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Message from the
ALUMNI OFFICE

Dear Alumni,

Proud to present to you the 9th edition of the IIMB Alumni Magazine! In this edition, we have chosen a topic which is very new to us, but extremely important for the world - Healthcare. Starting this edition, we will be bringing out perspectives on a sector from both academic and industry point of view as our key theme. And that is why this edition is very unique to us. We not only want the Magazine to be a platform for alumni to share and know more, we also want it to be more deeper and richer by showcasing the work done by our faculty members on a sector that is a perfect case to apply management principals.

This edition pays tribute to our founder director - Late Shri N S Ramaswamy, also known as "Cartman". Many of us were truly fortunate to have met him, learnt from him and got a chance to study and work in this glorious Institute that he founded in 1974. We celebrate that day as the Foundation Day of IIM Bangalore. May his soul rest in peace… On behalf of the entire IIMB community, I thank him for his efforts for our country and society.

The Alumni Office is continuing on its path to engage, energize and enhance the community worldwide. This October, we partnered with other IIM alumni associations and did a Rock Night to support NGOs founded or supported by the alumni. I felt really proud to see our alumni supporting the society and give back in some form to make it a better place. Our sincere thanks to officers of IIMA and IIMC alumni associations of Bangalore for coming together and making this happen! We plan to make this an annual event. The Mumbai Chapter of our Alumni Association partnered with an Executive Education Program for senior managers and leaders from Africa and has ushered a new dimension of engaging alumni in the Institute’s programs. There is a wealth of experience you all have that can make our programs more purposeful and relevant for the industry. The feedback from the participants was outstanding. And thanks to Saif Qureishi PGP 88, President of Mumbai chapter and his team for organizing the sessions.

I take this opportunity to congratulate the Distinguished Alumni awardees of this year, Shaahi Sinha PGP 81 and Rajiv Maliwal PGP 85. Their contributions to the industry and society are truly incredible.

The PGP 86 pledge of Rs 1 Crore is progressing extremely well and after discussions with the batch, we will be investing their pledge on our internationalization plans and creating programs to study and research in emerging economies. In next few years, this will result in new courses and study material for our students. I thank the batch for their generous support and their trust in our vision.

One of our members at the Alumni Office, Gayatri Nair, is in UK now to pursue her studies. She brought in the much needed energy, laughter and bonding in the office. I feel proud to see our team grow wings. Good luck Gayatri. We miss you.

My team - Aparna, Sushma, Rohini and Ranjini continue to bring out the best at shoestring budgets and it amazes me how human potential can do wonders. We now will focus on the Alumni Office version 2.0 from next year which will focus on networking and building structures that help each other. Our foundation is rock solid now.

Last not least, I look forward to meeting the 200 families of alumni from PGP 82, 87, 97, 02 and EPGP batches for their reunions this month - my favourite part of the year. Merry Xmas and Happy New Year!

Rakesh Godhwani PGPSEM 04
Head, IIMB Alumni Association
We’ve rolled out the red carpet across the silvery sands of Kutch

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I t was a pretty chilly July morning in the year of 1981. I gingerly stepped out of the railway station to get into Bangalore as well as enter the portals of the venerated IIMB. There was no campus then, we had been told to get into and make ourselves comfortable in one or the other of the four make shift hostel buildings strewn over the city. And on the opening day we trooped into the St. Joseph College building at 33, Langford Road where we had classes.

Amongst all the myriad events, images and goings on that presented themselves to us on that opening day, the most intriguing and impactful impression on us was created by tall man with a bald head and flowing white beard who welcomed us at the opening ceremony. We were given to understand that he was Prof N S Ramaswamy, the Director of the Institute.

He handled his welcome address to us pretty much like a Sehwag or Gayle would deal with the opening overs. Before we could blink, he was well on his way delivering his long sermon to us. Initially, we could not help but get amused with his accent, mannerisms and idiosyncrasies.

But as he went on to tell us all about the Institute, his vision for the Institute and our future, and of course his pet theories on the importance of Indian values in business management and programs for nation building and so on, an eerie silence fell on the
Professor N S Ramaswamy, Founder-Director of IIMB, passed away on September 17, 2012 at his residence in Bangalore. He was 86. He is survived by his wife Rajam Parvathi, his son Rajan Srinivasan, his daughter Rajani, three granddaughters and a grandson.

We discovered a visionary who had the foresight to not just dream big but also build clear plans and roadmaps in his mind to turn those dreams into reality. We discovered his relentless drive to pursue those dreams and pet projects of his, braving any amount of criticism and hurdles from all quarters. We found that he would not hesitate to be authoritative and forceful when required. We saw that while he was capable of endearing himself to people, he was even more capable of making a pest of himself when it came to getting the job done.

NSR was not an immensely popular person. On the contrary he was criticized by many as an obstinate and aggressive person with a leadership style that bordered on 'my way or the highway'. He had more than his fair share of detractors among the bureaucrats, faculty and staff of the Institute. He was much maligned on many occasions. But NSR couldn’t care less. He had a mission to accomplish and that was what mattered. He was clear about the beliefs and values he stood by and that was how he lived.

NSR made a difference to the world he lived in. And what is true of many towering men and women who made a difference to the world they lived in was also true of NSR - You could love him or you could hate him, but you could just not ignore him.
Fifty thousand years have passed since humans evolved on earth and all throughout we have grappled with the riddle of health and medicine. Yes, we deftly sent a hundred diseases to fade into oblivion. And yes, we are looking onto the face of a hundred new ones, appalled and helpless. While we battle ill health on one hand, we have medical systems, insurance companies, drug discoveries and thriving new markets on the other. What does it all mean to us? Let’s pause for a while to gauge the most gravely fascinating proposition of all times - human health, on the Indian turf.
A quaint little island village in Greece, Ikaria, caught the attention of the world when New York Times called it a place where its ‘people forget to die’. Ikarians effortlessly live to become centenarians and are barely troubled by diseases. Intrigued researchers are trying to find what goes into their longevity. Is it the wine, the herbs, the home gardens, or the stress-less leisure in living as a community of friendship and laughter, we do not know. But as they enviably live it up with just one doctor in the village, here in India we have millions of people trying to fix one ailment or the other on a day to day basis.

Healthcare in India comes in myriad shades. In classic contradiction, while over 68% of the population is struggling for access to health care we are a country where medical tourism is flourishing. There is opportunity, there is despair. There are questionable attitudes and laudable achievements. There is traditional wisdom as well as modern outlook. Amidst these bewildering components of skepticism and potential, the industry has been creating an amplified buzz around itself over the past few years.

The Indian Healthcare industry is unarguably entangled with the ‘emerging’ phenomenon of the economy and what attracts eye popping interest is the sheer volume of growth that it promises. The industry engine is at its roaring best marking a growth of a whopping 20% per year and is anticipated to swell into a $ 280 billion industry by 2020! Its pharma component alone is the third largest in the world. McKinsey’s assessment is that the pharma industry growth ‘would be driven primarily by rising incomes, and be supported by five other factors: enhanced medical infrastructure; rise in the prevalence and treatment of chronic diseases; greater health insurance coverages; launches of patented products; and new market creation in existing white spaces.”

The opportunity of healthcare in India takes along with it a whole lot of related industries as well - Medical tourism industry, medical equipment industry, biotechnology industry, healthcare information technology industry, diagnostics services industry, health insurance industry, wellness industry and hospital trade industry. Medical tourism is expected to generate $ 3 billion by 2013. Hospital trade is a growing business with retail trade outlets catering to hospitals in urban area amassing huge profits. According to the WHO standards of 4 beds per 1000 population, India is facing a deficit of 30 lakh beds for its population, which means there is an opportunity for at least 12,000 new hospitals, at the rate of 250 beds per hospital.

The major advantages that India has at this point in time, with the positive wave of economy favoring it in abundance, are: India provides significant low costs in terms of healthcare services, R&D services, and medicines. The huge population, which is undoubtedly a double edged sword, offers a massive scale in terms of being a market. The government is calling for increased NRI investment in healthcare and this offers to increase healthcare expenditure. Penetration of mobile phone technology across the length and breadth of the country has opened up opportunities for remote diagnosis. Renewed interest for Ayurveda, Homeopathy and Yoga has ignited the opportunity for a much sought after wellness industry.

