CRISIL

An S&P Global Company

ViewCube

February 2020

Hospitals

On the mend

Demand potential healthy

Regulatory action a key monitorable

ViewCube is a compilation of sector views expressed during CRISIL's webinars. These include CRISIL's own views, that of stakeholders, and those emanating from a poll done during the webinar.

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Our view

Healthcare demand on an upward curve

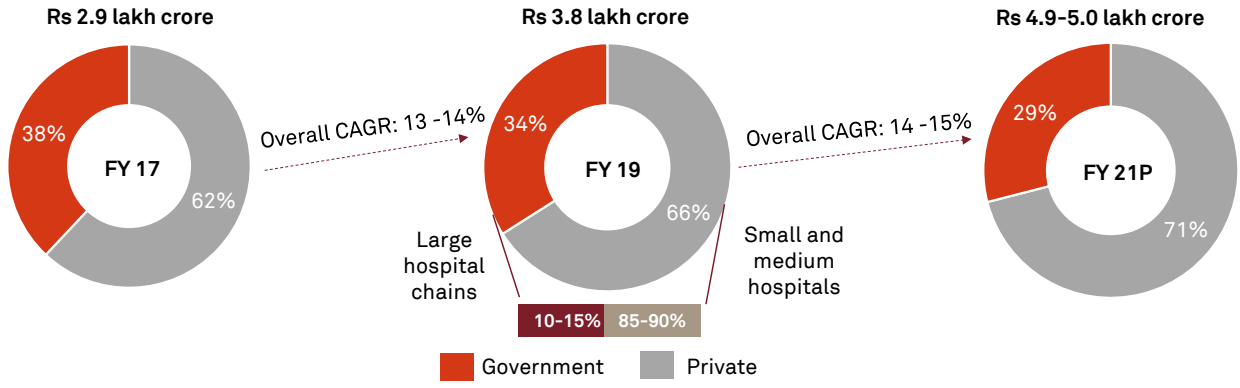
In the past two years, the hospital industry in India clocked a healthy 13-14% compound annual growth rate (CAGR), driven by deeper penetration of healthcare insurance, increasing incidence of non-communicable diseases, growth in urbanisation and awareness, and booming medical tourism.

In the two years through fiscal 2021, growth is expected to improve to 14-15%, given favourable demographics, tailwinds in the form of focused expansion of large corporates with adjusted business models into Tier II cities, and demand impetus on account of Ayushman Bharat.

The Rs 3.8 lakh crore industry (estimated as of fiscal 2019) includes inpatient treatments (~70% value share) and outpatient consultations (~30%).

The government's share of the industry is estimated at 34%, while the private sector commands the lion's share at 66%. Within the private sector, small and medium hospitals dominate (85-90%) and large hospitals account for only 10-15%, indicating the highly fragmented nature of the industry.

Healthcare delivery market



Note: P: Projected
Source: CRISIL Research

Growth impetus

Structural growth to continue	Improving insurance penetration	Increasing incidence of NCDs	Ageing population	Booming medical tourism
Players' initiatives to penetrate Tier II	Expansion beyond top metros to continue	Adoption of new business models		
Ayushman Bharat	Improved coverage	Improved access	Volume growth to aid utilisation	

Note- NCD refers to non-communicable diseases

Fundamental factors will continue to drive growth

Owing to increasing life expectancy, population in the age group of 60+ is likely to increase at a faster pace. This populace requires higher healthcare services in the form of support of intensive care units, specialised technologies, and home care services.

In addition, the 21-59-year-olds have started realising the importance of preventive and wellness health check-ups, thus supporting early detection and treatment of diseases.

Further, increasing incidence of lifestyle-related diseases has become a big concern. Of the total deaths in India in 2016, almost 63% was caused by lifestyle-related diseases. And, of the 7 crore population screened over the past four years, almost 9-10% had diabetes or hypertension.

Additionally, India has witnessed robust inflow of tourists for medical needs, thanks to availability of quality care at affordable prices.

Most medical tourists come from South Asian countries, mainly because average treatment cost in India is ~30% lower than in Korea, Thailand and Singapore, to name a few countries.
Key hospitals in Bengaluru, Delhi, Mumbai, Chennai, and Kolkata are gaining from growth in medical tourism.

Insurance penetration also augurs well for growth of the industry.

