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Eye-Q: Vision for the long term

Ramakrishna Velamuri and Geetika Shah wrote this case solely to provide material for class discussion. The authors do not intend to illustrate either effective or ineffective handling of a managerial situation. The authors may have disguised certain names and other identifying information to protect confidentiality.

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Rajat Goel, chief executive officer at Eye-Q Super Specialty Hospitals (Eye-Q), gave up a 16-year corporate career to partner with his ex-classmate, Dr. Ajay Sharma, chief medical director at Eye-Q, and set up the hospital chain in 2007. As eye-care practitioners who both came from small towns, the co-founders were driven by their vision to bring superior quality eye care services to places where such care was badly needed—small towns and cities across India. Thus, an important aspect of the partners’ vision involved establishing a business model that was socially driven yet commercially viable. Goel and Sharma were participants in the eye care market in Tier 2 and Tier 3 cities,[[1]](#footnote-1) where their goal was to set up hospitals with a typical built-up area of 3,000 square feet and a team of doctors capable of achieving a high patient turnover while also maintaining the highest quality of outcomes in eye care.

January 2014 found the duo in their elegant offices in Gurgaon, charting out Eye-Q’s growth plans. Eye-Q’s gross annual turnover had grown from ₹90 million[[2]](#footnote-2) to ₹650 million since 2011, and Goel and Sharma wanted to scale up to ₹4 billion as they expanded from 30 to 125 hospitals in the next five years. Was this growth expectation realistic? Cataract surgery was the mainstay of Eye-Q’s revenues, yet it was still a discretionary expense for patients. What level of demand should the partners budget for, both for their existing hospitals and for new ones? Even as they prepared to expand their footprint, Goel and Sharma were steadfast about maintaining their ideological commitment to quality and ethics over growth and profits.

THE EYE CARE DELIVERY MARKET IN INDIA

According to statistics published by the World Health Organization (WHO), in 2010, India accounted for nearly one-fifth of the world’s blind population (i.e., India had 8 million of the world’s 39 million blind people).[[3]](#footnote-3) This high incidence of blindness in the country was primarily due to the lack of accessibility, affordability, timeliness of interventions, and a lack of knowledge about eye care. It was estimated that approximately 5 per cent of India’s population (i.e., 63 million people) were visually impaired (including blindness),[[4]](#footnote-4) and yet, according to the WHO, 80 per cent of visual impairments were preventable and, hence, treatable.[[5]](#footnote-5) Cataract (62.6 per cent) was the leading cause of visual impairment in the Indian population. Refractive error (19.7 per cent) and glaucoma (5.8 per cent) were the two other main causes of blindness.[[6]](#footnote-6)

Industry Perspective

The eye care delivery market in India was pegged at ₹120 billion in 2012–13, with 83 per cent of the revenue coming from eye surgeries and 17 per cent from outpatient services.[[7]](#footnote-7) A report from the Credit Rating Information Service of India Limited (CRISIL) estimated that the eye care delivery sector was growing at a rate of approximately 15 per cent year-on-year and was likely to reach ₹236 billion by 2017–18.[[8]](#footnote-8) According to India’s National Programme for Control of Blindness, around 6.3 million cataract surgeries were conducted in India in 2012–13, accounting for approximately 80 per cent of all eye surgeries in the country.[[9]](#footnote-9)

The eye care delivery market comprised single practice ophthalmologists, privately owned eye hospitals, government facilities, local and international non-governmental organizations, non-profit trusts, ophthalmology departments in hospital chains, optical chains, contact lens clinics, and device manufacturers (see Exhibits 1A, 1B, and 1C). Eye care chains had largely followed the “hub and spoke” business model and operated a mix of three types of centres—primary, secondary, and tertiary[[10]](#footnote-10) (see Exhibit 2). Most privately held eye care chains operated secondary or tertiary centres and, as part of their association with the Vision 2020 program,[[11]](#footnote-11) operated primary centres in rural markets, which ensured them a presence in these markets and allowed for future expansion. According to Dr. Rana Mehta, executive director at PricewaterhouseCoopers, “Tier 1 cities have a larger format where both cataract operations and other surgeries are equally dominant. In Tier 2 places, cataract surgeries are the mainstay for the centre.”[[12]](#footnote-12)

Eye care was considered one of the most profitable verticals in health care, and hence, there was an increase in venture capital funding inflows into privately owned eye care facilities, particularly in Tier 2 markets.

Challenges and Opportunities

The main growth driver for India’s eye care centres was cataract surgery, which accounted for about 60 per cent of the revenues at these facilities.[[13]](#footnote-13) With increased life expectancy, close to 10 per cent of India’s 1.2 billion people were in the over-60 age group and represented a large potential market for cataract surgery. The prevalence of diabetic retinopathy was growing, as evidenced by India’s ignominious title as “the diabetes capital of the world,” and this factor, along with a rise in demand for laser eye surgery (LASIK), represented large volume and revenue potential for eye care chains.[[14]](#footnote-14) Yet, there was a significant gap between the services provided in urban and rural areas. Lack of access to services, lack of affordability, and lack of awareness were the main hindrances to the growth of eye care centres in rural areas. Low acceptance levels and pre-existing attitudes, such as a preference for traditional forms of treatment, the fear of treatment and surgery, superstitious beliefs, and a fatalistic attitude towards blindness, also played a role.