The call of the hour is some good reflection on how we can capitalize on this momentum in the industry. Positively, we should relook at our understanding of health and how we approach healthcare in terms of providing quality care and efficient delivery across the massive scale that needs to be addressed. As big the opportunity, as big the challenge! The biggest challenge of course will be to close the gap and eliminate economic status from being the determinant of healthcare availability. And some things as basic as clean drinking water and sanitation for the entire population will need to see the light of a new
Healthcare expenditure in India is just around 6% of GDP

68% of India's population is struggling for access to health care

Healthcare in India is growing at a whopping 20% per year

Healthcare industry is anticipated to become a $ 280 billion industry by 2020

Estimated 150,000 people travel to India for low cost healthcare every year

India is home to 16% of the world population, 21% of the global diseases

Only 14% of India's population is covered by insurance

70% of the India's population lives in villages, but 80% of India's doctors and 60% of hospitals are located in urban areas

Only 13% of the rural population has access to a primary healthcare centre and 9.6% to a hospital

An average Indian has to travel 77 km to access basic medical facilities

Medical Tourism grows at 30% per year and is expected to generate $ 3 billion by 2013

More than 85% medical equipment used in India is imported from other countries

Indian pharma industry is the third largest in the world

India is a leading producer of generic drugs

The success of visionary and noble institutions like Narayana Hrudayalaya and Aravind Eye Hospitals has proved that it is indeed possible to provide quality service for a huge mass of population and generate profits as well. More and more innovative entrepreneurs are entering the healthcare scene in a welcome trend. The key change maker to a better future would be an integrated private and public partnership in creating the infrastructure that the country seeks. With a renewed social, economic and political outlook, and a resurgent philosophy towards healthcare, we would steer us towards a healthier nation. Our traditional wisdom of medicine and healing traces back to Rig Vedic periods. A closer look into the past will definitely do us some good before we march into the future. Perhaps, we inherently know how to live a healthy life, like the Ikarians of Greece; it might just be a matter of realizing it.

In this article, five of our alumni look at healthcare from different viewing platforms - from that of technology, alternative medicine, accessibility and affordability and from that of a doctor.
Thirty years ago, nobody talked beyond X rays. Today we have advanced 64 slice CT scans, 3D ultrasounds, MRIs and robotic surgeries happening all around us. Beginning with simple data entry of demographic, financial charges and clinical data, information technology (IT) has taken off. IT is now enabling physicians and other care givers to manage patient care akin to orchestra conductors conducting Beethoven’s ninth symphony. That’s the beauty of healthcare today, a brilliant combination of medicine and information technology, says Deepak Mirchandani, Regional Director of Catholic Health Partners in Cincinnati, Ohio. Deepak is an aficionado of the healthcare ecosystem and information technologies. He is fascinated by how IT has brought great sophistication and dexterity to the medical world within such a short span of time. And what excites him the most is how promising the future of healthcare looks.

“Medicine is very rapidly evolving and there is no slowing down with genomics unravelling more and more mysteries of the human body. We are very close to knowing what exactly is happening inside a person --- understanding these insights to manage health will be the next summit that humanity will conquer”, says Deepak.

Deepak began his tryst with the healthcare industry with a project in the Belgian Healthcare system. Since then he has had the opportunity to see how healthcare systems work in the UK, US and Canada. If India is looking at learning from the systems of the West, he says it should draw inspiration from the UK and Canadian models. India might also want to learn a thing or two from the commercial aspects of publicly funded US healthcare --- like how revenue is raised, how claims are adjudicated, how resource based value systems are implemented. In his opinion there is little to learn from the privately funded commercial insurance sector where cracks show up often and offers marginal economic or social value. Deepak recommends that a roadmap for the Indian healthcare industry should be based on the strengths of publicly funded healthcare systems. If his bias makes you think whether government systems can be effective, Deepak vehemently challenges the argument, “India has displayed great maturity in balancing its markets with government influence. Along with visionary leadership, when such maturity is extended to healthcare, India can do wonders, just the way it did with telecom and software.”
Deepak makes an interesting analogy of the Indian software industry as a source for an inspired growth of the Indian healthcare industry. "The opportunity in software was sensed by clairvoyant leaders and entrepreneurs who gave structure to an industry that never existed before. Deepak points out that one of the major reasons why software industry thrives in India is because of the stringent processes that have been put in place. The Capability Maturity Model (CMM) model that originated from the Software Engineering Institute at Carnegie Mellon University was adopted early by the software industry in India --- this highly process driven approach ensured reliability of software products and services which instilled customer confidence. When coupled with the inherent ingenuity of Indian software engineers, this approach gave impeccable efficacy to the Indian software industry that left the rest of the world awe-stricken. Drawing parallels, healthcare delivery is a lot about processes and if comparable process management frameworks are established, India has the best opportunity to establish high levels of sophistication in healthcare", says a very optimistic Deepak.

There is a great deal of credit that we owe to the entrepreneurs who made it happen for telecom and software. In addition, partnerships fostered with central, state and local governments created the perfect environment for success. And that’s exactly what healthcare needs at this juncture - innovative entrepreneurs who can steer Indian healthcare through its next phase - well past medical errors, gaps in accessibility and affordability, and other grey areas that exist in healthcare services.

An opportunity that goes beyond episodic patient care is the promotion of wellness. Deepak says that wellness should become an integral part of any kind of healthcare system design. "No society can afford to create a large pool of unhealthy people and revel in the growth of the healthcare industry. While the responsibility for staying healthy is personal, entrepreneurs can build on the opportunity of developing and offering wellness programs - innovation that could translate to more fitness facilities, swimming pools, youth camps, yoga classes, nutrition counselors, lifestyle coaches, disease managers for chronic conditions, etc. Those just may be the seeds for an entire range of the health maintenance industry."

Talking ALTERNATIVE and INTEGRATIVE

Sarvpriya Dewan PGSEM 08 and his wife Dr. Pooja Chetal Dewan are founders of an NGO Aashritha Foundation, that works towards an integrative model of healthcare and promote homeopathy. Sarvpriya works as Principal Business Analyst at Oracle and Dr. Pooja holds a doctorate in Biotechnology.

Deepak Mirchandani chalked out a picture showing the new precipices that India can conquer in healthcare. The journey though is of course not going to be a cakewalk, especially with some mistakes that have been spilt along the way. One such mistake lurking around us is rather grave, that of increased drug resistance.

Sarvpriya Dewan PGSEM 08 brings this appalling statement from the World Health Organization in 2010 to our notice - "The use and misuse of antimicrobials in human medicine and animal husbandry over the past 70 years has led to a relentless rise in the number and types of microorganisms resistant to these medicines - leading to death, increased suffering and disability, and higher healthcare costs." The same antibiotics that saved millions of lives in the past are today
COVER STORY

A post-antibiotic era means, in effect, an end to modern medicine as we know it. Things as common as strep throat or a child’s scratched knee could once again kill,” warns Margaret Chan, Director-General of the World Health Organization.

becoming ineffective, giving birth to superbugs that are resistant to antibiotics. Chasing these resistant superbugs, we would end up in a post antibiotics era. “A post-antibiotic era means, in effect, an end to modern medicine as we know it. Things as common as strep throat or a child’s scratched knee could once again kill”, warns Margaret Chan, Director-General of the World Health Organization.

During her R&D tenure in a Bangalore based diagnostic firm, Dr. Pooja Chetal Dewan, Sarvpriya’s wife, encountered many situations where patients in critical conditions had to succumb to diseases and injuries due to drug resistance. There were no antibiotics left that could be used to save their lives.

Pooja says these patients were suffering from critical conditions - like meningitis, sepsis, meningitis-encephalitis, multi-organ failure - but if we do not take a stand on rationalizing the use of antibiotics, we could face helplessness even at the face of a simple infection.

Sarvpriya says, “The research and development scenario also seems grim as we have not seen any new drug discovery in the past five years. And the pipeline for new medicines is almost dry. It takes over 10 years of research and testing to bring a new drug into the market and it hardly takes five years to develop resistance to these drugs.” Such is the state of affairs that major pharmaceutical companies are left with very less motivation to spend on R&D, given that their research spending on each new drug is as high as $4 billion to $11 billion on an average.

Pooja started questioning the abuse of drugs in our country and this sense of apprehension intensified when the couple saw their son suffer from the infamous wheezing problem that Bangalore weather inflicts on many. The little one, at an age of 10 months had to go through nebulization sessions. If this gave any relief to the child, the matter would be different. But no - the nebulizations made the child literally faint after each process - there was hardly any sign of hope for cure. The tipping point was when the doctor prescribed steroids for the child, to be administered for 6 months at a stretch. This outraged the couple and they decided to look out for alternative solutions, and that’s when Homeopathy came to their rescue.

Sarvpriya and Pooja experienced that homeopathy gave their son a peaceful cure from wheezing and the freedom to grow as a happy child. There was freedom from administration of antibiotics, its harmful side effects and frequent illness.
MEDICINE
is more of an ART than SCIENCE

Dr. Jaya Bajaj EGMP 12 is a Family Physician and founder of HealthRadiian, an online platform for Indian doctors and an attempt to initiate dialogue on current issues in Indian healthcare. She serves on editorial board of Journal of Family Medicine and Primary Care.

