP rather than an instruction to consult somebody.

> **AND THE ANCHOR'S COMMISSION RULE APPLIES UNCHANGED. NIL referral commission is paid to any doctor, clinic, corporate intermediary or wellness consultant, and NIL package upselling occurs at the collection point — because a customer already gowned and cannulated is in no position to evaluate an offer.**

8. Operations Plan (stratify, screen, close, publish)

Package design

- **PPV measured per test in our own screened population**, not from manufacturer literature.
- **Tests below the published PPV threshold dropped** — 41 by Year 3.
- **Panels stratified by age, sex and risk**; nil marketing on test count.
- **Clinical governance committee independent of corporate sales**, able to drop a test outright.

The cascade

- **Every abnormal result followed to outcome** — 96% closure in Year 3.
- **Cascade results published** — proportion leading to diagnosis, proportion ending in nothing.
- **Median null-cascade cost published**, because the customer bears it.
- **Follow-up consultation paid to close a cascade**, not only to extend one.

The employer boundary

- **Nil individual results shared with an employer**, in any form, ever.
- **Aggregate reporting with a minimum group size of 25.**
- **Opt-out invisible to the employer**; attendance never reported by name.
- **Statutory occupational examinations handled separately** under their own legal basis.

Reporting

- **"No clinical action is indicated by this result" printed where true.**
- **"No further imaging indicated" on incidental findings**, per the imaging rule.
- **Every abnormal result carries a named next step**, not a general instruction.
- **Nil referral commission; nil upselling at the collection point.**

> **The operational hinge is a 4,000-employee corporate tender scored on a matrix with a column headed "number of parameters", where our 29-test stratified package scores below a competitor's 62-test bundle at a marginally higher price — and the HR head, who is sympathetic, explains that his committee will see a table and that "we found fewer false alarms" does not fit in a cell. So THE TENDER RESPONSE CARRIES THE PPV DATA AND THE CASCADE OUTCOME RECORD AS THE COMPETING NUMBER, with the plain statement that a 62-test panel will return an abnormal result in roughly nineteen of every twenty healthy employees — and we lose some of these. The system refuses rather than warns: a test below its PPV threshold cannot be added to a package in the quotation system at all, so a bid cannot be widened under deadline pressure, and NO CORPORATE SALES PAY IS LINKED TO PACKAGE SIZE OR TEST COUNT.**

9. Registration, Occupational Health & Data Compliance (India)

- **Clinical Establishments Act 2010** and state rules where adopted, with registration and minimum standards for screening centres.
- **NABL accreditation** for the laboratory component; **AERB licensing** for any X-ray or DEXA installation.
- **Occupational Safety, Health and Working Conditions Code and the Factories Act — certain examinations are MANDATORY for defined hazardous work, a genuinely different category from discretionary screening, and the only part of this business a regulator specifies at all.**
- **NMC conduct regulations** on referral commissions — binding on the doctor who receives, not the centre that pays.
- **Digital Personal Data Protection Act 2023 — an employee's health result is sensitive personal data, and THE EMPLOYER IS NOT AUTOMATICALLY ENTITLED TO IT MERELY BECAUSE IT PAID FOR THE TEST.**
- **Consumer protection and ASCI rules** on health claims in package advertising, where "comprehensive" sits uncomfortably close to a claim.
- **Bio-Medical Waste Rules**, including at mobile camps; GST; EPF/ESI and POSH.
- **The gap — nothing requires a screening business to know, let alone publish, whether its tests find anything: a package may contain any test the operator wishes to sell, at any pre-test probability, with no obligation to measure what happened next.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owns the PPV threshold
Physicians & nurses	28	86	**Follow-up closes cascades as well as opening them**
Technicians, phlebotomy & imaging	22	68	Six centres plus mobile camps
Field & camp operations	16	52	A thousand employees in three days
Corporate sales & account management	10	28	**Nil pay linked to package size or test count**
Finance, legal, compliance & admin	8	21	Holds the employer data firewall
Clinical governance, PPV & cascade tracking	5	18	**Independent of sales; can drop a test outright**
Technology, reporting & aggregate analytics	6	16	Minimum group size enforced in the system
Total	**96**	**290**	Governance and cascade tracking at 6%

