

Sustainability strategies of Small Hospitals in Kerala in times of COVID 19 Pandemic and Heightened competition



Sindhu R. Menon¹



Dr. Naseer Mohamed Jaffer²

The recent COVID19 pandemic has impacted the healthcare delivery sector in India quite adversely. Small hospitals, already distressed by a highly competitive and challenging business environment, were among the worst hit. This study aims to examine the measures adopted to maintain sustainability of small hospitals in Kerala during COVID19 pandemic. The study also examines the innovative strategies adopted by these hospitals to face competition from larger hospitals. To maintain business continuity through infection control, the state branch of Indian Medical Association launched I SAFE program and established a network of small and medium medical institutions for effective implementation of the program. The project help in infection control by providing infection kits, logistics and training to medical institutions. To effectively face competition from larger hospitals, small hospitals in Kerala have devised a unique 'co-operative model' network. Strategies include referencing patients within the network, data sharing, collective procurement of medicines and equipment and collective medical waste disposal. Small hospitals are also effectively managing the 7Ps of service marketing to attract and retain patients. These business practices can be replicated in other states as well to ensure survival of small hospitals which are critical in ensuring affordability of and accessibility to quality healthcare.

Keywords: COVID 19, Small hospitals, Kerala healthcare, Healthcare delivery

Introduction

It is ironical that COVID19 pandemic which should have brought in business and revenue to the hospitals impacted the sector adversely and that too quite significantly. At the onset of the pandemic, private hospitals had to forego all non-emergency procedures and shut down outpatient departments to prepare for a deluge of COVID-19 cases but the inflow of patients did not materialise and at one point of time outpatient visits and inpatient occupancy in private hospitals dropped by as much as 80 percent. Profits were hit hard as revenues dropped on

¹ Research Scholar, University of Mysore, Asst. Professor, Presidency College, Bangalore, sindhumenon.r@presidency.edu.in

² Professor, XIME, Bangalore, jaffer@xime.org

account of a sharp decline in both outpatients and inpatients, diagnostic testing, elective surgeries and medical tourism simultaneous with increased COVID-19 induced investments on safety. Though the revenue is slightly picking up now, Investment Information and Credit Rating Agency (ICRA) estimates that private hospitals and healthcare services companies will suffer at least 15 percent to 20 percent drop in revenues in FY 2021 (ICRA, 2020) [1]. Small and medium hospitals, already reeling under competition from large and corporate hospitals, were the worst hit. Small and medium hospitals in Kerala are devising strategies to meet the challenges posed by the pandemic, while continuing their efforts to ward off competition from the big hospitals. This research paper looks into the strategies adopted by small and medium hospitals in Kerala to ensure sustainability during pandemic and otherwise.

Review Of Literature

The hospital services market in India is estimated at US \$ 61.79 billion (FY 2017) and is expected to reach US \$ 132.84 billion by FY 22 growing at a CAGR of 16-17% (IBEF 2020) [2]. One of the characteristic features of Indian healthcare delivery system is the dominance and growing role of the private sector. 42.5 percent of ailments are treated in the private sector. Share of private facilities for outpatient care is 69.8 percent. 55.3 percent of hospitalisations are in the private sector. (National Sample Survey (NSS) 2019) [3]. Majority of private sector hospitals are small establishments (Rao, 2012; Planning Commission Report, tenth plan) [4], [5]. Indian private health care sector is dominated by ‘own account enterprises’, usually run by one doctor (Hooda 2015) [6].

