



# Sustainability and inclusiveness in a competitive market: A study of faith-based hospitals in India

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## Abstract

**Introduction:** The Christian Healthcare Network is the largest faith-based healthcare network in India, functioning, most often, in the hard-to-reach and underdeveloped areas. It is facing serious challenges such as being forced to comply with the recent changes in government regulations, policies, and globalized market situations. Such changes in the social and financial environment are driving hospitals to adopt newer strategies to remain sustainable. Some of the mission hospitals are compromising their mission goals for which they were founded. If financial viability becomes the goal, social responsibility to the community and the true meaning of mission gets distorted. Their mission must remain the primary belief system, which legitimizes the structural arrangements and ideology of business. Mission and business must go hand-in-hand.

**Methods:** An embedded case study method was used to purposively study 16 selected cases of Christian faith-based hospitals (FBHs) pan India with the objective to understand the nature of services employed, the role played by FBHs in India in different contexts, their challenges in the changing business environment, and how successful they were in remaining both sustainable and inclusive at the same time.

**Results:** The study found that despite the variation in the services and infrastructure of mission hospitals across India, these facilities have had an on-going commitment and a long-standing operation with regard to population health. In their different settings, they are either the only service provider or the referral centre for the public facilities and the trusted choice of the middle- and lower-middle class population. The least sustainable and inclusive among them seem to have deviated from their founding objectives due to market changes, but more than a quarter of them were successful in remaining inclusive and sustainable. In pursuit of competitive advantages, some of them remained sustainable by dropping their inclusiveness, while a few ended up in existential crisis because of their adhesiveness to inclusivism. The challenges of attracting professionals, generating funds for development, and operating within the ethical boundaries set by the church are well addressed by the models which are sustainable and inclusive.

**Conclusion:** In the context of drastic changes in both internal and external environments, some of the FBHs lost their business, some lost their mission and a few got corporatized. But a few remain successful in terms of inclusiveness and sustainability by innovative strategies.

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**Key words:** Faith-Based Hospitals, Indian mission hospitals, Sustainability, Inclusive healthcare, Not-for-profit hospitals

## Introduction

More than three-fourth of Indian healthcare facilities are owned by private providers. Christian faith-based hospitals (FBHs), which were the pioneers in introducing the practice of modern medicine in India four centuries ago,<sup>1</sup> form a major chunk of the service providers, mostly located in rural India. A study conducted in 1993 on the Catholic Health Association of India<sup>2</sup> (CHAI), the largest FBH network in India, pointed out that they were facing challenges such as getting doctors and other trained professionals, inadequate infrastructure facilities, financial constraints, non-availability of medicines, the inability to afford even basic care for the majority of their beneficiaries living in poverty, malnutrition and communicable diseases, and the emergence of small clinics in their neighbourhood. Researchers had already pointed out that changes in social and financial environments were driving hospitals to adopt newer strategies to remain sustainable.<sup>3</sup>

Economic liberalization of the early 1990s opened the market for corporate for-profit multinational players to invest in Indian healthcare. The government reduced tariffs on trade and provided incentives for foreign direct investment (FDI) of up to 100 percent. The proportion of healthcare provided by the private sector increased rapidly.<sup>4</sup> Unregulated imports and the installation of high-end medical technology was a strategy that the corporate healthcare industry used for market penetration.<sup>5</sup> Accreditation was another strategy used which benefitted in giving larger private hospitals a competitive advantage.

Reforms were also happening in the Indian public sector simultaneously. By the year 1999, Insurance Regulatory and Development Authority of India (IRDA) also opened the healthcare insurance market for investment to foreign corporates. The introduction of National Rural Health Mission (NRHM) in 2005 decentralized the organization of and resource allocation in Indian

healthcare. Infrastructure modifications and manpower availability in public facilities improved. Schemes offering financial protection from the central government (RSBY) and state governments came to the help of the people, especially the poor. In the meantime, the union government also brought a plan to control the private sector through the introduction of Clinical Establishment Act (2010). Still 60 percent of the total health expenditure is financed through out-of-pocket expenditure and the National Sample Survey (71<sup>st</sup> round) shows that the private sector caters to 75 percent of out-patient and 62 percent of in-patient services in India, holding 70 percent of the total hospitals and 40 percent of the total hospital beds in India.<sup>6</sup>

