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Impact of Strategic Alliance on Patient Volume: A Study of Rural Chandigarh Gastro Clinic and an Urban Tertiary Hospital

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Abstract: ***Strategic alliances in rural healthcare are common but usually focus on operational aspects. This is the study of alliance between a rural outpatient centre and a tertiary urban hospital to expand the scope of services at rural centre. This is a study to assess if the alliance can make a significant impact on patient volumes at a rural outpatient centre. It also analyses the benefits to bigger hospital in form of the conversion rate from smaller partner of alliance. The questionnaire-based survey was performed to identify the effectiveness of marketing activities for increasing patient volumes in rural scenario. The data is collected for a period of 8 months after the alliance and is compared with similar months' data prior to alliance. The paired t-test shows that alliance could not make a significant impact on patient volumes. There is a 62% conversion rate from rural outpatient to inpatient urban partner. The external marketing activities could influence just 8% of society whereas majority are influenced by the patients' word of mouth in the rural healthcare context. We conclude that over short duration, the alliance is unable to significantly impact the patient flow at rural centre.***

Keywords: Rural healthcare alliance, hospital partnership effectiveness, patient volume analysis, word of mouth referral trends

1. Introduction

Strategic alliances in healthcare sector in India is very common and has become an integral part of healthcare delivery. Despite being so common these are usually informal alliances and not much has been studied or reported in literature.

Chandigarh Hospital (now Chandigarh Gastro Clinic, CGC) was started in January 2010 as 15 bedded healthcare unit in rural area of Punjab. The organization was conceptualized, started and managed by a doctor couple who have strong core professional values of transparency and ethical business practices. The hospital had a vision of providing affordable and easy accessible super specialty gastroenterology services at doorsteps of rural population. The hospital was made out of capital generated from bank loans and had fixed recurring expenses. This healthcare unit has gone through phases of growth and decline. After initial few years of business, the hospital was unable to manage the challenges emerging from external general and healthcare environment. As a result, in 2015, the hospital adapted to the strategy of contraction of its scope of services. Gradually high- cost services like Operation theatre, Intensive care units and in -patient services were withdrawn over next few years and it primarily served as a centre where only limited services are available like OPD, endoscopy, pharmacy and laboratory services are available.

In July 2024 an alliance was formalized with a Famous Hospital of Ludhiana (FHL). This is a resource- based alliance which is manifestation of cooperative, rather than competitive strategies in organizations. Similar basis for alliance has been reported earlier by Eisenhardt et al[1] and Gulati R[2]. This alliance enables both partners to use the specific resources and skills of other to achieve greater common goals, as well as goals specific to the individual partners. The alliance was planned and executed with a frame work that could bring effectiveness and sustainability as per the suggestions made by Nawaf Aqeel et al[3]. There was early and continuous engagement with stakeholders like local health providers both registered and unregistered medical practitioners and chemists.

The important aspects of alliance between CGC and FHL include -

1) At CGC, FHL would extend its OPD services in the fields of Internal Medicine, Urology, Gynaecology and Oncology with doctors visiting once a week
2) The CGC would continue with its existing services of daily gastro OPD, endoscopy, pharmacy and laboratory services
3) The marketing activities for the alliance would be carried out by the team of FHL in the form of Press conferences, news paper advertisements, Free health camps, Online and social media marketing
4) Both alliance parters aim to develop each other's patient base and share their strengths and capabilities for the benefit of patients and society

For practical purposes, such kind of alliances are common but literature search could not bring forth any similar Indian study being published in the past. There have been studies on strategic alliance and customer impact, from community hospitals in USA, as has been studied by MH McSweeney-Feld[4]. This study is an attempt to study the impact of alliance on the foot fall of patients. The few unique aspects of this alliance include:

1) The two partners have existence in nearby but different geographic locations. Prior to alliance, FHL has almost negligible presence and patient flow from region of CGC.
2) The two partners have different scales of services and business. However, both partners have similar professional values and deeply ingrained ethical work culture.