Competition to small hospitals

A trend noticed recently in the healthcare sector is the emergence of large hospitals some of which are part of corporate hospital chains. The number of private hospitals, especially corporate chains like Apollo, Fortis, Max among others, has increased significantly in the last couple of decades (Rao, 2012) [4]. The Indian private hospital sector is shifting towards corporatisation (Hooda 2015) [6]. One of the major factors that contributed towards this shift is that in the year 2000, the government allowed 100% foreign direct investment in the hospital sector through automatic route facilitating investments with less restrictions. According to data released by the Department of Industrial Policy and Promotion (DIPP) [7] hospitals and diagnostic centers have attracted US \$ 6,342.40 million (Rs. 38,415.82 crores) from April 2000 to June 2019. Financial concessions offered to corporate hospitals in the form of subsidized sale of land, reduced import duties and tax concessions for medical research (Baru, 2000) [8] also helped in their growth. These large / corporate hospitals are run just like any other corporate and they create a very competitive environment for small hospitals. Corporatisation of healthcare poses difficulties for small hospitals and make them weak (Anand Kate, 2015) [9]. The share of own account enterprises (usually run by one doctor) declined during 2001-2011 period. This indicates that large hospitals are increasing at a fast pace replacing small hospitals (Hooda 2015) [6].

Impact of COVID19

COVID-19 pandemic had a significant impact on the healthcare delivery sector. According to guidelines released by government, hospitals were required to prepare for the pandemic by

creating isolation wards, mobilising additional staff and providing training to them and arranging high-oxygen masks and ventilators. These investments affected short term cash flow of hospitals. OPD to IPD conversion in hospitals is 10 to 12 percent and hence when footfalls in hospitals reduced both OPD and IPD revenues were affected. (ICRA, 2020) [1]. Nasta et.al. (2020) [10] reported that COVID-19 led to a major decline in outpatient and elective surgical practices in hospitals. Nair et. al. (2020) [11] conducted a survey among ophthalmologists and reported that majority of them did not see any patients during lockdown, with near total cessation of elective surgeries. Nilakantam et. al. (2020) [12] states that during the pandemic health-care utilization and medical services decreased considerably resulting in significant revenue loss. Shutdown of elective surgeries, decrease in patient volumes and investments to face a potential surge in hospitalizations created financial strain on healthcare delivery system. Lack of public transport prevented ordinary people without private transport from accessing healthcare facilities. Outpatient and other medical services were shut down with only emergency services operating. (Andrade C, 2020) [13]. A similar situation occurred during SARS outbreak too. Studying about hospital restrictions during SARS outbreak Schull et. al. (2007) [14] reported substantial reductions in the use of elective services in the US. Admissions for some acute serious conditions and inter-hospital patient transfers were also affected. The strain on the hospital sector was most felt by the small and medium hospitals with low cash reserves. During nationwide lockdown nearly fifty percent of the private institutions in the state of Kerala were closed. A recent survey by IMA (Kerala branch) revealed that of the hospitals that were closed 51.9 percent were closed down for a month or more, 17.1 percent were closed for 3 weeks, 19.8 percent for 2 weeks and 11 percent for a week. Most of these hospitals were small and medium hospitals.

Importance of Small Hospitals in Healthcare Delivery

Small hospitals, already under threat due to competition from large hospitals, are being pushed to the edge by COVID19 pandemic. If small and medium hospitals close down, corporate hospitals will dominate, leading to concentration in healthcare delivery system. Concentration can lead to higher healthcare costs. A 2010 analysis found that the cost for inpatient hospital stays in San Francisco (a highly concentrated market) was about 75 percent higher than in the more fragmented Los Angeles market (David Wessel, 2018) [15]. Corporate hospitals are largely foreign funded. Healthcare costs in such hospitals tend to be higher than that of small and medium size hospitals due to greater capital intensity (Rupa Chanda, 2015) [16]. Higher healthcare costs will lead to income determining access to medical services or in other words, inequity in access to healthcare. This can adversely affect the health of people who cannot afford the higher healthcare costs. Patients, faced with a cost barrier, may respond by using fewer services (Peabody, 1996) [17]. Since small hospitals are spread across a district / state they are important to ensure geographical access to healthcare as well.

Survival of clinics / small hospitals is critical not just to the doctors who own them or practice there but also to the patients who seek quality healthcare that is accessible financially and geographically. There are no studies that examine the strategies adopted by small hospitals for their survival. This paper attempts to cover that research gap. Such a study is

significant as successful models can be replicated in other parts of the country as well, to ensure survival of small hospitals.

