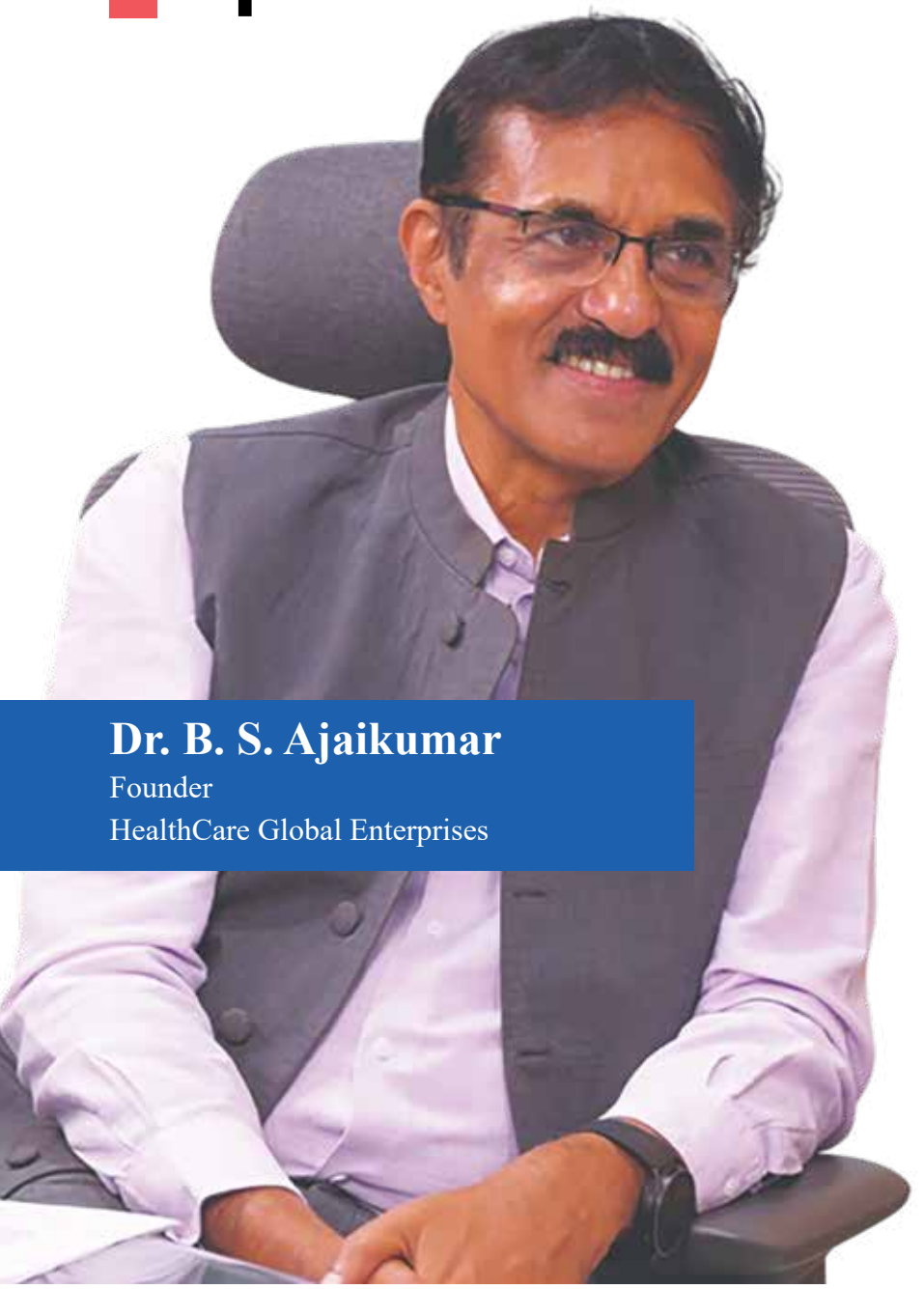
Prudent Cost Management is the Lifeblood of Healthcare operations



Dr. B. S. Ajaikumar
Founder
HealthCare Global Enterprises

Cost management is often reduced, both knowingly and unknowingly, to a euphemism for cutting corners. Nowhere is that erosion more consequential, even fatal at times, than in the critical sector of healthcare, where a cost decision is way more that what it implies in most other spheres, for it more often than not decides which patient gets treated, with which drug, on which machine, and how soon. Cut costs the wrong way in a factory and you get a defective product that can be recalled. Do that in a hospital and you get a missed diagnosis, a discontinued therapy, an equipment upgrade deferred once too often, patient outcomes gone awry, consequences that cannot be recalled and often involving life and death situations.