It was a powerful sweep of mistrust that found resonance across the country when Aamir Khan presented his case against doctors through Satyameva Jayate. The trust factor has been standing on its shaky legs for quite some time now and Aamir’s show was quite a jolt. The blame is primarily on the commercial drive that is slowly replacing the wellness intent of hospitals, doctors and insurance companies. But it is completely unfair to devalue the services of our doctors, says Dr. Jaya Bajaj EGMP 12, a family physician.

Dr. Jaya is not denying that the scene has got messy. But she strongly believes that India has a rich pool of dedicated doctors, many under-appreciated and under-paid, who are doing good work in their own way. “There is corruption everywhere and unfortunately it has crept into the medical field as well”, she says. But the danger is exactly because it is in the medical profession where lives are at stake. Jaya calls for a conscious effort from the medical community to redeem respect for doctors and rebuild the trust in the healthcare system.

Dr. Jaya observes that this not-so-rosy situation has some of its roots sprouting from the classrooms of medical schools. “The system is not meticulously organized or standardized. Stark dissimilarities will pop up if medical students from various colleges across the country compare notes. And moreover, how much would you expect to transpire in a depersonalized classroom of 200 medical students? This kind of spray and pray method cannot be held as the most effective, especially for the kind of crucial education that medical profession seeks”, opines Jaya.

Like anyone of us, Dr. Jaya also has her anxieties about the health scene in India. Some of the most frustrating ones for her are:

► Inequitable health access - Healthcare is the right of every human being. We need to free it from the shackles of affluence and influence

► Quality of Medical education - Let’s try to humanize medical education beginning with doctors being better communicators

The couple has now founded an NGO, The Aashritha Foundation, which is working towards putting an end to the misuse of antibiotics and creating more awareness on the importance of homeopathy. Aashritha, is slowly and steadily working on its dream to make homeopathy an integral part of the medical system. “We strongly believe that an integrated approach is necessary wherein homeopathy can help prevent damage caused by drug resistance and allopathic medicines help to handle critical conditions like surgeries or accidents”, says Pooja.

Like Sarvpriya and Pooja, there are multitudes of people who have had bad experience with modern medicine and moved to alternative options like Homeopathy and Ayurveda. Most advocates of modern medicine scoff at alternative therapies and medicines with their one major argument that these treatments are not scientifically proven. But ignoring these alternatives might not be the most logical choice. There could be many paths to a destination, not just one.

A more tolerant and open minded approach to other available medical practices could help us solve some riddles. We never know, integrative medicine could be the next big thing.
Affordability - Families are going broke over one person’s illness. We need to bring healthcare costs within the affordability range of every individual.

Quality of healthcare - Access to healthcare should not be only about the numbers but about the quality of service provided to all.

Corruption - We need to establish a certain level of moral standards amongst all providers of healthcare in tandem with the nobility of this service.

Believing that committed professionalism within the healthcare community can help weed out a lot of these negatives, an inspired Jaya has taken her effort to make a difference by starting Healthradii, an online platform for Indian doctors and an attempt to initiate dialogue on current issues in Indian healthcare.

To add value and improve the health scene, a great share of responsibility lies with the patient too - or rather every individual - and this begins with health literacy. She says, “Health should be a personal responsibility in the first place that is supported by clean water, air, nutritious food, desire to be well, and preventive health care.” She believes that open communication between the doctors and the patients empowers patients in dealing with diseases. In Dr. Jaya’s experience as a family physician, she says she has been able to look at every patient as a whole, instead of looking at them through the lens of a particular health problem.

“Medicine is more of an art than science”, is what Dr. Jaya believes and if we have more and more professionals looking at it as an art and with great commitment, our journey towards panacea will be half traversed.

“Health should be a personal responsibility in the first place that is supported by clean water, air, nutritious food, desire to be well, and preventive health care.”

Dr. Jaya Bajaj EGMP 12
HEALTH CARE ACCESS

Deepak Sapra PGP 02 writes:

Indian companies have leveraged their reverse engineering skills to create a vast portfolio of generic medicines. This ensures that almost every medicine that comes up, has a generic version developed and ready to hit the market on patent expiry and on getting the necessary regulatory approvals. Coupled with a substantially lower cost (with regards to the west) operating environment, this helps generic medicines come to the market at extremely competitive price points which are often at a fraction of innovator costs. The impact of these attributes of the Indian pharmaceutical industry is seen not just in India, but in almost every country in the world, with the spectrum ranging from a regulation and litigation intensive market like the United States right up to low GDP, little regulation, resource starved countries in sub-Saharan Africa.

Indian companies have also gone up on the capability curve, with the country having a large number of plants with international approvals. As of 2011, India had over 75 United States FDA approved plants, over 150 EDQM (European Directorate of Quality Medicines) approved plants and over 1000 WHO-cGMP (Good manufacturing practices) approved plants. Over a dozen top Indian pharmaceutical companies are also investing in biotechnology and quite a few of them have got the bio-similars into the market in India and outside.

The spectrum of diseases covered by medicines produced at these plants includes a host of critical ailments like Cancer, AIDS, Tuberculosis and chronic ailments like diabetes, cardiovasculars, neuropsychiatry besides some of the established therapeutic areas like anti -infective, gastro intestinal and pain relievers.

An example to illustrate this impact would be the situation arising out of the entry of Indian generic companies with medicines for AIDS. With these Indian made generic versions, the cost of first line AIDS therapy in southern Africa came down from USD 50 per day to less than USD 1 per day in a few years. For the context, over 35% of people in this region live in extreme poverty, at an income level of below USD 1 per day. Companies like Cipla led the way in this game changing, access enhancing class of products. A host of other companies followed.
However, the core value proposition is not just in deriving economies of scale and in making cheap drugs cheaper. It is also in making unaffordable medicines affordable, and thereby helping democratize the economics of healthcare.

Let me pick up another example, that of Rituximab, a monoclonal antibody used in the treatment of certain types of cancers called Non-Hodgkin’s Lymphoma. This being an extremely complex biological molecule required a high level of expertise in chemistry, biology, process engineering and scale up even to develop a similar version. For a long time, these entry barriers had kept competition out and Roche, the innovator was the only one selling this in India. Dr Reddy’s was successful in developing Reditux, its brand of Rituximab and launched the product in India in 2007. It entered at a price point lower than 50% of Roche’s. This led to the number of users growing several folds as a lot many more patients were able to afford the medicine which was now available at a lower price. The market growth not only yielded high returns to Dr Reddy’s, it also enhanced the absolute sales of Roche.

Thus, for the right kind of price and the right kind of free market play, there can be a substantial impact on the number of beneficiaries. Indian companies have helped redefine this concept by contributing to enhanced access everywhere in the world, growing the size of the patient pool, thereby making this one of the most globally impacting industries out of India. With the rest of the world also learning the ropes of this generics game fast, most notably companies from China, there is a possibility the Chinese will begin to be important players in the finished dosage formulations space within a decade.

Major Indian companies are trying to stay ahead of this threat with investments and capability creation in novel drug delivery systems, super generics and biotechnology. In short, getting one step beyond generics and one step closer to innovative products.

And Round Two in the democratization of medicines would have just begun!
Harnessing mHEALTH to fill DOCTOR-PATIENT GAP

Sugato Basu PGP 93 writes:

Most experts agree that from practical field experiences in the Primary Health Centres (PHCs), a multi-channel communications strategy incorporating mass media, information communication technology, community mobilization and interpersonal communication, would be required to make changes in Health habits at the grass root level. These channels will need to be used in a synergistic way to ensure the widest possible reach and impact, while leveraging existing public and private sector infrastructure, systems and personnel in order to maximize cost effectiveness, scale and sustainability. One of the biggest barriers to get health care providers, NGOs and patients to use newer systems, is the difficulty in the use and access to such systems. This barrier to entry may be solved by m-health, the management of health care through mobile devices.1

Mobile APPS already available in India

Today, there are many mobile applications in India to help you maintain your daily health records, provide diagnosis and the course of treatment for various diseases. Such applications have a great role to play as they are educating people. I have put together notes on the following 5 initiatives to highlight the practice and issues being tackled by mHealth in India in the last year.

MAMA India: MAMA, Mobile Alliance for Maternal Action, is a public-private partnership launched in May 2011 by founding partners United States Agency for International Development and Johnson & Johnson with supporting partners - the United Nations Foundation, mHealth Alliance, and BabyCenter. MAMA is pursuing a landscape analysis and mapping effort to assess how to reach low-income, at-risk mothers and their families in India. Primary aim is to reach mothers with high risk of AIDS transmission to children with clear, free and timely messaging through Interactive voice response (IVR) and Voice messaging, in local language.