As of fiscal 2018, almost 38% of India's population was covered by some form of insurance. Within this, 28% was covered by government schemes, 7% by corporate and 3% by individual schemes.

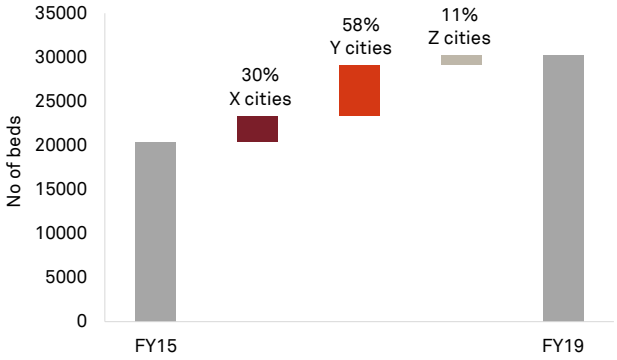
Including the population covered under the government's trust model, overall health coverage is ~60%.

Penetration into Tier II and III locations aiding growth momentum

In terms of supply creation, major hospital chains have expanded into the next level of creamy Tier II and III cities. This is evident from the fact that almost 70% aggregate bed additions by 10 large hospital players in the past four years was in these areas. Given the significantly lower revenue per bed in these locations, players had to adjust their business models, such as a hub and spoke model, along with tight control on operating costs.

Players have adopted multiple business models, including leased, operating and management models for expansion in Tier II locations, which helps reduce capital expenditure (capex) and minimises breakeven timelines.

Large hospitals added 70% of incremental beds in Tier II and III locations (under owned and leased models) in last four fiscals



Note: Based on city category classification followed by 7th Pay Commission, Tier I - X cities (top 8 cities), Tier II – Y cities (next 88 cities), Tier III – Z cities (the remaining cities)

Innovative business models help penetrate Tier II cities

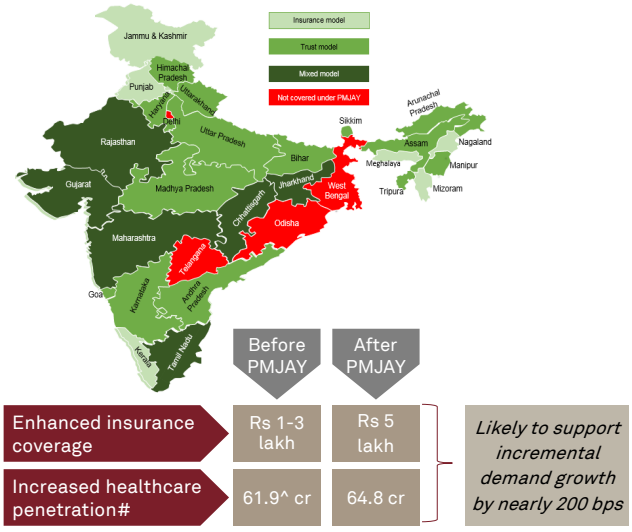
	Owned hospital		Leased model	O&M model
Structure	• Company constructs the hospital structure and building, and also installs the medical equipment • Company is also responsible for day-to-day operations	vs.	• Landowner develops building as per specifications by company • Company takes it on long-term lease	• Company takes contract for managing a stand-alone hospital • Company gets fixed management fees and share in revenues/ profits
Impact on capital intensity	• Highly capital intensive		• Lower by ~50%	• Low capital requirements
Impact on breakeven	• Breakeven at operating level in 2-3 years		• Breakeven delayed due to payment of lease rentals; however, payback period lower	• Company not impacted by duration of breakeven for fixed fees • Variable fees dependent on breakeven

Ayushman Bharat's potential high, private sector participation can improve with better package rates

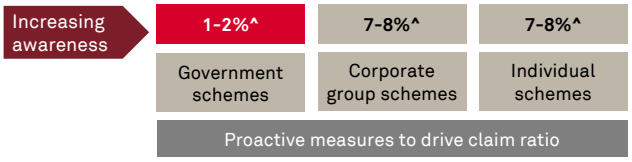
Ayushman Bharat, in its full scale of implementation, will provide health coverage to 50 crore people with insurance cover of Rs 5 lakh per family, providing volume momentum for the sector. Most states have signed a memorandum of understanding with National Health Authority to implement the scheme and are following a mix of implementation models such as trust, insurance and hybrid. Increase in coverage and awareness will improve the claim ratio under the scheme. Historically, claim ratio under government schemes has been in the 1-2% range compared with 7-8% in corporate and individual schemes. With the government taking initiatives in spreading awareness and making adequate funds available, the scheme is likely to support incremental demand growth by nearly 150-200 basis points (bps). However, its success hinges on two key monitorables – timely payment to hospitals and package rates under the scheme.