Internally, FBHs had already been suffering from a shortage of financial support as “funds from the sending churches have tended to diminish materially in recent years.”<sup>7</sup> In this context, FBHs had to face a changed business environment with several new challenges. One such challenge was complying with the regulatory framework as per the Clinical Establishment Act (2010),<sup>1</sup> and another was the competition for the paying patient from the growth of commercial health sector consequent to government incentivizing investment in healthcare infrastructure,<sup>8</sup> increased FDI in healthcare,<sup>4</sup> and unregulated penetration of high-end medical technology in the Indian market.<sup>5</sup> Studies on Christian FBHs, their challenges and sustainability are not reported in the past decade. In the context of the recent National Health Policy of India (2017), which is imploring more private participation in healthcare delivery, it is momentous to study how Christian mission hospitals make themselves sustainable<sup>†</sup> and inclusive<sup>††</sup>.

## Materials and Methods

The objectives of the study were to understand the nature of services and the role played by FBHs in India in different contexts, their

challenges in the changing business environment, how successful they were, and the strategies they adopt for remaining both sustainable and inclusive at the same time.

The multiple embedded case study method proposed by R.Yin<sup>9</sup> was used to study sixteen purposively selected FBHs across India. The case study method makes extensive use of qualitative data and limited use of quantitative data, both from primary and secondary sources including archival reports. When multiple variables of various cases are analysed for their similarities and differences, the method is called multiple embedded case study. Each case setting may have its own culture, values and ways of thinking, judging, and talking about living experiences. All these contribute to make evidences in a case study research which is the basis for theorizing. According to Gillham, “Case study method uses both objectivity and subjectivity in its pursuit to understand the underlying reasons. It has its own dynamics.”<sup>10</sup>

The three major FBH service providers in India, namely Christian Medical Association of India (CMAI), CHAI, and Emmanuel Hospital Association (EHA), all of which have a wide presence across the different states of India, were considered as population for the study. Three sample hospitals each from the five regions of India, namely North East, North, Central, Western, and Southern India with at least 40 years of existence, were purposively selected based on discussions with key informants\* who assessed the performance of these hospitals as successful or struggling to survive. The sample had two Catholic hospitals and one protestant hospital each from all the five regions. An outstanding case of nearly one hundred years of existence from the North East was added to the sample during the data collection period, resulting at a final sample size of sixteen hospitals. Site visits and in-depth interviews with administrators, senior managers, doctors, and beneficiaries were conducted after obtaining informed consent. Additionally, statistical and financial data were also collected.

This study was conducted as part of a doctoral research study and not funded in any way.

Ethical clearance was obtained from the institutional review board of Tata Institute of Social Sciences, Mumbai. However, the identities of the hospitals studied are not disclosed due to ethical reasons. Detailed case study reports are ready for reference and may be made accessible on request.

## Results

### Services offered by FBHs

Three of the sixteen hospitals studied had less than 100 beds, three of them had more than 300 beds, and the rest of them had 100 to 300 beds. The percentage of “general beds” in these facilities varied between 40 to 95 percent. Bed occupancy level showed a range of 40 to 90 percent; the majority of them had more than 60 percent occupancy.

Three of the hospitals provided primary care; eight of them also provided secondary care; and only five of them provided both secondary and tertiary care. The range of out-patient services utilized was 40 to 1200 patients daily, but six had more than 100 outpatient department (OPD) visits per day, and another six had more than 400 OPD visits per day. Emergency visits ranged from 20 to 120 per day with the median being 25. The number of surgeries varied between one and 30 per day, with a median of 8.1. Five of them had more than five surgeries a day, another three had more than 10 surgeries a day, and one had more than 30 surgeries a day. The number of deliveries ranged from 80 to 5000 per year.

Ten of these hospitals had their own licensed blood-bank, and one used an outsourced facility. Five of them had their own ambulance, but three of them depended on a public ambulance (Dial 108 system). In one sub-district (Taluka), there was no ambulance; only autorickshaws were available for moving patients.

All the hospitals studied had ECG and Ultrasonography. Six of them had CT scanners, four had MRI scanners, four had Cath-labs, and one had a Cobalt Unit. Only one of them had an integrated IT system. Five of them had limited IT

applications, mostly for registration and billing. Others had no IT applications.