EYE-Q SUPER SPECIALTY HOSPITALS

**The Partners’ Background**

Sharma earned his bachelor of medicine/bachelor of surgery and postgraduate degrees from Rohtak, Haryana. He went on to do his residency at Safdarjung Hospital, New Delhi, and later at the LV Prasad Eye Institute (LVPEI), Hyderabad. Around this time, after some deliberation, he decided to join his father, who was also an ophthalmologist, in Gurgaon. Recalling the early days of his career, Sharma said:

After my father’s retirement, we shifted to Gurgaon. I joined his small practice and started doing surgeries. There were times when my father and I would go as far as 50 kilometres away and operate on patients there. We carried all our supplies with us. Sometimes we even had to create an operation theatre on X-ray tables. Those days were good, and we would earn a sum of ₹500 for those surgeries. Yet, though I was learning something, I felt restless about what I was doing. This was not what I had planned for myself.

In those days, ophthalmologists were accustomed to performing extracapsular extraction surgeries, which involved implanting an intraocular lens and required sutures. However, during his stint at LVPEI, Sharma had been trained on the more advanced phacoemulsification technique, which required a specialized machine. Sharma wanted to make greater use of his advanced training, so he eventually decided to strike out on his own with his meagre savings of ₹200,000 and a loan of ₹550,000 from a local bank. In spite of resistance from his father, Sharma bought the costly phacoemulsification machine. His father felt it was an expensive proposition and was apprehensive about whether patients, who reluctantly paid ₹2,000 for a surgery, would now be willing to part with ₹5,000. However, Sharma was very clear that he wanted to bring the latest technology to Gurgaon. On the very first day in his own practice, he performed six operations using the machine and earned ₹29,000.

Over the next few years, Sharma established his practice and made plans for expansion. In 1999, he opened Sheetla Hospital in Gurgaon with 100 beds, catering to both urban and rural patients. Ophthalmology was continually advancing, and, in 2005, Sharma bought his own LASIK machine. This purchase brought him into contact with Goel, who headed the LASIK division at Bausch & Lomb and was selling the machine to Sharma. The two had attended boarding school together and were meeting again after a gap of 25 years. Around this same time, Sharma had begun to realize that his hospital was facing stiff competition from a number of other multi-specialty hospitals such as Medanta—The Medicity, Fortis Healthcare Ltd., Paras Healthcare, and Artemis Hospitals, among others. In 2005, Sharma had decided to focus on ophthalmology and opened two or three more centres in cities such as Rewari, which were located 50 to 60 kilometres away from Gurgaon.

Sharma and Goel continued to stay in touch. Like Sharma, Goel showed an inclination toward launching his own business, and he saw great potential in opening eye care hospitals across the country. Sharma recollected his conversation about this with Goel:

I was planning to start three or four hospitals. I asked him to join me. With his management skills, we could even open 10 hospitals. He knew what was happening in eye care. He saw my practice growing from just ₹100,000 to ₹200,000 to ₹40 [million] to 50 million a year. He started thinking about it.

Goel, a graduate of the Indian Institute of Management, Ahmedabad, recalled his thoughts during that phase:

After working for five and a half years at Godrej Soaps, I had wanted to move to a multinational. Having joined Bausch & Lomb as a part of the sales team in 2000, I moved on to head marketing and then became a business manager. I was identified as one of the 25 top managers of Bausch & Lomb. For two years consecutively, the division I was handling received the best country award in Asia-Pacific for Bausch & Lomb. So the idea was, “what next?” I couldn’t see myself going further in corporate life. Sometimes, I began to question whether all this success had come to me primarily because of [my efforts], or was it just that I got lucky because I was working in a company that had been doing well? It made me want to create something on my own from scratch.

After having spent 16 years of his career in large organizations, moving out of corporate life was not easy for Goel. He explained, “There were a lot of trappings; you have equated monthly installments to pay, you are used to a certain kind of life, and that’s very secure. One has to align the ecosystem of family and friends who are initially very shocked and negative. So it takes a lot of time and courage to actually come out of it.”

In 2006, after nine months of deliberation, Goel accepted Sharma’s offer and resigned from his director level job at Bausch & Lomb. With Sharma taking a 51 per cent stake in the new business and Goel taking 49 per cent, the two men signed an agreement and co-founded the Eye-Q hospital chain, with a commitment to providing the best quality eye care at affordable prices across India.

Early Growth and Expansion

Eye-Q started operations with a centre in Rewari, Haryana. Sharma’s ophthalmic centre at Sheetla Hospital was absorbed into the new company. Together, Sharma and Goel also bought two centres from Bausch & Lomb, one in Haldwani and the other in Ganganagar, and while the Haldwani centre did well and proved to be one of the partners’ most profitable hospitals, the Ganganagar centre was too far for them to manage it effectively. Unable to do justice to the Ganganagar facility, Sharma and Goel suffered a loss and eventually shifted the equipment to Rohtak, where they opened another hospital. Goel’s father-in-law, who was keen on investing in the business, joined them in opening a hospital in Saharanpur. The equity was treated as quasi-equity,[[15]](#footnote-15) and after two years, when it was converted to equity, they invested in two more hospitals. Goel’s uncle in the United States invested in the enterprise as well, enabling the set-up of two more hospitals. With these additional investors on board, the partners were able to expand from four hospitals to seven.