On full-scale implementation, with an estimated claim ratio of 2% and per case spend of Rs 16,000, the scheme needs annual expenditure of around Rs 16,000 crore. Since most beneficiaries would come under higher coverage for the first time, the claim ratio may rise in initial years of implementation, leading to significant increase in expenditure. Thus, payment days will remain crucial for private hospitals just like during erstwhile government health insurance schemes when there were instances of hospitals suffering financial losses on account of delayed payment by state authorities or insurance companies.

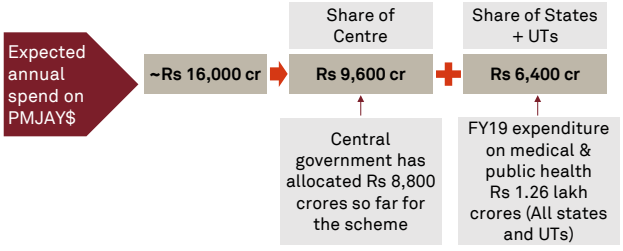
PMJAY* to add volumes in the medium term



Claim ratio likely to go up under PMJAY



Most states spend 1-2% of GSDP on healthcare



*Note: * Pradhan Mantri Jan Arogya Yojana; # denotes persons covered; ^ includes data from IRDA report FY18, $ Based on estimation of 2% claim ratio and at average treatment cost as witnessed till September 17, 2019*
Source: PMJAY reports, RBI state finances report, CRISIL Research

It is also in this context that players in Bihar, Uttar Pradesh, and Madhya Pradesh, which are implementing insurance schemes for the first time and have fiscal deficit ranging from 1.7% to 3.2%, need to exercise some caution.

Our assessment suggests the average treatment cost in large hospitals is around Rs 92,000 compared with Rs 36,000 in small and medium hospitals. On the other hand, Ayushman Bharat package rate is almost 30-35% of the General Insurance Public Sector Association (GIPSA) rate for key treatments.

Both these factors have contributed to the low participation of the private sector, with only 29% of the 33,000 private hospitals (under the Registry of Hopitals in Network of Insurance, or ROHINI, database) empanelled under the scheme. Despite this, the private sector's share is 53% in total treatments, indicating people's preference for private facilities.

The government is taking measures to empanel more hospitals and is open to price rationalisations for the same. Narrowing cost differential could encourage private hospitals to empanel, especially in Tier II cities, where dependence on government schemes is high.

Government pushing penetration into non-creamy Tier II cities and beyond, but incentives and operational efficiency key to success

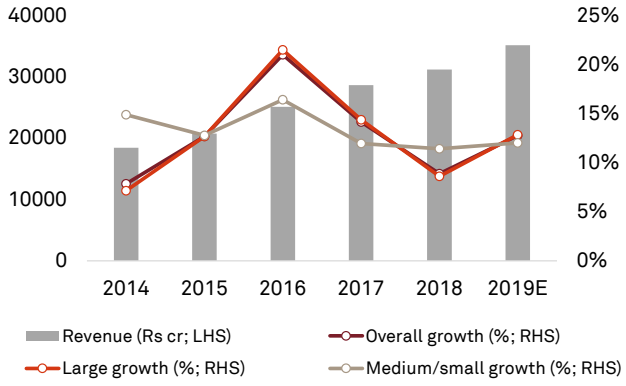
Given that 65% of population lives in rural areas, the government is trying to incentivise private investment in these regions. However, private players find it difficult to replicate the model that works for them in Tier I and premium Tier II locations, paving the way to rethink strategies given the extremely low revenue per bed in these regions.

A volume-centric model focusing on secondary and lower levels of tertiary care segments with tight control on cost are important to sustain in these areas.

Taking note of these challenges, the government has launched incentives for private investments such as viability cap funding of up to 40% on total project cost. However, as per our analysis, the proposed 40% viability cap funding will not be adequate to fuel private investments given that treatments have to be under Ayushman Bharat package rates.