Most of the earlier authors like Das TK[5] and Oliver C[6] have focussed on alliance sustainability and the relationship between alliance partners, in terms of trust and conflict. This study is being done to understand the relationship of alliance

with its customers in the rural Indian healthcare scenario. There is not enough information available on alliances of different class of healthcare facilities in rural Indian scenario to conclude if there is actually a demand of such alliances and whether such alliances are beneficial for business growth of either of the partners.

Problem definition

Chandigarh Gastro Clinic is in a phase of business decline over last 10 years. The CGC is gradually reducing its scope of services. Despite having land and building of a hospital, it is being run only as a clinic with a large portion of its building not being utilized.

The probable reasons for the poor business performance of CGC are

1) Not aligned with market practices like "incentives", which is prevalent for super specialty services
2) Scarcity of trained paramedical staff in rural area.
3) Limited financial resources of the owners of CGC.
4) Gradually reducing availability of lead doctor as he offered part time services at other centers.

As CGC has been unable to resolve the above problems, despite being aware of them, it plans to work together with another hospital which is a market leader. The alliance with FHL is an attempt to revive its business. The strategy is to run a multi specialty OPD for six months, as a pilot project, to increase the foot fall of patients at CGC and later expand the services into a rural hospital with secondary healthcare facilities. The patients needing tertiary facilities can be referred to FHL.

As there is no literature evidence to suggest the outcome of such alliances in the Indian rural scenario, it is not clear if the brand and services of FHL will really add value to that of CGC. Hence this study is designed to understand the impact of alliance on its primary objective of increasing the patient pull and analyzing the factors which bring the patients to CGC.

At the same time FHL is interested to expand its foot prints in nearby small town and villages to attract patients at FHL for in-patient services. While CGC is leveraging the manpower of specialist doctors and marketing team of FHL, the FHL plan to take advantage of good will and patient pool of CGC to generate the in-patient customers.

The CGC and FHL share a common ideology of ethical and transparent practices and have agreed upon the common marketing activities of newspaper advertisements, flyers, free health camps and social media activities to influence the people. The effective reach of these activities in general population also needs to be evaluated by questionnaire based population sample survey.

2. Methodology

The data of all patients visiting CGC is collected. The doctors are classified into two groups - CGC doctor and FHL doctor. The CGC doctor includes only gastroenterology surgery, while FHL doctors include internal medicine, gynecology, urology and oncology.

Apart from consultation, the patients using services of endoscopy, laboratory and pharmacy are recorded separately.

Criteria for Inclusion and Exclusion:

All the patients attending to regular services of CGC were included in the study.

The patients who attended CGC as part of the free health check up medical camps are excluded from the data analysis, as these camps are a part of marketing activity and not not a part of OPD services at CGC.

The data is collected for the number of patients attending CGC for the period of study and is tabulated month wise. It includes pre alliance data from August 2023 to March 2024 and post alliance data from August 2024 to March 2025. The data includes -

1) Number of patients visiting CGC for OPD consultations
2) Number of patients Visiting Endoscopy Unit Services
3) Number of patients Visiting Pharmacy services
4) Number of patients visiting Laboratory services

To avoid seasonal variations, the data of same months from consecutive years were considered for analysis. As the alliance started from August 2024, the eight months data after the alliance till March 2025 will be compared with pre-alliance data of same season of eight months from August 2023 till March 2024.

The total number of patients utilizing these four services were tabulated on monthly basis. The data collection was both retrospective for pre-alliance period and initial five months of post alliance period. The data was collected prospectively for last three months of post-alliance period. The data is then subjected to statistical analysis to determine if the creation of alliance has made any significant impact on the number of patients. The data is analyzed using paired t-test. The paired t-test is appropriate because -

1. The data is randomly selected and hence, it is normally distributed
2. The data is paired, i.e., patient counts are available for each service before and after the alliance with FHL for the same time periods (i.e. 8 months)

To study the impact of alliance, a hypothesis was made at the beginning of alliance. It was hypothesized that the alliance would not impact the number of patients at CGC. The paired t-test was applied to test the hypothesis. The paired t-test compares the mean number of patients that used the services at CGC before and after the alliance with FHL. The result of paired t-test either confirms or rejects the hypothesis.

