

The Provision of Public Goods and Services by Socially Oriented Entrepreneurs:  
Experiences of Indian Healthcare

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It is 2004 in Assam, North East India. Lacking health care and transport to take her to a mainland medical facility some hours away, a young woman has died in childbirth on the bank of the Brahmaputra River. This is all too familiar; India has been spending less than one percent of its gross domestic product on publicly funded health care and there are no such health services in this area notorious for flooding in the monsoon season. But the head of a university based Centre for North East Studies in Delhi is visiting the region and hears of this young woman and others like her. He regards this as unacceptable in the 21<sup>st</sup> century.

Moreover, he resolves to act. Through his Centre he forms a team to undertake an analysis of the health service needs of these marginalized communities. The result is a plan to take care to these peoples in a way that fits with the way they live their lives and the dominance of the river in those lives - by boat. By 2005 he has brokered a partnership of private and charitable supporters to design, build and staff a prototype boat health clinic in one of the state districts. By 2012 he has funding from state government and private benefactors and foundations to support 15 such boat clinics, each staffed with two doctors, three nurses, a laboratory technician, a pharmacist and a crew of three. Together they see 20,000 people a month and serve nearly 500,000 people.

Elsewhere in India a different type of health care initiative is well under way. After obtaining his medical degree in India, a cardiac surgeon qualifies at Guy's Hospital in London. He returns to India and takes up the post of director of a new heart hospital in Kolkata. He is alarmed and frustrated by the reality that only 2% of his patients are able to afford the lifesaving heart surgery they need and that many others become permanently impoverished by meeting their health care costs. He founds a new hospital group with the vision of **“affordable quality healthcare for the masses”**. **It focuses on both reducing costs and extending the opportunities to the poor to access funding through low cost insurance and charitable trusts. Scale is part of the recipe:** in 2001 the group begins with a single 225-bed heart hospital in Bangalore. By 2014 it has expanded to a network of 26 hospitals comprising 7000 beds. No patient is turned away for lack of funds.

These stories tell of entrepreneurs working for public good. In this chapter we shall relate how both were moved by the evident health care needs of the disadvantaged, how both responded by establishing new enterprises to improve access to health services and how both have made a significant difference to the lives of those they provide for. But our analysis will show that each has had its own distinctive way of contributing to the public good.

### **A field of curiosity: social entrepreneurial contributions to public services**

Across the globe we are hearing that the state has to be cut back in order to foster a post-crisis recovery, unleashing the power of entrepreneurship and innovation in the private sector. This feeds a perceived contrast that is repeatedly drawn by the media, business and libertarian politicians of a dynamic, innovative, competitive private sector versus a sluggish, bureaucratic, inertial, ‘meddling’ public sector. (Mazzucato 2011)

Our opening stories stimulate interest not simply for their humanity and inspiration. They are part of an apparent worldwide increase in the work of non-government

contributions to public goods and services including those human services that contribute directly to the health and well being of populations. In OECD countries, for example, resource constraint that has stimulated governments to find different, preferably cheaper, ways to provide these services. Their search has extended to charities, voluntary, philanthropic and private sector organizations. In the UK health economy, for example, government policy is explicitly to open up the National Health Service to new providers from the private and charitable sectors (British Medical Association 2013; NHS Commissioning Board 2012; Social Enterprise UK 2013).

Other circumstances and other countries have also opened up the provision of public goods and services to non-government providers including socially oriented entrepreneurs. In countries degraded by war and geo-physical disaster these providers are rebuilding infrastructures as well as communities (Friedman & Desivilya 2010). And elsewhere, expanding economies have left gaps in government provision that other enterprises, including those established by socially oriented entrepreneurs, are filling (Leadbeater 1997).

Such non-governmental provisions of public services may bring much needed contributions to public goods and services, but they also bring a range of issues for public policy. With opportunities to expand services come also increased shares of tax revenues in the hands of entrepreneurs. Contributions that target specific groups and conditions may reinforce discrimination and aggravate inequalities (Dwyer and Parutis 2013; Vickers 2009). Their distinctive business models, which trade on moral goodwill, philanthropic capitalism and entrepreneurship, may bring different rationalities to governance and decision-making (especially resource allocation) that contrast with and sometimes deliberately contest traditional government conceptions of service and user (Fountain 2001). Thus they may present policy and delivery dilemmas that challenge service commitments entrenched and

valued in policy communities. In so far as these increasing contributions are procured as agents of government, they along with the issues they raise are state sponsored.