So far, major corporate chains have decided to take unit level decision to participate in the Ayushman Bharat scheme. Given the low margins under the scheme, significant supply addition just on account of Ayushman Bharat is unlikely. However, players operating at low occupancy are more likely to participate in order to improve utilisation.

Performance of large players was impacted the most by regulatory actions



Regulatory actions in fiscals 2017 and 2018 adversely impacted the performance of hospitals. Postponement of non-critical treatments due to cash crunch post demonetisation and ban on cash transactions of over Rs 2 lakh significantly lowered occupancy. Price caps on cardiac stents and knee replacement further affected revenue growth of players.

Our assessment of the sector reveals that the impact was not uniform across players. Given that most of the regulatory actions were targeted towards the tertiary care segment, revenue growth of large hospitals and corporate chains in Tier I cities with greater exposure to these segments was impacted the most. Medium and small hospitals, largely present in Tier II/III cities with limited exposure to tertiary care segment, performed relatively better.

The impact on profitability was also higher for large players. While greater exposure to the tertiary care segment allows these players to generate higher revenue per bed, it also entails higher fixed costs. Large players have high proportion of doctors on roll, higher ratio of support staff to patients and higher cost of infrastructure maintenance, leading to high proportion of fixed costs. Therefore, dip in occupancy levels following regulatory actions coupled with price caps impacted profitability of large players.

Large players also have higher capex intensity than smaller players. While this has allowed them to increase their scale and geographical presence, it has impacted overall profitability given the high gestation period of new hospitals.

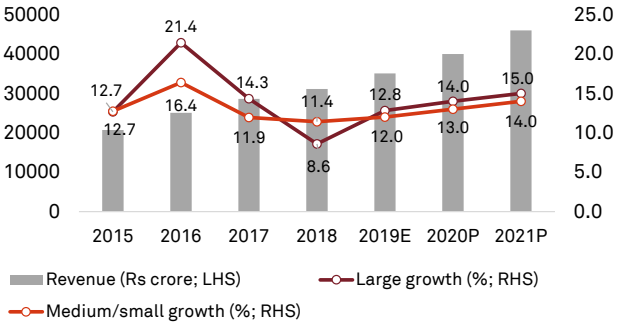
Medium and small players, however, were able to sustain higher margins as their fixed costs are relatively lower. Further, most of the small and medium players are based out of a single location, leading to focussed operations and greater cost control, further benefitting their margins.

Outlook for the sector

With improvement in occupancy rates and players gradually adjusting themselves to the new regulatory regime (including by reworking their package rates), revenue growth and profitability witnessed modest improvement from fiscal 2019 onwards.

Going forward, CRISIL believes the hospital sector is set to thrive with a healthy growth rate of 14-15% over the medium term. Structural factors, specific push from private players as well as government initiatives to make healthcare accessible and affordable facilities augur well for the industry.

Revenue to log 14-15% CAGR

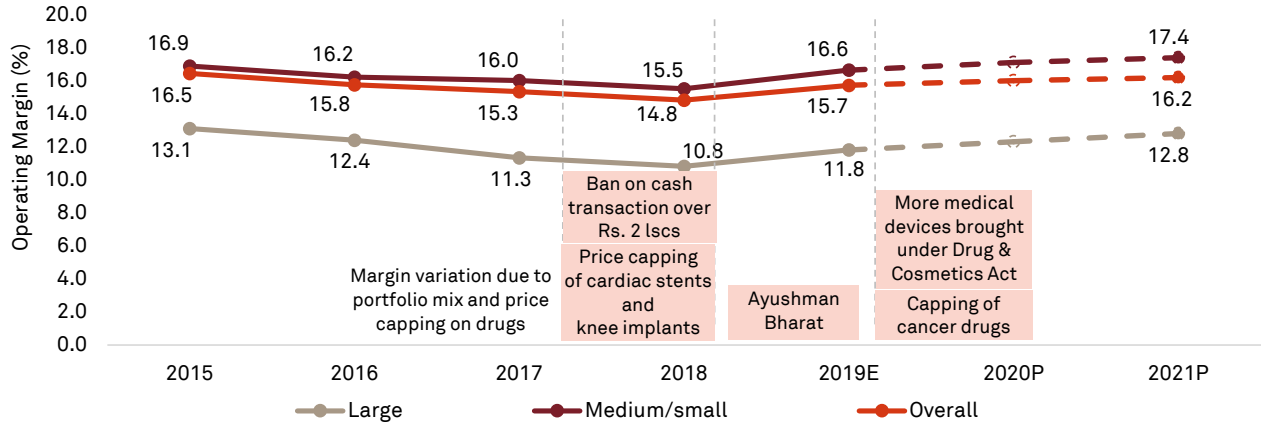


Source: CRISIL Ratings + Company reports

Further, supported by improving monetisation of previous capex and various steps taken by the players, such as reworking package rates, profitability which had bottomed out in fiscal 2018 should also improve 50-100 bps going forward.