A record of patients, who were referred to FHL for tertiary treatment and services not available at CGC, is maintained. This is compared to number of patients who actually attended FHL facilities to determine the proportion (conversion rate) of patients successfully converted form CGC to FHL.

With the start of alliance, a number of marketing activities are being done to generate the awareness into people about

the enhancement of scope of services at CGC. These marketing activities include - press conferences, news paper advertisements, news articles, flyers, free health checkup camps and social medial (Facebook and instagram) campaigns. A questionnaire- based interview is being conducted in a sample of 100 people from the society. The sample size of 100 people from society were selected randomly. A large number of people from the sample were unwilling to participate and were unable for the interview schedule. The question is asked about the source of information based on which people decide to visit CGC. This to identify the most effective tool of marketing activity which brings the patients to CGC. The answers to the questionnaire were tabulated to score the proportion of each kind of answers. The findings of the answers were analyzed to determine the questions that are asked in the interview.

3. Results

Observations

Table 1: Data of number of patients availing services at CGC before and after the alliance

Number of patients availing the services in different departments of CGC									
Before Alliance									
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Gastro-Surgery OPD	114	118	136	105	114	92	95	105	**879**
Endoscopy	3	3	5	2	2	4	1	0	**20**
Pharmacy	131	144	164	122	128	115	130	121	**1055**
Laboratory	23	22	28	21	11	20	14	23	**162**
After Alliance									
	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Gastro-Surgery OPD	129	138	104	93	100	96	115	143	**918**
Internal Medicine OPD	0	6	32	15	16	12	9	12	**102**
Gynaecology OPD	0	0	2	2	3	1	0		**8**
Urology OPD	1	5	4	3	2	1	No Service	No Service	**16**
Oncology OPD	1	No Service	No Service	No Service	No Service	No Service	No Service	No Service	**1**
									1045
Endoscopy	4	2	2	2	3	4	3	5	**25**
Pharmacy	148	146	148	129	122	116	159	178	**1146**
Laboratory	22	37	31	25	26	23	12	28	**204**

The data of patients availing the services was collected as per plan. The detailed description of data collected regarding the number of patients at CGC during the two comparative periods is shown above in table 1. The data from table 1 shows that during post alliance period, of eight months, out of total 1045 patients, 918 (88%) patients were for CGC (gastro-surgery) and remaining 127 (12%) were for FHL OPD. The response to FHL OPD was not as per expectation of FHL and its team. As a result two (Urology and Oncology) out of four specialties opted out of the alliance and remaining two specialties (General Physician and Gynecology) were willing to continue the plan of alliance.

The table 1 shows that there is increase in number of patients in all services like OPD, endoscopy, pharmacy and laboratory. But we need to ascertain if the increase is meaningful and significant statistically. This is done by application of paired t-test.

The data in table 1 was subjected to paired t-test as is shown in table 2.

Table 2: The application of paired t-test is shown in the table below

S. No (n)	Services	Pre-alliance	Post-alliance	Difference (X)	(X-Xbar) Sq.
1	OPD	879	1045	166	8100
2	Endoscopy	20	25	5	5041
3	Pharmacy	1055	1146	91	225
4	Laboratory	162	204	42	1156
Mean of differences (Xbar)				304 / 4 = 76	
Sum					14522
Sum / n-1					4840.67
Std. dev. (SD)	Sq root(sum/n-1)				69.57
Std. Error of mean (SE)	SD / Sq root of n.				34.78
t-calculated	Xbar / SE	76/34.78			***2.185***
t-critical (significance level 5%)	From table				***3.182***
Null Hypothesis	t-cal < t-critical	2.185<3.182			**Retained**
Inference	**The alliance has not made any significant change in the number of patients at CGC**				

The table 2 shows the application of paired t-test where it is found that there is no statistically significant change in number of patient at CGC before and after the alliance. In other words, the alliance has not made a significant impact on patient flow at CGC.