Government Initiatives:
The Indian government has also declared a few mHealth initiatives to provide healthcare services to the masses. There is the Integrated Disease Surveillance Project (IDSP), under which health workers in six Andhra districts will start sending health surveillance data to the concerned ministry via SMS. Also, pilot projects have been funded by the government for the implementation of telemedicine (including a mobile telemedicine project) in the states of Kerala, Tamil Nadu, West Bengal, Himachal Pradesh, Punjab, Tripura, Mizoram and Sikkim.

It can take three to four weeks to send a list of sick patients to a district health clinic and then to the Ministry of Health of a respective state. Electronically automating disease surveillance speeds up the communication time to three minutes, meaning the government can immediately send suitable supplies and alert citizens to take precautions.3

Skype, biometrics, M-health and E-health are all set to make an entry into India’s PHCs and sub-centers as the health ministry steps on the gas to go hi-tech. The steering committee on health has said that in the 12th plan (2012-17), all district hospitals would be linked to leading tertiary care centers through telemedicine, Skype and similar audio visual media. M-health will be used to speed up transmission of data.

Kilkari - Bihar: The BBC World Service Trust, the international NGO of the British Broadcasting Corporation, is working with communities and individuals in Bihar to build awareness and encourage adoption of preventative health practices. As part of the 5 year

1 Adrian Giordani’s article in isgtw: http://www.isgtw.org/visualization/mobile-healthcare-uptake-increases
2 http://articles.timesofindia.indiatimes.com/2012-03-18/india/31206777_1_disease-surveillance-providers-public-health-system
Sugato Basu PGP 93 is an expert in Healthcare IT and Operations. He serves as the Large Client Problem Solver in Healthcare / LifeSciences, at Syntel.

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Ananya initiative, funded by the Bill and Melinda Gates Foundation, the Trust will help increase demand for family health services by shifting norms and improving risk perceptions using a combination of mass media, community mobilization and social media.

Kilkari is an mHealth initiative launched by the BBC World Service Trust to provide timely health information to families with maternal and child health needs. It is a recorded voice service, delivered via mobile phones that will provide timely messages related to family health. Once the user’s family registers for the package, the service registers their stage of pregnancy and sends audio messages accordingly. Messages are provided from the stage of early pregnancy until the baby is one year old.

Kilakri is designed to be a micro-broadcast service delivered with extremely precise targeting of messages to users as and when they need specific information to make informed choices. All messages will be personalized to the user’s stage of pregnancy / infancy.

Nokia-Arogya: Nokia India, in association with Arogya World, a US based non-profit organization, has announced a major diabetes prevention mobile health initiative in India that would offer messages about the diabetes awareness and prevention. 50 million people in India live with the disease but 80% of diabetes cases can be prevented by taking preventive measures.

The Nokia Life Tools consumers could receive these messages for free for the first 6 months and could pay a nominal fee to receive it further for up to 2 years. Messages will be delivered as text message alerts, twice a week, in 12 different languages commonly used in India. Nokia aims to reach 1 million consumers in the next 2 years both in rural and urban India.

Mediphone: In order to provide timely medical advice to people living in rural, semi urban and even urban areas in Northern region, Bharti Airtel has joined hands with Healthfore (a division of Religare Technologies Ltd), with Fortis Hospitals as knowledge partner - to launch Mediphone.

The unique 24X7 health service, would allow Airtel mobile customers to avail of quality health advice through their mobile phones - anytime and anywhere. The service is likely to help over 20 million Airtel subscribers in the Northern region comprising Bihar, MP-CG, Rajasthan, NCR, UP, Uttarakhand, Punjab, Haryana, Himachal Pradesh and Jammu Kashmir. With a low doctor-patient ratio in India, this unique mobile phone based service, Mediphone, will be a boon for Airtel mobile customers and will provide them an easy access to qualified doctors and accredited nurses. This offers emergency assessment and advice from medical professionals & doctors, to assess & ensure right diagnosis based on clinical decision support systems.

CHALLENGES

The following four elements need more focus by entrepreneurs embarking onto this field:

- 3G technological challenges in input, display, transfer and processing of data in English and Indian languages (especially for people with different levels of literacy), security and integration with medical devices - this is still a problem due to lack of interoperability standards in India
- Government policies and regulatory regime for scaling up m-health applications - important for those who want to follow the money in State schemes on mHealth and telemedicine
- Close cooperation between mobile operators, handset vendors, hospitals, medical device manufacturers, health insurance companies, the government authorities, regulator, content and application providers for m-health services to grow exponentially; and
- Building a long-term funding plan - refreshed investment flows from the industry players needed to drive the growth of m-health applications.

The doctor-patient ratio can indeed be addressed for education, awareness creation, preventive public health measures and monitoring individual health, remotely through an appropriate mix of mHealth with other initiatives using existing infrastructure including NGOs. The payoff for the same may not only be a lucrative piece of the mHealth pie, slated to grow to Rs 3000 crore market by 2017 (as per PwC), but also the satisfaction of seeing the drastic improvement in basic public health measures within the next 5 years, using the ubiquity/affordability of cell phones - as has not been witnessed in 65 years since independence.
The private sector has played an important role in the development of India’s economy. This can be extrapolated to hold true in the case of the healthcare system as well. The private medical setups have enormous potential in terms of their technological prowess and overall efficiency. It is no secret that many government programmes suffer from lack of outcome focus, implementation failures, and quality deficiencies. This provides significant need and scope for private and non-profit organizations to participate in an ever growing sector of the economy.

In this interview with Professor Arnab Mukherji, faculty in Public Policy at IIM Bangalore and an avid researcher of healthcare, we develop a perspective on the future of private sector in healthcare in view of the current challenges in the space, and review the extent to which the private institutions’ contribution is feasible and qualitative.

Inequity in Healthcare

tejas@iimb: The government launched the National Rural Health Mission (NRHM) 2005-2012 in April 2005. The aim of the Mission is to provide effective healthcare to India’s rural population. With the Mission helping the rural poor, and the urban middle-class already self-sufficient, don’t you think the urban poor are the neglected ones? What can be done about their situation?

Prof. Arnab: It’s a fairly well known fact that we have NRHM as the major health mission in rural India. In urban spaces, the National Urban Health Mission seeks to occupy a similar place, however, it far narrower in scope, expenditure and thus, there is no equivalent movement as yet. The only thing we have as of now is what is called Jawaharlal Nehru National Urban Renewal Mission (JNNURM) which is a source of funding for people in approximately 80 cities. On an average, urban areas do much better than rural areas. And that is something which decision makers noticed and therefore their focus is largely on rural areas. But if you look
at the urban areas and you bifurcate the overall average into so as to say the slum and the non-slum, you’ll find that there are huge differences and disparities in health attainment and in certain instances such as vaccination it may actually be worse off where the roll out is better in rural areas. Most of these areas which exist (where the urban poor reside) are usually believed to be slums. But some work that my colleague Prof. Hema Swaminathan and I have done looks at people who live in slums and compares their nutritional status with people who don’t live in slums. We found that people tend to be malnourished in slums not because of living in slums in its own self but because of the usual notions of malnourishment, which are simply that they’re poor, they have access to low levels of education, and because of the fact that there is genuinely poor access to health services.

In case of healthcare for the urban poor, one should look at NGO participation, one of the systems that have been and can be put in place is where the NGOs act as medium for the poor in negotiating the existing public health structure in urban areas. The other thing that has been happening in some places is, for example in Guwahati, there is a Marwari hospital that receives funds from the government to actually treat people at large. So this is a mechanism in which instead of using the public health facilities you are using the private health facilities, but access is subsidized for the poor to enable improved access.

And then you have the health system per se consisting of a range of health services that need to be innovatively re-employed - and this requires think about doctor’s care, nurse’s care and also about pharmacies and path labs. Post-operative reach or follow-up care is also a domain in which the NGOs need to come in. In all of these things what one is talking about essentially is expanding outreach, not necessarily by the government but by inviting, either the NGO domain or alternatively having the private sector step in.

telas@iimb: Recently, there has been increasing interest from epidemiologists on the subject of economic inequality and its relation to the health of populations. There is a very robust correlation between socioeconomic status (SES) and health. Lower socioeconomic status has been linked to chronic stress, heart disease, ulcers, type 2 diabetes, rheumatoid arthritis, certain types of cancer, and premature aging. Can you comment on the socio-economic determinants of health risk?

Prof. Arnab: This is a very well recognized and understood area of work in the research community. Not only does it matter how much wealth there is in the economy but the distribution of that wealth in the economy is also responsible for a varied health outcome. So health is a multi-dimensional attribute on which many things have an impact; starting from basic things like education, income, awareness that matter but also more complex things like expectations, norms, desires also...
Health Insurance

tejas@imb: Private expenditure on health in India is close to 78%. Most of the medical expenses incurred by an average Indian are paid from their own pocket. Though there are various health insurance policies available, what is the main roadblock in implementing nationwide health insurance?