Research Objectives

The objectives of the study can be stated as:

1. Examine the measures adopted in Kerala to maintain sustainability of small hospitals in the context of COVID19 pandemic outbreak.
2. Examine the innovative strategies adopted by small hospitals in Kerala that helps them in staying competitive in the context of evolving healthcare ecosystem in Kerala.

Methodology

Data collection was through experience surveys and secondary research. Experience surveys were conducted with office bearers of Indian Medical Association, Kerala branch and Kerala Association of Small Hospitals and Clinics (KASC), a member of Kerala Medical Council and proprietors of small hospitals in Kerala. Twelve depth interviews were conducted, each lasting thirty to forty five minutes. Secondary research was used to get a wider understanding of the subject area. For this, a systematic review of available literature including research journal articles and reports published by government bodies and consultancy firms was carried out. The study was conducted in August 2020.

2.1 Operational Definitions

Small hospitals: Establishments of private medical practitioners, clinics, hospitals with 0 to 50 beds (in line with the definition of Small Healthcare Organisation as given by National Accreditation Board for Hospitals and Healthcare Providers – NABH – that defines a SHCO as those health care organizations having a bed strength up to 50 beds and are in possession of supportive and utility facilities that are appropriate and relevant to the services being provided by the organization) [18].

2.2 Scope

Geographical scope is limited to Kerala. The study covers only allopathic hospitals as these hospitals comprise more than three quarters of the healthcare delivery system. 83.6 percent of people seeking health care utilizes allopathic medical service in Kerala (Levesque et al 2006) [19].

Findings and discussion

COVID19: Survival Strategies for Small Hospitals in Kerala

Kerala State branch of Indian Medical Association launched I SAFE, an infection control model for medical institutions of the state. The project was launched well in time, immediately after the first week of lockdown and this timeliness ensured that hospitals did not remain closed for long. I SAFE imparts training and provides equipment for infection control. Training to the staff is imparted using online platforms as zoom. Infection kits consisting of sanitiser, disinfectant, soap solution, masks, face shield and gloves were distributed to 1080 institutions in April and May of 2020. In the second phase of the I SAFE program a network (I Safe network) of small (OP alone) and medium institutions (up to 20 beds) was established. 769 institutions, spread across the entire state, especially suburbs and

villages, are part of the I Safe network. More than half of these hospitals has only one doctor, a fifth has 2 doctors. More than 50% percent has only 1 to 5 staff members. I safe institutions displayed certificate, so that public could identify and also posters about infection control methods. Member institutions are given periodic training on infection control. A system to provide equipment is also in place. According to a recent IMA survey, all the network institutions are actively participating in the project and are very keen to continue (Average rating: 9.75 on a 10 point scale with 83.1 percent of the respondents giving a perfect score of 10).

The I Safe project and the network is a novel initiative. It helps in providing logistics, training and information updates to IMA members running medical institutions, thereby enabling safe and continued medical practice during the challenging time of COVID 19. Though there is increase in infection rate amongst health workers, more than 96 percent of the institutions in the I Safe network did not have any staff diagnosed with Covid. This has helped them to continue business as usual. More than 96% of small and medium medical institutions that closed down in the state during lockdown are functional now.

This model if replicated in other states can ensure business continuity in hospitals. This is especially important for small and medium institutions for which business continuity is critical for survival.

Competition: Survival Strategies for Small Hospitals in Kerala

Fierce competition from large / corporate hospitals has made it inevitable for small hospitals in Kerala to devise a strategy for their survival. Individually they may not be able to face competition, but working together they may be able to rise up to the challenge. This thought process has lead to a 'co-operative model' networking of small hospitals (IMA hospitals) which is done in such a way that these hospitals, while maintaining their independence, will function as part of a statewide network of small and medium hospitals. Main advantage of this network is the strength that comes with numbers. To survive, small hospitals also had to rethink certain operational aspects in running their establishments. To begin with, two important operational aspects - purchase of medical equipment and disposal of medical waste – are being addressed. IMA Kerala has conceptualised a system for collective purchase of medical equipment that would make commonly used medical instruments available to registered members at rates cheaper than otherwise available. Small hospitals are taking advantage of the economies of scale that comes with such an arrangement. IMA Kerala has also devised a collective disposal system for medical waste which again the small hospitals are making use of. Small hospitals are also having a fresh approach towards managing the 7Ps of service marketing.