The other aspect of the study was to calculate the conversion ratio of patients who opted for treatment at FHL amongst the patients who were advised to do so. The collected data is shown below in table 3, where specialty wise conversion of patients has been shown along with overall conversion.

Table 3: Data on Proportion of patients moving to FHL for treatment

After alliance (August 2024 to March 2025)			
	Proportion of patient conversion to FHL		
	Patients referred to FHL	Patients attended FHL	Percentage conversion
Gastro-Surgery	41	26	63
Internal Medicine	8	6	75
Gynaecology	0	0	0
Urology	5	1	20
Oncology	1	1	100
ENT	0	0	0
TOTAL	55	34	62

The table 3 shows the overall conversion ratio for FHL from CGC is 62%. Out of all conversions (34), the majority (26) were from CGC (Gastro-Surgery), which constitute 76.5%.

When we combine the results from table 1 and table 3, we understand that with 12% contribution to OPD patients, FHL gets a 62% conversion rate. It suggests that although the alliance with FHL may not be so popular, still the patients who come to CGC accept FHL for advance treatments. It indirectly suggests that CGC has developed a reputation where patients follow the recommendations of CGC. This is evident from the fact that 76.5% of total conversion rate is with the recommendation and good will of CGC.

Based on tables 1, 2 and 3 we can infer that although the alliance might not be of benefit to CGC, but it is fulfilling the FHL's objectives of collecting patients from CGC for further treatment at FHL.

The questionnaire- based interview of sample of 100 persons from society and visitors, was conducted. The Observations from the questionnaire- based interview are presented in table 4 below

Table 4: Summary of observations form questionnaire- based interview of sample population

Sample Size		100
Sampling Method		Random allocation
Population		Society and Visitors of CGC
Awareness of alliance		50/100 = 50%
Reference factors for choosing CGC	Patients' word of mouth	69%
	Doctors' and Chemists' reference for CGC	14%
	Free Health Camps	3%
	Flyers in newspapers	3%
	Social Media	1%
	News Paper Advertisements	1%
	Self	4%
	No Information	5%

The observations from table 4, suggest that all the efforts of marketing could create awareness of the alliance in 50% of the population. The majority (69%) of population had inclination towards CGC because of goodwill created by the patients of CGC who had received treatment there, and another 14% preferred CGC because of the reference from other doctors and chemists. The good words of old patients was found to be the most common factor that draws more patients to CGC. The reference from other doctors and chemists contributes a significant number of patients that prefer CGC. Only 8% of population was influenced by direct marketing efforts like Free health camps, Social media, news paper flyers and advertisements.

4. Discussion

A Mutually beneficial relationship is called a strategic alliance. It is developed with goals of achieving business needs together but still independent of each other. The alliance brings the advantages both to partners and customers. The perceived advantages to the providers include -

1) Better efficiency and improved quality of services
2) Reduction of cost
3) Innovation

At the same time these alliances provide advantage to customers in terms of accessibility.

Along with above advantages, the alliances have their own challenges

1) Building trust and managing relationships
2) Creation of common goal and alignment
3) Cultural differences between organizations
4) Sustainability

The study of healthcare alliances from Spain by Bernardo M[7] has identified three main types of collaboration -

1) Alliances with other hospitals (most common)
2) Alliances with primary care centers (second most common)
3) Alliances with other types of institutions (e.g., government, medical companies and universities)

The current study is regarding the alliance between two organizations, of different capabilities and magnitude, to understand the impact of alliance on the business in the rural and small town context.

Usually the alliances between bigger hospitals and primary care centers are of three type -

1) Telemedicine

2) Specialists 'support. This is the case in our current study.
3) Treatments

Framework of creation and management of strategic alliance partnership

The above shown framework was followed in the creation of the current partnership under study. The desired outcomes of both partners were clearly defined. The working pattern of both organizations was not to be altered. It was decided to continue CGC as OPD centre only, till the time we get the results of the alliance. The plan of expansion of CGC is dependent on the results of alliance. The current study is to assess the effectiveness of the alliance. The only weakness in the application process of the framework is the fact that desired outcomes were vague and not objectively defined. It was desired that CGC would get an increased patient load and FHL would get in-patients in different specialties.