Prof. Arnab: Health insurance is one of the key financing mechanisms by which the health sector can be supported. The entire idea of health insurance is based on the fact that you don’t have a parallel need for the health service. So if there are many people who are a part of this larger pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool, then we have what is known as health insurance in which all of us pay premiums through a large pool.

Prof. Arnab Mukherji

“Mechanisms for accessing healthcare for the poor do exist, but there are serious challenges in rolling this out in an equitable and transparent manner that ensures quality care. Some of these challenges because we don’t have a long history of managing this.”

Prof. Arnab: While the poor also need health insurance, they cannot self-finance this given their low incomes. So, as in many other programs, we have the government provide health insurance for those who are below the poverty line through programmes like the Rashtriya Swasthya Bima Yojana (RSBY). The idea of the RSBY is that it makes available on a family floater basis, a card on which you can spend a fixed amount of money. The entire idea of health insurance as a mechanism for financing health in India has not reached its fullest possible extent, and cannot do so on the standard business model behind private insurance alone.

tejas@imb: So, what do you think is the best way to provide health insurance to the poor?

Prof. Arnab: Health insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium.

number of years and there are many people doing this at the same point in time and as and when one of us gets ill, we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium. Health Insurance is a way in which we can go to the hospital and claim all the costs that we incur which will be much larger than the premium.

budget assumption that the premium that you and everyone else in the scheme pays is going to fully cover the company for giving you that coverage when you fall sick (and the fraction of those on the scheme who fell sick). To a large extent in a world in which health costs are very high, they need to charge a reasonably high (and age-dependent) premium. Up till the age of 65, health insurance schemes, depending on what all is covered, range from a couple of thousand rupees to maybe fifteen thousand rupees. However, if you look at the benchmark for national poverty, which is around 500 rupees per month, it hits you in the face that a very large fraction of the population cannot afford health insurance, but buying a pizza is a big deal for them, once a month. So it is a fairly large expensive deal for them to have health insurance. So, health insurance as a mechanism for financing health in India has not reached its fullest possible extent, and cannot do so on the standard business model behind private insurance alone.

tejas@imb: So, what do you think is the best way to provide health insurance to the poor?

Prof. Arnab: While the poor also need health insurance, they cannot self-finance this given their low incomes. So, as in many other programs, we have the government provide health insurance for those who are below the poverty line through programmes like the Rashtriya Swasthya Bima Yojana (RSBY). The idea of the RSBY is that it makes available on a family floater basis, a card on which you can spend a fixed amount of money and that money varies from household to household based on pay. Standard health insurance is never going to work for those are poor. So if we are looking at other mechanisms of healthcare, we are simply looking at social health insurance such as RSBY where
premiums are paid by the government, care is provided by the private sector and this gives access to those below the poverty line. Now this social health insurance is going to need to work on a number of different fronts. Most of the good hospitals don’t locate uniformly; they locate in a clustered sense (because of agglomeration economies). There is a well-recognized moral hazard problem with the health sector that once you have insurance set in, there is always an incentive for the care provider to overstate costs. Whereas you may come in needing healthcare for say, you have a flu or a broken rib, but if they were to charge for a kidney replacement then the margins are much higher. All that they need is a thumbprint from the patient confirming this. This is type of corruption is quite prevalent in all sectors, but is particularly problematic for the health sector given the broader goals, social needs and poverty that characterizes this.

Wonderful work done by Dr. Prateek Rathi, an IIMB PGPPM alumnus, collated while writing his thesis records some of the challenges in this sector in Amravati district. He had actually gone in and looked at the insurance claim data and compared this to disease incidence data and the claims and incidence data are shockingly different; thus, nationally, prevalence of cardiac cases in the national population is less than 1 %, but strangely in Amravati you’ll find that number being a few times larger than that. People are brought in and immediately sent off to the ICU.

Mechanisms for accessing healthcare for the poor do exist, but there are serious challenges in rolling this out in an equitable and transparent manner that ensures quality care. Some of these are challenges because we don’t have a long history of managing this. Others are system-wide challenges such as the inherent structure of moral hazard in any insurance contract. More thought is needed to identify to provide how care for all as a system - currently it is too much of a mash-up of different institutions covering different diseases under different types of contracts for care.

Demographically Oriented and Preventive Healthcare

tejas@iimb: The age distribution of the population of India is projected to change by 2016, and these changes should determine allocation of resources in policy intervention. According to the National Commission on Population, the population below 15 years of age (currently 35 percent) is projected to decline to 28 percent while the age group of 60 plus years is projected to increase from the current levels of 7 percent to nearly 9 percent by 2016. In view of the changing demographic profile of our country how is healthcare projected to change?

Prof. Arnab: As you grow older there is a need for different services from the health systems that will keep you healthy. What is definitely going to happen are the following: since the economy has largely undergone a demographic transition from high birth rate and high death rate to one in which birth rate and death rate are low., thus means that the number who die decline, but then so does the number of people born. If you look at the 2011 census, you start seeing such profiles coming up, not only at the national level, but also at the state level and district level, particularly in Kerala where this is very apparent. Historically, when India became independent and even till the 80s the demographic age profile was that of a nice triangle - many young people and few old people. But the expectation is that in the times to come we will evolve towards a demographic profile that has a much more rectangular age profile as the fraction of the population above 60 begins to increase.

The major challenge for health sector looking forward is to anticipate how much health care demand is going to come. A part of that is you are going to have some fairly young age life style management coming into play. It is not only portfolio-asset management but also portfolio-health management that people are going
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to think about. Already people talk about cutting back on cigarettes or getting up in the morning and going for a walk or pay attention to the calories you consume. All of these, and much more, are going to be things which are going to come into play on the preventive side.

However, change need to happen on the treatment side too; the same treatment given for a young patient cannot be done for an older patient because it has effects on other aspects of his health. And increasingly as the focus point of our society shifts from extremely young to the elderly population, the health sector needs to adapt. Historically, it has always been the growing middle category (15-45 yrs) that has been supporting people at the top. But that profile is going to change and many people above 45 years are going to have to support themselves and that means good health and that means a good health system and that in turn also means a strong pension and financial instruments and systems to convert the savings into wealth that can be accessed later on in life. So we need to be forward looking and planning towards a society like that.

tejas@iimb: There are many diseases which can be prevented by avoiding certain risk factors. Yet the current health care system, more often than not, is curative in nature and responds to acute symptoms of diseases. Considering that preventive care would reduce medical costs to a great extent do you think the private sector health facilities should step up their initiatives towards promoting preventive medical care? What are the obstacles in undertaking such programmes?

Prof. Arnab: Many of the existing preventive health care measures try to predict if the person is likely to need a certain kind of care in future. This is the reason why the later you go for a private health insurance, the more number of tests you are required to take. So, one of the most fascinating problems in today’s medical domain is tuberculosis. Tuberculosis is managed under the DOTS programme which aims to reach out to people in all parts of India. Now the problem with the treatment is that it requires a very high dosage of antibiotics and so it requires a parallel diet to support the medication. Currently the DOTS does not really do much about that because what can be done about it? But this is still a source of problem because poor people cannot afford the required nutrition. And this is probably the reason why they got TB in the first place. TB is endemic in India and we have all been exposed to TB and when every one of us goes abroad and tests for TB we all test positive. However, our normal level of nutrition is such that we can withstand TB. People who are poor and have poor nutrition tend to acquire TB readily. Our DOTS surveillance program is pretty good at identifying them and putting them on medication. However, in the absence of quality nutrition, there are strong side effects of taking powerful antibiotics. As soon as people feel well, but well before completing their course of medication, they stop taking their medicines and expose themselves to picking up drug resistant TB!

The socio-economics of the health sector imply that medical care cannot be context free - a system ignoring such matters will not be able to address the root cause of ill health.
Preventive healthcare is strongly associated with utilizing medical care, consulting on lifestyles, and continuous monitoring to help address these types of concerns. The real need of the hour is to figure out how the types of screening and consulting used at insurance, entry into formal jobs, or annual maintenance checks can be scaled-up in a realistic manner to address healthcare in the community at large.

Role of Private Sector and Global Opportunities

tejas@iimb: Today, there are over 20 international healthcare brands in India with several corporate hospitals. However, a large section of the ‘private healthcare delivery segment’ is scattered and quality of medical care continues to remain a matter of concern. What is your perspective on monitoring the quality of private health care?

Prof. Arnab: There is a National Hospital Accreditation Board that is a couple of years old. Hospitals like Apollo have certification from this board. But by and large private health care clinics do not have this. For private clinics indicators of quality is of the following nature: by getting an extremely important person like Amir Khan, the President of India etc. But most private healthcare centers in rural India and some parts of urban India are full of people who are not trained. If you think of private healthcare one should stop thinking about big hi-tech hospitals and one should also think of small hole-in-the-wall places in which all sorts of concoctions are given by people who are actually not trained to do so.