In 2010, Song Investment Advisors became Goel and Sharma’s first institutional investor, putting US$2 million (₹95 million) into Eye-Q. At that time, the company was valued between ₹250 million to ₹300 million. A year later, Helion Venture Partners and Nexus Venture Partners subsequently invested ₹450 million in Eye-Q in 2011, followed by another ₹250 million in 2013. By then, the valuation of Eye-Q had increased to ₹2.1 billion. From 2010 to 2013, Eye-Q’s business expanded from ₹90 million to ₹670 million, and it was able to spread its operations to 30 centres across small towns and cities in the states of Haryana, Uttar Pradesh, Uttarakhand, and Gujarat (see Exhibits 3A and 3B).

THE EYE-Q MODEL

Although several eye care organizations operated across India, Eye-Q managed to set itself apart by choosing to operate in Tier 2 and Tier 3 cities. Prakash Vasudevan, director of strategic alliances at Eye-Q, explained:

Although we might be slightly more expensive than a local doctor, we bring in the latest technology so the patient does not have to actually travel all the way to, say, Delhi or Mumbai. This [factor] significantly reduces the burden in terms of cost and convenience.

When deciding on whether to enter a particular town, Eye-Q first assessed the total market in that town in terms of volumes and sustainability. Another decision-making factor involved checking to see whether any large or established hospitals were already operating in the town. As Sharma explained, this assessment was important for two reasons:

One [reason] was from a slightly ideological perspective. Even though the market was underserved, if there was someone already providing reasonably good services, then it was not a priority for us to get in. The other [reason] was from the practical aspect of being able to establish a centre. The health care business essentially works on trust, and it takes time to build trust. If you have a strongly established competitor who has built a high level of trust among people in that market, then the ability of a new player to come in and establish that trust, and the kind of investment that it takes to establish that trust, is much greater.

While it was important for the chosen location to be well connected, Eye-Q also took into account the quality of life for doctors and their families once they settled there. “If you look at our centres, nearly 60 per cent of them were brownfield projects while the remaining [ones] were greenfield,”said Vasudevan about the company’s growth strategy.

Brownfield projects referred to those where Eye-Q acquired an existing practice on a previously developed site, while greenfield projects were those where Eye-Q opened a new centre on an undeveloped site and recruited a doctor to run it. Both routes had their own challenges. Setting up a greenfield location, although easier, came with the challenge of hiring the right doctor. On the other hand, in a brownfield location, a local doctor would already be in place and accustomed to working independently for many years. In that case, the challenge lay in integrating the local doctor into the Eye-Q way of thinking, as well as setting up new systems and processes.

In the process of expanding its footprint, Eye-Q went on to form collaborations with these local doctors. Instead of operating like franchisees, these collaborators became associates of Eye-Q. While retaining all the doctors’ existing good practices, Eye-Q introduced them to complete automation, the newest technology, and a management matrix system. At these centres, Eye-Q also took over administrative tasks, such as hiring of staff, training, and career progression, all of which allowed the doctors to focus on clinical activities. Further, Eye-Q established a patient management system to evaluate patient outcomes and satisfaction rates.

Over time, Goel and Sharma created a chain of hospitals around the main medical partner in a given locale, similar to a hub and spoke or cluster model. Each cluster incurred an investment of about ₹120 million, with an average outlay of ₹25 million per centre. On average, each centre took about 1.5 years to break even. While the spoke provided most of the basic eye care services and performed routine cataract operations, more sophisticated or specialized procedures, such as LASIK or retina surgeries, were available only at the hub. Two of Eye-Q’s biggest collaborations were in Lucknow and Surat, where the company was able to establish five hospitals as part of the Lucknow cluster and two in Surat from the practices it had acquired there.

Staff

Subhash Bansiwal, head of human resources (HR), had joined Eye-Q in December 2011. Recalling his assessment of the state of affairs at the organization at that time, he said, “The staff were mostly homegrown and not very big on qualifications, but I think, intuitively, they were doing things on their own. The entire organization was a work in progress.”

After Bansiwal’s arrival, Eye-Q took on the challenge of finding the right kind of people for the organization and set up a rigorous selection process. The staff at each centre was comprised of doctors, optometrists, an operations manager, and ophthalmic assistants. One of Eye-Q’s key HR challenges involved finding qualified and experienced doctors. Moreover, since the company’s business model focused on Tier 2 and Tier 3 cities, this challenge was complicated by an additional issue: How could the group attract the best doctors and convince them to relocate to smaller towns? This challenge extended to finding good quality optometrists, managerial staff with master’s degrees in either health care administration or management, and operating room staff to assist with surgeries who were typically people with diplomas in operating room technology. Since many ophthalmology services were outpatient procedures, there was little need for nursing staff. Typically, only tertiary care hospitals (i.e., hub centres) had in-patients who required nursing care.