**Challenges for FBHs today**

A comparison of the challenges observed in this study with those found in the 1994 study using the Delphi method,<sup>11</sup> would be interesting. The top ten items are taken for comparison (Table 1).

*Table 1. Comparison of challenges identified among CHAI hospitals in 1994 and 2018*

<b>Findings of the Delphi study in 1994</b>	<b>Findings of this study in 2018</b>
1.Lack of infrastructure and facilities	1.Doctors, their availability and retention
2.Difficulty in getting professionals such as doctors and nurses	2.Government regulations including CEA and pollution control
3. Financial constraints	3.Financial constraints – inability to raise funds
4. Social issues like poverty, illiteracy, etc.	4.Turnover of nurses
5.Expectations of free care and medicine	5.Demands from customers for high-end technology and facilities
6. Non-availability of drugs	6.Mushrooming of hospitals and competition raised by corporates
7.Follow-up of cases due to lack of education among patients	7.Infrastructure limitations
8. Large number of communicable diseases	8.Accreditation as a need
9. Mushrooming of private clinics	9. Poverty among the beneficiaries
10. Lack of referral facilities	10.Violence against hospitals

A few items among the top ten challenges reported in 1994 are not among the top ten now. (1) Non-availability of drugs. This shows that drugs and medicines are available everywhere in the country now, even in very remote locations. None of the cases studied faced this problem. In fact, the North East hospitals reported that introduction of the goods and services tax (GST) made the movement of medicines and supplies faster than before. (2) Challenge of follow-up. Better education and awareness among patients seem to have changed the situation. (3) Communicable diseases are still present. The management of them might not be as big an issue now as it used to be. (4) Referral facilities are available now in most of the locations. Most of the mission hospitals themselves have grown into referral centres. There is difficulty in accessing referral centres reported in the cases studied. But this challenge seems to be a relatively small threat now.

A few challenges which were not among the top ten items formerly have now found a place

there. (1) Government regulations including CEA and pollution control. This is not only a new entrant but has also received the second highest place among the major challenges. This is an indication that the recently introduced policy changes and regulations, especially those by the CEA, have raised a serious challenge for FBHs in India. (2) Turnover of nurses is an issue now. In 1994, they faced difficulties in getting professionals; now retention of nurses is a challenge. This points to the fact that nurses trained at FBHs are also not staying with them; rather they are moving away for better prospects. FBHs are becoming training centres from which other institutions are benefitting. This seems to be a serious threat when associated with the statement from some patients that they are not happy with the services of FBHs because they mostly have inexperienced junior nurses. (3) Accreditation as a need: Some of the cases studied inform us that accreditation is an essential requirement for sustainability, but they do not have the trained

personnel or resources for it. (4) Among the top ten challenges, there is a surprising new entrant—violence against hospitals. This indicates that the response of the people towards healthcare providers, even those who are mission hospitals, is changing, and this could be due to increased expectations and awareness.

One can also see that “infrastructure limitations” has moved from the leading constraint faced in 1994 to a much lower position by 2018. There are infrastructure modifications happening in FBHs, but other challenges have become a greater priority. In the earlier study, the demand was for free care and medicines, but now the patients are demanding better technology and amenities. For instance, an administrator in Jharkhand said: “They (patients) have become aware about the machines and technology in hospitals in the city. They have started demanding for such high-end technology which we cannot afford.” Another one in Jharkhand said: “People have become very demanding, aggressive, and violent irrespective of their socioeconomic class. They live with better facilities now. In hospitals, also, they like to see better facilities and technology.”

Only clinics were reported to be mushrooming in their immediate business environment in 1994, but now more hospitals have come up, and corporate players are raising challenges for FBHs. The result of these changes is that the affordable class of beneficiaries are moving away from FBHs, and with it, not only does sustainability come under threat, but also inclusiveness since the financial surplus needed for cross-subsidy is much less available.