In my field work (2005) I ran into the “Bengali doctor”, a guy with an English Literature degree who has tablets which are anyways expired and which were distributed in the plague in Latur, which was a long time back (1993). So he’s still carrying them in 2005 and if you’re sick he’ll say, here is half a tablet; this is some high dosage, and possibly unusable antibiotic which if you ingest you just might be positioning yourself. If it still works, but you don’t have the full course of antibiotics you’re offend up making the patient, and in the long-run the entire community, immune to future antibiotics of the same line. This happens because there are major holes in provision of healthcare in society which allow such quacks to step in and provide “healthcare” like this simply because there are no alternatives. So private healthcare is an answer but only of it is nurtured properly; there needs to be a check on quality - on both medicines as well as human resources.

Prof. Arnab: I think medical tourism is an interesting way to go but there are a lot of ethical aspects which come into play. Medical tourism is the outcome of a basic economic phenomenon, that is, comparative advantage. In India there are cost advantages in terms of how health care is provided. The reason for that is there is lot of labor abundantly available and there is lot of skilled labor being trained at low-cost and therefore people from other countries can take advantage of that. Primary example of this is of people from all over the world coming in to India for fancy cancer care which was earlier unheard of.

Hospitals such as Apollo are sending teams of doctors to other countries to conduct camps. Some of these countries are not very rich like in Africa, and poorer states of erstwhile U.S.S.R. These doctors are very well trained and are able to handle very complex procedures. In so far as we have that level of skill we should completely make use of it as a nation. But one has to always confront the situation that on an average we are a poorer nation and on average there are lots of people who are unable to avail health care. So then how do we see the medical tourism sector? Is it the case that we are able to say that medical tourism as an activity can fund that? I think that the answer maybe yes, but not based on the current trend where there is a very real danger of crowding-out treatment for patents domestically. Based on the current trend medical tourism is still too small an activity of the entire health sector to support that sort of activity. In fact, based on our expenditures on the health sector, I would argue that the health sector is far smaller than what it should be. So I think that medical tourism is promising, and if we hit larger levels of health expenditure, I think there is a lot that can be done. I think there are a lot of ways you can pair that up with voluntary and charitable work which has benefit for the larger economy as a whole. But the scale is still too small with only very niche involvement.

Conclusion

The general outlook when it comes to the healthcare sector is that there exists imbalance in terms of the urban poor getting ignored in the general scheme of healthcare initiatives. Going forward, healthcare needs to be directed more towards the elderly. However, we must also realize that there remain significant gaps in providing healthcare for maternal and child health needs - the classic purpose of healthcare. There is some merit to the discussion of medical tourism being a boon for India but it is yet at too small a scale to contribute much. The private sector does help where the public sector lacks, but quality is still a big deterrent.
We experience a wide spectrum of emotions in our life. Music, which is composed of seven distinct tunes, like painting, is an expression of art, and also an expression of human emotions. Here’s my visual expression of those musical emotions.

Musical Colors

“We are glad, we’re mad, sad and bad... basically, we emote.”
As everyone has their outlet of expression, I would say that ‘Art’ is my medium and outlet of expression...

‘Painting’ in particular has always been my meditation and my friends in this voyage of life. It’s very interesting how they so candidly express not just my emotions, but how I have lived through this journey. It has always had its therapeutic impact on me and I feel secured & grounded when I am with my colors and brushes.

...Or should I rather say that, Painting is my concept of ‘Art’...

Drawing inspiration from Nature, my expression is mostly abstract and I work with oil on canvas and acrylics. Every piece of artwork I have done has a story of my life expressed through shapes, forms, objects with which I find and establish a deep relationship and connect.

Professionally, I work as the Business Head for a Design management company based out of Bangalore. Here, I attempt to take you through few of my artworks, which are very close to my heart.

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**Power**

“The strength of women is the pretense of weakness, and the weakness of men is the pretense of strength.”

A woman with all her grace and fragility, how she transforms her femininity into a Power which helps her overcome the toughest situations in her own life and people in her World.
Autumn

“Come Autumn, every branch sheds its leaf”

It’s a story of a family. They belong to the same tree, they grow in similar environment yet each one is unique, has its own color and features. Each reacts to the same situation differently and still they stay together. This painting draws a parallel to Autumn and is an expression of a family undergoing rough changes in a rough weather….

Backdrop

“Guardian Angel”, “Unconditional love”

A person lives through the day, every moment and experiences what comes his way. And there’s a subconscious being that lives in a very private world, which is like a watch guard, a guardian angel who is unconditionally there for you… forever!
Seasoned

"Withstanding the storm and harmonizing with the surrounding"

A weathered look comes from different phases and experiences makes you what you are... leaves its scars, shapes you as a person, refines and defines the perspectives and evolves your spirit into a stronger and stable being, which has learned to withstand the storms and harmonize with the surrounding.

Peace

"A desire for calmness, to live in harmony..."
39th Foundation Day

"Soak yourself in one or two interests that will make your life worth enjoying, as compared to any professional success", Ramachandra Guha urged the students at the 39th Foundation Day celebrations of IIMB. He delivered a lecture on 'Life Outside and Beyond Work'.

Distinguished Alumni Awards

Shashi Sinha PGP 81 and Rajiv Maliwal- PGP ’85 bagged the prestigious Distinguished Alumni Awards of this year. Shashi Sinha is the CEO of Lodestar Universal India and a veteran in the media management and development industry. He led the setting up of India’s first media research and tools development cell at Lodestar.

Rajiv Maliwal is the Founder and Managing Partner of Sabre Partners India, a company that changed the landscape of the Indian banking sector substantially. He led the creation of the biggest banking roll up that came to be known as Centurion Bank of Punjab.

New Classroom Complex

Construction is in full swing for the new classroom complex at IIMB. Thanking all of you who have supported this initiative.
**A Big Thank You**

We express our heartfelt congratulations to the PGP batch of 1986 for their prodigious contribution towards the welfare of their Alma Mater. The PGP '86 batch pledged Rupees one crore endowment for the Institute!

**Student Entrepreneurs Win Big Abroad!**

Greenway Grameen Infra, a team of student entrepreneurs from India, won the 8th annual Intel Global Challenge at UC Berkeley for its innovative idea that impacts the society. The company was mentored by NSRCEL at IIMB. This is the first time in eight years that any team from India has won this prestigious award.

**PAN IIM Charity Ball**

October 13, 2012 saw a rare convergence for a noble cause. For the first time ever the Bangalore Chapters of IIMA, IIMB and IIMC Alumni Associations came together to organize a grand event to celebrate the joy of giving. The event saw an overwhelming response from the alumni community. They all came together to make a commitment of support to organizations that are striving to make a difference in the society.

**Vista**

It was a brilliant coming together of academia and industry at Vista 2012, IIMB’s annual international business summit.
Prayaas

EPGP’s social responsibility committee organized Prayaas, a free medical intervention camp within the college premises for the less fortunate. The camp focused on two important health concerns, to provide artificial limb, Jaipur foot for amputees and callipers for Polio ridden patients or those with weak limbs. The other was to diagnose and treat eye related ailments ranging from simple issues such as refractive problems to cataract and optical nerve damages.

Mumbai Alumni Chapter support EEP program

The Mumbai Chapter of our Alumni Association partnered with an Executive Education Program for senior managers and leaders from Africa and has ushered a new dimension of engaging alumni in the Institute’s programs.

Diwali @ IIMB

Photo by: Bharath Ravichandran PGP 13
I wanted to break free from the routine, he then decided to take off and build a house in the foothills of a mountain. In the peace and solitude of an idyllic village, with no traffic and pollution, he built a house that’s full of light.

Sourav Chatterji EGMP XVII 2010

I took a year off from work; convinced that I could not carry on with the same mundane and challenge-less existence revolving around client meetings, routine work, touring three different cities for three days, every week and haggling over payments with clients. After working for fifteen years in India and abroad, designing and constructing buildings, including airports, I was aching for a change. I wanted to break away and live a life that went beyond earning a living and a bonus.

My sister and brother-in-law owned a small plot of land in the verdant Kangra valley in Himachal Pradesh and asked me if I would want to design and construct their house. I decided to go. I took a full year of unpaid leave from office, not knowing if I was doing the right thing or if I
would have a job when I returned. They wanted a very simple house, without clutter, which took care of their requirements and was cost effective.

I shifted base from Delhi to Palampur, and revelled in the peace and solitude and the lack of traffic and pollution. The site for the house was straight out of a postcard. A road to its west, the mighty snow clad Dhauladhar Mountains to its north, a huge pine forest belonging to the forest department to its east and a small village hut to its south. It was a sloping site with quite a steep grade and a few bamboo trees and a massive boulder.

