



# UROLOGICAL ASSOCIATION OF KERALA

## NEWS LETTER

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## Identifying Financial value in Clinical Practice

### Industrialization of Healthcare : A Reality

The healthcare sector has evolved into a vital industry characterized by substantial capital investments and intricate integration with ancillary sectors such as pharmaceuticals, diagnostics, equipment manufacturing, and the associated financial apparatus. The substantial influx of human resources essential for the smooth operation of medical departments, coupled with the necessity for proficient professional management, further cements its industrial nature, moving away from a mere altruistic pursuit.

In the realm of governance, the healthcare sector teeters on the brink of commercial equivalence, evident in taxation structures, certifications, registrations, and the intricate legal framework enveloping its operations.

The discerning public is drawn to corporate entities boasting cutting-edge facilities and an air of opulence, contingent on financial capacities. A proclivity for establishments radiating a luxurious ambience prevails among those with the means. Conversely, the narrative within the healthcare industry, government circles, and public discourse exhibits notable disparities. Despite the industry's acknowledgment of commercial realities, there exists a reluctance among some to fully embrace this shift, rooted in the longstanding perception of healthcare as a charitable endeavour. Acknowledging this truth is crucial; denying it hinders progress, and true advancement is only possible when we confront the prevailing reality.

Within the realm of industry, every facet is subject to the meticulous assessment of financial worth, governed by the unyielding principles of pure mathematics. Emotions and sentiments, no matter how passionately expressed, prove inconsequential in the face of these mathematical certainties. Despite the fervency with which we may implore, the sum of one and two remains unwaveringly fixed at three, resolute in its refusal to yield to our emotional pleas.



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In the intricate machinery of healthcare industry, where different other industries weave their delicate patterns, doctors who stand as the central wheel, a linchpin in the relentless motion of the apparatus also need to be valued.

Determinants of Financial Value of Doctors:

The doctor's educational profile is a pivotal determinant in shaping their financial valuation. Specializations enhance their market value, expanding the range of medical services they can provide within a hospital setting. The prestige of the institutions granting their qualifications significantly influences this valuation.

Clinical experience, quantifiable in terms of years and the diversity of institutions served, becomes a tangible asset in the financial assessment. The temporal investment in the field, coupled with the esteemed institutions associated with the doctor's career, contributes to the valuation.

The nature of services offered, whether encompassing intricate treatments or complex surgeries, especially within specialized domains, elevates the doctor's financial significance. Patient outcomes and feedback, if quantifiable, form integral components that attest to the doctor's effectiveness and contribute to the overall valuation.

Geographic considerations play a significant role in the valuation process. The demand for specific medical services may vary by region, influenced by a hospital's historical standing or brand recognition. The cost of living and healthcare demands in a given geographic area directly impact the doctor's financial worth. Urban settings or regions facing a shortage of medical professionals may experience an escalation in doctor compensation, reflecting the supply and demand dynamics. In the Indian context, rural regions with fewer physicians witness higher remuneration compared to their urban counterparts.



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### **Problems of Assessment of Financial Value**

Negotiations regarding financial valuation transpire between the doctor and hospital management, each rooted in their respective financial viewpoints. Disparities may arise as the physician advocates for remuneration aligned with perceived value, while the hospital seeks a balance that aligns with its fiscal estimations. In the negotiation process, compromises are brokered, leading to the formulation of a memorandum of understanding that reconciles the disparate financial outlooks.

As the contractual arrangement commences, both parties initiate a re-evaluation of their financial viability, a juncture that often ushers in challenges. The fiscal soundness of a healthcare professional is conventionally quantified by assessing the patient volume and the resultant revenue generated. The ensuing gross income becomes the benchmark against which the remuneration extended to the doctor is juxtaposed. Unfortunately, meticulous financial assessments are seldom conducted by most healthcare managements, with subjective evaluations predominantly guiding their decisions.

If the management determines through financial assessments that a program is not yielding the expected profitability, it initiates a course of action that applies pressure on the doctor. This situation often leads to heightened stress for the doctor.