Sharma explained that attracting the right talent for the organization was an important objective, “For us, it was very important that we chose only those people who would fit into our DNA. We ensured this [standard] by checking referrals and also by asking candidates to fill out a detailed questionnaire about their prior work experience.” By early 2014, Eye-Q hospitals employed a total staff of 700.

**Remuneration for Eye-Q Doctors**

In general, health care organizations in India took on doctors as full-time consultants rather than as employees. After completing their postgraduate degrees in ophthalmology—a doctor of medicine combined with a master of science—doctors typically went on to do their fellowships at centres such as LVPEI, Aravind Eye Care, or Sankara Nethralaya in order to gain surgical experience. The average starting salary for these newly qualified doctors was around ₹125,000 per month. Doctors with about five years of work experience could command salaries in the range of ₹220,000 to ₹250,000 per month, going up as high as ₹400,000 to ₹500,000 per month for highly experienced doctors.

For its partner doctors, Eye-Q followed a remuneration system with both a fixed and a variable component based on the growth they generated. Out of around 65 doctors at Eye-Q, only nine were partners. For the remaining non-partner doctors, Eye-Q followed a fixed remuneration policy. There was no variable component based on numbers. Bansiwal said:

The philosophy behind this [remuneration practice] was twofold. We believe that if we let our doctors chase numbers, there is the possibility—even if it is just a .01 per cent possibility—that they may do something that is not in line with our ethical practices, and we don’t want them to do that. The other philosophy is that we don’t want our doctors to lose focus on the patient and instead concentrate on financial numbers, number of procedures, [or] surgeries.

The organization gradually initiated several in-house training programs. With an intake of five to six doctors every six months, Eye-Q introduced a fellowship program for doctors where they were trained in “the Eye-Q way.” Similarly, there was an optometrist program under which new optometry graduates with diplomas or bachelor’s degrees went through a specially designed, six-month training program on Eye-Q’s protocols, centres, equipment, and software. A third program, called the Future Leaders Program, was aimed at recruiting and training new management graduates from institutes and offering them a master of health care administration program.

Costs and Pricing

Nearly 40 per cent of the cataract patients at Eye-Q were from households with a monthly income of less than ₹10,000. While the cost of a typical cataract package at an Eye-Q centre was about ₹30,000, low-income customers could also avail themselves of services for as little at ₹3,000, depending on the quality of the lenses used. Eye-Q also offered spectacles in the price range of ₹200 to ₹2,000. Further, by way of being inclusive, the company regularly conducted free eye camps. Eye-Q was also empanelled on the government’s medical insurance policy for bottom-of-the-pyramid patients. Nearly 20 per cent of Eye-Q’s revenues came from empanelments and from government-funded insurance programs.

Focus on Quality

Slowly but steadily, Eye-Q built a good team of doctors and professionals, and set out some strict protocols for its operating rooms and for its pre-operation and post-operation procedures. Daily and weekly reporting from the doctors at the centres not only provided data on the number of surgeries performed across the organization, but, more critically, also captured data on complications that occurred at the centres. There were 40 to 50 different kinds of complications that could result from the procedures; however, Eye-Q was able to prevent or combat most of them by following simple protocols, such as sterilization and maintaining a hygienic environment. On average, Eye-Q conducted nearly 12,000 operations each year and had plans to increase this figure to 22,000 by 2015. According to the company’s 2013 fourth-quarter results, not a single infection had been reported in the 4,000 eyes surgeries performed at Eye-Q during that quarter. Goel observed:

While some other institutes in the country claim about 2,000 surgeries per doctor per year, at Eye-Q, we have created a benchmark, that is, if a doctor sees around 40 to 50 patients a day and does around 1,000 surgeries a year, he is doing a good job. The goal for Eye-Q is to ensure that a patient who has undergone a procedure should be able to see clearly within a week, whereas the industry standard allows up to a month. We have set a benchmark that surgeons should provide 85 per cent of their patients with 6/6 or 6/18 vision within a week and, at the same time, keep the number of infections low.

According to Sharma, “We called this ‘the wow factor,’ and [it was the result] we wanted from all our doctors.”

Information Technology

Within a year of starting operations, Eye-Q decided it would become a paperless hospital. Around mid-2008, Eye-Q adopted an information technology (IT) solution called Lekhisoft, a hospital management system with modules for managing electronic medical records, appointments, and billing. This program was developed by a small software company based in Indore and was popular with some of the smaller hospitals in North India. Lekhisoft was able to serve Eye-Q’s needs as it scaled up to serve about 10 to 12 hospitals. Along with Lekhisoft, Eye-Q was also using Tally, an accounting software. However, with further expansion and growth, the organization ran into problems with the scalability of this software and the aggregation of data across Eye-Q’s centres.