> **Eighteen people on clinical governance, PPV measurement and cascade tracking is a function that exists nowhere else in this category, and its work product is almost entirely negative: it removes tests, shrinks packages and publishes uncomfortable outcome data. It reports independently of corporate sales, because the panels a sales team can sell most easily are precisely the ones with the worst yield, and because dropping a test removes revenue from somebody's target. The physician and nursing line at 86 is heavier than a throughput-optimised operator needs, and the reason sits in the follow-up stream: closing a cascade properly — explaining to a frightened person why a result was a false alarm and why nothing further is needed — takes longer than opening one, and nobody else is paid to do it.**

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & first centres	Month 0–8	Incorporation, registration, two centres, laboratory linkage
PPV baseline study	Month 3–12	**PPV measured in our own screened population, test by test**
Package restratification	Month 10–18	26 tests dropped; average package 44 → 36; PPV published
Cascade tracking programme	Month 12–24	Abnormal results followed to outcome; first cascade data published
Corporate scale & data firewall	Month 14–28	Minimum group size in system; opt-out invisible to employer
Scale & publication	Month 26–36	686,000 screenings; 41 tests dropped; 68.8% null-cascade rate published

Training and competence

- **Explaining a false positive** without either dismissing the person or extending the cascade.
- **Selling a smaller package** against a competitor's larger one, using PPV data.
- **The employer boundary** — declining a wellness manager's reasonable-sounding request for names.
- **Camp throughput without shortcuts**, where a thousand people in three days invites them.

12. Financial Plan (Illustrative)

> **All figures are illustrative model assumptions, not forecasts or guarantees.** They exist to show the drivers of a preventive screening P&L and how the PPV, cascade and data-boundary disciplines move them. Every input is editable. **The defining economics are that this business deliberately sells a smaller product than its competitors at a similar price, and funds the difference through follow-up consultation, corporate retention and a cost base that is not carrying an unmeasured cascade.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Centre build-out & clinical equipment (6 centres)	748	Consultation capacity, not only throughput
Imaging & cardiac equipment (ECG, TMT, USG, DEXA)	462	AERB licensing where applicable
Working capital — corporate receivables	396	Employers settle at 60–90 days
Technology, reporting, cascade tracking & analytics	**264**	**Minimum group size enforced in the system**
Mobile camp units & field equipment	176	Corporate screening at employer premises
Clinical governance, PPV study & protocol development	**110**	**Measuring what nobody in the category measures**
Licences, accreditation, deposits & pre-operative	44	Registration, NABL, AERB
Total project cost	**2,200**	₹940L investor + ₹760L term loan + ₹320L promoter + ₹180L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
POSITIVE PREDICTIVE VALUE PUBLISHED PER TEST in OUR OWN screened population / **tests DROPPED because PPV fell below the published threshold** / **tests sold whose PPV we have not measured** / revenue forgone (₹cr)	100% / 26 / NIL / 0.86	100% / 34 / NIL / 2.14	**100% / 41 / NIL / 4.28**
THE CASCADE TRACKED — abnormal results followed to OUTCOME / **proportion that led to a real diagnosis** / **proportion that ended in NOTHING after further testing** / median cost of a null cascade, borne by the customer	78% / 21.4% / 78.6% / ₹6,800	89% / 26.8% / 73.2% / ₹6,200	**96% / 31.2% / 68.8% / ₹5,400**
Panels STRATIFIED BY AGE, SEX AND RISK rather than by test count / **packages marketed on the NUMBER OF TESTS** / **average tests per package (falling)** / customers choosing a smaller panel once shown PPV	100% / NIL / 44 / 34%	100% / NIL / 36 / 41%	**100% / NIL / 29 / 48%**
INDIVIDUAL RESULTS SHARED WITH AN EMPLOYER / aggregate reporting minimum group size / **employees able to decline WITHOUT THE EMPLOYER LEARNING THEY DECLINED** / attendance reported by name	NIL / 25 / 100% / NIL	NIL / 25 / 100% / NIL	**NIL / 25 / 100% / NIL**
"NO CLINICAL ACTION IS INDICATED BY THIS RESULT" printed where true / **"no further imaging indicated" on incidental findings** / abnormal results carrying a NAMED next step	100% / 100% / 100%	100% / 100% / 100%	**100% / 100% / 100%**
REFERRAL COMMISSION paid (vertical anchor) / **package upselling at the collection point** / screenings / corporate share of revenue / repeat rate	NIL / NIL / 118k / 40% / 52%	NIL / NIL / 342k / 40% / 64%	**NIL / NIL / 686k / 40% / 74%**

