Entrepreneurship and E-Health: How Promises of Innovation are Transforming India's Primary Care Sector

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By

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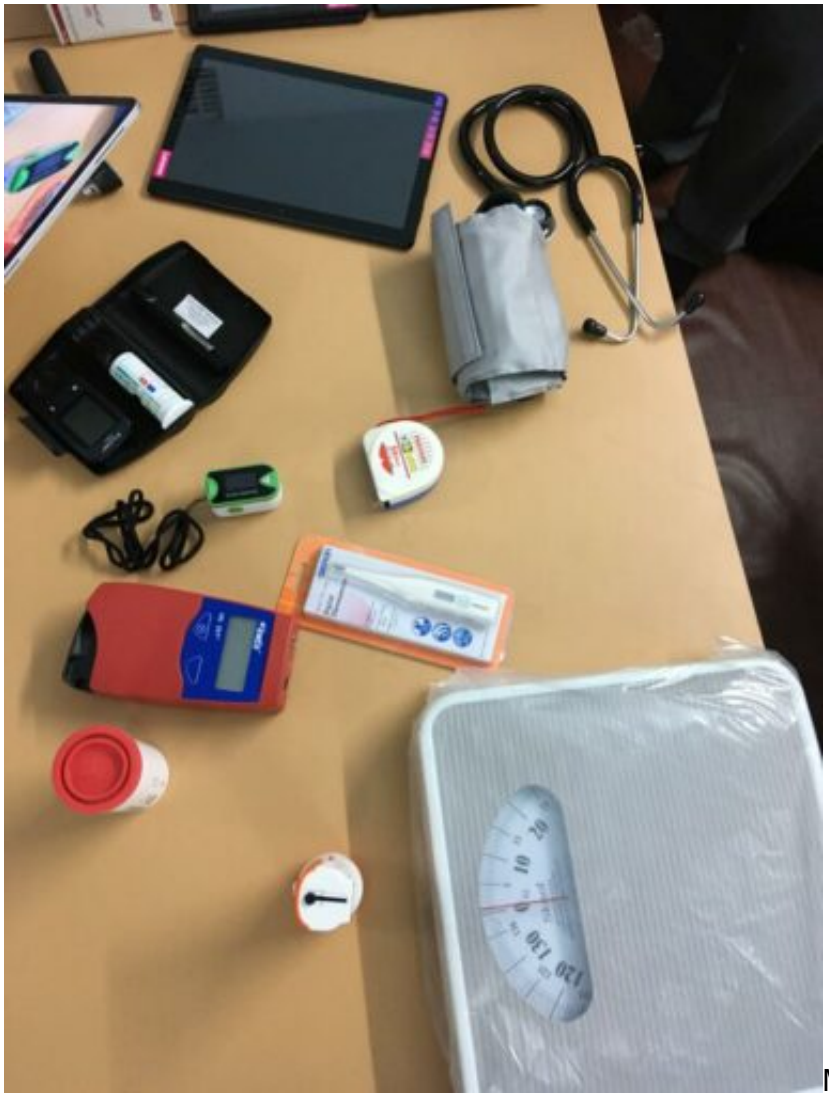
"Health for All?" ***critically explores global moves towards Universal Health Coverage and its language of rights to health, equity, social justice and the public good. Highlighting emerging ethnographic and historical research by both young and established scholars, the series explores the translations and frictions surrounding aspirations for "health for all" as they move across the globe. The series is edited by Ruth Prince.***

On the Frontline

Large banners that line the untarred road leading through a village in West Bengal, India announce that a new "e-health center" named *Horizon*[1] will open its doors in a few weeks. Funded by the West Bengal state government, the project is being implemented by a social enterprise called *Healthcare Solutions*. In the small, damp room on the ground floor of the village council (*panchayat*) building where the center will be located, renovation work had been done at full speed over the past weeks: walls were whitewashed, furniture was delivered, and medical instruments were stored in cupboards together with tablets and printers (see below). Today,

twenty “frontline health workers” who will be employed by the center have travelled for up to two hours to assemble at their new workplace. They are women and men in their 20s or 30s who have a high school or college degree and are members of “scheduled castes” or “scheduled tribes” – official categories designating marginalized communities in India. Although they have all completed six months of medical training, they are here to take a one-month medical refresher course and receive additional digital training before the center opens. Since I am observing the project’s implementation as part of my fieldwork on digital healthcare, I join in as well.


Medical and digital equipment (Sandra Bärnreuther, November 2019)

After *Horizon’s* inauguration, the frontline health workers will start to operate the center from the small room in the *panchayat* building. Some workers will wait for patients to arrive, while others will cycle to nearby villages to offer their services. While there are other medical options

available in the area, the physician responsible for the governmental health post only visits once a week, and local “rural medical practitioners” (most without any formal medical education) are perceived by many villagers as expensive. *Healthcare Solutions* prides itself on the fact that patients will be able to consult a “real” doctor for a much lower fee. When a patient arrives, health workers feed their demographic data into a software program and inquire about their medical complaints. The program then automatically prompts specific questions (e.g. “when did this complaint start?”). The answers must also be recorded digitally. Next, the health workers take the patient’s vital signs, perform the physical examinations that the software elicits, and conduct point-of-care diagnostic tests. Finally, they send the electronic health record to one of the backend doctors – primarily located in Kolkata – via the installed broadband connection. After surveying the data, a doctor will briefly speak with the patient by phone (mainly to assure them that there is indeed a physician behind the scenes) before sending their instructions and a prescription via the software.