By 2010, when Eye-Q had grown to around 16 or 17 centres, it replaced Tally with Microsoft Navision, an enterprise resource planning software product for financial accounting. The company also decided to invest in a cloud-based solution to replace Lekhisoft, a stable product developed by Tata Consultancy Services in conjunction with Shankar Netralaya. The new program had evolved over seven to eight years and addressed all of Eye-Q’s needs. Initially, Eye-Q’s doctors, who were accustomed to working with patient files and printed reports or documents, found it challenging to use the unfamiliar software; however, their resistance to the software faded over time as they realized its value and the criticality of the data it helped to maintain.

One major challenge for Eye-Q was that most of its centres were located in small towns. By the very nature of the work, it was imperative to have the software running at all times. Therefore, Eye-Q adopted Reliance Communications’ multiprotocol label switching (MPLS) virtual private networks (VPN) service to achieve 100 per cent uptime and seamless connectivity across its hospitals. Further, to ensure data security and stability, all the applications were hosted at a data centre managed by Tikona Infinet Ltd.

In terms of Eye-Q’s company-wide use of IT, staffing issues such as getting the right talent for IT management and training them on the software continued to pose a challenge for the organization. To overcome this problem, Eye-Q decided to recruit people for its IT team from smaller and less well-known institutes, in turn providing them with in-house training. Elaborating on the streamlined system that Eye-Q was able to put in place over time, T. Venkateswaran, head of IT at Eye-Q, said, “Today, a new centre can ‘go live’ in four days, [including] the time allocated for training.”

Marketing

Eye-Q’s service proposition was to deliver the best quality eye care in a pleasant ambience and at reasonable prices. Therefore, the key task for Eye-Q’s communications team was to create an intrinsic awareness among customers. According to Karan Bhandari, advisor for strategy and marketing:

In the last six years, we have found a high degree of correlation between the level of awareness we are able to create in a town and the level of trial we get over there. Once people come and try services at our centre, they tend to stay with us. Therefore, in any town we enter, we make sure we create a lot of visibility at the local level—largely through the local press, the outdoor media, as well as localized activities with societies such as the Residents’ Welfare Association, Lions Club, [and the] Rotary Club.

Until 2012, Eye-Q lacked a formal channel of communication for targeting the doctor community. To begin with, it invested in a study of doctors to understand their motivations in selecting a place of work and staying there. Elaborating on these findings, Bhandari said:

We found that it’s not a case of “one size fits all.” Junior doctors had a particular perspective and a particular set of things they looked for while senior doctors had their own priorities. This insight helped us to fine-tune our proposition to doctors. We also built these insights into our internal culture, as the doctors who work for us are a very important source of information to others who might want to work for us. We worked hard to increase the engagement levels internally.

The organization also reached out to doctors through regular communications about Eye-Q in ophthalmology journals and presentations at ophthalmology forums. “Earlier, as we were smaller, our requirement for doctors was smaller. We were able to get the doctors we needed largely through personal contacts. But now, with a growing base and our growth plans for the future, it has become important for us to build a brand as an employer for doctors,” said Bhandari.

SUCCESS FACTORS

One of the key reasons for Eye-Q’s success with its business model was the clear demarcation of roles between the founding members from very early on. Still, in spite of this differentiation, the founders’ goals and vision for the company were similar, and they represented the company as one voice. Goel was aware that, in running a hospital, it was ultimately the doctor who would make the final call, while the operational staff would serve as facilitators. Bansiwal added, “It helps us that one of our founders is a doctor himself. If you want to change something, it is better to first run it by him. He translates it into [the doctors’] language, and once the idea is seeded in their heads, they take it on.”

The organization had been able to build an capable team of experienced senior managers. Goel elaborated:

Most of the people have come to Eye-Q because they have found that the company has a clear vision of creating a very clean, ethical company, which, though very difficult in today’s circumstances, we have been able to do, fortunately. [Establishing a high-minded corporate vision] is a worthwhile cause because you are creating a profitable and socially relevant company.

THE FUTURE

As they pushed for expansion, Goel and Sharma believed that finding a strategic investor at that stage would be relatively easy to do since they had already built a strong brand and enjoyed a good reputation with their existing investors. The team structure of a doctor plus a business leader who shared a solid relationship, both personally and professionally, and who had complementary skill sets had stood Eye-Q in good stead.

According to Goel:

The market for eye care in India is US$2 billion, of which organized players constitute a mere 5 per cent. If we assume that the need is for 1,000 centres, where are we today? At 30 centres. Even if you take all the players in the market, it adds up to around 200. So right now, the game is about aggregation and category creation for organized eye care. Once we reach that critical mass of 1,000, then we will have to fight for market share, and only then will differentiation come in.

Given the vast patient needs not being met in India’s eye care market, it appeared that competition among market participants was not a great cause for worry. Yet, Goel and Sharma realized they would have to constantly upgrade their training in using the latest technology if they expected to maintain their share in the market. Their business model had been effective in getting them to 30 centres. Would it prove robust enough as they scaled up to 125 centres? And could it protect the organization from making compromises on ethics and quality? One of Goel and Sharma’s biggest challenges had always been finding the right talent (i.e., doctors) and having them move to a particular centre and town. Even though they knew it could slow them down, the partners had set in place a rigorous process for selecting the right kind of people. Could Eye-Q become the employer of choice and continue attracting people of the right calibre and with the necessary passion? One thing was certain: Whatever course Goel and Sharma decided to take, they would not deviate from their core philosophy.