Our assessment reveals a slowdown in capex intensity in fiscals 2018 and 2019, especially in Tier I cities. While players did expand selectively in smaller cities in pursuit of growth opportunities, the focus was largely on consolidation and ramping up of operations in the existing facilities. With no major additional regulations in the past one year, occupancy levels have started to increase. Consequently, CRISIL expects capex intensity to also pick up, albeit gradually, from fiscal 2021 onwards.

Margins to improve 50-100 bps



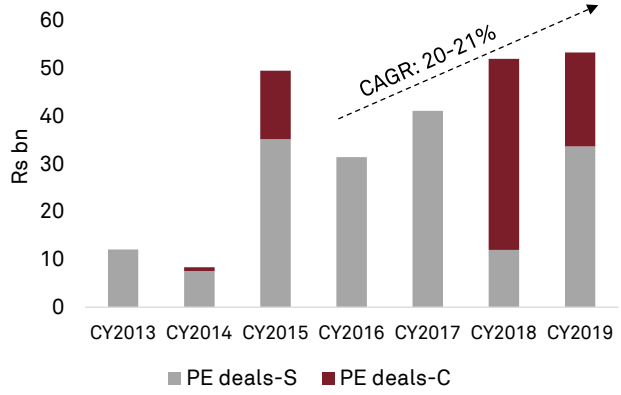
Source: CRISIL Ratings + Company reports

Portfolio consolidation by private equity players gathering pace

Recent years have seen significant interest in the sector from private equity (PE) players despite regulatory actions adversely impacting performance of large incumbents. PE players are increasingly looking at healthcare assets in India as attractive opportunities given the healthy growth prospects. Additionally, they are starting to consolidate their hospital investments.

PEs typically come with an investment horizon of 5-7 years, which is in line with the long gestation nature of the hospital business. Hospital operators benefit from access to equity funding, which helps them maintain prudent financial risk profile. Interestingly, global investors are also getting into operations and sharing their knowhow and expertise on healthcare industry, rather than being just financial investors.

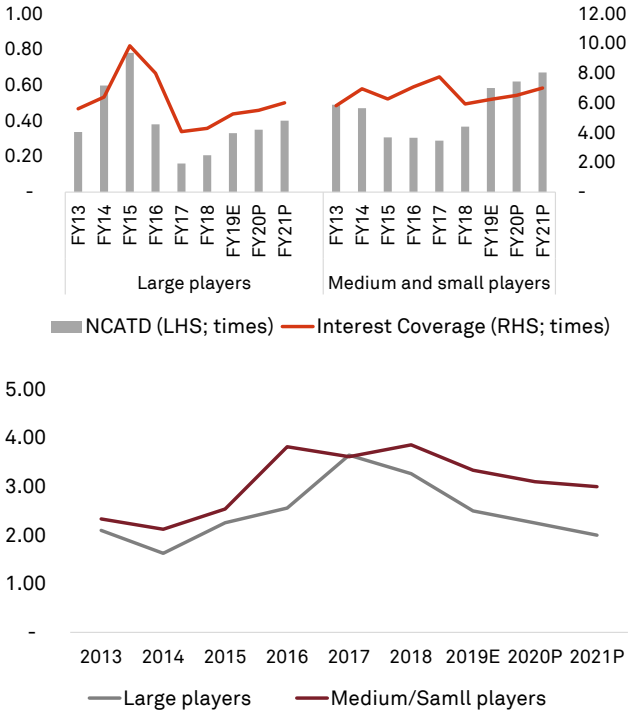
Regulatory hiccups haven't deterred PEs



Note- PE deals- S denotes acquisition of stake/ investment; PE deals-C denoted hospital portfolio consolidation
Source: Secondary reports

Credit metrics to benefit from better cash generation and financial prudence

Credit metrics to improve



NCATD: ratio of Net Cash Accrual to Total Debt
CRISIL Ratings

While large players' capex has been high, they have also exhibited prudence in funding their capex, which mitigates the impact of project risk. Typically, they go in for long-tenure loans and structure their

obligations in such a way that initial repayments are low and subsequent repayments, which are higher, are aligned with the increase in cash generation. This way, large players have been able to reduce cash flow mismatches. Small and medium players have also been able to maintain their credit profile supported by low debt intake.