Co-operative Model Networking of Small Hospitals

'IMA hospitals' is a network of small and medium hospitals in Kerala. Through this co-operative model networking, small and medium hospitals provide mutual assistance in working towards a common goal – their survival. Currently the network is piloted in three districts in the state viz. Thiruvananthapuram, Kottayam and Trissur and soon will extend to other districts as well. When it is completed, the network will be like a huge hospital spreading over the state and small and medium hospitals will be like departments of the

hospital. The stated aim of the network is to provide quality and affordable care to the patients with a humane, personal and ethical approach. The unstated aim is to ensure survival of small and medium hospitals.

Website of IMA hospitals (imahospitals.com) maintains a database of all small / medium hospitals registered with them and give information about the specialty and services offered, doctors available at the facility, timings and contact details. Patients can also book appointments through the site. Network of IMA hospitals offer many benefits to the patients that include priority consultation in the referred hospital, waiving of registration fees in the referred hospital, 10% discounted rates in all network hospitals, doctors' home visit, home nursing (on request), sample collection services and special offers by participating hospitals. There is also a helpline that patients can use for booking or voicing grievances. The venture introduces the concept of 'parent doctor', in line with the concept of 'family doctor' of earlier times. The parent doctor can act as the first contact point for treating ailments or referring to the right doctor for treating the ailment. The parent doctor would take care of the healthcare needs of the individual and his/her family adding a personal touch to patient care which is very much lacking in large / corporate hospitals. All the networked hospitals are expected to share medical information of their patients so that the medical history of the patients will be easily accessible to all doctors. This would mean that a patient going for treatment in a small or medium hospital anywhere in the state will have his or her medical history available with the doctor. This will be an unmatched advantage over corporate hospitals.

Collective Procurement of Medical Equipment

PEPS MED is an initiative by Indian Medical Association, Kerala which aims at distribution of commonly used medical supplies and equipment among registered hospitals / practitioners at very low rates (the slogan of PEPS MED is 'power of buying together'). Manufacturers / suppliers extend discounted rates because of increased purchasing power arising from high volume purchases. All orders are placed through a common channel and PEPS MED charges 0.5 percent of the total amount of purchase for the assistance they offer. The scheme gives choice of manufacturers, dealers & distributors from whom medical supplies can be purchased. Through this scheme members are extended such benefits as free delivery (from Rs. 1000 onwards), 365 days for free return, customisation if required, online purchase with secure payment gateway, coordination for after sale service and 24/7 customer service. Though this is not a scheme exclusively for small hospitals, it is small hospitals that stand to gain the most from this scheme as otherwise they will be purchasing individually in small numbers and consequently, higher prices. Small hospitals thus are taking advantage of economies of scale that comes with high volume purchases thus mitigating one of the advantages corporate hospitals have over small hospitals.

Collective Waste Disposal

IMA Kerala branch established IMAGE (IMA Goes Eco friendly) a waste disposal program for hospitals. Currently 1474 private hospitals subscribe to this waste management program. Combined bed strength of these hospitals is 64,114 making an average of bed strength of 44. In other words most of these private hospitals are small establishments. Under the scheme bio-medical waste collection bags & needle burners according to the quality parameters

specified by the pollution control board is supplied to all member hospitals. Hospital wastes are collected and disposed off in a centralised facility. Membership is not limited to small hospitals, but as in the case of PEPSMED small hospitals stand to gain maximum benefit from this collective program for disposal of bio medical waste.