At the center of our opening stories are two entrepreneurs that are part of this new order of service provision. We regard them as ‘socially-oriented entrepreneurs’ as they are working to improve the health and wellbeing of deprived communities. India has provided “one of the most fertile arenas for social entrepreneurship globally” with new activity in two fields covered here – the application of western models to local circumstances and new alliances between government and civil society (Nicholls and Young 2008: viii). The literature on such entrepreneurs is relatively underdeveloped; “rigorous theories of entrepreneurship are few and the study of entrepreneurship is not cumulative” (Schneider, Teske and Mintrom 1995). Moreover the “concept of social entrepreneurship is still poorly defined and its boundaries to other fields of study remain fuzzy” (Mair and Marti 2006). However, this literature does suggest some common characteristics of social entrepreneurial styles and how they make a difference to public goods and services.

For Leadbeater, who in a politically influential book analyzed the work of five community-based entrepreneurs in the UK during the 1990s, such entrepreneurs display a range of distinctive characteristics (1997). They excel in ‘spotting unmet needs and mobilizing underutilized resources to meet these needs’. They are ‘driven and determined, ambitious and charismatic’ (p11-12), ‘communicating a mission and inspiring staff, users and partners’ (1-2) They are social in that they are driven by a social mission, their organizations ‘are part of civil society, rather than the state’ (11-12).

Their contribution is built on ‘five pillars’ of provision (Leadbeater 1997: p21-5). They help to solve social problems by novel approaches. They improve supply-side efficiency by reducing bureaucracy, increasing adaptability and stimulating staff commitment. They offer new models of active welfare in which users ‘embrace a philosophy

in which welfare and well-being are inseparable from self-control and self-confidence' and service providers mobilize and integrate diverse networks. They increase jobs and output thereby benefitting individuals and local economies. And they create social capital through relationships built on cooperation and trust that 'underpin economic partnerships and alliances' for which the ultimate 'dividend is itself social: a stronger community, more able to look after itself, with stronger bonds of trust and cooperation.'

How do they bring these benefits? They exploit opportunities. They deploy often-limited financial resources to build creative, flexible organizations in what can be complex interactions of state, private and voluntary agencies with distinct and overlapping professional communities. Leadbeater finds that social entrepreneurs in particular often "find ways of combining approaches that are traditionally kept separate" by exploiting and building social capital, i.e. relationships and networks. The more socially entrepreneurial organizations are also distinctly inclusive: "they create a sense of membership by recognizing that their users all have distinct and different needs" (1997: p3).

These characteristics of the socially oriented entrepreneur have been confirmed by more recent studies (including Alvord, Brown and Letts 2004; Bornstein 2007). These studies have also confirmed that such entrepreneurs are not confined to private or voluntary ventures. In industrialized countries the developing mixed economy of welfare provision has brought a more pronounced contract culture and a greater variety of providers. Partnerships of provision are also more common, often themselves the product of entrepreneurial initiatives. Thus organizations large and small from public, private and third sectors are finding and providing opportunities for entrepreneurs to realize both their commercial and social missions (Leadbeater 1997:11-12). As Leadbeater's ven diagram shows, such entrepreneurs and their enterprises ends are found most notably at the interface of these sectors.

FIGURE 1 ABOUT HERE

### **Health care provision by socially oriented entrepreneurs: two Indian cases**

The two socially oriented entrepreneurs that feature in our cases are consistent with many aspects of these profiles. Here we elaborate their stories. In the following section we shall ask the book's research questions to compare and contrast them as contributions to public good and as challenges to evaluation.

Whilst India has a publicly funded health system, government spending on health has been very low by international standards. By the end of the 2000s, for example, the National Health Accounts revealed this spending to constitute only 1% of GDP (Ministry of Health & Family Welfare 2009). Due to this underfunding, there has been a host of problems with public facilities including absenteeism, overcrowding, poor hygiene and a lack of surgical equipment (Peters et al 2002). Additionally, private spending is one of the highest in the world and accounts for 71% of total health expenditure (Ministry of Health & Family Welfare 2009). Over the past 60 years, the diverse and largely unregulated private sector has grown from 8% of health care facilities to encompass 93% of hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients (Peters et al 2002; Radwan 2005). Patients prefer to seek care in private facilities, regardless of socioeconomic status (World Bank 1995; Bhat 1999). Private care, however, often comes at a cost that is simply too high. One quarter of Indians fall below the poverty line as a result of hospitalization each year (Peters et al 2002). And for much of the rural population, including in the Brahmaputra Valley, there have been historically no acceptable services at all, public or private.

### **Sanjoy Hazarika and the Boat Clinics of the Brahmaputra: primary care for marginal communities**

In 2000 Professor Sanjoy Hazarika, a former New York Times journalist and filmmaker, became Director and Managing Trustee of the Centre for North East Studies and Policy Research (CNES), a Delhi based University Trust dedicated to developing policy and service for the marginalized communities of North East India. While visiting the water villages along the Brahmaputra, a valley notorious for flooding in the monsoon season, he heard of the young woman who had died in labor for lack of local services and transport. He regarded this as unacceptable in the 21<sup>st</sup> century.