Located in a village thirty bumpy minutes by car from the main road and about one hour from the nearest local train station, the health workers are seen as operating on the “frontline.” They are employed to provide primary healthcare to populations who face barriers in accessing good-quality and affordable medical care.

In this contribution, I focus on two processes that are often described as innovative approaches promising to revolutionize the availability, access, and quality of primary healthcare, not only in India but in many parts of the world: entrepreneurship and digitalization (see Prince 2020a, this series). The fact that these processes converge in the example of *Horizon* is no coincidence – both are heavily promoted by the Indian state[2], which has itself embraced entrepreneurial and digitalized modes of social service provision for the past decade.

Making Entrepreneurs

Every time curious villagers peek through the slightly open door during the health workers’ training session to ask questions about the new facility, one of the *Healthcare Solutions* employees steps out and explains that it is a project being conducted in cooperation with the West Bengal government. By explicitly associating itself with the state, the social enterprise hopes to gain credibility and trust. It projects *Horizon* as a more permanent and reliable structure than the many NGO initiatives that frequently come and go in rural areas.

Providing healthcare for all has been an aspiration throughout India’s postcolonial health policies. Budget allotments, however, have remained

relatively modest. The IMF's and World Bank's structural adjustment programs in particular have severely affected public health financing since the 1990s and led to a steady deterioration of state-sponsored services, the proliferation of private providers, and a system that is, to a large extent, based on out-of-pocket expenditure (Qadeer 2013). Recent policies directed at universal health coverage by both the central government and the West Bengal state are mainly insurance-based, targeting the secondary and tertiary sectors. Reducing the role of the state to that of a payer rather than provider, they have been criticized as yet another way to curtail public services (e.g. Al Dahdah 2020, this series).

While the involvement of various kinds of private investors has a long history in India's secondary and tertiary healthcare sector, the shift towards market-led developments in the primary sector is arguably a more recent phenomenon. It seems that for-profit providers see more and more economic potential in a field that chiefly serves low-income populations. In the style of micro-finance (e.g. Kar 2018), 'micro-healthcare' is expected to succeed financially through scale.

In contrast to global funds or multinational companies that are also trying to capitalize on this market in India (e.g. Al Dahdah 2019), *Healthcare Solutions* is an Indian-owned business, based in Kolkata (Neumark 2020, this series). Situated at the juncture of philanthropy and capitalism (McGoey 2015: 21), *Healthcare Solutions* calls itself a social enterprise: working for the "social good" while simultaneously making it financially valuable. Dr. Chowdhury, the founder and driving force behind the company, is a physician who has tried for decades to provide high-quality and affordable private healthcare in rural West Bengal. Although Dr. Chowdhury is devoted to the idea of health as a public good, he also finds it necessary to operate through a private, for-profit model. According to him, healthcare provision can only be financially sustainable if it works independently of erratic government funding cycles and is understood as a paid-for service. Dr. Chowdhury further argues that sustainability can only be achieved by "sowing the seeds of entrepreneurship."

This vision of sustainability through enterprise directly translates into the project's funding architecture. The first of seventy such e-health centers in West Bengal, *Horizon* will operate in a franchise-like, entrepreneurial model. Although the state is providing financial support, it is allocated in the form of a loan to the frontline health workers themselves. They are expected to repay this loan after a few years and later run the center profitably on their own by generating revenue from charging patients for consultations, tests, and pharmaceuticals. Additionally, instead of the health ministry, the loan has been given by a development agency that focuses on the provision of credit and the development of skills among marginalized communities. Over the past decades, skill development

initiatives, which support livelihood generation on the one hand and supply adequate “human resources” on the other, have prospered in India (Gooptu 2018). In a context where levels of un- and underemployment are extremely high, the skilling of “underprivileged youth” from rural areas as entrepreneurial health workers not only constitutes an economical way to provide healthcare but also an economic measure to provide employment.

While the frontline health workers started their medical training with the hope of securing a government job, or at least stable employment (*chakri*), they are now engaged in an entrepreneurship model (see below). This divergence has at times led to confusion and discontent, as most health workers were unfamiliar with and anxious about an entrepreneurial approach. They perceived the loan as risky and worried what would happen if they were not able to repay it. Concerns about their future have intensified ever since India enforced a lockdown to prevent the spread of COVID-19 in the end of March. Although many health workers would clearly have preferred a paternalistic but caring state, they received training and seed funding with the expectation of being able to care for themselves (and others) by running a healthcare enterprise.