Every alliance has its own challenges

1) Fear of losing health care professionals to other institutions as a result of human resource sharing. Strategic alliance is powerful technique in business, but it has a potential to harm the interest of business or even result in a loss of business altogether. Hence, it is a kind of a "*double-edged sword"* which can cause damage if not handled properly
2) Competition-collaboration tightrope - it indicates lesser degree of alignment to alliance objectives. Each alliance should have goals to balance the competition and collaboration. The problem arises when partners individual goals are not aligned with combined goals. It is very difficult when the alliance could hurt their competitive position against competitors or significantly threaten their current structure of business
3) Sustainability
4) Culture differences between the partners
5) Alliance governance and management, working relationship
6) Earnings and knowledge sharing

For any strategic alliance to be successful it should have following characteristics -

1) Clarity of purpose
   a) Build a clear understanding of the rationale for alliance across all business aspects
   b) Clearly define the vision of the new organization from the first day
   c) Select strong leaders to manage the alliance -ideally from all involved parties
   d) Build blueprint as early as possible
   e) Identify the source of benefits and drive to achieve them
   f) Consider and discuss the potential exit scenarios with the partners

2) Control
   a) Do not let the alliance divert attention from everyday business
   b) Implement the robust planning and program management processes
   c) Make planning and reporting frameworks practical
   d) Track benefits rigorously and ensure alignment
   e) Discuss performance with partner and identify potential remedies
   f) Tackle risks and issues quickly and take tough decisions early

The alliance under the current study has few weaknesses -

1) The alliance was started without a proper need assessment and context analysis. There is no scientific assessment of local health needs and community priorities.
2) The alliance was started without predefined measurable goals. Although the alliance was planned and executed with a framework, but there were no measurable goals for alliance or either of the partners

3) The alliance was started without funds for workforce development to ensure longevity of the alliance.

The business leaders and authors have arguments both in favour and against the Strategic Alliances. An extensive study by Taucher G[8] concluded that "strategic alliances are doomed." It has been argued that alliances are mere "transitional devices rather than stable arrangements" and hence "destined to fail." The challenges come with unforeseen situations which were not anticipated. They give rise to conflicts over goals, and the resolution of such matters may result in setbacks to the alliance. At the same time, if used properly the alliance synergy may benefit the partners by mutual support and amicable resolution of problems. Alliances always incurs some costs as well as gains benefits compared to the situation without alliance. The firm bears the cost of getting committed to the goal of its alliance partner. The firm also compromises the autonomy and ability to unilaterally control the outcomes.

The Cost and Risks of alliance include -
a) Cultural barriers
b) Trust deficit
c) Loss of autonomy
d) Lack of clear objectives and objectives
e) Lack of coordination
f) Lack of commitment
g) Creation of potential competitor
h) Potential for conflicts

At the same time the firm gets benefit of competitive positioning. The firm's strength are supplemented with that of its partner. The failure of alliance can cost a lot of time, money, reputation and competitive position.

The benefits of alliance include -
a) Entry into market segment or location
b) Reduction of cost
c) Shared business risk
d) Competitive advantage

When organizations move towards cooperativeness, it has been shown to achieve greater goals to an extent that some authors like Varadarajan, PR[9] have termed these alliances as "one plus one equals three". The literature reveals a number of studies on the relationship between strategic partners and that between partners and customers, but it is difficult to find a study like the current study which statistically analyzes the impact of alliance on one (number of patients) of the several parameters of business outcome in a rural Indian healthcare scenario. As there are no publications available for comparison, the current study is an attempt of its own kind to study the impact of alliance on its business.

The study is conducted at the centre which is working with the idea of providing specialized private healthcare consultations to rural population at a reasonable cost. The healthcare center has the capability of expanding the scope to in-patient services. The condition of public medical facilities in rural areas is poor. Majority of rural population in India now prefers to opt for private healthcare centers. So certainly there is a scope of private healthcare in rural India which need attention of both big and small hospitals. The corporate chain of tertiary hospitals in India are mainly confined to urban regions. It has been the opinion of business leaders that over the next decade the rural areas would witness the presence and growth of corporate tertiary hospitals. Such shifts in business strategies usually begin with alliances where urban and rural set up come together to experience the market condition for few years. The current study is such a kind of alliance with specific goals and objectives which will provide the road map for future strategic decisions.

