Cancer treatment can ruin families. But one doctor thinks he has made it affordable for one-third of India

By Seema Singh

PE-backed oncology chain HCG is changing hands, and investors haven't been kind to the stock. But founder BS Ajaikumar won't let either distract him from his "focused factory" approach

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4 Comments

KAVIPRIYA O G

Seema has over two decades of experience in journalism. Before starting The Ken, Seema wrote "Myth Breaker: Kiran Mazumdar-Shaw and the Story of Indian Biotech", published by HarperCollins in May 2016.

READ SUMMARY

"I am for doctor-entrepreneurs," says BS Ajaikumar, even though deep in his heart he knows this species is thinning out, if not getting extinct.

As a minority shareholder in his cancer hospital chain, Healthcare Global (HCG), this oncologist and entrepreneur will soon have a new majority shareholder. Four years after acquiring about 60% stake in the company, CVC Capital Partners is selling its shares to the private equity firm KKR and, as per the Sebi regulation and the PE tradition, the latter will likely make an open offer for the remaining stakes.

Ajaikumar wouldn't confirm or deny the pressure on him to divest but he's resolute about not selling any shares or relinquishing medical control that would change the hospital's "culture". With a little over 10% stake, he has had equal control as CVC, thanks to the deal structured in mid-2020. It's unlikely KKR would allow the founder that privilege but with his doctors "aligned to him", he thinks CVC's exit is just one investor giving way to another.

The stock market doesn't see it that way, though. From the time the news of KKR's likely buyout broke, HCG's stock price has seen a nice bump and is continuing the climb.

When the company listed in 2016, it traded below the issue price on the opening day. Brokerages found the business capex-heavy and dubbed the stock "pricey". That perception continues. HCG's market cap seems subdued at nearly Rs 6,700 crore but it's trading at 126X its earnings, higher than most hospitals. The stock is still "pricey".

Ajaikumar appears blasé about the market's perception of HCG, but he knows that PEs see value in the business he has built. A runner at 73, he may come across to some as too long in the tooth to effect changes at India's largest cancer chain that touches about 500 million lives, but

READ

the doctor-entrepreneur tells The Ken his job isn't finished. Edited excerpts:

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***The Ken*: HCG was the first, and is probably the last, cancer-focused chain in India. Now multi-specialty hospitals are beefing up their cancer offerings. Is single specialty better for cancer care or multi-specialty? Your latest investor presentation quotes a US study that says it's the former.**

A single specialty certainly does better for patients and outcomes. A multi-specialty has oncology as one of the specialties along with cardiac, orthopaedic, and several others. When a patient comes, doctors mostly go by protocols. But cancer is a complex disease. You must understand the story behind the story: why a patient does or doesn't respond to a treatment. It requires an enormous amount of time and effort. Single specialty is the only way where you can really focus on that and give the right treatment to the patient.

It's called the "focused factory" approach. It's like a restaurant. If the restaurant says, "I'll give you idli, vada, pizza, dhokla…everything," how can it be good; it will be average. That's what a multi-specialty is.

If a place says I only make dosa or pizza, then we could expect better quality. That is what we are; we are only pizza makers. (Laughs.)

***The Ken*: In that case, how have you improved your outcomes?**

In 2017, we had 5,000 discharges in a month across our centres. Our mortality rate was 3.4% and I thought it was too high. Today, we have 9,000 discharges, and the mortality has dropped to 0.74%. (That is, if 1,000 patients are admitted in any month, only 7.4 die compared to 34 in 2017.) You can see we have brought down the death from cancer.

***The Ken*: How does it compare with the industry standard?**

Can't say, nobody [in India] publishes their numbers.

Look, people say cancer means hospice care. Give morphine for pain management. Let me tell you, HCG doesn't have hospice or palliative care. Because we believe if cancer is treated the right way, there is no need for it. Even with advanced cancer, a patient can lead a normal life. Suppose the pain is coming from a nerve, or a tumour is sitting on the nerve; you treat that properly with, let's say, Cyberknife [a fully robotic radiotherapy device], you can be pain-free. The concept of painful cancer, stage 4, terminal cancer—all these terminologies were brought up by some of the major institutions in India. In the US, it was all phased out [by the time I started here].