> **Row two contains the number this entire plan exists to produce, and it is not a flattering one: 68.8% OF OUR ABNORMAL FINDINGS ENDED IN NOTHING after further testing. It is printed anyway, because a screening business that will not say how often it frightened somebody for nothing has not measured its own product — and the improvement from 78.6% is the evidence that dropping low-PPV tests works. The median null-cascade cost of ₹5,400 is stated because THE CUSTOMER BEARS IT, not us, and a package price that excludes the predictable downstream cost is not the real price. Row three's average package falling from 44 tests to 29 is an inverted metric of the sort this library has used before — a number every competitor would be alarmed to see fall. Row four's opt-out figure is the one that loses contracts, because attendance data is exactly what a wellness manager wants and exactly what an employee's participation should not depend on.**

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Corporate annual screening contracts	400	1,200	2,480	**44.0%**
Retail packages, age/sex/risk-stratified	250	750	1,550	**58.0%**
Follow-up consultation & risk-management programmes	130	390	806	66.0%
Executive / comprehensive assessments	100	300	620	52.0%
Occupational & statutory screening	80	240	496	48.0%
Employer aggregate reporting & population analytics	40	120	248	78.0%

Total revenue	**1,000**	**3,000**	**6,200**	**52.8% blended**

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	1,000	3,000	6,200
Cost of screening — reagents, consumables & outsourced tests	(472)	(1,415)	(2,924)
Gross profit	**528**	**1,585**	**3,276**
Clinical staff — physicians, nurses & technicians	**(268)**	**(428)**	**(682)**
Centre premises, equipment & running	(168)	(248)	(372)
Field & camp operations	(112)	(186)	(285)
Clinical governance, PPV & cascade tracking	**(96)**	**(162)**	**(248)**
Marketing & corporate sales	(96)	(148)	(217)
Technology, reporting & analytics	(72)	(102)	(149)
Admin, legal, compliance & other	(86)	(126)	(186)
EBITDA	**(370)**	**185**	**1,137**
Depreciation & amortisation	(168)	(268)	(372)
Finance cost	(62)	(96)	(124)
Other income — corporate programme fees and analytics licensing *(disclosed)*	60	120	186
PBT	**(540)**	**(59)**	**827**
Tax	135	15	(207)
PAT	**(405)**	**(44)**	**620**
Net margin	**(40.5%)**	**(1.5%)**	**10.0%**
ROCE	**(24.5%)**	**(3.8%)**	**34.8%**

The follow-up consultation stream at ₹8.06 crore and 66% margin is the line that makes this model financially coherent, and it deserves a caveat rather than a boast: a business that earns from follow-up has an obvious interest in generating findings to follow up. That is precisely why the PPV threshold sits with a governance committee outside sales, why the cascade outcome is published, and why the null-cascade proportion is reported at all — the disclosure exists to constrain the incentive the revenue line creates. Clinical governance and cascade tracking at ₹2.48 crore is 4.0% of revenue spent measuring something no competitor measures. Other income of ₹1.86 crore is corporate programme fees and analytics licensing, disclosed as a line and never derived from individual-level employee data. Commitments of ₹7.62 crore against ₹6.20 crore of profit mean an operator with the same six centres running trade-standard practice would earn ₹13.82 crore.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment

Base	₹62.0cr	₹6.20cr	As modelled, 29-test average package
Trade-standard practice	₹67.7cr	₹13.82cr	**No PPV threshold, no cascade tracking, commission paid**
Packages sold on test count without a PPV threshold	₹66.3cr	₹8.89cr	Bigger package, worse yield, higher price
Corporate book doubles	₹86.8cr	₹11.23cr	Operating leverage sits in camp delivery
A quarter of the corporate book lost	₹55.8cr	₹4.75cr	**The data-firewall position costs contracts**
Repeat rate falls to 60%	₹56.4cr	₹4.66cr	Retention, not acquisition, is the business

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	940	Centre rollout; PPV-threshold and data-firewall covenants
Term loan	760	Centres, equipment and camp units; 5–6 years
Promoter contribution	320	Cash and corporate relationships
Working capital facility	180	Corporate receivables at 60–90 days
Total	**2,200**	Illustrative structure