Dr. B. S. Ajaikumar, founder of the global cancer hospital chain HealthCare Global Enterprises (HCG), and now its Non-executive Chairman, understood the criticality of prudent cost management in oncology, at a time when it was widely seen as the preserve of government and trust hospitals.

CMA Sudhir Y Raikar
Writer, Management Consultant &
Thought Leadership Content Architect

Following his MBBS from St John's Medical College, Bangalore, Dr. Ajaikumar completed residency training in Oncology from the University of Virginia Hospital in Charlottesville, and Fellowship in Radiation and Medical Oncology from the renowned MD Anderson Hospital in Houston, Texas. While building his practice in the US, he founded Bharath Hospital and Institute of Oncology, a Mysore-based not-for-profit hospital in 1989. In the subsequent year, he incepted Healthcare Global Enterprises Ltd, a hub-and-spoke institution headquartered in Bengaluru. He shifted his base back to India in the year 2003.

Today, HCG's hub-and-spoke "focused factory" model has grown into a pan-India, and pan-African, cancer care network, and has been duly documented in a widely cited Harvard Business School case study. The global chain is built on the unflinching conviction that cost consciousness and quality consciousness cannot be allowed to work against each other, that indiscriminately "low cost" care exacts its own hidden price in poor outcomes, and that the sounder route to affordability is not to cut corners, but to design a fool-proof system, from cost-effective real estate acquisition and need-based procurement to capital equipment and training of frontline staff, so that cost and value move in the same direction and never prove counter-productive.

In this tete-a-tete, **Dr. Ajaikumar** spoke at length with **CMA Sudhir Raikar** on his vision, mission, values, and modus operandi that seamlessly align high-end cancer care with affordability at scale, and also serves the larger cause of the community through social development initiatives.

What convinced you that a private, comprehensively oncology-focused model could work affordably vis-à-vis government and trust hospitals?

We incepted HCG in India amid the presence and proliferation of the multispeciality-driven model of healthcare that catered to oncology as one of the specialities. The challenge before HCG was about changing the landscape of oncology to make it more accessible, affordable, and affable pan India, in a work in progress of moving targets and progressively improving phases.

At the time, the thinking in the market was that since multi-speciality hospitals were more aligned with self-sustaining financial modelling, they would cater to oncology effectively within a larger umbrella, through primary diagnosis and referral patterns. But oncology had evolved into several sub-specialities that called for exclusive focus, both from a research and a practice perspective, and in India this exclusivity was not being followed by the private sector. The pressing needs of oncology were being addressed solely by government bodies. Given the sheer size of India's patient population, the challenge was how to meet the quality parameters that this intricate practice demands. That is what led HCG to set up a comprehensive oncology practice founded on value-based quality care, and to usher in a paradigm shift from multi-speciality hospitals to a tertiary-care, super-speciality, oncology-driven approach.

How does the hub-and-spoke structure reduce cost without compromising outcomes?

Hubs provide all three treatment specialties, medical, radiation, and surgical oncology, with advanced technology, while our Bangalore-based Centre of Excellence hub provides specialised services like robotic radiosurgery, molecular imaging, nuclear medicine, and sub-specialties in oncology. Spokes, on the other hand, are located

in small cities and towns, typically serving as chemotherapy centres providing basic therapy and follow-ups. HCG also has mini-hubs in metros like Delhi and Ahmedabad, providing the whole range of services with the exception of premium diagnostics and therapy.

The hub contains the expensive radiation and surgical equipment often required during treatment. Community-based spokes provide patients easier access to less capital-intensive chemotherapy and rehabilitation services, referring patients to the hub only when needed. Pricing of hub services also varies by time of day, which drives round-the-clock utilisation of expensive capital equipment and reduces average costs. Financially able patients typically receive treatment during the day, and low-income patients receive treatment at night, and this does not add to costs, since HCG staff work regular eight-hour shifts rotating between day and night, and patient volume is naturally lower at night. Despite being a for-profit organisation, we set aside a fixed share of its profits to subsidise poorer patients, which is how low-cost, high-quality cancer care has disseminated so rapidly across India, and now in Uganda, Kenya, and Tanzania as well, again using low-cost, telemedicine-enabled models that leverage HCG's scale.