***The Ken*: We have seen single specialty hospitals become multispecialty, for growth and better margins. Now you have a new investor in KKR who will probably try to replicate its Radiant-Max success story. After all, PEs invest for returns.**

Private equity has been good for us. Or else, coming from a middle-class family I could have never built HCG. It's true that a single specialty becomes a multi-specialty for growth. But I am an oncologist, I know only oncology. I am expanding into genomics, proteomics, and I'm doing research… but by getting into other specialties, I'll become a manager [not really a care provider.]

***The Ken*: KKR buying nearly 61% from CVC will likely trigger an**

open offer; they'd want to own more, maybe even take the company private. You own just over 10% and you must be under pressure to sell.

I am not selling my shares; I am not going anywhere. Whoever comes can do whatever they want to improve the business, but the medical care and quality are on me. My 400 doctors are aligned with me to ensure the quality is not disturbed. We publish our outcomes. On triple-negative breast cancers ⓘ [India has the highest incidence of this cancer type], our survival rate is equal to MD Anderson's [one of the top two cancer hospitals in the US].

Along with my doctors, we have 15% ownership. So, an open offer is not going to be on the table.

(As per the Sebi rule, KKR will have to make an open offer to allow other public shareholders to exit. What Ajaikumar is implying is that even if there's an open offer, he will not sell his shares; nor will the doctors. KKR will need to get to at least 90% shareholding if it intends to take the company private.)

***The Ken*: Let's be honest, a single specialty has growth as well as margins problem. But even by single-specialty business metrics, HCG's returns look underwhelming. It's criminal to compare a mother-and-child care hospital like Rainbow with HCG (cancer is a high-capex and high-specialisation business), but still, Rainbow's market cap is nearly 3X of HCG, even though its revenue from operations in FY2024 at about Rs 1,240 crore is only two-thirds.**

It is because the perception is we are capex-heavy. I've never worried about markets. We don't give dividends; we plough back the money into research and expansion.

As for investors, CVC came in at Rs 130 [share price in 2020] and is now exiting with 4X returns. KKR is coming in because they see the opportunity for growth…I am only focused on why I came back from the US [nearly 20 years ago.] I am not a serial entrepreneur; I am a social entrepreneur. I cannot give up.

***The Ken*: On metrics like return on equity or return on capital employed, HCG lags behind most listed hospitals. You acquired the fertility chain Milann. For diversification?**

Our mature hospitals are doing better but the new centres are dragging us down. Just before the pandemic we expanded like gangbusters, and opened seven new centres but then the slowdown happened. Now most of those centres have started to grow and you see that in the overall revenue and Ebitda bump. In oncology, we are growing at 19%, which I think is good.

Our margins were good even before, at 16–18%. That has sustained. If you remove the new centres, our margin is 22–23%, and that's where we want to be.

As for Milann, it was a mistake. People do make mistakes, right?

***The Ken*: What is a fair margin in your business because some hospitals operate at 28–30%.**

High margins don't send a good message—it shows you are squeezing too much. The low 20s is a good margin in healthcare, especially in a chain.

***The Ken*: One more time, is single specialty a handicap in this business or is it a plus?**

It depends on where you started. If you started as a business, you should do multi-specialty. But if you start because you know what you are doing, you should do a single specialty.

***The Ken*: When you started you’d said you wanted to make cancer a manageable disease—like non-communicable diseases. Now you have a pan-India presence. How far along on that journey are you today?**

We’ve made cancer care accessible for almost half the population. Our back-of-the-envelope calculation shows nearly 50 crore (500 million) people can get treatment at an HCG centre and go home and sleep in their own beds.

We were the trendsetters, so others have followed. For example, when we began putting Linacs in tier-2 and -3 towns, people said we’d fail and lose money. Now others have put Linacs in smaller towns. In 2000, *The Week* magazine wrote, “Cancer care is the worst investment, cardiac is the best.” Today, everybody is after cancer care.

When I started, people told me “No patient will come to you because there will be a stigma of cancer—if they go to HCG then everyone will know they have cancer”.

Today, we see 120,000 new patients in a year, one of the highest in the world. We have 38 linear accelerators. All I want to say is patients’ families want the best of care. They come to a place where they know they will have a better outcome. We are a destination.