Providers who were interviewed also perceived a change in perception of what good healthcare is among the new generation. This is not surprising since the new market situation, experienced in all realms of life, modifies the perception in healthcare also. This has been perceived as behaviour changes in health seeking in the mission hospitals studied. On the contrary, providers perceive the older generation as still looking for ethical and value-driven healthcare,

irrespective of the nature and location. For example, a doctor in Karnataka said in the interview:

*Now the patients are dictating the plan of treatment and they even propose diagnostic tests to be done. Still, the older generation show much respect and trust. The young generation comes with demands and they look for magical remedies. They have some knowledge, but no comprehensive knowledge.*

One of the administrators in Assam said: *The older generation still has trust and confidence in this hospital and its treatment. But the young generation turns demanding and violent very soon. They feel that because they are paying, they should get guarantee of recovery.*

To a large extent, this is an urban trend, but as markets penetrate rural areas and similar perceptions emerge, it could result in decreased sustainability of many mission hospitals which would, in turn, result in a vacuum of healthcare provisioning in many rural regions. The corporate hospitals that have already signalled their interest in rural healthcare would exploit this situation, leaving the poor rural Indians further impoverished.

### Strategic choices

Under the pressure of changing external and internal factors affecting the business environment, FBHs were forced to make a strategic choice and adapt themselves in the changed situation. The three major choices available to them were: (1) to be like their corporate counterparts in the market and be “successful” according to the market logic, which is equivalent to being financially sustainable, (2) to offer selective services and ensure that either sustainability or inclusiveness is maintained, and (3) to stick to inclusiveness, which is the *raison d’être* of mission hospitals,<sup>12</sup> and adopt innovative means with utmost professionalism to ensure sustainability. A fourth and the worst choice is to exit the market and be non-existent. The outcome of their choices would

be reflected in four decisive indicators: (1) the ability to generate funds to subsidize the care for the poor; (2) the capacity to invest in high-end technology and infrastructure to attract specialists as well as paying middle-class patients who would otherwise seek affordable private sector options; (3) “witnessing” the Christian mission by serving the poor.<sup>13,14</sup> According to Christian teachings, an act of serving the poor with utmost humility is the act of serving Christ and, thus, an end in itself; and (4) fidelity to the original objectives of the organization and the ethical norms of the Church.<sup>12</sup> Certainly, the underlying consideration, which is the pivotal point of their choice, is the sustainability-inclusiveness spectrum and reaching an equilibrium balancing the two.

**Sustainability versus Inclusiveness**

**Sustainability**

Sustainability,<sup>†</sup> in this study, is theorized as being associated with four variables: (1) the ability to generate running costs and a surplus over that, (2) the potential of charging higher fees from at least a section of the customers being served,<sup>15</sup> (3) the capacity to provide comprehensive services, and (4) lower dependency on high-end medical technologies, since studies have indicated that this could render them more vulnerable to a debt burden<sup>16</sup> and push them into excessive use of

technologies compromising affordability and value for money.<sup>17</sup> Regaining running cost and surplus generation capacity are evaluated based on the financial data and the track record of repayment of loans without external funding. The customers are the source of income for any cross-subsidy model which can function without external funding. Hence, the customers’ ability to pay higher user charges has a bearing on cross-subsidy. Being selective about services delivered was also considered a potential threat for sustainability; since, in our case studies, the selected essential services are not the most remunerative (in contrast to the experience of corporate hospitals which focus on high cost services like in-vitro fertilization [IVF] or cancers), but the most that the poor needed, like care in delivery, common infections, and injuries.

A scoring pattern of zero to ten (0 to 10) was set for all these four variables. The highest surplus generation capacity was rated as “10” and the lowest as “0.” Customers who belonged to the middle-class, lower middle-class, and below were rated as ten, five, and zero, respectively. The comprehensive nature of services offered was scored “10,” moderate services was scored “5,” and selective services was scored “0.” Lowest dependency on technology was given a “10” and higher levels of dependency was scored lower with a “0” for the most highly dependent (Table 2).

Table 2. Details of scoring method used to assess “sustainability”

Score	Characteristic	Indicators
10	Lowest dependency on high-end medical technology  High ability to generate surplus Comprehensive nature of services Customers can be charged higher fees	Absence of CT scanners, MRI scanners, cath labs, fully automated labs, etc.  Break-even achieved and loans repaid All basic specialties available Majority of customers belonging to middle-class or above
5	Moderate dependency on high-end medical technology  Moderate ability to generate surplus Focus on selective services Customers can be charged moderately higher fees	Presence of one or more of CT scanners, MRI scanners, cath labs, fully automated labs, etc.  Moderate dependency on external funding Higher utilization of selected specialties Majority of customers belonging to lower middle-class