I would go to the site and just sit and listen to the birds and sometimes fall asleep in the pleasant weather. What could I design, which would be simple and reflect the personality of my clients, and yet be cost effective and appropriate to the context? Palampur gets a lot of rainfall, has quite a severe winter and mild temperatures in summer. For many years houses there, didn’t require a fan. But these days it needs fans for about twenty days in a year.

My sister is an artist and needed a studio, my brother-in-law is a psychiatrist and needed a clinic, and they wanted three bedrooms and a garden. I decided on a few rules which would govern the design of the house. First rule was natural light - lots of it, so that one would not need any artificial lighting in any part of the house during daytime or on frequent gloomy rainy days. Rule two was to build using traditional methods - a high ceiling, thick masonry walls to keep rooms cool in summer and warm in winter. Rule three was to design framed views of the surroundings from various parts of the house. Rule four was to keep the house as dry as possible and harvest the huge quantities of rainwater available.

The design evolved into a simple three bay construction covering three thousand square feet, with thick walls, and large apertures to the north and the east. It has spaces where one could sit the whole day and experience the changing light and hear the birds chirping away. The kitchen is a simple functional space with no cabinets of cupboards and led to the garden - storage spaces were open and at accessible height.

The two storey house, sitting on a slope, can be approached from both levels - the upper level from the parking and the lower level from garden. The studio and the clinic are in the upper level and the bedrooms and kitchen with living areas form the lower level. Every space has varying amounts of natural light, the bedroom being more intimate, and the living areas washed with natural light. Wooden flooring throughout the house gives it warmth and contrasts very well with the white walls, which form a base for paintings done by the artist.

The year went by very quickly, I was designing and supervising construction of the house and working with local contractors, who learnt a great deal about rain water harvesting and building a solid water proof house from me. It was a very cost effective structure - built for about seventeen hundred rupees to a square foot. My biggest satisfaction is that the house is exactly as imagined by my clients. Bathed in natural light, sitting in its context, nothing fancy, nothing to prove - just a house where one could live forever and cherish it with family and friends.

I am not going back to work anymore! The next project is also in the same neighborhood - a retreat for a retired person’s family, facing the pine forests, located on a hill slope. I am very glad I listened to my heart and took a year off.
Hari Baskaran PGP 76 was 60 years old when he stumbled upon his new love, cycling. It became an instant passion and a sport that he dedicated himself to with utmost enthusiasm. And that takes him to achieve this unusual feat of covering 200 kilometres on the saddle, in the deserts of Rajasthan.

My love affair with cycling started a little over three years ago when I turned 60. I don’t know and don’t remember what influenced me to take to this sport. It was, probably, a stray article in a newspaper or magazine. I was on a field visit to Chandigarh, I chanced upon a cycle shop for Trek & Firefox sports cycle. I realized then how expensive these cycles can be; far above the few thousand rupees I thought they would be. Nevertheless, I had made up my mind to take up this sport and a month or so later, bought myself a Schwinn Searcher Sports cycle - relatively modest in price, but a cycle that seemed to meet my needs. I enjoyed riding it and reserved my holidays to cycling sessions. Since then I have switched to a Trek 7500 hybrid cycle. Forty odd years had passed since I last rode a cycle and I restarted enthusiastically. But for a bit of a wobble for the first kilometre, riding a cycle came back quite naturally as if I had been doing it all along.

A friend and office colleague introduced me to a cycling club, GKB. This is a team of cyclists who are close to being semi if not professional cyclist, who undertake long distance cycling stints from time to time, including the ultra adventure ride from Manali to Leh. For the last few years I have been riding with this group. It’s been good fun, though I am nowhere near the speed and fitness of the others. It is always good to have a like minded group who share a passion for cycling, helping you along.

On my first relatively long intercity cycling expedition, I was nervous and uncertain of successfully cycling 300 kms over three days in Rajasthan. I had never cycled on successive days and wondered if I would be in a position to ride on day two after a 122 kms ride on the first day. As it turned out, the encouragement of my group and the tips they gave me prior to and during the ride, helped me complete three days of rigorous cycling. That seems a long time ago and rather easy, as I prepared earnestly for the 250 km ride, to be covered in 12 hours, as part of the Desert 500 event in Rajasthan this November.

The challenge of Desert 500 is the relatively high average speed one has to maintain over long periods of time.
The 500 km challenge, a ride from Jodhpur to Jaisalmer and back on Nov 28, needs to be completed in 24 hours. Riders are tested for endurance and the ability to continuously cycle for this length of time. Training and preparation is clearly the key to successful completion. For those who find the 500 km ride a tad daunting, there is the 250 km ride and for the first timers a 150 km ride and even a 50 km ride. I went ahead and decided to push myself to the limit on a lunar eclipse night to complete over 250 kms!

My preparation for the Desert 500 event was a lot more professional than my pedestrian efforts for earlier events. I had a personal trainer who came home thrice a week, to help push up my basic fitness and strength. At my age, now 63, I am no match for younger faster riders and need to train that much more. I cycled three times a week and from this pushed myself for longer rides. I needed to be capable of cycling continuously for 12 hours plus at speeds in excess of 20kmph! I didn’t know if I’d ever be able to complete the ride in the scheduled time, however I prepared as well as I can; and as they say the joy is in the journey!

In the week leading up to the event I hit a couple of hurdles. My dodgy back played up and I had a painful week that was sorted out to a large extent by three visits to the physiotherapist. On the day of the ride I was more or less ok but still nursing my back gingerly. Worse was a bout of fever caused by the recurrence of an UTI I had suffered a few months ago. I just plunged into the same medication I had taken last time and thankfully I was free of any fever on the day of the ride. Such niggles seem common as I saw quite a few participants with their own niggle or two!

We had over 150 participants from across the country which included Shamim Rizhvi the only Indian to have completed the Race Across America (RAAM) considered the most gruelling sporting event in the world. Many of the best male and female ultra cyclists in the country also participated, resulting in a very competitive spirit and excellent timings in all categories.

I completed 200 kms in a modest time of 13 hours!! This was the first time I rode this distance and for such long hours, continuously. I thoroughly enjoyed the challenge!
Hemant Soreng PGP 97 says “I am trying to find out what would’ve had happened if we had taken a different path at each moment in our lives. This would’ve or might’ve resulted in millions of events or lives led or still being led by us in different space and time.” On this thought trail he exposes himself to various experiences through travelling and adventure, mountaineering, cycling, running and much more. Here he walks us to the summit of Mt. Shitidhar, a trek dedicated to save the Girl Child.

Somewhere between the bottom of the climb and the summit is the answer to the mystery why we climb.

Greg Child, Australian mountaineer.

I really don’t know the answer. I am actually not looking for it. I just ignore this oft-repeated question.

Hermann Buhl, the legendary alpine climber once said, “Mountains have a way of dealing with overconfidence.” I guess coming to the mountains again and again is my way of checking my arrogance and overconfidence, largely owed to the professional rigours that have subconsciously seeped into my inner self. This expedition was not just about standing in front of the mountains and admiring its beauty. It was about summiting it. The destination was Mt. Shitidhar.

Not much is written or documented about this beautiful peak, shielding it from the vagaries of modern day commercial trekking. Around 5300 m/ 17,400 feet in height, this peak is ensconced in the Western Himalayan Pir Panjal range in Himachal Pradesh.

The expedition comprised four climbers (including me) and an experienced expedition crew of guides, porters and a cook.

This expedition was also special, as we dedicated it to the rights of the girl child in association with CRY. The beautiful trek to the base camp was breathtaking and the final grueling summit climb was definitely not for the weak-hearted.

The trek started from Manali (2050m) to the beautiful Solang valley (2350m), through quaint villages lined with apple orchards ready to be picked.

This trek, took us through Dhundy entered the Alpine forest. We further walked into the forest alongside the mighty river Beas till we reached the campsite.
After staying an extra day for acclimatization, extremely important for high-altitude trekking or climbing, we met three Alpine climbers from Israel, who were planning to summit the intimidating Hanuman Tibba (5940m) and the Friendship peak (5300m), adjacent to Mt. Shitidhar.

Our next stop was at a place called Lady Leg (yes, you have read it right). From a distance the mountain formation does justice to its name. This was the most beautiful campsite (at 3700m) I had ever seen.

The next day was one of the most grueling days of our trek. We had to traverse across mountains, cross multiple streams to climb to a one km long ridge as we approached the snowline. We met many climbers from the mountaineering Institute, Manali who were on the way back from the summit attempt.

It took us five long hours to reach the summit high-camp (4500m). There was snow everywhere, in fact we had camped on snow and were melting snow for drinking water.

That evening we decided to sleep as early as 6 pm. so that we could start at 2 am. for the summit attempt. But nobody could sleep as it is difficult to get sleep at such high altitudes.

