COVID-19 Pandemic Brings Gastrointestinal Endoscopy Practice to Its Knees—Financially!

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The novel coronavirus disease 2019 (COVID-19) pandemic has plummeted almost every aspect of our economy including the health care industry. In this issue, Chirag et al discussed the financial implications of the COVID-19 pandemic on practice of gastrointestinal (GI) endoscopy[1].

GI endoscopy faces a peculiar double whammy since most procedures (>85%) are elective and it is an aerosol-generating procedure (AGP).[2] The various national and international GI endoscopy societies have recommended performing only urgent endoscopies to prevent cross contamination and also to protect endoscopy unit staff.[3] This effectively has cut-off more than 80% of all procedures. Although, during our national lockdown, medical practice of all nature has been exempted, in reality, GI endoscopy practice has reduced by 80 to 100%. This sharp fall in the number of procedures has resulted in a major financial crisis.

We need to adhere to various other practice changes while performing GI endoscopy during the pandemic which are resulting in compounding the problem of spiralling costs and falling revenue. The use of personal protective equipment (PPE), including the expensive and elusive N95 mask for most of the endoscopy staff has resulted in increased costs. Infrastructural upgrades and modifications, such as negative pressure rooms, dedicated corridors for patient and staff movement, PPE donning and doffing areas, spacing (decreasing) recovery beds, and spacing out reception area seating, have also added to escalating costs. Also, procedures need to be spaced out in time resulting in a decrease in the daily number of procedures per room further decreasing the revenue generation. Employing additional manpower or redeployment of staff for maintaining sanitation, keeping reserve staff, screening at entry, and adhering to other local health authority regulations and standard operating procedures (SOPs) has burdened the endoscopy practice. There may be indirect financial losses in the form of devaluation of stocks, shares, and decrease in real estate valuations.

Chirag et al also have detailed the impact of the financial crisis in various practice set-ups. In this context, the paramount issue will be the financial reserves of the individual/group or institution and the recovery path. A low reserve with a slow recovery can be a death knell!

The issue at hand is how to navigate through this time and is there light at the end of this dark tunnel. The first and foremost is to halt any capital expenditure immediately. In times where the cash flow is limited, decreasing the fixed outgoings can help to keep afloat. Rent or loan readjustments/moratoriums can be negotiated or sought. Reuse of N95 respirator masks may be done adhering to the Centers for Disease Control and Prevention (CDC)/National Institute of Health (NIH) guidelines. Staff salaries can be renegotiated but only after the lockdown period. And as a last resort staff may be furloughed. Unlike in the West (particularly the United States) where the federal government has allocated billions of dollars to partially mitigate financial woes of the health care industry as a whole, in India the government is investing heavily on sprucing public hospitals and making new dedicated COVID hospitals. The private health care sector will need to reinvent themselves on their own to overcome this unprecedented crisis.

Lastly, the issue of timeline for full recovery is an open-ended question with no clear answers. Recovery will depend on the pandemic curve in that area. However, once the lockdown period is over and shortly thereafter, provided the above SOPs are in place, time sensitive procedures may

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be restarted. In population dense urban areas of India with high positivity rates, we may reach at 50% of pre–COVID-19 practice by June/July and at 70% by September/October. Reaching beyond 70% may occur at a variable timeline extending well into the next year.

Conflict of Interest
None declared.

References

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