> **A lender should read repeat rate, corporate concentration and the cascade outcome series, and should treat the last of these as an asset rather than a curiosity. Repeat rate at 74% is what this business runs on — a screening customer who returns annually is worth several years of predictable revenue, and retention rather than acquisition is where the growth comes from, which is why a fall to 60% takes profit to ₹4.66 crore. Corporate concentration is the sharper exposure: losing a quarter of the corporate book takes profit to ₹4.75 crore, and the data-firewall position is a genuine reason contracts are lost, since attendance and individual results are precisely what some wellness managers want. The PPV threshold deserves a covenant because relaxing it would add revenue immediately, would look like better value to every buyer, and would be invisible in every financial statement.**

- **Use of funds** — 34% centre build-out, 21% imaging and cardiac equipment, 18% working capital, 12% technology and cascade tracking, 8% mobile camp units, 5% clinical governance and PPV study, 2% licences.
- **Repayment** — term loan from Year 3 cash flow; working capital revolving against corporate receivables.
- **Investor exit** — sale to a diagnostics chain, a hospital group or a corporate wellness platform; or promoter buyback. **PPV-threshold and data-firewall commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation

The package whose product is the false positive	A reference interval is built to contain 95% of a healthy population, so ONE HEALTHY PERSON IN TWENTY FALLS OUTSIDE IT ON ANY SINGLE TEST BY DEFINITION AND BY DESIGN. Run 60 tests on a well 40-year-old and SOMETHING WILL BE ABNORMAL, ALMOST CERTAINLY — and the package is MARKETED ON THE VERY PROPERTY THAT GUARANTEES THIS, so THE THING BEING SOLD AND THE THING CAUSING THE HARM ARE THE SAME FEATURE. What follows is a cascade: a repeat test, a consultation, an ultrasound, a specialist opinion, occasionally a biopsy, and for most people SEVERAL MONTHS OF LOW-GRADE FEAR ENDING IN THE WORDS "IT'S NOTHING". NOBODY LIES AT ANY POINT — every result accurate, every reference interval correct, every follow-up defensible. And the commercial loop closes neatly: THE CASCADE GENERATES REVENUE FOR SOMEBODY, THE RELIEF OF THE EVENTUAL ALL-CLEAR IS EXPERIENCED AS VALUE RECEIVED, AND THE CUSTOMER RENEWS NEXT YEAR WITH THE SAME PACKAGE OR A LARGER ONE. THE INDUSTRY HAS NEVER BEEN ASKED WHAT PROPORTION OF ITS ABNORMAL FINDINGS LED ANYWHERE, AND HAS THEREFORE NEVER FOUND OUT	**MAKE AND PUBLISH THE MISSING MEASUREMENT. PPV MEASURED PER TEST IN THE POPULATION WE ACTUALLY SCREEN — NOT THE MANUFACTURER'S FIGURE FROM A DISEASED COHORT, WHICH IS A DIFFERENT NUMBER ENTIRELY — and published test by test. ANY TEST BELOW THE PUBLISHED PPV THRESHOLD FOR ITS AGE AND RISK GROUP IS DROPPED (41 by Yr3), with NIL tests sold whose PPV we have not measured. THE CASCADE TRACKED AND PUBLISHED: 96% of abnormal results followed to outcome, 31.2% leading to a real diagnosis and 68.8% ENDING IN NOTHING, at a median null-cascade cost of ₹5,400 BORNE BY THE CUSTOMER. THAT 68.8% IS PRINTED ANYWAY, BECAUSE A SCREENING BUSINESS THAT WILL NOT SAY HOW OFTEN IT FRIGHTENED SOMEBODY FOR NOTHING HAS NOT MEASURED ITS OWN PRODUCT (₹4.28cr). GENERAL RULE: WHERE THE CUSTOMER IS WELL, THE TEST'S VALUE IS NOT ITS ACCURACY BUT ITS PRE-TEST PROBABILITY — SO PUBLISH THE PPV AND DROP WHAT CANNOT CLEAR IT**
The tender with a "number of parameters" column	A 4,000-employee tender scored on a matrix where our 29-test stratified package SCORES BELOW A COMPETITOR'S 62-TEST BUNDLE at a marginally higher price — and the HR head, WHO IS SYMPATHETIC, explains that his committee WILL SEE A TABLE and that "we found fewer false alarms" DOES NOT FIT IN A CELL	**THE TENDER RESPONSE CARRIES THE PPV DATA AND THE CASCADE OUTCOME RECORD AS THE COMPETING NUMBER, with the plain statement that A 62-TEST PANEL WILL RETURN AN ABNORMAL RESULT IN ROUGHLY NINETEEN OF EVERY TWENTY HEALTHY EMPLOYEES — AND WE LOSE SOME OF THESE (a quarter of the corporate book lost takes profit to ₹4.75cr). THE SYSTEM REFUSES RATHER THAN WARNS: a test below its PPV threshold CANNOT BE ADDED TO A PACKAGE IN THE QUOTATION SYSTEM AT ALL, so a bid cannot be widened under deadline pressure; and NO CORPORATE SALES PAY IS LINKED TO PACKAGE SIZE OR TEST COUNT**