You've called the "cost of low-cost" a vicious trap…

In the context of healthcare, most conversations in India hover around the cost angle. The phrase 'low cost' has become popular by default both in the fraternity and community at large. To an large extent, the cost-over-value approach is a direct consequence of our economic realities. We are a country where majority of the populace belong to the low and middle income groups, and a significant number is economically challenged.

I deeply value the significance of cost-effective operations and the need to keep costs in check. That said, when the cost of a healthcare delivery is necessarily kept low as an overriding mandate, but the ensuing outcomes are not duly measured, I can't come to terms with the self-defeating nature of this mechanism, as the 'cost of low cost' impacts the quality of outcomes, which is a unpardonable price to pay in healthcare.

Today, almost any therapy in healthcare calls for constant clinical progression, adoption of latest technology, and recruitment and retention of the best of breed specialists, doctors, nurses, and support staff. Take the case of cancer. What was once known as a killer disease is today fast becoming a chronic disease, thanks only to the phenomenal transformation in the way we stage cancer, adopt a multi-disciplinary approach to cancer care, make use of genomics and molecular diagnostics, and strive to deliver the correct treatment from the outset. Needless to say, this advancement comes at a price tag.

We have to recruit and retain a talent pool of experts across different practice areas including surgical oncologists, medical oncologists, radiation oncologists, genomic experts, radiologists and the like. Technology is an integral part of the healthcare dynamic and it is a well known fact that best-of-breed technologies call for massive investments – whether robotic surgeries, laser therapies, use of AI and mixed reality devices for surgical augmentation and training, molecular targeted imaging, digital pathology, or radio genomics. On top of it, we have to continually invest in research and academics, as also big data analytics, to keep pace with the evolving paradigms of tomorrow as also to make the most of the research breakthroughs, some of which are game changers in their own right.

If one skips using the proper therapies and medications or grossly overlook the need to use cutting-edge technology in healthcare simply to maintain affordability, the outcomes will obviously be far from good. One can claim to provide affordable solutions for the sake of it, but to what avail? Of what use is the low cost if it makes the end users pay a heavy price in the ultimate analysis?

Prudent cost management is the lifeblood of healthcare operations. If the profit margins are consciously and consistently used for reinvestments, the cost of treatment comes down over time from the increased efficiencies and economies of scale.

Technology is expensive and at times even cost prohibitive, yet you have been an early adopter of high-end equipment like CyberKnife and PET-CT. How does one justify capital-intensive technology in a cost-sensitive market?

Any disruptive technology is ahead of its time, which is what makes it disruptive in the first place.

And for the disruptive technology to unleash itself towards the fulfilment of your goals, one needs to focus on its value, not its cost. If we get bogged down by the cost, we will never deliver value. This is especially true of healthcare, where the epicentre of all the action is a patient seeking the right treatment and quality of life. In the long run, value always triumphs over the cost.

My philosophy is that these investments come good in serving referrals or the needs of external users for a fee, notwithstanding the fact that the price tags may not be immediately justified by current patients alone. After we procured the CyberKnife, previously unavailable in India, radiation oncologists, neurosurgeons, urologists, and other external specialists were encouraged to use the technology alongside our own trained consultants. We put a strong emphasis on maximum use of its technology in this manner, all night if need be.

Having said that, technology is a golden enabler, not a silver bullet. Healthcare revolves around the patient, so unless technology serves the larger cause of the patient, it cannot serve its purpose, however disruptive it may be. The debacle of "Haven," the failed enterprise founded by Berkshire Hathaway, Amazon, and JP Morgan Chase to revolutionise healthcare, is a classic case in point. Healthcare is too niche a domain to be fathomed in toto by outsiders to the field, however tech-savvy they may be.

I am a firm believer of Intelligent Efficiency, a smart orchestration where the best of human minds make the most intelligent use of technology, aimed at enhancing outcomes, lowering costs, and improving resource management based on the risk and severity of the disease, from pre-admission to post-discharge.

As a founder, how did you manage the tight rope walk around the Equity vs Debt decision?