All cancer treatments are doing far better than even 10 years ago. I have patients with liver cancer who are living longer. Because we manage them with genomics—as cancer treatment progresses, the tumour genomics changes.

***The Ken*: You seem to be against delisting, going private and becoming multi-specialty. But in your list of centres, there are three multi-specialty hospitals.**

These are hospitals [in Bhavnagar, Rajkot, Ahmedabad] we acquired but could not fully convert to oncology. Please understand, it takes time to get all approvals and put bunkers—at least three years. Some may not be 100% oncology but as a group, we are 85% oncology today.

***The Ken*: If you were to start HCG today, what would you do differently?**

If I were to do it today, I’d probably not do 25 centres. I would do a few and make them centres of excellence in a big way. Since my idea was to make cancer accessible and affordable, I went to Ranchi, Angol, Nasik… But if I have to do it again, I will focus more on a few centres, say, in Bengaluru, maybe Ahmedabad, Kolkata, or Mumbai.

***The Ken*: What has been the trade-off in spreading out**?

I created the hub-and-spoke model back then because in my travels across the country I saw the acute lack of cancer care. I was idealistic and I thought I could bring the same level of care in Gulbarga or Cuttack as I would have in Bengaluru. I assumed that doctors would refer complicated cases to the hub but during reviews, it became clear that it didn’t always happen. So, I think I failed in achieving a true hub-and-spoke model. Because as a doctor, the outcome is the most important metric for me.

I guess that’s true worldwide too. Recently, Mass General Hospital in downtown Boston compared its results to its peripheral centres and found that the outcomes were not the same. I feel even though I have very strict rules, and everything has dramatically improved, the outcome levels are not at par whereas in Bengaluru, I have more than surpassed the global benchmark.

That said, I have achieved putting Linacs in smaller towns and shifted the thinking from cobalt [often considered worse than the disease due to side effects] to Linacs and showed that high-quality therapy can be given at the point of care. Nobody thought dedicated cancer centres in the private sector would do good. But we did. We also demystified this nonsense about starting hospice care for terminal patients.

> *For our platform, cancer is almost like a lifestyle disease like diabetes. People are beginning to accept that they can live with cancer for 20 years*
>
> BS AJAIKUMAR, FOUNDER OF HCG

***The Ken*: You speak of centres of excellence. If you are one, you’d be offering Car-T (a type of cancer immunotherapy) to patients.**

We do offer Car-T. Working with Dr Reddy’s Labs, we offer it for multiple myeloma. We are also ramping up this treatment but remember Car-T is only for hematology, not for solid tumors. Possibly new alternatives are coming for Car-T. So, you cannot say Car-T will sustain 10 years from now.

When I say “centres of excellence”, it means each patient, irrespective of their financial status, should undergo every examination. Not only biopsy but its detailing, genomics, molecular diagnostics, PET scan, proteomics—to analyse the onset of cancer and what is the right treatment even before you start any therapy. Such a centre doesn’t run on volume [of patients].

***The Ken*: You pride yourself on the platform you have built. Give us some examples of how mining the patient data has helped improve care or reduced cost.**

If you take prostate or breast cancer, people have lifelong side effects earlier, especially in anatomically aligned organs. Now I can treat them with literally no side effects. We’ve achieved this with the feedback loop. Earlier, it was impossible to treat brain tumours; patients would die of brain necrosis but with Cyberknife treatment, patients are living beyond 10 years.

In head and neck cancer, we are evaluating if we can lower the dose because genomics lets us see which patient responds to a lower dose and which requires a higher dose for the same outcome. It’s an exciting field for us.

For example, in immunotherapy, we are now showing one-fourth the dose is enough. We are collecting data to publish but that takes time—a few years.

***The Ken*: Isn’t such an evaluation routine for top hospitals?**

No, no, no, no, no. Absolutely not.

***The Ken*: But lower dose also means less earning for the hospital…**

As long as I'm in the chair, hopefully, even in the future, this will never happen. Our doctors have never been under any financial pressure. There are ways to earn more; suppose I bring a new piece of equipment worth US$5 million, instead of one costing US$2 million. Obviously, I'll charge more. But look at our PET scan charges—it hasn't changed since 2008.

That is also partly why I'm not going to sell [my stake]. If I did, I would have got good money and I could have done a lot of philanthropy work, but I said no.