Based on the results of the study, the following inferences are drawn -
1) The impact of alliance on the number of patients at CGC was statistically not significant.
2) Out of all the patients referred from CGC to FHL, the actual conversion rate is 62%
3) The marketing efforts have penetrated into 50% of the target population
4) The most important pulling factor for the CGC is the goodwill and word of mouth from the already existing patients, followed by reference from nearby doctors and chemists. The other marketing activities contribute only for a small proportion of patients.

The inferences of the study have been surprising and contrary to popular assumptions. The study suggests that FHL has not been able to positively impact the patient flow at CGC. However, the CGC could convert a large number of patients towards FHL for in-patient care and other treatment. Similarly the marketing activities could penetrate to half of the population, but still could influence only 8% of population and contribute only 12% of total patients at CGC.

These inferences are exactly the opposite of what was assumed to be the outcome of alliance. These findings suggest that strategic planning is not just the perceptions based on limited information, but it has evolved into the newer model which should be data driven and inclusive of insights of all stake holders particularly the front line grass root workers.

The study has answered the following four questions-
1) Has the alliance led to a significant change in patient footfall at CGC?

The answer is -No. Although there is an increase in the patient footfall, but it is not a statistically significant. Contrary to the concept and belief of Varadrajan et al (1995)[9], Our study reports no significant positive impact of alliance on the number of patients. It also highlights the changing market scenario in last three decades. In 1995 Varadrajan et al[9] opined that the alliance in manufacturing and marketing has an effect of "one plus one equals three", but our study of healthcare service in 2025 does not show similar observations. It also demonstrates the absence of any negative impact i.e. reduction in patient footfall. The reasons for the failure of alliance have not been specifically studied but there is a definite need to analyze the possible causes of failure. There is a need to study and confirm those factors in another study to develop an emergent strategy.

The possible reasons for unfavorable impact could be -

a) The services from FHL were available only once a week. Some patients are fearful that in case of necessity at times the doctor and services might not be available.
b) The two specialties opting out of alliance in the middle of study period, sent a message to the society that alliance has been put on hold
c) The doctors were available for only a specific hours, which might not suit some of the patients
d) Rural and small town population has a fear that doctor coming from a bigger hospital and a bigger town might be more expensive
e) The penetration of marketing activities was not deep enough into the society
f) Few referring medical practitioners were not supportive because of absence of incentives
g) A majority of rural population and small town population still prefers unqualified and un-registered practitioners as first option for OPD services. The concept of specialized medical care at doorstep is still not popular. Often this population prefers practitioners who do home visits for patients.

2) Is there a need for the strategic alliance (Patient demand versus service supply) ?

Once the alliance is there (supply), but still there is no significant increase in the patient footfall (demand) one can infer that there is no demand in society for such an alliance. The current alliance failed to attract patients for super specialties like Urology and Oncology. Even the specialties like general physician and gynecology were unable to attract the patients. Such findings in our study are in contrast to previous reports like "outpatient healthcare market in India" report of Praxis global alliance[10], where the top specialties for OPD consults in India were found to be general physicians and gynaecologist. It is clearly evident that there is not much scope if the alliance continues to provide same services. The demand is for a different product, "we are offering apples when demand is for oranges". The alliance must work on expanding the scope of services to emergency, extensive OPD, in-patient services and inclusion of other necessary units like radiology to actually provide what the community needs. Although the reasons for gap in supply and demand were not studied, but there could be various reason for absence of demand, like -