Going forward, CRISIL expects hospitals to maintain financial prudence. This, coupled with growing scale and improving profitability, should lead to improvement in credit quality over the medium term.

Conclusion

The hospital sector benefited from monetisation of high capex and a healthy operating environment in fiscal 2016 and most of fiscal 2017, before regulatory issues impacted performance. Performance has since started to improve. This trend is also reflected in CRISIL's credit ratio, which is the ratio of the number of upgrades to the number of downgrades. While credit ratio was below 1x in fiscals 2018 and 2019, it was largely because of volatile ratings in the sub-investment grade. Limited cash flows from existing beds makes these players vulnerable to project risk.

For the investment grade ratings, the credit ratio has been largely stable over the years. The ability to grow while simultaneously adding capacity and maintaining prudent capital structure has benefitted the ratings of these players, despite higher debt on their books.

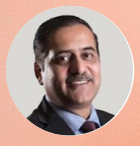
CRISIL expects the credit ratio to remain above 1x going forward, although key monitorables will include ramp-up of occupancy at the newly added capacity and how hospitals cope with the changing regulatory landscape.

Their view

**Views excerpted from a panel discussion during the CRISIL webinar on the healthcare sector.
The webinar was attended by 231 external participants representing 147 organisations.**

The panelists were:

Dilip Jose
Managing Director & CEO
Manipal Health Enterprises



Raajiv Singhal
Managing Director -
Head India Operations
Evercare Group

Kesavan Venugopalan
Group CFO
Narayana Hrudayalaya Ltd.

Madhavi Darbha
Group CFO
Care Hospitals

On growth and demand

Investing in underserved micro markets while focusing on cost management to ensure growth

Tier I cities such as Bengaluru and Delhi may have a high density of beds, but even here, certain micro markets are underserved. Hence, one strategy would be to invest in a new hospital or collaborate with an existing hospital to serve these micro markets. Additionally, hospitals could focus on only 4-5 key clinical specialties instead of having a presence across specialities.

Operationally, hospitals should also focus on cost management, particularly in view of the regulatory pressures such as impact of price cap on stents and knee caps, and work towards enhancing operating efficiencies, in terms of material consumption and staff productivity.

Finally, asset light models like operations and maintenance (O&M) and lease models can be explored.

Using technology to lower cost for patients in remote regions

While the need for hospital care is high across India, the paying capacity of patients in several areas do not match the healthcare requirement. A case in point is north India, where low number of private medical colleges has translated into low number of doctors. As a result, the cost of attracting and retaining doctors is high.

To counter this, hospitals could employ technology. Major healthcare chains are already increasingly adopting telemedicine services. In fact, telemedicine will have a major role in bridging this regional disparity by extending low-cost consultation and diagnosis to the remotest areas via high-speed internet and telecommunications.

Employing asset-light models to expand into Tier II and III cities

From a demand perspective for private healthcare, there is a certain level of uncertainty when it comes to Tier II and III cities. Compared with metros, private insurance penetration is very low in these cities. Majority of the volume is driven by government schemes, such as the Central Government Health Scheme, which have low package rates. At the same time, hospitals cannot charge a premium in these markets owing to the low paying capacity of patients.

These challenges mean that hospitals will have to employ asset light operating models as they expand into these cities. While these models do reduce the capital intensity, they also reduce the management's ability to have a complete say in operations because of the requirement of a local partner.

Hence, managing expectations of both partners as well as ensuring a cultural fit are important elements to consider while entering into a partnership based on the O&M model.

Focusing on medical tourism

A simple heart surgery, which costs $ 150,000 in the West, is possible at $3,000-10,000 in India. The cost factor alone provides immense scope for growth of medical tourism in India. There is government push to incentivise medical tourism, including allowing foreign nationals to get treated without medical visas, except for organ transplant cases. Certain restrictions on medical visas have also been removed, and patients are now allowed multiple entry and longer stay.