People are always taught in business schools that equity is more expensive than debt, because higher returns are expected from equity than from debt. I have always felt that equity money is more precious than my own money. In debt, there is no dilution, you repay your debt and keep your shareholding percentage. In equity, you can reverse the initial dilution by buying back the new investor's shareholding, and offer more returns through capital gains if the company performs well. I liked the equity route because there was no sword hanging over your neck every day, as there is with debt. A medical entrepreneur should not be burdened every month with debt servicing and repayment stress, because the primary role of a healthcare provider is to restore the health of patients and add years to their lives.

Oncology therapy is a drawn-out affair. It doesn't end in days, but takes months, if not years, of long treatment and follow-up. To provide top-quality medical care and make it accessible and affordable, it was crucial to establish comprehensive cancer care across the country, and that would only work if we could focus on our patients without being constantly worried about paying interest or repaying principal, which is the norm with debt funding. Debt servicing tends to eclipse entrepreneurial vision. So it was obvious that private equity was the best route for us, even with equity dilution, because the bigger purpose came ahead of the financial implications. A true entrepreneur should not worry about dilution of stake, as long as there is no dilution of vision.

The 'Suchirayu' turnaround is a striking example of rescuing a fellow venture in distress. Could you elaborate on your approach to 'value beyond the balance sheet'?

Suchirayu, a hospital in the north Karnataka city of Hubli, was built by a group of highly reputed doctors as a world-class centre, complete with amenities like a helipad. But their ambition got ahead of their purpose. They exhausted their personal funds, borrowed close to 120 crore rupees, and fell into a classic debt trap, with the monthly interest burden alone close to a crore. When they approached us in August 2017 for an operations and management contract, my own team literally wrote them off and warned me against taking on their woes. But these doctors had pledged their personal properties as collateral for the bank loans, and I felt that to let a genuine vision be wrecked for want of support would have been criminal in our ethical books.

Our director of projects came up with a revival plan. We brought the Suchirayu doctors, the private bank, and the principal lender together, negotiated down the dues, and restructured the funding without

any significant debt coming onto HCG's own books, with HCG itself picking up a stake. The whole process took ten months. We paid the doctors what they were due, and all the top doctors returned to practice at Suchirayu, which today is in a healthier state than ever before. More than the financial recovery of Suchirayu, we were happy to help deserving doctors avert financial ruin. Value-based healthcare, in terms of optimal cost and increased accessibility, can only scale up in good time if doctorpreneurs in distress are bailed out by the wider value chain of healthcare providers.

You have advocated for a $150 billion annual investment for universal healthcare access. What is so broken today that makes a number that large imperative?

What purpose would a nation's economic progress serve if the majority of its citizens are deprived of quality medical treatment? The government has a vital role to play in bridging this rich-poor gap of healthcare. Given the scanty approvals granted under government schemes, whether Ayushman Bharat or ESIC, patients have to make do with "compromise" treatments in the name of care, which in the case of serious illness do more harm than good. Most patients get the impression that these schemes are ensuring the right treatment, but the reality on the ground is quite the opposite. The schemes work fine for patients who require minimal chemotherapy or radiation, but what about patients with advanced disease who need longer-term immunotherapy at a higher price tag, typically INR one lakh a month for twelve to eighteen months? Government schemes don't reimburse these top-tier, life-saving therapies.

The only way to counter this is to roll out a universal healthcare model through an autonomous body for reimbursing healthcare without ceilings and limits, with the government acting as a monitoring agency to evaluate approvals and outcomes. I have proposed a healthcare cess, scaled by income levels, which citizens could easily contribute via smartphones. This could generate approximately $140 billion, which, if managed effectively, could transform India's healthcare landscape. That is a feasible commitment in a $4 trillion economy, and the government also has the option of creating a fund that invests this money like a private equity firm and uses the market returns to fund the country's healthcare needs.

There's a common assumption that not-for-profit hospitals serve patients better than for-profit ones. How does one decode this popular perception?

Not-for-profit trustees don't take personal remuneration, and the premise of making them tax free rests on the logic that profits get ploughed back rather than distributed as dividends. Even so, not-for-profit hospitals raise money mainly through grants, donations, and bank loans, none of which arrive consistently, and bank loans often prove exorbitant. Since the tax laws governing donations are ambiguous, donations aren't guaranteed either. On the expense side, not-for-profit entities need the same real estate, infrastructure, doctors, nurses, and equipment as private hospitals do, and many not-for-profit and medical college-run hospitals charge patients almost at par with what private hospitals charge. That dependence on grants and donations puts a natural limit on how much a not-for-profit hospital can grow in clinical excellence, technology, and network expansion.