"Comprehensive" is a harm claim dressed as a benefit	Every additional test in a well population adds A SMALL PROBABILITY OF A TRUE FINDING AND A MUCH LARGER PROBABILITY OF A FALSE ONE, so a bigger package is NOT A BETTER PACKAGE — IT IS A PACKAGE WITH LOWER YIELD AND HIGHER CASCADE COST, SOLD AT A HIGHER PRICE ON THE STRENGTH OF THE WORD	**PANELS STRATIFIED BY AGE, SEX AND RISK rather than assembled by test count; NIL packages marketed on the NUMBER of tests; AVERAGE PACKAGE FELL 44 → 29 WHILE YIELD PER PACKAGE ROSE — an inverted metric every competitor would be alarmed to see fall; 48% of retail customers choose a smaller panel once shown PPV, AND THE HONEST READING IS THAT A MAJORITY STILL DO NOT, WHICH IS WHY THE STRATIFICATION IS BUILT INTO THE PRODUCT RATHER THAN LEFT TO THE CUSTOMER'S CHOICE**
The corporate buyer is not the patient	The employer pays, receives the invoice, negotiates the package and QUITE REASONABLY EXPECTS TO KNOW WHAT IT BOUGHT — while the person on the table is an employee whose BLOOD PRESSURE, LIVER FUNCTION, HIV STATUS AND MENTAL-HEALTH SCREEN ARE NOBODY'S BUSINESS BUT HIS OWN. Under DPDP the employer IS NOT AUTOMATICALLY ENTITLED TO A RESULT MERELY BECAUSE IT PAID FOR THE TEST	**NIL INDIVIDUAL RESULTS SHARED WITH AN EMPLOYER IN ANY FORM, EVER; aggregate reporting with a MINIMUM GROUP SIZE OF 25 so no individual can be inferred from a small department; and 100% OF EMPLOYEES ABLE TO DECLINE WITHOUT THE EMPLOYER LEARNING THEY DECLINED — THE PART THAT COSTS CONTRACTS, BECAUSE ATTENDANCE DATA IS EXACTLY WHAT A WELLNESS MANAGER WANTS (₹68L). Statutory occupational examinations are the SOLE exception, handled under their own legal basis, separately and explicitly**
The incidental finding and the follow-up incentive	A bundled scan finds things NOBODY WAS LOOKING FOR and an incidental finding reported without guidance GENERATES ITS OWN MOMENTUM; and a business earning from follow-up HAS AN OBVIOUS INTEREST IN GENERATING FINDINGS TO FOLLOW UP	"NO FURTHER IMAGING INDICATED" and "NO CLINICAL ACTION IS INDICATED BY THIS RESULT" printed where true; every abnormal result carrying A NAMED NEXT STEP rather than an instruction to consult somebody; and THE PPV THRESHOLD HELD BY A GOVERNANCE COMMITTEE OUTSIDE SALES WITH THE CASCADE OUTCOME PUBLISHED — THE DISCLOSURE EXISTS PRECISELY TO CONSTRAIN THE INCENTIVE THE FOLLOW-UP REVENUE LINE CREATES
Camp throughput and quality	A thousand employees screened in three days invites shortcuts in consent, history-taking, blood pressure technique and sample handling, none of which anybody would ever see	Camp staffing ratios fixed rather than flexed to the booking; pre-analytical discipline per the vertical anchor with rejection rates published per camp and ZERO READINGS INVESTIGATED; consent and history taken by clinical staff rather than by registration desks; and no camp accepted whose headcount exceeds the staffing available on the days offered
Corporate concentration and receivables	40% of revenue from corporate contracts settling at 60–90 days; losing a quarter of the book takes profit to ₹4.75cr, and the data-firewall position is a genuine reason contracts are lost	Retail and follow-up streams grown to 38% of revenue as employer-independent income; corporate contracts staggered by renewal date; the data firewall stated in the contract BEFORE the first camp rather than discovered at reporting; credit terms tightened for new corporate accounts; and contribution reported per stream so a shrinking corporate book is visible early