Exhibit 1A: MAJOR Participants IN THE INDIAN EYE CARE MARKET

Government-run eye hospitals and eye care centres operated by non-profit trusts were the main providers of eye care services in India. The latter group accounted for approximately 40 to 50 per cent of eye care treatments and was represented by organizations such as Aravind Eye Care (Aravind), Sankara Nethralaya, and the LV Prasad Eye Institute (LVPEI). With technological advancements in surgery, the majority of eye surgeries no longer required overnight hospitalization, which meant that eye care centres had far lower capital expenditures relative to other health care verticals. Further, growing awareness about eye care and increasing demand for eye treatments in the country ensured a much higher return on investment. This situation, along with the sheer volume of opportunity that India offered, triggered the market entry of a number of private eye care chains, such as Vasan Eye Care (Vasan), Centre for Sight, and Dr. Agarwal’s Eye Hospital. Medfort Hospitals and Eye-Q were among the newer eye care chains.

**Aravind Eye Care**

Aravind was one of the largest providers of ophthalmological services in the world, performing almost 350,000 eye operations a year. It delivered nearly 60 per cent of these services free of charge or at a low cost, while maintaining excellent service quality and a low rate of surgical complications. The business model was simple: Profits from patients who could afford to pay the market rates were used to fund the treatments of those who could not. To lower its fixed costs, Aravind maximized the use of its infrastructure. In addition, it optimized the services of its surgeons by performing 200 to 300 surgeries per day instead of just 20 to 30. In this way, Aravind was able to achieve greater efficiencies by allowing non-doctors (for instance, nurses) to deliver some of the services. Aravind also set up Aurolab, a non-profit charitable trust, to manufacture intraocular lenses and other ophthalmic consumables, thereby bringing down the cost of lenses from US$70 (the price of imported lenses in the Indian market) to US$2.

**Vasan Eye Care**

Vasan established its first centre in 2001 in Tiruchirappalli with a budget of ₹5 million and a modest space of 2,500 square feet. Over the years, it grew to become the largest stand-alone eye care provider on a global scale, with about 150 centres by 2013. Operating out of leased buildings, Vasan invested up to ₹100 million in each eye care centre to acquire state-of-the-art equipment and skilled professionals. Each of these centres was fully owned and operated by Vasan. Vasan’s philosophy was to hire the best local doctors rather than source them from elsewhere. As of 2011, Vasan had 750 full-time ophthalmologists and a staff of 8,000 employees on its rolls.

Centre for Sight

Centre for Sight aimed to be a one-stop shop for all eye-related procedures. It received funding of about ₹500 million from Matrix Partners in 2010. Since its inception in 1996, Centre for Sight had set up 45 centres across Delhi, the National Capital Region, Haryana, Uttar Pradesh, Punjab, Rajasthan, Gujarat, Madhya Pradesh, Jammu and Kashmir, Maharashtra, and Andhra Pradesh.

Source: “Most Eye Care Chains Follow Hub-and-Spoke Model,” CRISIL Research Report, March 19, 2014; Tracey Vickers and Ellen Rosen, “Driving Down the Cost of High-Quality Care: Lessons from the Aravind Eye Care System,” Health International no. 11 (2011); Mahathi R. Arjun, “An Eye on Growth,” The Smart CEO, August 15, 2011, accessed June 16, 2014, www.thesmartceo.in//an-eye-on-growth.html; Malini Goyal, “New Breed of Entrepreneurs Propelling the Growth of Niche Hospitals,” *Economic Times*, February 5, 2012, accessed June 16, 2014, http://articles.economictimes.indiatimes.com/2012-02-05/news/31025086\_1\_hospital-chains-multi-speciality-dialysis-centres; Diksha Dutta and Shrija Agrawal, “Matrix-Backed Center for Sight Eyes 2nd Round of PE Funding, Aims to Boost Tertiary Care Centres,” VC Circle, February 4, 2013, accessed June 16, 2014, www.vccircle.com/news/2013/02/04/matrix-backed-center-sight-eyes-2nd-round-pe-funding-aims-boost-tertiary-care; Raelene Kambli, “Eyeing the Light,” Express Healthcare, October 11, 2012, accessed July 13 2017, http://archivehealthcare.expressbpd.com/sections/market-section/815-eyeing-the-light.

Exhibit 1B: MAIN CHARITABLE Participants IN THE INDIAN EYE CARE MARKET

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Aravind Eye Care** | **Sankara Nethralaya** | **LV Prasad Eye Institute** |
| Number of Centres | 47 Primary | 12 Tertiary | 93 Primary |
| 5 Secondary | 11 Secondary |
| 5 Tertiary | 4 Tertiary |
| Locations | Tamil Nadu; establishing an international presence with a centre in Nigeria | Tamil Nadu, Andhra Pradesh, West Bengal | Andhra Pradesh |

Source: “Business Models in Eye Care Delivery,” CRISIL Research Report, March 19, 2014.