0	Highest dependency on high-end medical technology	Presence of CT scanners, MRI scanners, cath labs, and fully automated labs
	Least ability to generate surplus	Running at a loss and dependence on external funding
	Selective services only	Only selective/outsourced services
	Customers cannot be charged any higher fees	High proportion of the poor among the total beneficiaries

### Inclusiveness

Inclusiveness<sup>††</sup> was evaluated based on the associations made by our analysis of the case studies. It was reflected by three indicators: (1) the percentage of annual turnover spent as free or subsidized care, (2) the percentage of beds available in the general category, and (3) the nature of community and outreach services offered. Scores were assigned with the highest having a “10” and the lowest a “0.” Considering 80 percent as the required score, it was found that seven of our case studies rated high in inclusiveness, and the rest were low in inclusiveness.

### Categorization of cases according to the Sustainability-Inclusiveness Spectrum

Based on these indicator readings, we categorised our sixteen case studies and built an analytics framework that gives us a better understanding of what happens to the mission hospitals operating in widely different contexts across the country where forces linked to economic globalization have been changing the nature of healthcare practices. We have categorized the case studies into four groups: (1) Category A: least inclusive and least sustainable, (2) Category B: more sustainable and less inclusive, (3) Category C: more inclusive and less sustainable, and (4) Category D: highly sustainable and highly inclusive.

The results showed that hospitals W and H had high inclusiveness but were low in sustainability (category C). Five hospitals, N, S, F, J, and ME, had high sustainability scores but were low in inclusiveness (category B). Five hospitals, BC, B, D, C, and ST, were high in both sustainability and inclusiveness (category D). The weakest status of having low sustainability and low

inclusiveness (category A) was found in four case studies, namely SC, R, P, and L.

### Features of Category A: least inclusive and least sustainable cases

These hospitals were located in urban Assam, Goa, urban Gujarat, and semi-urban Karnataka. Certain common features are found in their external environments. All these hospitals were situated in locations with well-developed road and transportation infrastructures. They had a common feature of being situated in the midst of healthcare markets with a large number of private nursing homes and corporate hospitals as their competitors in the same geographical area. Most of such competitors had adopted high-end technologies and set a culture of practice. None of these four case studies had any external funding. Insurance schemes were not providing resources nor bringing in customers for them, though the reasons for this varied. The political climate in their locality was not conducive for them, and government support and collaboration are minimal or non-existent.

The internal factors affecting them also showed commonalities. These providers did not articulate “inclusiveness” as one of their main objectives, although they initially had it in their original objectives, as noted in their documents. There was no sign of management techniques with focus on quality found in any of these four case studies. They did not have active links with the community being served, nor do they engage with the government in any form of healthcare for the people. The public healthcare facilities in these locations functioned better, and therefore, even the poor had an option. They have lost competitiveness in the market as they did not seem

to understand the changing needs of the middleclass customers who were able to pay, but who would seek affordable care. The push to maximize insurance as a source of funds was not found in these case studies. And these models, like many others, have difficulty in attracting specialists.

These cases were not able to invest in technology or infrastructure that attracts doctors, and they were not able to raise funds to subsidize the poor. For example, the administrator of one of them said: “We are not in a position to offer free service. Mission in terms of serving the poor remains nominal.” There was poor internalization of objectives related to inclusiveness and poor readiness to take on the extra burden of effort that would be required to adapt to changing times.

### **Features of Category B: More sustainable and less inclusive**

Urban settings with higher competition were the locations for these hospitals, for example, Punjab and Kerala. The external factors influencing the business of the hospitals in this category were not different from that of category A. But the internal factors showed significant differences. A majority of the beneficiaries of these hospitals were the middle-class population. Political polarization and legal regulations manifest highly in the settings of these cases. All these hospitals function as referral centres for primary and secondary care in their settings. They have adopted high-end technology to gain competitive advantage in the market as well as to attract specialists. Most of them are accredited hospitals under National Accreditation Board for Hospitals (NABH), a mark of their stature with regard to their business and marketing skills. Inclusiveness is not a part of their articulated or emphasized objectives. For instance, an administrator of one of them said: “The poor do not know that they can avail free service here. Mostly, the middle class are the beneficiaries of the services of this hospital.” Their management focus is on carefully ensuring that all the services

provided by them break-even and do not run into loss.