For-profit hospitals, by contrast, can raise funds from private equity, high-net-worth individuals, and angel investors, all of whom expect a return and keep the organisation committed to fiscal responsibility and a growth-centric approach.

The benefits of this financially-powered agile system are pivotal. While the system ensures unflinching fiscal responsibility and proper accounting of revenue and expenditure, it also adopts a growth-oriented approach to healthcare through efficiencies of scale. More importantly, it helps doctors meet their aspirations of ushering in emerging technology, gain specialization and depth of knowledge in key areas of research and development, and thereby move up the ladder of medical science and service. The greatest beneficiary of this set up is of course the patients who get the best, high-quality treatment at the right time.

The focal point is not the money charged for the quality treatment, but the manner in which the resultant revenues are built and deployed. For instance, if a healthcare organization abstains from giving dividends and ploughs the money

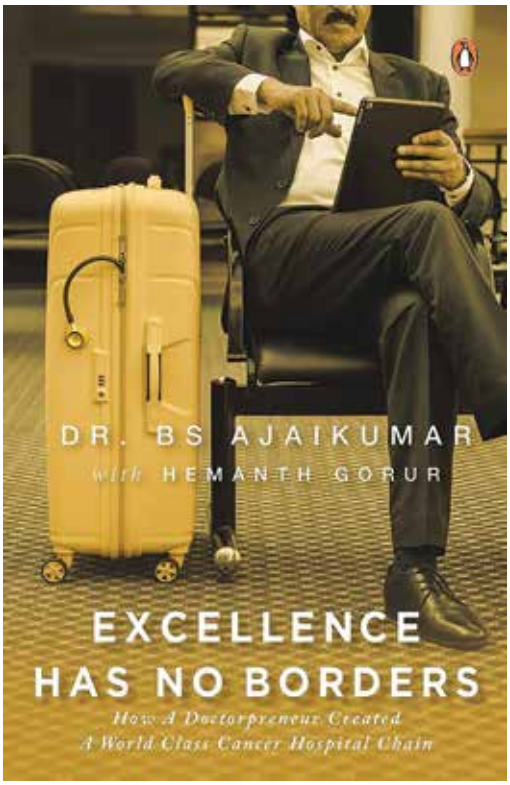
back into the system, for a variety of key purposes – including service expansion into tier 2 and 3 cities and towns, infrastructure development, as also top-notch talent acquisition and state-of-the-art technology adoption - it is definitively making productive and ethical use of the revenues. It is in fact serving the broader mission of healthcare way better than a setup offering 'low cost' services but sacrificing the quality, reliability, and sustainability of outcomes in the process.

As for serving poor and needy patients, private hospitals can always create not-for-profit foundations guaranteeing subsidized treatments. This way, we can ensure no patient is denied treatment, and healthcare is made accessible, affordable, and humane in the same breath. Again, rolling out such a social development initiative and ensuring its long term sustainability, any hospital would need massive funds and how does it raise them? Obviously through the market rates of quality treatments of the populace that can easily afford to pay for such services.

You've called early detection "a veritable game changer." What is the cost case for shifting resources toward prevention and screening rather than advanced-stage treatment?

About 80 per cent of cancers in low- and middle-income countries are detected at an advanced stage. Most patients don't present themselves at hospitals during stages one and two; they are invariably referred at stages three and four. A simple intervention of shifting the curve to the left, catching cancer earlier, can be a bigger game changer for patient outcomes than pouring resources into therapy innovation for advanced, life-threatening cases. Early diagnosis is focused on minimising the cost and time of treatment while maximising survival rates, and delayed diagnosis, as we saw acutely during the pandemic when cancer patients were relegated to the background, increases the overall cost of treatment and reduces survival spans.