While the bulk of patients currently are from Afghanistan, Bangladesh, and Commonwealth of Independent States countries, going forward, the focus should be to increase medical tourism from Africa and Gulf Corporation Council countries to further strengthen India's position as a major medical tourism destination.

Reducing dependence on star doctors

The culture of star doctors is here to stay. So, mitigation of the risk of exit of a star doctor is important.

Mitigation can work at multiple levels. If a hospital has a star doctor, it is important to have tie-in with multiple hospitals. This ensures that the particular specialty grows in other hospitals, and is able to compensate in case of exit of the doctor.

Also, there needs to be expansion into other specialties and constant recruitment of new talent to reduce dependency on star doctors.

On profitability

Improving operating efficiencies can help hospitals cope with regulatory challenges

While all hospitals are affected by regulations, the impact is not uniform. For instance, hospitals in the organised sector have a higher proportion of insured patients and hence, are not affected because of the ban on cash transactions over Rs 2 lakh. Also, the impact of price cap on stents and knee caps is dependent on the product/procedure mix of hospitals.

To cope with these, hospitals have focussed on improving operating efficiencies, whether it is length of stay, billing of materials for procedures, or prescribing generics, where possible. Hospitals are also moving away from commoditised procedures to differentiated or niche areas, where they can charge a premium for the service.

Foray into Tier II cities may not improve profitability

It is a myth that Tier II cities have a lower cost structure. Except for the possible wage cost being marginally lower than Tier I cities, all other costs are either on par or higher. Doctor salaries in case of high secondary and tertiary specialties are actually higher in Tier II cities in many cases, owing to the hardship compensation provided to doctors to relocate. Additionally, while competition is lower, the addressable market is also relatively small in Tier II cities. With paying capacity also comparatively lower than in the Tier I cities, the margins in Tier II cities are comparatively lower for a similar size hospital.

Hence, hospitals can explore the hub-and-spoke model, where small regional centres in Tier II cities can drive volume into larger hospitals in Tier I cities. Further, while tertiary care hospitals may not be viable in a Tier II city, hospitals can look at secondary and low level tertiary care.

On PE participation

PE players running of hospital and driving consolidation

PE players are realising the need to guide the hospitals they invest in. Being part of the decision-making is anyway important for PE players, in order to ensure growth. But they also add considerable value by bringing in global best practices in human resources, information technology, and supply chain. Also, given that PE players have multiple healthcare investments in India and abroad, they bring learnings from within India and outside into the functioning of the hospital. Additionally, these players, working alongside the existing management team, bolster the management bandwidth.

Further, as hospitals grow, it is important to bring in operational efficiencies. Consolidation is a key lever to drive that. It is very difficult for standalone hospitals to survive, especially given the regulatory challenges. PE players are thus driving consolidation in India.

Despite change in business dynamics over past 2-3 years impacting returns, hospitals remain attractive for PEs

More areas are expected to come under the ambit of regulations. Hospitals, however, will continue to be an exciting space for PE players. While the returns on fresh investments may not be 24-25%, as was the case five years ago, it could still be around 20%, given efficient operations – both clinical and administrative.

Hence, India is definitely a sweet spot from a return perspective.

On capacity addition

Capex intensity to pick up going forward

Due to challenges in recent past, bed capacity addition has been phased and slower than in the past. Going forward, while capex intensity will pick-up, it will be balanced with financial prudence. Bed additions may be targeted more towards specific lines of businesses such as quaternary care, where the demand is growing.

Viability gap funding may not be enough to spur Tier II penetration

Despite being a lifesaving industry, the healthcare sector has never received preferential treatment from the government. Also, viability gap funding (VGF) in its current form comes with several conditions. So, while VGF is welcome, whether it will encourage private participation is not clear. Rather, benefits in terms of indirect and direct taxes may do more to motivate private sector participation.

Key monitorables going forward

Healthcare is a social sector and regulations are still at a nascent stage. Hence, government intervention through legislation will continue. Hospitals must anticipate more price controls, price capping on procedures, etc, and adjust their operating models to remain viable and ensure returns that investors expect.