Customer expectation and repeat rate	The market measures value by test count, and a repeat rate falling to 60% takes profit to ₹4.66cr — retention, not acquisition, is where this business lives	PPV and cascade data used as the retention argument rather than package size; follow-up consultation included so the relationship survives the report; risk-management programmes for genuinely abnormal findings; annual stratification updated with age and risk so the package changes as the customer does; and honest acknowledgement in marketing that a smaller panel is the point rather than a cost saving

15. SWOT Analysis

Strengths

- PPV published per test in our own screened population
- 41 low-yield tests dropped; nil unmeasured tests sold
- Cascade tracked to outcome on 96%; 68.8% null rate published
- Average package cut from 44 tests to 29
- Nil individual results to employers; opt-out invisible

Weaknesses

- ₹7.62cr forgone against ₹6.20cr of profit
- Sells a visibly smaller package than every competitor
- Loses tenders scored on parameter count
- Follow-up revenue creates an incentive to be constrained

Opportunities

- Corporate buyers who must justify a wellness spend
- Customers who have been through a null cascade once
- Follow-up and risk-management as retention revenue
- Aggregate population analytics with no individual data
- Any regulation of package claims or PPV favours us

Threats

- Competitors selling test count as comprehensiveness
- Corporate concentration and the data-firewall cost
- Repeat-rate erosion on price comparison
- Clinical staff cost in a consultation-heavy model

16. Recommended AiSevak Tools for This Business

- **PPV register** — measured per test in our own screened population, published, with threshold enforcement.
- **Package composer** — a test below threshold cannot be added to any quotation or package.
- **Cascade tracker** — every abnormal result followed to outcome, with null-cascade rate and cost published.
- **Stratification engine** — panels built from age, sex and risk rather than from a price point.
- **Employer firewall** — minimum group size enforced in the system; opt-out never visible to the buyer.
- **Actionability statements** — "no clinical action indicated" and "no further imaging indicated" where true.
- **Camp staffing guard** — a booking cannot exceed the clinical staffing available on the days offered.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, screening volumes, package sizes, PPV thresholds and cascade rates are editable inputs; actual outcomes depend on corporate contracting, clinical staffing and customer acceptance of smaller panels. Figures are in Indian rupees. **This plan inherits the diagnostics anchor's rules from `pathology-lab`, the actionability rule from `specialty-diagnostics`, the incidental-finding rule from `diagnostic-imaging-centre`, and the buyer-is-not-the-consumer rule from `corporate-canteen`.**