Millions of dollars are being invested into molecular research aimed at treatment breakthroughs, but a simple intervention like examining the mouth for abnormalities in oral cancer is often more prudent than focusing all our energies on complex therapeutic drugs. Given that most of India's population lives outside tier one cities, and the doctor-patient ratio is heavily skewed towards urban areas, we need a brownfield approach that helps distressed hospitals in tier two and tier three cities upgrade their facilities, alongside a rationalised tax structure on life-saving drugs and emergency treatments, and nationwide CSR programmes that put prevention versus treatment in perspective for India's youth.



Your book "Excellence has no borders" unfolds several aspects of your persona: oncologist, philanthropist, dancer, tennis enthusiast, swimmer, backpacker, mountaineer, marathon-runner, and travel freak…

The book narrates my offbeat journey to set up a thriving cancer care chain against all odds, spanning my student days, emigration to US, residency training, fellowship, and practice, and finally, the homecoming to set up cancer care centres in India. This is a no-holds-barred account where I lay open familial, professional, and social trials and triumphs. It is my earnest hope that my story helps aspirants among the GenZ and Gen Alpha chart their trajectories across diverse verticals and spheres – and not just healthcare.

You describe yourself as a contrarian leader. Could you share a key decision where going against the grain turned out to be the right call?

Being a contrarian is not about being difficult, it is about refusing to accept a consensus you know is wrong. When I brought the Linac machine into India, almost everyone around me, including fellow oncologists, argued for sticking with Cobalt. I negotiated a loan with Siemens at a fraction of the prevailing market rate and pushed ahead anyway, because I believed the technology was right for our patients. Years later, when I decided to take HCG public, I was told single-speciality hospitals do not do well on the bourses, that the market only rewards multi-speciality stories. I went ahead regardless, because I trusted the market would eventually recognise HCG's intrinsic worth, and it did. The lesson I keep relearning is that a leader who waits for consensus before acting has already given up his or her edge.

Your social development organization IHDUA grew out of a school you started in a village called Mullur, which itself grew out of health camps. How did one lead to the other?

Our International Human Development and Upliftment Academy (IHDUA) is not about any strategy, it is only about patterns I can't ignore. We were running health camps across rural Karnataka, and camp after camp, the conversation with villagers would drift away from medicine and toward their children's schooling, or the lack of it. People weren't just asking us to treat their fevers, they were asking us to help them build a future they had no other route to. That's what led to Vinayaka Gyanashaala in Mullur back in 1994, a school that went on to post nearly a hundred per cent pass rates and send out scientists and software engineers from a village most people couldn't place on a map. Once you see that healthcare, education, and economic condition are three legs of the same stool, you can't unsee it. IHDUA, and everything from the Model Village Project in Chikkhundi to the skill development institute at Gundlupet, is really just that realisation scaled up: don't treat symptoms in isolation, treat the conditions that keep producing them.

It is such a tragedy that although women comprise more than 50 percent of the country's population, but their representation in leadership roles including the political arena is extremely constricted. Our leadership training program will facilitate their inclusion in the mainstream of leadership action and positions. Being more accountable and more diligent, women leaders can transform the political arena and hence more women need to contest elections.

How should a CMA sitting in a hospital's finance team go about his job?

A CMA in a hospital shouldn't be measuring cost per bed or cost per procedure in isolation; they should be tracking cost per outcome: did the patient get cured, and at what true cost, including the cost of a recurrence we could have prevented by not cutting a corner. That's a harder number to compute than a standard cost variance, but it's the only one that keeps you honest. My advice to any cost professional entering the healthcare space: benchmark relentlessly, run your value-chain analysis, chase every efficiency, but build one non-negotiable rule into the model, that no efficiency is allowed to touch clinical prudence. Once you separate "where can we be lean" from "where we cannot ever be lean," heathcare cost management becomes what it should be: the reason more people can afford it at all.

Last but not the least, any message for students and young members of our institute?

I would like to make an earnest appeal. I urge them to delve deep into financial management, cost-benefit analysis and number-crunching, but only in service of something larger. Cost consciousness should be a lifelong discipline, not because saving money is the goal in itself, but because every rupee saved responsibly can be reinvested into a better outcome for the community at large. Too many young professionals chase the low hanging fruit: the quick certification, the easy assignment, the fastest route to a comfortable salary. That is a race of poor longevity. A career driven by a larger purpose, one that keeps asking what problem you are actually solving and for whom, takes longer to pay off, but it eventually pays off in enduring ways, both in employment and entrepreneurship, and across every sector and sphere. MA