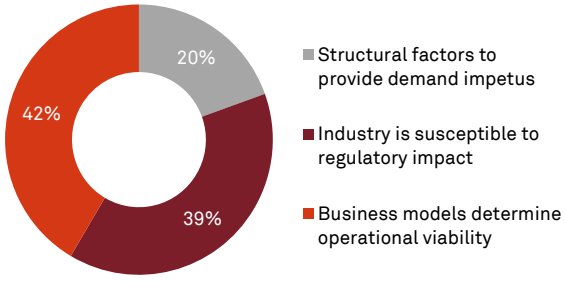
The other monitorable will be the wage structure. About 40-45% of the total cost of a hospital is towards doctors and staff. Hence, any regulatory change in the wage structure would have a cascading impact. For example, if a particular government is upwardly revising the salary of nurses, it is not only the nurses' salaries that would be impacted. There will be a cascading impact on technicians, operators and everybody else up and down the line.

Poll view

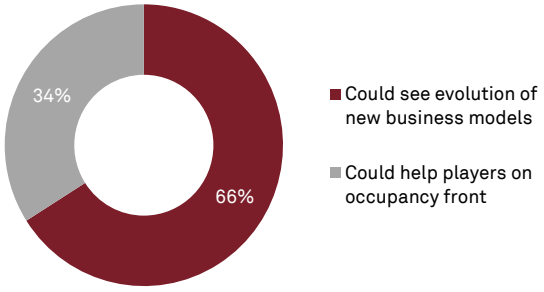
Results of the survey held during the CRISIL webinar on the healthcare sector

Based on responses from over 65 participants

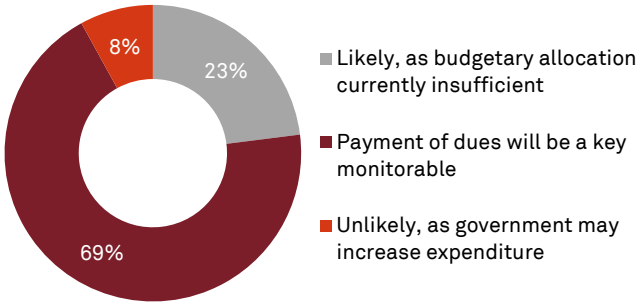
Is healthcare delivery an evergreen industry?



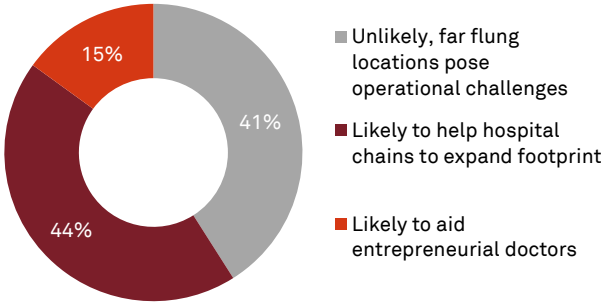
Will universal health coverage fuel growth of private hospitals?



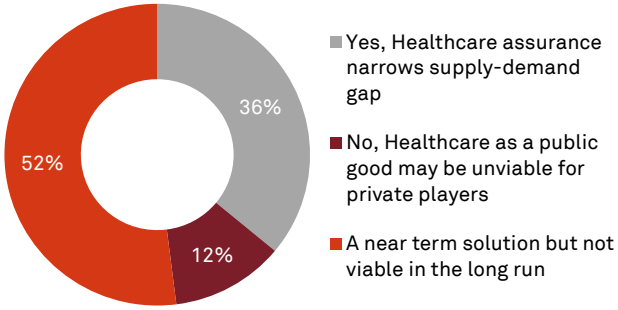
Will PMJAY face financial constraints?



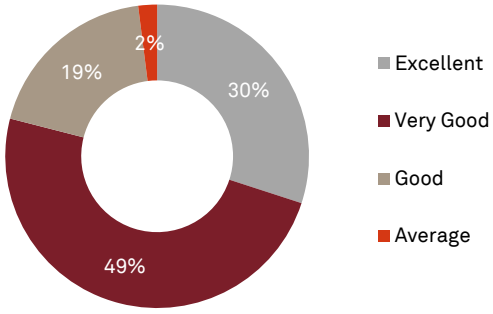
Will government incentives nullify the skew in healthcare infrastructure?



Should the government incentivise private players v/s asset creation?



Please share your feedback on the overall session, on a scale of 1 to 5, 5 being the highest and 1 being the lowest



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