a) Rural population preference to public hospitals over private hospitals, particularly when majority of rural population is dependent on Ayushman Bharat (Public Insurance) Scheme which is not applicable in our location
b) Lack of patient awareness about the existence of alliance. The survey shows awareness in only 50% of target population
c) The supply was inadequate i.e. the FHL doctors visits should be more frequent and services (stock) always available
d) The cultural difference in geographic context; The FHL doctors being professional, while rural population demanding a personal and a family physician. As a result the doctor-patient rapport could not be established over the short duration of alliance
e) Alliance may take longer to built trust and create a demand. The alliance in the current study is too short a duration to produce the results.
f) Limited availability of doctors at the clinic. The doctors timing were not suitable to many patients
g) Limited facilities at the clinic. There were only few specialties and emergency services were not available. Only a specific class of patient could utilize the services. So it was not just the demand, but also the limited supply of limited services that was responsible for demand from a selected section of patients

3) Are alliance partners getting benefit out of it ?

Although the alliances are made for mutual benefit, it may still have a tilt in favor of one partner. For CGC, it has been shown that there is no significant benefit. The operations and productivity at CGC remain the same as they were prior to alliance. For FHL, which had almost no presence in the region, there is a conversion rate of 62%. In eight months 34 patients got advanced treatment at FHL. This is almost one patient every week. Out of these 34 patients, 26 patients (76%) were from doctor and resources of CGC. The CGC is providing all its resources and good will to benefit its alliance partner. The CGC is contributing a major portion to FHL from a geography which is new to FHL. There is unequal benefit to the partners. In other words, CGC's performance in rural area is better than that of FHL. There is no value addition for CGC, but FHL has made entry into a new geographic territory. This difference in performance is probably due to long standing presence of CGC in the area with adherence to its core values of medical ethics and patient centric approach. The cultural difference between CGC and FHL may be another factor which gives an edge to CGC in rural population. FHL is a manager led culture while CGC is a clinical led model which is more patient friendly and gets more acceptance in small town and rural areas.

When the benefit to partners is disproportionate, the relationship may move towards non cohesion. As per framework model of relationship strength between alliance partners and goal achievement of customer (table 5), the current alliance in our study would lie under Quadrant C where there is strong relationship with customer, but at least one partner is dissatisfied. This relationship is not sustainable in the long run.

Table 5: 2x2 table showing the customer satisfaction and partner relationship for sustainability

Good	**Quadrant C**		**Quadrant A**
	Strong relationship with customers		Strong relationship with all parties
	Only Customer satisfied		All satisfied
	Not Sustainable in long run		Sustainable in long run
Customer Satisfaction			
Poor	**Quadrant D**		**Quadrant B**
	Weak relationship with all parties		Strong relationship with partners
	None satisfied		Only Partners satisfied
	Not sustainable in short run		Can sustain with different customers
	Non Cohesive	**Partner Relationship**	Cohesive

Alliances must try to stay in quadrant A, where both parties and customers are happy and only then the alliance can sustain in the long run.

In the current study, if the alliance continues to remain ineffectual for CGC, the structure of alliance and sharing of resources need to be renegotiated and adjusted as per need and benefit of both organizations. The CGC should try to take leverage of something other than specialist doctors, something form FHL which can be installed at CGC and is available all the time e.g. up gradation of endoscopy unit, starting of day care services with minor operation theatre etc.

The CGC along with FHL should make special efforts to address the needs of the society, one of which could be starting a rehabilitation centre for drug de-addiction candidates. A specialized de-addiction centre is the need of society and taking a lead in this direction can not only attract more patients but at the same time build trust in the society. The de-addiction centre in collaboration with treatment of alcohol related liver disease by the gastroenterologist could be an excellent example of CGC and FHL partnership.

4) Which is the most effective marketing and awareness tool in our specific geographical location?

The external marketing activities, done by FHL, could attract only 8% of the population. On the other hand 83% of population was attracted to CGC as result of goodwill of CGC and words of appreciation from previous patients, local doctors and chemist. This 83% share is the result of internal marketing (satisfied patients and their family doctor) of CGC over last 15 years. It shows the importance and result of core values of CGC like patient centric approach with perseverance, that builds a trusted image in the society. This difference between the two aspects of marketing (internal and external) is certainly not a fair comparison in the current study. The external marketing which is contributing 8% is of only 8 months standing, while the internal marketing has been there for last 15 years. The time it takes for marketing to establish a brand in a new area can vary a lot depending on several factors.