Management of 7Ps of Service Marketing

Small hospitals in Kerala are effectively managing all 7Ps of service marketing. 'Product' (healthcare service offered) is designed to provide maximum relevant services under one roof. They offer consultation by specialists in their clinics on specific days, comprehensive health checkups, special consultancy services for relevant target customers etc. Some of them have laboratories and pharmacies too so that patients don't have to go elsewhere for diagnostics and medicines. As an additional source of revenue generation, they also sell health related items as special foot ware for diabetes, insulin pens, BP apparatus, thermometer etc. Promotion is done subtly and is focussed on customer retention and relationship building rather increasing customer base. Small hospitals rely mostly on word of mouth. Generally small hospitals do not advertise using print media or outdoor media, though exceptions are there. However, many of them have a small but definite place in the digital space mainly because the belief is there that it is required to create a certain 'tech savvy' image. Many of these small hospitals have their own websites and facebook pages. They enlist their establishment in sites like just dial which ensures that their names come up in google searches. They use the services of sites such as Practo to make it easy for patients to take appointments. Informal tie ups with local medical laboratories and pharmacies is another method that works both ways in attracting patients. Doctors of small hospitals strive to create visibility and build credibility as a part of their marketing strategy. For creating visibility for themselves they participate in various medical programs aired by regional channels. Also, in case of medical related social issues (as spread of dengue fever, nippa scare etc.) doctors of small hospitals address medical concerns during news programs or special programs aired by regional channels. Credibility is usually built by displaying the doctors' medical degrees and awards and recognitions won. Being part of professional bodies also help in building credibility. Pricing decisions are taken based on affordability of healthcare consumers in the locality. Lower overheads enable small hospitals to charge way less than large / corporate hospitals giving them an obvious advantage over corporate hospitals. Placement (location) focuses on accessibility. Small hospitals are generally located in residential areas giving easy geographical accessibility to patients. When it comes to 'People' recruiting staff from the locality helps these hospitals to connect with the community. 'Process' and 'Physical evidence' are areas that leave a lot of scope for improvement for small hospitals. Though technology is used to book appointments and manage crowds it is not exploited enough to improve processes. Infrastructure can best be described as basic in comparison to the swanky set up of corporate hospitals.

Conclusion

Small hospitals in Kerala are succeeding in ensuring business continuity through infection control during Covid. This challenge however is not as long lasting as the other major challenge – competition from large / corporate hospitals. Small hospitals will have to

continue on their current networking, adding new dimensions to the existing frame of operations. Network of small and medium hospitals is in the nascent stage of operation. Once all small hospitals are integrated into the system the network can help further the cause in many ways: One of the weaknesses of small hospitals is that there is wide heterogeneity in quality of service delivered. If there is a system to prescribe a protocol for healthcare delivery and quality assurance it can help in reducing this heterogeneity and improve reliability. The system should also ensure monitoring of quality of healthcare delivery by small hospitals and offer suggestions to improve service. Small hospitals lack in effective deployment of technology that can help them further their business. IMA hospitals can explore the possibilities of using advancements in technology to their advantage. For instance the network can tie up with pharmacy apps in a mutually beneficial way. Currently small hospitals do not market their services and this can be suicidal given that corporate hospitals resort to aggressive marketing. The network of hospitals can take up collective marketing based on a common theme ('parent doctor' / personal care / quality care at affordable rates) to create preference for small hospitals. One weakness of small hospitals is that they operate individually and as such lack collective bargaining power with stake holders as medical equipment manufacturers, government, insurance agencies etc. This weakness can be overcome if IMA hospitals coordinates with the stakeholders on behalf of all small hospitals. For example IMA hospitals can coordinate with the state government and private organisations for availing healthcare services of small and medium hospitals for their employees. It can also coordinate with insurance companies for insurance coverage for treatment in hospitals in the network. Insurance companies also will be at an advantage as cost of healthcare delivery will be comparatively cheaper than in corporate hospitals. Small hospitals can come together to ward off challenges posed by covid pandemic or competition. The cooperative model for small and medium hospitals that is taking shape in Kerala seems to be a viable solution to face competition. This model can be replicated in other states as well, as survival of small hospitals is critical to ensure affordability of and accessibility to quality healthcare.