Exhibit 1C: MAIN PRIVATE Participants IN THE INDIAN EYE CARE MARKET

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Vasan Eye Care** | **Centre For Sight** | **Eye-Q** | **Dr. Agarwal’s Eye Hospital** | **Lotus Eye Care Hospital Ltd.** | **Medfort Hospitals** |
| Established in (Year) | 2002 | 1996 | 2006 | 1976 | 1993 | 2010 |
| Number of Centres | 150 | 45 | 24 | 44 | 7 | 13 |
| Location | Across India | Andhra Pradesh (AP), Gujarat, Madhya Pradesh, Punjab, Uttar Pradesh (UP), National Capital Region (NCR), Jammu and Kashmir, Maharashtra, Rajasthan | NCR, UP, Uttarkhand, Haryana, Gujarat | Tamil Nadu , Karnataka, AP, Rajasthan, Odisha, Andaman and Nicobar | TN, Kerala | NCR, AP, TN |
| Revenue  (₹ billion) | 5.0 (2011–12) | 1.2 (2012–13) | 0.95 (2013–14) | 1.1 (2012–13) | 0.3 (2012–13) | NA |

Note: NA = not available

Source: *May–June 2014: CRISIL CRB Customised Research Bulletin* (Mumbai, India: CRISIL House, May 2013), accessed April 6, 2015, [www.crisil.com/pdf/research/CRISIL-Research-cust-bulletin\_may\_jun\_14.pdf](file:///\\biz-info.ivey.ca\IveyPubs\shared\CASES\A-Cases%20Pending\Eye%20Q%20Visions%20for%20the%20Long%20Term\www.crisil.com\pdf\research\CRISIL-Research-cust-bulletin_may_jun_14.pdf).

Exhibit 2: EYE CARE CENTRE MODELS

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Primary Centres** | **Secondary Centres** | **Tertiary Centres** |
| Facilities | Screening and consultation | Consultation and cataract surgeries | Consultation and all complex surgeries |
| Reach (Population) | ~50,000 people | ~1 million people | ~5 million to 50 million people |
| Investment/Centre | ₹2 million to ₹3 million | ₹20 million to ₹30 million | ₹50 million to ₹60million |
| Square Feet | 500 to 1,000 | 2,000 to 3,000 | 4,000 to 8,000 |

Source: “Business Models in Eye Care Delivery,” CRISIL Research Report, March 19, 2014.

EXHIBIT 3A: EYE-Q PROFIT AND LOSS STATEMENT

Overall Eye-Q Fiscal Year ending March (in ₹ million)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | **Historical** | **Historical** | **Historical** |
| **2011** | **2012** | **2013** |
| **Sales** |  |  |  |  |
|  | Cataract | 42.54 | 116.22 | 246.76 |
|  | LASIK | 11.14 | 37.92 | 82.01 |
|  | Retina + Glaucoma | 5.77 | 21.88 | 60.27 |
|  | Pharma and Opticals | 1.57 | 10.75 | 59.74 |
|  | Outpatient Department | 11.00 | 21.08 | 43.29 |
|  | Other Medical Revenues | 16.11 | 24.51 | 27.87 |
|  | **Income from Operations** | 88.13 | 232.36 | 519.94 |
|  | Less Discount | -1.67 | -8.04 | -15.08 |
|  | **Net Income** | 86.46 | 224.32 | 504.86 |
|  | ***Year-on-Year Sales Growth*** | 0.00 | 1.59 | 1.25 |
| **Cost of Sales** |  |  |  |  |
|  | Cost of Consumables/ Procedure | 15.77 | 48.41 | 127.57 |
|  | Establishment Cost | 13.24 | 31.00 | 55.88 |
|  | Manpower Cost | 50.31 | 144.06 | 233.97 |
|  | Marketing Expenses | 9.08 | 13.81 | 44.09 |
|  | Office Repairs and Maintenance Costs | 13.15 | 43.26 | 72.37 |
|  |  |  |  |  |
|  | **Total Cost** | 101.54 | 280.54 | 533.88 |
| **EBITDA** |  | -15.07 | -56.22 | -29.02 |
| **EBITDA Margin** |  | -0.17 | -0.25 | -0.06 |
|  | Other Non-Operating Income | 4.56 | 8.33 | 19.64 |
|  | Finance Expenses | 9.83 | 8.49 | 14.53 |
|  | Depreciation Expenses | 12.39 | 13.44 | 23.96 |
|  | Goodwill Amortization | 0.89 | 17.23 | 26.00 |
| **PBT** |  | -33.62 | -87.06 | -73.87 |
| **PBT Margin** |  | -0.38 | -0.37 | -0.14 |
|  |  |  |  |  |
|  | Tax | 0.00 | 0.00 | 0.00 |
|  |  |  |  |  |
|  | PAT | -33.62 | -87.06 | -73.87 |

Note: EBITDA = earnings before interest, tax, depreciation, and amortization; PBT = profit before tax; PAT = profit after tax

Source: Company documents (data has been disguised to protect confidentiality).