At the end of the day, there has to be a balance between how much you can charge the patient and how many you can serve. It is also important because we participate in the government schemes serving tier-2 and -3 towns. There you have to accept a lower return on investment. Major private hospital chains do not participate in government schemes.

But I am happy about it.

***The Ken*: Do you think another cancer chain can come up in India? WHO says by 2025, one in nine people will have cancer in their lifetime. Do we not need more centres?**

In India, it is one in 12 persons, but it will catch up [to the WHO projection.]

There are enough centres in big cities, but not enough in tier-2 and -3 cities.

Entry barriers are very high for a specialty cancer chain. You can have multi-specialty hospitals putting in more centres but to do independent cancer centres and sustain them is very difficult. It'll have negative Ebitda for five years [and nobody has patience today.]

***The Ken*: Some people in this field say cancer care is out of control in India. You have no business being pessimistic, but honestly, what's the ground reality?**

People who make those comments don't have a pan-India view; they don't understand it fully. India has leapfrogged to a whole different level in the last two decades because we now have high technology even in smaller cities. We have made a lot of progress. No question.

Where we are still lacking is research, development, academics, and providing the right care to the patient who can't afford it. That is the major problem. The Ayushman scheme doesn't pay for this. How do we bridge the gap?

The only answer for India is universal healthcare.

***The Ken*: That's not going to happen**.

It has to happen. I've proposed a plan and sent it to Niti Aayog. Say based on my phone bill, I am charged a cess that goes into a healthcare fund. We need US$150 billion [a year] to bridge the healthcare gap—so that an Ayushman [card holder] patient and a Mercedes [-owning] patient get the same treatment. That's all we need to do.

Let an autonomous body run it and create a system where the government is not involved. It just needs to monitor the quality and the outcome. It'll work phenomenally.

Almost 70% of healthcare delivery is already in the private sector.

***The Ken*: Are you suggesting a super insurance scheme beyond Ayushman? An outcome-linked payout?**

That's right, the government should not run hospitals. Look at the state of education in rural India. Why is it not improving? The government should give vouchers and students should go to private schools.

The government has to create universal care. For example, our hospital in Bengaluru is only one mile from the [state-run] Kidwai Hospital. There are categories of patients who come to us. One says, "I will pay Rs 15 lakh and take the service." Another says, "I can't afford it, I'll go to Kidwai." That's fine. The third category says, "I know that HCG is a better place, I'll borrow money from friends and relatives for the treatment."

It's the fourth category that bothers me—they come here and want to sell their land and property to pay for cancer care. These patients should go to Kidwai, but they come here. We do whatever we can through our charitable foundation, but that's not enough. Why are they not going to Kidwai? It's a reasonably good hospital; they can go there, but they don't want to.

> *When patients sell for treatment, it gives bad names to private hospitals. But people don't understand this. We are not a monopoly, patients have options*
>
> BS AJAIKUMAR, FOUNDER, HCG

But our costs are high. If you look at a PET scan, we do it for US$225–230. In the US, it's US$3,000, with the same equipment and same process. How can you beat the cost down more when doctors today demand US [-like] salaries? There are doctors who make Rs 15, 20, 30, even 40 lakh a month. You can't do anything about it, you have to pay them to make sure the quality is maintained.

The government has to step in now; that is the only way to bring equality in health.

***The Ken*: Since everything is boiling down to some kind of insurance, what is your view of cancer-focused private health insurance? Does that help patients?**

Cancer insurance has not worked well. One, that's age-restricted. Two, there are many fine prints and pre-conditions. In my view, insurers don't pay much to patients in these cases. I think general health insurance where cancer is covered is better.

***The Ken*: There's a distinct PE-driven consolidation in Indian hospitals. Practitioner-led clinics and nursing homes are also selling. As a doctor, how do you see this?**

I am always for doctor-entrepreneurs. I think those who have started hospitals should look at how they can sustain themselves. One way to do that is to bring efficiency to the system and create succession planning. I have started a small [Rs 200 crore] fund. It's an alternative investment fund to support doctors, researchers, and healthcare innovation. (It will not do oncology.) If small hospitals or clinics attain certain quality outcomes, people will feel comfortable going there, especially those who cannot afford corporate hospitals.

As for consolidation, it depends—are you doing it for efficiency or valuation?

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