- **The central integrity finding is that a preventive package is sold to people with no symptoms, which inverts the entire logic of testing.** A reference interval is constructed to contain ninety-five per cent of a healthy population, so one healthy person in twenty falls outside it on any single test by definition and by design — and running sixty tests on a well forty-year-old makes an abnormal result close to certain. **The package is then marketed on the very property that guarantees this, so the thing being sold and the thing causing the harm are the same feature. The false positive is not a defect of the package; it is its product.** What follows is a cascade — repeat test, consultation, ultrasound, specialist opinion, occasionally a biopsy, and for most people several months of low-grade fear ending in the words "it's nothing". Nobody lies at any point: every result accurate, every reference interval correct, every follow-up defensible. **And the commercial loop closes neatly, because the cascade generates revenue for somebody, the relief of the eventual all-clear is experienced as value received, and the customer renews next year with the same package or a larger one.**
- **So the missing measurement is made and published.** Positive predictive value is measured per test in the population we actually screen — not the manufacturer's figure from a diseased cohort, which is a different number entirely — and published test by test. Any test below the published threshold for its age and risk group is dropped, 41 by Year 3, with nil tests sold whose PPV we have not measured. **The cascade is tracked and published: 96% of abnormal results followed to outcome, 31.2% leading to a real diagnosis and 68.8% ending in nothing after further testing, at a median null-cascade cost of ₹5,400 borne by the customer rather than by us. That 68.8% is uncomfortable to print and is printed anyway, because a screening business that will not say how often it frightened somebody for nothing has not measured its own product. WHERE THE CUSTOMER IS WELL, THE TEST'S VALUE IS NOT ITS ACCURACY BUT ITS PRE-TEST PROBABILITY — SO PUBLISH THE PPV AND DROP WHAT CANNOT CLEAR IT.**
- **"Comprehensive" is a harm claim dressed as a benefit.** Every additional test in a well population adds a small probability of a true finding and a much larger probability of a false one, so a bigger package has lower yield and higher cascade cost while commanding a higher price. **Panels are therefore stratified by age, sex and risk rather than assembled by test count, nil packages are marketed on the number of tests, and the average package fell from 44 tests to 29 while yield per package rose.** 48% of retail customers choose a smaller panel once shown the PPV data — and the honest reading is that a majority still do not, which is why the stratification is built into the product rather than left to the customer's choice.
- **The corporate buyer is not the patient.** An employer pays, receives the invoice, negotiates the package and quite reasonably expects to know what it bought, while the person on the table is an employee whose blood pressure, liver function, HIV status and mental-health screen are nobody's business but his own — and under the DPDP Act the employer is not automatically entitled to a result merely because it paid for the test. **So nil individual results are shared with an employer in any form, aggregate reporting carries a minimum group size of 25 so no individual can be inferred from a small department, and 100% of employees can decline without the employer learning they declined — which is the part that costs contracts, because attendance data is exactly what a wellness manager wants.** Statutory occupational examinations are the sole exception, handled separately under their own legal basis, because mixing them with discretionary tests would let a commercial package ride on a legal obligation.
- **The follow-up stream deserves a caveat rather than a boast.** Follow-up consultation at ₹8.06 crore and 66% margin is where an abnormal result becomes either a genuine care plan or an explicit closure, and it is the only line in the business paid to CLOSE a cascade rather than extend one — most operators leave follow-up to somebody else, which is precisely why nobody knows what happens next. **But a business earning from follow-up has an obvious interest in generating findings to follow up, which is exactly why the PPV threshold sits with a governance committee outside sales, why the cascade outcome is published, and why the null-cascade proportion is reported at all: the disclosure exists to constrain the incentive the revenue line creates.**

- **The economics are a deliberately smaller product sold at a similar price.** Clinical governance and cascade tracking at ₹2.48 crore is 4.0% of revenue spent measuring what no competitor measures, and the physician and nursing line is heavier than a throughput-optimised operator needs because closing a cascade properly takes longer than opening one. **Commitments of ₹7.62 crore against ₹6.20 crore of profit mean an operator with the same six centres running trade-standard practice would earn ₹13.82 crore.** Repeat rate at 74% is what the business runs on, corporate concentration at 40% is the sharper exposure, and losing a quarter of the corporate book takes profit to ₹4.75 crore — with the data-firewall position a genuine and stated reason some of those contracts go elsewhere.
- **Compliance and professional advice.** The Clinical Establishments Act 2010 and state rules with registration and minimum standards; NABL accreditation for the laboratory component and AERB licensing for X-ray or DEXA installations; **the Occupational Safety, Health and Working Conditions Code and the Factories Act, under which certain examinations are mandatory for defined hazardous work — a genuinely different category from discretionary screening and the only part of this business a regulator specifies at all**; NMC conduct regulations on referral commissions; **the Digital Personal Data Protection Act 2023, under which an employee's health result is sensitive personal data and the employer is not automatically entitled to it merely because it paid for the test**; consumer protection and ASCI rules on health claims in package advertising; Bio-Medical Waste Rules including at mobile camps; GST; and EPF/ESI and POSH. **Nothing requires a screening business to know, let alone publish, whether its tests find anything — which is why the commitments above are business decisions rather than compliance ones.** Professional advice should be taken on centre registration, statutory examination scope, employer data boundaries and package advertising claims.

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