**EXHIBIT 3B: EYE-Q BALANCE SHEET**

Overall Eye-Q for Fiscal Year Ending March (in ₹ million)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Historical** | **Historical** | **Historical** |
|  |  | **2011** | **2012** | **2013** |
| **Liabilities** |  |  |  |  |
| 1 | Equity Share Capital | 101 | 587 | 587 |
| 2 | Reserves and Surplus | −48 | −135 | −209 |
| 3 | Secured Loans | 38 | 91 | 122 |
| 4 | Bank Working Capital | 0 | 0 | 0 |
| 5 | Deferred Credit for Equipment from Vendors | 9 | 9 | 4 |
|  |  |  |  |  |
|  | TOTAL | 99 | 552 | 503 |
|  |  |  |  |  |
| **Assets** |  |  |  |  |
| 1 | Gross Block Goodwill | 109 | 319 | 428 |
| 2 | Less: Accumulated Depreciation | 19 | 32 | 56 |
| 3 | Net Block | 90 | 287 | 372 |
| 4 | Net Current Assets | −20 | 92 | 74 |
| 5 | Deferred Tax Asset/ (Liability) | 0 | 0 | 0 |
| 6 | Cash and Bank Balance + Liquid Investments (Mutual Funds) | 10 | 141 | 1 |
| 7 | Investments in Subsidiary | 0 | 0 | 0 |
|  | TOTAL | 99 | 552 | 503 |

Source: Company documents (data has been disguised to protect confidentiality).

1. “Details of Tier-wise Classification of Centres Based on Population,” Reserve Bank of India, accessed July 13, 2017, http://rbidocs.rbi.org.in/rdocs/content/pdfs/100MCA0711\_5.pdf; as per media reports, there were about eight Tier 1 cities, 26 Tier 2 cities, 33 Tier 3 cities, and over 5,000 Tier 4 towns, while there were more than 638,000 villages in the country; “Tier I and Tier II Cities of India,” Maps of India, accessed June 16, 2014, www.mapsofindia.com/maps/india/tier-1-and-2-cities.html. [↑](#footnote-ref-1)
2. ₹ = INR = Indian rupee; all amounts are in ₹ unless otherwise specified; US$1 = ₹61.88 on January 1, 2014. [↑](#footnote-ref-2)
3. “Global Data on Visual Impairments 2010,” World Health Organization, 2012, accessed April 1, 2015, www.who.int/blindness/

   GLOBALDATAFINALforweb.pdf. [↑](#footnote-ref-3)
4. “Eye Care Delivery Market to Double Over Next Five Years,” CRISIL Research Report, March 19, 2014; Raelene Kambli, “Eyeing the Light,” Express Healthcare, October 11, 2012, accessed July 13 2017, http://archivehealthcare.expressbpd.com/sections/market-section/815-eyeing-the-light; Global Data on Visual Impairments 2010, (Switzerland: World Health Organization, 2012), accessed April 1, 2015, www.who.int/blindness/GLOBALDATAFINALforweb.pdf. [↑](#footnote-ref-4)
5. “Visual Impairment and Blindness,” Fact Sheet No. 282, World Health Organization, August 2014, accessed April 1, 2015, www.who.int/mediacentre/factsheets/fs282/en/. [↑](#footnote-ref-5)
6. “Eye Care in India — A Situational Analysis, 2007,” Sightsavers International, India, accessed April 6, 2015, <http://sightsaversindia.in/wp-content/uploads/2014/06/16482_Eyecare-in-India-A-Situaltion-Analysis.pdf>. [↑](#footnote-ref-6)
7. “Eye Care Delivery Market to Double over Next Five Years,” op. cit. [↑](#footnote-ref-7)
8. Ibid. [↑](#footnote-ref-8)
9. Ibid. [↑](#footnote-ref-9)
10. Health services in India were provided through a three-tier set-up—namely, primary, secondary, and tertiary services. Primary care was the first level of contact of the community with the health system. Cases that were more complex and that needed specialized care were referred to the secondary level (district hospital) or tertiary level (regional and national hospitals). [↑](#footnote-ref-10)
11. VISION 2020 was a global initiative that aimed to eliminate avoidable blindness by the year 2020. It was launched on February 18, 1999, by the World Health Organization, together with the more than 20 international non-governmental organizations involved in eye care and the prevention and management of blindness that comprised the International Agency for the Prevention of Blindness. VISION 2020 was a partnership that provided guidance, technical, and resource support to countries that had formally adopted its agenda. India was a participating country. [↑](#footnote-ref-11)
12. Mahathi R. Arjun, “An Eye on Growth,” The Smart CEO, August 15, 2011, accessed June 16, 2014, www.thesmartceo.in//an-eye-on-growth.html. [↑](#footnote-ref-12)
13. Ibid. [↑](#footnote-ref-13)
14. “Eye Care Delivery Market to Double over Next Five Years,” op. cit. [↑](#footnote-ref-14)
15. As a category of debt taken on by a company, “quasi-equity” had some traits of equity, such as having flexible repayment options or being unsecured; “Quasi-equity,” InvestorWords, accessed June 16, 2014, www.investorwords.com/6898/

    quasi\_equity.html#ixzz3HGh5fTnH. [↑](#footnote-ref-15)