It is a usual belief that a continuous marketing effort of 18 months is needed for recognition and local engagement. The word of mouth and trust is more relevant in smaller towns and tight-knit communities, particularly for healthcare practices in rural areas.

These findings may appear to suggest that marketing activities are ineffectual and consume just person-time and money. However, this may not be absolutely true. The marketing activities take a longer time with persistence to establish a connect with the society. As marketing team continues with the efforts, it should at the same time venture into newer activities of public engagement. These activities should include meetings with village Sarpanch, community education outreach programs and adjacent small town connect with local bodies like municipal councils for health education drives.

While the current study shows the potential benefit of alliance in rural and small town healthcare in India, it also highlights the challenge of further growth for the smaller partner.

With above findings and conclusions of the current study, the concern arises with regards to future of alliance. Collaboration is easier when partners 'mission and purpose are similar. The success of strategic alliances depends on two factors: the relationship between the partners and partnership performance. The longevity of alliance depends on the age of alliance and is directly proportional to it.

The current study is a short study of eight months and has raised few important aspects of the alliance that could be the focus of future research. The future research should focus on at least few of the following aspects -

1) Outcome of long-term healthcare alliances in rural and small towns, with regards their impact on business outcomes and sustainability.
2) Exploring the scalability of alliance models and their potential in different geographical and cultural contexts.
3) Exploring the population health needs of the region which can be better handled by alliances
4) Exploring the outcome of public private partnership and alliance in rural sector of healthcare industry
5) A larger sample based population survey to identify the most effective tool of marketing that creates awareness and influences public choices

5. Conclusions

This is a unique Indian study of alliance between a small rural clinic, which is gradually contracting its scope of services and a large urban hospital which is gradually increasing its urban footprints. The study, conducted at rural centre, shows that the alliance, in its initial eight months have failed to result into a statistically significant impact on patient footfall. There was 62% conversion rate for patients who were referred to the larger alliance partner. The most important factor which pulls the patients in the rural population is patients' word of mouth which constitutes 69% of all patients and only 8% patients are influenced by external marketing activities.

6. Future Scope

Based on the observation, experience, results and conclusions of the current study, the following recommendations are being made with regard to healthcare alliances in rural Indian context -

1) The alliance is a useful technique for growth, but must be created under the framework as has been discussed in this study report.
2) The alliance must be have clearly defined goals and objectives.
3) The activities of alliance must be in alignment with the local healthcare needs
4) The partnership type must be clearly defined in a formal manner.
5) The choice of partner must be made carefully with due considerations.
6) The roles and responsibilities of each partner must be clearly defined.

7) Frequent communication and trust between partners is the key to resolve issues.
8) Frequent assessment of performance and navigation through emergent strategy is the key to identify and mitigate unexpected challenges.
9) For mature and lasting alliance both partners should have large hearted attitudes and follow the concept of cooperation and inclusive growth rather than competition.

With regards to the current study of CGC, the I would like to make following recommendation for CGC -

1) The study must continue till the data is available for 18 months of alliance. The final conclusions should be drawn after the analysis of 18 months data
2) If the study gives similar results, the alliance conditions must be re-negotiated to build the following more services
   a) Expand In-patient services at rural set up
   b) Start new OPD ventures like rehabilitation counseling and consultation along with liver treatment for alcohol de-addiction
   c) Expand marketing activities to develop better connect with society (Sarpanch connect, health education melas, health safety drives with municipal councils etc)
3) If the study gives similar results, but alliance partners are unwilling to reach a re-negotiation, the CGC should make efforts to stand alone and expand the scope of services with more professional management of hospital with clinician led cultural values and patient centric approach
4) New studies must be designed and conducted to evaluate
   a) The needs of healthcare in local society (patient needs and demand)
   b) Impact of health insurances for OPD services
   c) Critical success factors for alliance partnerships in healthcare
   d) The role of immovable assets and facilities which can aid the specialist at a distance eg video conferencing for patient assessment

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