On the contrary, in instances where the doctor's workload experiences an escalation without a corresponding adjustment in perceived compensation, the doctor tends to voice concerns and advocates for a renegotiation of the terms. Such scenarios are ubiquitously observed across various hospitals.

Even when adhering to the established determinants of financial value in remuneration calculations, there is a recurrent failure to achieve accuracy, indicating the omission of crucial considerations.



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Doctors often perceive their substantial contribution to hospital revenue through consultation fees, investigations, and procedure charges. Some may even deduce this income from hospital statistics to substantiate their claims. However, managements may frequently reject such assertions. Are there crucial aspects being overlooked in this evaluation?

The doctor's role in patient treatment can be broadly construed as the evaluation of patients and recommending necessary treatments. In cases requiring procedures or surgeries, the doctor is tasked with their execution. Additionally, doctors are required to oversee the treatment process, even if they are not directly administering it, such as in nursing, drug administration, and monitoring. This demands a significant commitment and expertise, a fact acknowledged by all.

A doctor's impact on the hospital extends beyond direct involvement in patient treatment. They serve as a supportive figure for colleagues in various specialties and within their own department. Possessing goodwill among numerous patients, some may specifically choose the hospital due to the doctor's presence. Engaging in cross-referrals, the doctor aids other specialties within the hospital. Their role extends to supporting the emergency care team, a vital component of the hospital's credibility. Despite having limited working hours, the doctor is consistently available on call to provide assistance when needed.

Simultaneously, it's imperative not to overlook the system that expends considerable effort to bring a patient to the consultation room, ensuring that the doctor has access to all necessary facilities, equipment, and support systems for safe treatment. This extends to providing mental and physical comfort to the already stressed patient. This comprehensive effort includes maintaining well-equipped operation theatres and procedure rooms with state-of-the-art facilities, efficient nursing management and support systems, intensive care units, and other vital departments staffed by expert healthcare professionals. A robust management and administration team is crucial for the seamless functioning of these systems.



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This multifaceted activity necessitates substantial investments in infrastructure, human resources, and finances.

Both the doctor's role and the supportive healthcare system are complementary and equally vital components of the overall patient care framework. Determining the percentage of income share for each party in financial terms requires an evaluation of the overhead expenses of each institution. Overhead expenses are often directly proportional to the amenities provided to patients, investments in infrastructure and equipment, and promotional expenses. In smaller clinics, a larger portion of the income may be allocated to the doctor, given lower overhead expenses. Conversely, in larger hospitals, the financial stake of doctors may be comparatively lower, considering the higher overhead costs associated with maintaining extensive facilities. Unfortunately, these critical nuances are frequently overlooked in financial considerations.

The central question at hand is whether we can accurately ascertain the true financial value of a doctor. This task proves exceedingly challenging unless the doctor operates a solo practice independent of any hospital affiliation. Even a hospital attachment, particularly for inpatient or surgical treatment, may introduce a minor bias. The undeniable reality is that patients seeking treatment are typically influenced not solely by the doctor's expertise or reputation but also by various other factors inherent in the dynamics of patient choice. These factors are often predominantly managed by the hospital.

The scientific separation of these interdependent and influential factors poses a significant challenge, often escaping thorough evaluation by both the medical community and the healthcare industry. The question then arises: how can we navigate this complex puzzle? In response to this challenge, hospital managements have devised various payment strategies as a means to overcome these intricacies.



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### **Financial Models of Compensation**

The conventional approach of paying a monthly salary is a widespread method, akin to practices in other sectors. Under this arrangement, the doctor adheres to a fixed working schedule and receives a predetermined salary each month, regardless of the volume of work performed. While this method provides stability, it does pose the risk of diminishing incentives, potentially leading the professional to operate within the confines of a standard salaried structure. In such situations, the management's push for increased productivity can be a cause for concern. Insufficient productivity may even result in removal from the job.