Signing the loan agreement (Sandra Bärnreuther, November 2019)

This model of healthcare entrepreneurship in West Bengal mirrors more general transformations in the country's welfare programs. Although the Indian state still holds enormous popular traction, its nature has significantly changed over the past decades: from a developmental state that attempts to manage poverty to an entrepreneurial state that provides "austerity welfare" (Kar 2017) and supports the "proliferation of enterprise around poverty" (Irani 2019: 4). Lilly Irani's (2019: 1) diagnosis that an "ethos of innovation and entrepreneurship (…) has colonized philanthropy, development projects, [and] government policies" in India since the 1990s certainly rings true for healthcare. Moreover, that this ethos has even colonized state institutions is probably best exemplified by the replacement of the central Planning Commission with the "National Institute for Transforming India" (NITI Aayog) in 2015. Signifying a move away from planned development, NITI Aayog is conceptualized as a "think tank" reacting flexibly to contemporary challenges by promoting "innovation." In

this sense, the state is not only facilitating entrepreneurship, but has itself (at least in parts) turned entrepreneurial.

Building Digital Bridges

Apart from entrepreneurship, promises of innovation have come to structure thinking about healthcare in yet another way – digitalization. To give one example: NITI Aayog is in the process of formulating a *National Digital Health Blueprint* (NDHB), which spells out a vision for a "digital health ecosystem." Ever since the 2000s, the Indian state has expedited the introduction of digital technologies in the social sector. Prominent examples are the various welfare schemes that have started to operate through *Aadhaar*, India's biometric ID project (e.g. Khera 2017; Rao and Nair 2019). In the realm of healthcare, the 2019 draft of the NDHB proposes to "leverag[e] digital technologies for enhancing the efficiency and effectiveness of delivery of all the healthcare services." Internet connectivity even in remote areas, combined with ever-increasing smartphone ownership and cheap data plans, provide the conditions of possibility for this vision. However, whether and in what exact ways digital technologies will indeed have a "huge potential for supporting Universal Health Coverage" (NDHM 2019: 5) remains an open question.

The NDHB (2019: 6) further articulates the hope that the digitalization of health services "will generate enormous amounts of health data." With regard to the primary sector, it is highly likely that frontline workers will play a crucial part in this endeavor, as generating digital data usually involves a great amount of manual labor. This leads me back to the training session in the village in West Bengal. Standing in front of the twenty women and men, an employee of *Healthcare Solutions* teaches them how to use a tablet. Installed on the device is medical software that has been developed by *Healthcare Solutions* in cooperation with a well-known foreign university. The software creates electronic health records and enables communication with backend doctors. *Healthcare Solutions*' stated goal is to "build bridges" between rural populations and urban healthcare specialists – a phrase that evokes the technological optimism so characteristic of modernization theory. Although some of the frontline health workers are able to expertly navigate the screen after a few moments, others, particularly those who have never operated a computer, tablet, or smartphone before, struggle. Only used to "small" (*chhoto*) phones, they strive to move their fingers across the screen to open the software, select fields, and enter data (see below). However, they are excited to "learn the software." Many health workers highly value digital skills, not least because they believe they might help them find more secure and well-paid jobs in the future.


Digital training (Sandra Bärnreuther, October 2019)

Besides working on the medical frontline, once trained, the frontline health workers will also function as “foot soldiers of digitalization” – an expression that was used at a telemedicine conference in Delhi. Or, to put it another way: apart from building medical bridges between patients and doctors, they will also build digital bridges between data providers and data analysts. Although *Healthcare Solutions* is planning to use the data entered into its software only for improving clinical decision-making and designing targeted public health programs, it is conceivable that digital healthcare initiatives could turn data into profits down the line. Initiatives like *Horizon* might thus create financial value, not only through the provision of medical services, but also by the compilation and sale of health data. Issues of data security and ownership therefore remain extremely relevant, particularly in contexts without any legal regulations, such as India (Prince 2020b, this series).

Questions of availability, access, and quality of healthcare on the frontline certainly remain complex challenges on a global level. They gain even more urgency at a time when a pandemic relentlessly reveals the dysfunctions, exclusions, and inequalities built into current models. In this context, social enterprises like *Healthcare Solutions* offer novel visions and approaches to reshape the provision of care. It is nevertheless worth asking why certain answers (e.g. innovation) become dominant, and how their promises structure ways of thinking about these sets of problems. In what manner have entrepreneurship and digitalization been heralded as solutions and gained political traction? And how can we "reckon with" (Erikson 2019) healthcare as it is increasingly being imagined and realized in entrepreneurial and digital terms?

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Notes:

[1] The names of institutions and people mentioned here are all pseudonyms.

[2] Although health is a state subject in India's federal structure, some government schemes are initiated on the central level. In many cases, particularly with regard to West Bengal, center-state relations are extremely complex due to political differences between ruling parties, and demand a more thorough analysis. For this blog post, it is sufficient to say that both levels share a general drive towards privatization, public-private partnerships, and entrepreneurship.

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