References

- [1] Covid-19 Impact: Short-term Negative Impact on the Healthcare Sector (2020). ICRA. <https://www.icraresearch.in/Research/ViewResearchReport/2916> Accessed on 01.09.20
- [2] Indian Healthcare Industry Report (2020). India Brand Equity Foundation. <https://www.ibef.org/industry/healthcare-india.aspx> Accessed on 08.09.2020
- [3] Key Indicators of Social Consumption in India: Health (2019). NSS 75th Round (July 2017 to June 2018)
- [4] Rao P. H. (2012). The Private Health Sector in India: A Framework for Improving the Quality of Care. *ASCI Journal of Management*,41(2),14–39
- [5] *Report of the Steering Committee of Health, Planning Commission, Tenth Plan (2002-2007)*.
- [6] Shailender Kumar Hooda (2015). Private Sector in Healthcare Delivery Market in India: Structure, Growth and Implications. Institute for Studies in Industrial Development – Working paper 185.
- [7] Fact Sheet on Foreign Direct Investment (FDI) from April 2000 to June 2019. P10. https://dipp.gov.in/sites/default/files/FDI_Factsheet_4September2019.pdf (accessed on 03.11.19)
- [8] Baru, R. V. (2000). Privatization and Corporatization. Seminar May2000, 489.
- [9] Anand Kate (2013). Future of Small Hospitals in India. *Medicine Update - 2013*, The Association of Physicians of India. Chapter 155:686-687.
- [10] Nasta, A.M., Goel, R., Kanagavel, M. et al. (2020). Impact of COVID-19 on General Surgical Practice in India. *Indian J Surg* 82, 259–263.
- [11] Nair AG, Gandhi RA, Natarajan S (2020) Effect of COVID-19 Related Lockdown on Ophthalmic Practice and Patient Care in India: Results of a Survey. *Indian J Ophthalmol* 68,725–730
- [12] Nilakantam Sathish Raju, Kishor M, Dayananda M, Shree Amogha (2020). Novel Coronavirus – 19 Pandemic Impact on Private Healthcare Services with Special Focus on Factors Determining its Utilization: Indian Scenario. *International Journal of Health & Allied Sciences*, 9(5), 77-80
- [13] Andrade C. COVID-19: Humanitarian and Healthcare Crisis in a Third World Country. *J Clin Psychiatry* 2020
- [14] Schull MJ, Stukel TA, Vermeulen MJ, Zwarenstein M, Alter DA, Manuel DG, et al. Effect of widespread restrictions on the use of hospital services during an outbreak of severe acute respiratory syndrome. *CMAJ* 2007,176:1827-32.
- [15] David Wessel (2018). Is Lack of Competition Strangling the U.S. Economy? *Harvard Business Review*.
- [16] Rupa Chanda (2005). Foreign Investment in Hospitals in India: Status and Implications. Report made in collaboration with WHO India Country Office, New Delhi and WTO Cell, Ministry of Health and Family Welfare, Government of India.
- [17] Peabody, J. W. (1996). Economic Reform and Health Sector Policy: Lessons from Structural Adjustment Programs. *Social Science Medicine*. 43(5),823-83
- [18] <https://nabh.co/shcoDefinition.aspx#:~:text=Those%20healthcare%20organizations%20having%20bed,services%20being%20provided%20by%20organization>. Accessed on 09.07.20
- [19] Levesque J., Haddad S., Narayana D. & Fournier P. (2006). Outpatient Care Utilization in Urban Kerala, India. *Health Policy Plan*. 21(4),289-301

Secondary Data Sources

- [20] <https://www.imageima.org/> accessed on 09.08.20
- [21] <http://imapeps.com/> accessed on 06.08.20
- [22] <https://imapepsmed.com/> accessed on 07.08.20