Another system involves a combination of a monthly salary and additional professional income derived from the generated revenue. The percentage share may be granted in entirety or when it surpasses the basic salary. The proportion of the revenue share fluctuates based on the baseline salary and other specified conditions. In all these scenarios, working conditions may differ, and there exists an incentive for the doctors to increase their workload as it directly impacts their overall remuneration. Challenges emerge when the doctor fails to render services adequate to cover even the basic salary. To address this, some managements may opt to set the salary at a minimal level, a decision that may not be grounded in any specific calculations.

Certain consultants operate solely on professional charges, which constitute a share of the revenue generated without any additional payments. In this arrangement, the consultant may experience stress, as their income is contingent upon a variable share that can fluctuate over time, rendering it unstable. The management, on the other hand, benefits from a secure position, as they are not obligated to make extra payments. Consultants, in this scenario, do not face pressure from management for underperformance since there is no loss to the management at any point. Managements may vary in the percentage of revenue shared with the consultant and in what is considered as the revenue.



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**For Beginners :** A salary system may work well, providing a stable income when goodwill is limited. However, there may be pressure from management to increase workload

**For Middle-Level Consultants :** A salary plus revenue-share model could be considered ideal. This approach reduces management pressure and offers incentives to work more

**For Senior-Level Consultants :** The revenue-share system might be preferable, as it grants more freedom and independence, freeing senior consultants from management pressure.

Ultimately, the consultant's choice should align with their individual preferences, experience, and professional standing in the field.

Challenges emerge when doctors opt for high salaries but deliver less output, leading to dissatisfaction. Similarly, if consultants receive only a small percentage of the revenue share, discontent may arise. Achieving a clear understanding of these dynamics is crucial for both management and consultants. A practical and scientific approach grounded in financial analysis can bring transparency to these matters. However, the discussions often revolve around the bargaining power of each party, adhering to the market dynamics that have already ensnared us.

## Valuation of Clinical Practice

A thought-provoking scenario presents itself for examination. Let us delve into the circumstances of a singular practitioner contemplating retirement and the subsequent sale of his/her practice, a familiar transaction within the western paradigm. The procedural roadmap for such an event begins with the fundamental question: How does one conduct a financial valuation of the practice?



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The primary undertaking in this process involves a rigorous assessment of the practice's intrinsic value. Extracting the unadulterated annual income and removing any subjective biases, we arrive at a precise financial metric. The computation of the capital required to generate his annual income, factored with a standard return of 10%, dictates the initial evaluation. Assuming an annual income of 12 lakhs, the calculated value of the practice stands at a commendable 1.2 crores.

However, the financial calculus introduces an additional layer of complexity through the consideration of depreciation. Employing a conservative approach, a fifty percent reduction is applied, accounting for the potential decline in the practice's value over time. In the illustrative example, this adjustment leads to a refined valuation of 60 lakhs. Hence, Six lakhs are earmarked as immediate returns, while the remaining six lakhs are strategically earmarked for inclusion in a corpus. Over a decade, this corpus matures into a substantial 60 lakhs, accruing interest along the way. Finally, we may conclude that the valuation oscillates between a floor of 60 lakhs and a ceiling of 1.2 crores, contingent upon the intricacies inherent to each unique scenario. Tangible assets, inherently distinct, warrant a parallel and separate financial consideration within this methodical analysis.

## Conclusion

In the evolving landscape of healthcare as an indispensable industry, the financial valuation of doctors hinges on multifaceted determinants, including education, specializations, clinical experience, geographic nuances and patient dynamics. Challenges persist in accurately assessing their value, exacerbated by the complex interplay of patient volume, revenue, and remuneration. Payment structures, encompassing fixed salaries, revenue shares, or professional charges, introduce additional complexities based on consultants' standing. Achieving a true understanding necessitates a nuanced blend of practicality, financial analysis, and acknowledgment of evolving industry dynamics, balancing contributions, infrastructure, and market forces shaping doctors' financial worth.