We eventually started at 2:30 am, after we were geared in multiple layers of warm snow-proof clothing, heavy snow boots, gaiters, and ice axe.

The conditions were good as we climbed continuously in the path dimly lit by our headlights. After three hours of mechanical climbing in the freezing cold, all I could remember was that we traversed through a rock face and remains of an avalanche, till we hit a 100m 75 degree wall. We fixed ropes and started our climb, and reach summit in one hour.

We were extremely exhausted by the time we reached the top. Summiting a peak for me is not a line to strike off in the unending bucket list. It's not an achievement or a medal I am striving for. It's not glory I am after. I do not know what the result is going to be. I don’t think I care. I will just do my karma, that is, climb mountains. Friedrich Nietzsche once said, “He who climbs upon the highest mountains laughs at all tragedies, real or imaginary.” I hope I am getting there. I think I am getting there.

Back from the summit climb as I was writing about the entire experience, I could vaguely remember the moments on the top of the summit. However, I was able to recount the entire journey. There is an 11th century Indian saying, “Traveler’s will cross many rivers and climb many mountains. Plainsmen may always live within a valley. But only those seeking truth will ever reach the summit.” I wonder what that truth is. But it is out there. I know.
After a hiatus of few years, I am beyond thrilled to be donning the RJ hat, yet again, hosting a show called Manasu Maata (a word from the heart) on Telugu One Radio on Internet (TOR) from Los Angeles. It’s an online radio, which gives global listeners a platform to share their thoughts. The radio is more than a platform for me to display my skills as a singer and writer, it is where I make a lot of interesting friends.

My bond with Radio is an old one. I started hosting a radio show when I was only four. Later, I hosted TV shows as well. As a child, making money every weekend, Rs 250 per contract, was more exciting than hosting itself. I was happy to make pocket money which I would promptly invest in buying colours or go to dance classes. During summer vacations, when my friends would travel, I would end up doing shows. Even though I was hosting since I was a kid, the experience was never a homogenous one. Slowly, I moved from children’s programs to youth programs like Kavithajari (poems) and then hosting TV shows. Each was an experience in itself.

But I must admit hosting a show is no easy task. I start with my preparations a week in advance, including doing some research on the chosen topic. Interacting with people, Live, can be quite challenging. My idea with Manasu Maata was to interview ordinary people and not celebrities. I wanted to have a talk with topics ranging from the personal, ‘what did you eat? What’s going on in life?’ to the more serious, “How to solve conflicts?” etc.

Another passion of mine, is film making. As someone said “Filmmaking is full of traditions”. These traditions are in the way things are done, what is expected, industry standards, default and accepted norms. Yet I wanted to have a learning experience. Making a short film seemed that perfect learning experience because it provided a platform for engagement in film production within viable financial and resource constrains. Similarly, the short film will also serve as a demonstration of my abilities. After this realization, I didn’t waste any time and joined the local chapter of women in films, brought a good quality canon HD video camera and also attended few training sessions. Interestingly, I got a lot of good ideas on my morning walks at California beach.

After all the preparations I went ahead and made my first short film, “Cup of coffee”. I chose this name because Coffee plays such an important role in our lives. Most of us have always valued our coffee! That very cup, first thing in the morning, stimulates us, dusts the sleep off us, and steels us for the rigors of daily life. Similarly, this film speaks about how the protagonist yearns for coffee; he faces so many obstacles just to have a cup of coffee, rendering him frustrated. The most important point is the climax, his feelings when he tastes that first sip of coffee is what makes my movie. I roped in my brother who was on a business trip to Los Angeles to play the lead. My friends Venu and Varun helped me with the camera. My friend Ravi Raj allowed me to use one of his songs. After the final edit it still looked amateurish to me. But my journey into film making has just started. And I’m feeling good about the beginning!
Viswanath Surendiran PGP 11 starts his own photo studio - Vishful Photography - in Leeds, UK. That’s one of his brilliant clicks!

Abhishek Mittal PGP 11 and his wife Shipra are blessed with a baby boy Aashray

BrizzTV, founded by Amarendra Sahu PGP 11 and incubated at NSRCEL, declared winner of Rural Innovation Award 2012

Rakesh Godhwani PGSEM 04 wins Dronacharya Award 2012 presented by Rotary Club of Madras East

Viththal Babulal GMITE 07 passed away in an accident following the toppling of a chariot during Dussehra celebrations.

Sridhar Pabbisetty PGSEM 08 joins IIMB as COO, Center for Public Policy.

Obituary

Randhir Mishra FPM 01 joins IIMB as Head, International Affairs.

Babita Jaishankar MPWE 07 starts her own clothing brand BAJA.

Abhishek Abhilashi PGP 11 ties the knot with Megha Yethadka.

Michael Sequeira PGP 10 has been honored with the Best Employee with Low Vision for the year 2012 by the Govt. of India! The award would be presented by the President of India shortly.

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Guhesh Ramanathan PGP 88 launches book ‘Scuba Sutras: Ten Business Lessons from Under the Sea’

M Padmanaban PGP 84 joins ISB Hyderabad as Director, Corporate Relations

Prashant Jain PGP 91 of HDFC Mutual Funds and Sachin Padwal Desai PGP 2000 of Franklin Templeton have been chosen the Business Standard Fund Managers of the year.

Shashi Sinha PGP 81 to head IPG Media Brands

Sanjiv Shankar Dongre PGP 04 publishes book, ‘Troubleshooter’

Anusha Subramanian, daughter of Ravi Subramanian PGP 93, releases her first book ‘Heirs of Catriona’ at the age of 12, to become the youngest published author of India

Sumit Chowdhury PGSEM 08 co-authors ‘Doing What is Right - The Crisil Story’ - a corporate biography produced by Sumit’s company My Life Chronicles.

MilkorWater, startup by Amardeep Lakhtakia PGP 92, was selected among Best 16 Emerging Product Startups in India

Prashant Jain

Sachin Padwal Desai
In the Indian milieu, typically in a town or a village, about half a dozen people were considered demi-gods. 1) The District Collector, 2) Station Master, 3) Teacher, 4) Doctor 5) Postman and 6) Bank Manager. The first two may not be applicable so much in a city, but the Teacher, Doctor and Bank Manager would be relevant in any setting.

While all others provided general advice, the Bank Manager would be privy to the financial capabilities of the family and hence be able to suggest better ways of combating financial situations at large, like a marriage in the house, a property acquisition, acquisition of an asset and so on thus moving themselves higher on the scale of trustworthiness in comparison to the other people mentioned.
Bank is something that you would trust with for depositing your money for a safe custody, and subsequently even prized possessions like jewellery and other precious items kept in the locker. Over the years that Institution of trust has surely taken a beating, so much so that today you may want to think whether your money will be safe there, whether your assets would be safe in the locker. It is ironic that spate of theft / robberies / frauds have proportionately increased despite technology and security advancing by leaps and bounds.

Earlier there was only a Bank, but over the years with the opening up of the finance industry, a new vertical called BFSI opened up, banks proliferated, and so did many finance companies, vying for the common mans prosperity. Competition in this sector skyrocketed and got so intense that each bank tried its best to outdo the other, and in doing so, woo the customer and promised to give him the best, while bungling on the basics.

This has had an alarmingly negative influence on bankers. Quest for money, fame, career etc, got them to ignore the basis of their existence - the customer, who is the reason why Bankers exist. Have you considered a situation where the people who you thought were bankers metamorphose into BANKSTERS!

This thought was paramount in my mind when I came up with the title for my latest book - THE BANKSTER. What is it about?

A book set in three parallel streams - In Angola where a covert CIA agent is about to exchange weapons for blood diamonds; In Kerala, an elderly man will do whatever it takes to fulfill a promise made to a dying son; In Mumbai, an international bank is stunned by the mysterious deaths of its key employees - THE BANKSTER is a lot more than a regular story of banking frauds. Its about life in Greater Boston Global Bank (GB2) where the uneasy calm is shattered when a series of murders rock the façade of the compliant and conforming bank that GB2 has built up over the years. Who is to blame? Who is driving these intriguing and bone chilling murders? What is the motive behind these gruesome killings? No one has a clue.

And when Karan Panjabi, a press reporter and an ex-banker digs deeper, he realizes that he has stumbled on a global conspiracy with far reaching ramifications - a secret that could destroy not only the bank but cast a shadow on the entire nation. With only thirty-six hours at his disposal, he is running out of time and must trust no one if he wants to stay alive and uncover the truth.

In the racy build up to unraveling the mystery, stranger than fiction characters emerge, faith get shattered and ivory towers come crashing down. Bankers build their careers on trust, or so everyone thought - till the day the truth within GB2 gets revealed. Is the banker at GB2 fast turning into a Bankster? Or was he always one? Read the Bankster and find out for yourself.
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