These case studies showed the ability of hospitals to generate funds for capital investment and growth. But subsidizing for the poor was not a consideration or objective they set for themselves in their present scope of business. The Christian “witnessing” to individuals was not apparent in the interviews, and, organizationally, their values were more linked to portraying a professional stature and being seen as one among other private “market leaders” in their area. The social teachings of the church and their parent body were relatively low, and what had been characterized as a “culture of globalization” (Pope John Paul II,1993) had a significant influence in their decision-making.

### **Features of Category C: Less sustainable and more inclusive**

There are two case studies among the sixteen samples studied that were in this category. Both these hospitals were situated in poverty-affected locations, one in Maharashtra and the other in Chhattisgarh. Political polarization in their settings was very evident. State control through the enforcement of legal regulations was also strictly practiced in these contexts. They were not in a position to charge higher fees for services from their beneficiaries. Their dependency on government schemes for financial protection was very high. Nearly 20 to 40 percent of the total income of these two hospitals come from this source. Their survival currently rests on this funding mechanism. They also offer some of the loss-making services for the benefit of the poor in their locality. To quote an administrator:

*We are here for the poor people of this tribal belt. We know that. We give a lot of charity. This RSBY is a loss in many of the cases. There are times when (what) we spend for treatment is much higher than what the insurance company repays. But we cannot deny the patient treatment even if the government denies the claim.*



Inclusiveness is found to be of high priority, but sustainability is a challenge.

These two hospitals were pooling all their funds to give free or subsidized care to the poor. The hospitals were unable to generate funds for investment in technological or capital developments. Building renovation and infrastructural development were planned only when they felt they could raise external funding support, and without this, they were unable to do the renovations. Providers in these hospitals emphasise motivations consistent with the concept of “witnessing,” and hospital management emphasizes their goals of missionary service and gospel values as reflected in the founding objectives.

#### **Category D: Highly inclusive and highly sustainable**

The fourth category of hospitals had demonstrated a higher level of sustainability and inclusiveness. These hospitals were in rural locations with underdeveloped roads, poor accessibility, and insufficient power supply. The public healthcare facilities in their regions are weak and functionally lower than that of the other FBHs. There were hardly any competitors in their contexts. All other facilities, including that of the government’s, depended on these hospitals for referral support and technical expertise. They had not invested in high-end medical technology, nor are they following accreditation as a means for gaining competitive advantage. Political polarization is not manifested in their settings. These hospitals had regular and organized community health activities by which they reached out to the poor and needy. They were constantly engaged with the public system, identified more with it, and tried to empower it. In most cases, they were functioning as an extended arm of the government and as resource centres for the public health system. These hospitals showed higher utilization of their services, but not higher human resource availability. They were offering comprehensive care and were not focused on any selective care. Both the poor and the elite

benefitted from the services that they were able to provide under the cross-subsidy model. They followed differential pricing, and the poor were not left unserved because of their inability to pay. Absence of these hospitals would leave a huge vacuum in the health system of these locations.

These hospitals were able to generate a nominal surplus they can invest for future developments, but they too would seek external funding from local sponsors and churches for expansions and renovations. Good HR practices were also followed that helped in attracting and retaining their workforce. The most important of this is a positive practice environment which places high value on excellence in service and dedication for the poor. Here too, interviews of providers emphasise service to the poor and sick as central to their faith and an organizational commitment to its founding objectives, as reflected in their documents and work processes. The medical administrator of one such hospital said:

*We will continue to focus on the poorest and those who are still not able to reach the healthcare facilities. We try to keep the balance by reaching out to the poorest through our CDHP activities. The rich have increasing demands for high quality care. We are not after them. Our focus is on the poorest who are denied even the primary care.*

#### **Discussion**

The strategic choices made by our case study hospitals may have been deliberately planned. They may also have been the result of unplanned but gradual adaptation to situational changes. But we tried to understand what could have been the driving force that led to the outcomes to which they arrived, whether desirable or undesirable.

In the absence of external funding, the ability to raise funds became a challenge for the mission hospitals. Some of them raised their tariff rates, but this was not grounded on strategic pricing policies or a deeper understanding of the profile of beneficiaries. The lion’s share of their beneficiaries, poor and of lower middle-class,

opted to use the public facilities which were by that time providing facilities and services as good as that of the mission hospitals. They were unable to attract the rich due to their limited facilities and technology. The fear of reduced working capital prevented them from empanelment in government health financing schemes and entering into contracts with insurers. Sustainability and inclusiveness were diminishing in these cases.

