

Case Study: The Financialization and Transformation of a Regional Healthcare Hub – Coimbatore

The Historical Paradigm: Physician-Led and Trust-Based Infrastructure

For decades, Coimbatore in Tamil Nadu was a model of sustainable, high-quality, and accessible private healthcare in India. Pioneering medical practitioners developed it, often in partnership with local industrial philanthropy and local financing. These legacy institutions, such as the **G. Kuppuswamy Naidu Memorial (GKNM) Hospital**, were established in 1952 by the Kuppuswamy Naidu family charitable trust, owners of Lakshmi Mills, when no other speciality care hospital of its kind existed. It set the standard for trust-run healthcare and for other private institutions to follow. It operated on a highly resilient cross-subsidy model in which surpluses from affluent patients directly funded medical care for underprivileged agrarian and industrial labourers in the region.

Another example of this entrepreneurial spirit is the emergence of hospitals such as **Ganga Hospital** (Orthopaedics and plastic surgery), which began as a small nursing home in the 70s. A Harvard Business Review case study in 2023 tracks the Ganga family's tremendous growth from a small hospital to a 600-bed hospital with 40 operating rooms, 230 salaried doctors and 1200 staff. However, the case study also emphasises that this was achieved with locally raised funds, ethically, and in response to patient demand rather than being driven by external financing or private equity.

These hospitals are not isolated in their approach or growth strategy, but they show that it is possible to grow and thrive without private equity, even if it is more challenging and requires risk-taking and a robust cross-subsidy model that allows differential payment options to make healthcare more affordable. More importantly, this approach maintains the clinical autonomy of the medical practitioner and enables cost-effective treatment without resorting to over-investigation, over-medicalisation and unnecessary interventions. Additionally, these developments follow emerging demand rather than having to manufacture demand for their health services to meet their financial goals.

The Influx of Speculative and Foreign Capital

Over the past decade, this locally nurtured growth model of medical care has faced an aggressive onslaught of global private equity (PE) consolidation and foreign institutional investment. Coimbatore's high density of affluent middle-class patients drawn from across southern Tamil Nadu and neighbouring Kerala, strong health insurance penetration, and existing medical reputation make it a prime target for global financial institutions.

- **The Single-Specialty Roll-Up:** The most striking structural shift is evidenced by networks like **The Eye Foundation**, a prominent chain rooted in Coimbatore, which secured a massive **\$75 million investment from Verlinvest**, a premier consumer-focused global private equity firm based in Belgium.
- **The Corporate Conglomerate Infiltration:** At the same time, national corporate maternal-child health networks like **Motherhood Hospitals**, backed by the global private equity giant **TPG Capital (Texas Pacific Group)**, have aggressively expanded into the city.
- **The Secondary Market Flip:** Networks like **CARE Hospitals** have further reshaped the multi-speciality landscape, as global asset management titan **Blackstone acquired controlling ownership** (purchasing it from TPG). This channels foreign speculative finance directly into the regional healthcare matrix. Even listed local giants like **Kovai**

Medical Centre and Hospital (KMCH) are subject to **Foreign Portfolio Investor (FPI) volatility**, tying local operations to the demands of public-market quarterly earnings reports.

Systemic Distortions and Localised Fallout

The entry of foreign and speculative capital into Coimbatore has triggered three distinct systemic crises that threaten the survival of the ethical medical practice in the region:

- a. **The Artificial Talent Drain:** Massive venture capital and the entry of PE-backed corporate chains have created an unsustainable talent drain, siphoning elite specialists and senior consultants from government and district hospitals. They also draw from legacy trust hospitals and pull specialists from other centres such as Madurai, Trichy, Salem, Erode, and Tirupur, clustering regional expertise in Coimbatore alone (market monopolisation).

By itself, this may not be a crisis, provided there is a well-organised referral system, such as within the government health system, rather than leaving it to touts, unethical middlemen, and misleading online ratings to woo patients. Ultimately, the regional health system needs decentralisation and sufficient health infrastructure in Tier 3 and Tier 4 towns to ensure efficiency, by encouraging private healthcare institutions to support small, ethical family practices and health promotion to address lifestyle changes and strengthen primary healthcare. Meanwhile, the government of Tamil Nadu has made considerable investments in rural infrastructure and upgraded most district hospitals, yet specialists remain hard to find to fill these vacancies, as most young doctors prefer moving to Chennai or Coimbatore for employment but also seeking a better lifestyle (schools, colleges, shopping malls, restaurants and the charms of a cosmopolitan lifestyle)

- b. **The Fracture of the Cross-Subsidy Safety Net:** Starved of these critical revenues, institutions like GKNM face extreme structural pressure, narrowing the margins available to subsidise free and low-cost care for the rural poor of western Tamil Nadu. This needs to be studied and documented. Nursing homes, trust hospitals, and mission hospitals have faced tremendous pressure to retain staff and provide more affordable medical care. Unfortunately, this has often forced them to raise prices (due to rising staff salaries and development costs, and to ape some of the practices followed by for-profit hospitals), reducing their ability to care for poor patients. These institutions depend on patient volumes to stay financially viable, and even a small reduction in patient numbers can cause them to spiral downward.
- c. **Impact on Government Health facilities:** Infrastructure and the quality of care at government hospitals have been reasonably good in Tamil Nadu. Unfortunately, people, especially the rich and middle class, still do not trust the Government hospital and prefer to go to private hospitals. While poor people still go to government hospitals, specialists and consultants are moving away from them. Also, to maintain quality of care, many doctors have begun shifting to low-cost protocols to pursue prevalent clinical practices. This will further escalate the average cost per patient.
- d. **The Outsourcing of Price and Policy:** This is based on anecdotal and journalistic reports, but we still need to track how these financing changes have affected the Eye Foundation and KMCH by comparing the period before PE's entry with the period after. It would also be useful to track the pricing and maternity protocols of motherhood hospitals, and to

assess how these pricing shifts influence pricing in other private hospitals in Coimbatore. It is anticipated that there will be a considerable escalation of prices. Insurance companies claim a 28% increase in the amount claimed after PE took control of hospitals. While these are only anecdotal reports, documenting them could confirm or dispel these fears. Journalists say that the pushback they receive from hospital management and the lack of transparency regarding pricing policies are indicative; however, we need to establish citizen forums and patient groups to actually enquire into this sensitive matter.

Strategic Conclusion

The growing involvement of venture capitalists and private equity firms, especially foreign investors, in acquiring many trust and charitable hospitals and in financing new hospitals in Tier two cities like Coimbatore will put pressure on legacy hospitals and the old paradigm. It often comes in the guise of “world-class care”, while Coimbatore has been a stellar example of how committed local doctors have already been delivering high-quality medical care. In the race to outdo others, increasing financial investment from these private equity institutions will eventually erode clinicians’ autonomy and pressure them into unethical medical practices.

The growth and concentration of tertiary and quaternary care in Tier 1 cities is a warning for Tier 2 cities like Coimbatore. This has a negative impact because it causes an internal brain drain and attracts more and more doctors, nurses and technicians, which will negatively affect health care in Tier 3 & 4 towns and rural areas; it will starve small nursing homes, trust hospitals and mission hospitals, which essentially have survived on small margins on a cross-subsidy model and lack the capital and operational capacity to provide subsidised care to poor patients as they did in the past. So, the impact is on the large health ecosystem, including government health institutions. A hallmark of this phenomenon will be the irrational but exponential increase in the cost of medical care, with catastrophic consequences not only to the poor but to the working middle class and their families.