Some of their counterparts instead went for loans and invested in infrastructure renovation and high-end medical technology. They could either maintain market leadership or be at par with the top players in the market. Doctors and patients with financial means were attracted to such facilities. In their struggle to mitigate financial liabilities, they were pressured into focussing on revenues and repayment rather than subsidized care. The culture of globalization seems to have influenced their choice of service delivery, as reflected in a greater proportion of earnings coming from high-end diagnostics and procedures and market-driven healthcare patterns. Empanelment in government health schemes, with the maximisation of insurance as an earning opportunity, helped them in resource mobilization. The third group, which were traditionally known for giving free and subsidized care, continued as before because they could not drop the poor whom they consider as the target of their services. Professionalism, for these hospitals, seemed to be their missionary objective, and they do not value success in the market as a critical measure. Sustainability of the mission seemed to surpass financial sustainability in these hospitals.

The fourth category, which is both sustainable and inclusive, made careful choices with regard to appropriate technology required in their context and retained their clientele, both the rich and the poor, by their excellence and empathy in service. They leveraged “cross-subsidy” to serve the poor. A careful balance of sustainability and inclusiveness was maintained by these hospitals by choosing to serve the “mass” and not the “class.” They served a nominal percentage of the class in order to cross-subsidize for the poor.

Attracting specialists was another crucial issue for the FBHs in the changing contexts. Those who could not attract them by offering money or assuring the presence of high-end technology, switched over from employing doctors to “attaching” doctors, leaving them to use the facility of the FBHs to run their own clinic at their disposal. This method seemed to have relieved the hospitals from the financial liability of paying salaries; but it also showed a loss of control of operations and assurance of doctors’ presence and quality and resulted in dissatisfaction of the beneficiaries. On the contrary, the second category of FBHs attracted specialists by installing high-end medical technology for accurate diagnosis and effective therapies. The third category of hospitals retained full-time doctors with more monetary benefits. The fourth category pulled doctors to them by their service excellence, dedicated work, team spirit, and their personal example of living a humble life. They adopted different HR techniques such as a careful selection of doctors in line with their missionary objectives, participative management, and transparency in administration.

Laxity and compromise seemed to have crept into the minds of the missionaries helpless to serve the poor in the changing contexts. Providing options for the poor was the inspiration, on the other hand, for some of their co-players to continue the mission, even in resource-constrained situations. Community health services were the strategy for many of them to reach out to the poor and the underserved. Good service quality and becoming referral centres for other facilities in the location brought the poor and the rich to the hospitals with high sustainability and inclusiveness. Those who left the poor were left by the poor also; those who stood for the poor were demonstrating the love of God for the poor, the value that the Church wants to uphold by healthcare.

## Conclusion

While there remained a variation in the services and infrastructure of mission hospitals across India, these facilities had long-standing

operation and ongoing commitment to population health that could and would make meaningful contributions to the Indian health system. They are offering a wide range of services from primary to tertiary care and home-based to critical care. Their presence was the only provision of healthcare in certain remote and hard-to-reach locations in India. They were leading providers of rural healthcare, while they continued engaging with the community and the public system for the good of the people at large.

The challenges faced by these hospitals have changed over the last 25 years from predominantly patient care issues to market-related issues in the present context. The economic changes, market trends, and the culture of globalization coerce FBHs to retreat from the mission of being inclusive and to shift to a strategic choice of profit-based, technology dependent, market responsive sustainability. A few hospitals have, however, been able to resist this coercion, and to do so, they have had to make strategic choices that balanced an adoption of the right technology, an active engagement with government programs and public health systems, building mechanisms of continued engagement with the community and professionalizing management. They had to do all of this without losing the core values that defined their mission—where it is the spirit of service and not market leadership or professional pride that is the main motivation of both management and individual providers.

\* The key informants were the leaders of the associations of the faith-based hospitals at state and national levels who were very familiar with the functioning of the hospitals. Leaders of other NGOs also were consulted.

† Our notion of ‘sustainability’ is limited to market sustainability which denotes the ability to continue in the given market context. Other aspects of sustainability of the mission, organizational values, etc., are not in the scope of this term.

†† Inclusiveness indicates the ability of the hospital to serve all sections of the community, including the poor and the marginalized, which is core to the existence of the mission hospitals.

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