Back at CNES he says he “realized that the key to better services was to improve access. The most effective way to reach those in need was by the traditional transport they used in their lives - boats - but designed and equipped to carry medical teams, medicines and equipment” (Hazarika 2012). He formed a team to undertake an analysis of the health service needs of these marginalized communities and by 2005 he brokered a partnership (including UNICEF and private supporters) to design and fund a prototype boat clinic (the Akha) in the Dibrugarh district.

The success of the prototype helped to secure World Bank funding to build seven more boats with engines refurbished in local yards. By 2012 the scheme has developed into a more formal public private partnership funded by the National Rural Health Mission (NRHM) of the State Government of Assam. That supported the project in expanding to 15 boats covering 13 districts, each with its own territory.

Each boat clinic is staffed by 2 doctors, 3 nurses, 1 pharmacist, 1 laboratory technician and 3 crew – all recruited and managed by CNES. Each boat visits one or two sites a day in a 16-20 day tour each month. The clinics are held on the boats or in village camps up to 6 kilometers inland depending on location. The services include clinical checkups and health information, basic tests (such as hemoglobin, urine sugar, albumin and malaria) by the boat’s laboratory, prescribing and dispensing, antenatal and postnatal care, family planning

services (including free contraceptives), immunization program of public health (polio, Japanese encephalitis, malaria, vitamin A supplements), minor surgical procedures and transport of patients to more specialist facilities.

The health camps are now organized in association with the National Rural Health Mission Joint Directors of Health with CNES teams of District Programme Officers (DPO) and Community Workers who are in contact with the boat and make sure the site is ready for the visit. Occasionally, boats are sometimes flagged down from the riverbanks - local people are aware of the itineraries.

Together the clinics now deal with almost 20,000 people each month and a population of approaching half a million. Sanjoy Hazarika plans to keep expanding the scheme hoping to include all accessible parts of the valley - a population of 1 million. A hospital ship with operating theatre is planned for commission with government support in 2014. The challenges are no longer sustaining the funding as the state government now funds all but a few of the boats. Rather, it is the need to secure staff capacity for the boats and especially to manage the ever present climatic extremes: the frequent floods threaten the boats and make it difficult to reach people moving to higher ground and dry seasons lower the water levels so much that boats may not be able to reach communities and clinics have to downsize craft or go overland.

### **Dr Devi Shetty and Narayana Health provision of low cost acute care**

*“If the solution isn’t affordable, it’s not a solution” Devi Shetty*

The vision of Dr Devi Shetty, the founder and chairman of Narayana Health is **“affordable quality healthcare for the masses”**. He has dedicated his working life to drive down the cost of tertiary health care and has achieved this by employing a high volume approach.

The group began in 2001 with a single 225-bed heart hospital in Bangalore but in little over a



decade it has expanded to 16 locations across India and entered into non-cardiac specialties. The original cardiac hospital has grown to 1000 beds and now sits on a 25 acre, 3,000-bed 'health city' which houses, amongst other facilities, a cancer center and an orthopedic and trauma hospital. Narayana Health currently serves 80,000 patients and performs 3,500 surgeries each month through its network of 26 hospitals.

After obtaining his medical degree in India, Dr Shetty trained in cardiac surgery at Guy's Hospital in London. He returned to India 6 years later where he took up a post as director of a new heart hospital in Kolkata. Whilst practicing in Kolkata, Shetty became frustrated by the inability of his patients to afford the care they required. In an average outpatient session, he found that only around 2% of patients would be able to pay for lifesaving heart surgery. Shetty performed the first neonatal heart surgery in India and also served as Mother Teresa's cardiac surgeon. As a result, he soon became a well-known public figure in his country.

Narayana Hrudayalaya hospitals are now the largest cardiovascular group in the world and have completed over 50,000 heart surgeries to date. Shetty's approach has led to him being dubbed the Henry Ford of heart surgery. By performing a high volume of procedures, he has managed to reduce significantly the cost of surgery and he passes these efficiency savings onto patients. The breakeven cost for open-heart surgery at NH is \$1800, only half of what it costs elsewhere in India and abroad. Shetty has a dedicated cadre of surgeons working in his institutions and there is no shortage of new recruits willing to join the team. On a visit by one of the authors to the hospital in 2010, a hopeful doctor was seen to throw himself at the feet of Dr Shetty, begging for an opportunity to serve in one of his hospitals.

**A three-tier pricing system allows cross subsidization. Whilst the full price of open-heart surgery is \$3,300, financially constrained patients pay only \$1,300, with NH absorbing the extra cost. The very poor are treated for free with the NH charitable trust**

**organizing payment. The hospital also offers care to patients covered under the Yeshasvini insurance scheme, another of Dr Shetty's initiatives. This scheme allows farmers in Karnataka state to insure themselves against healthcare expenses for just 5 rupees per month. It is one of the largest self-funded health insurance programs in the world with an estimated 3 million members.** The hospital has a reputation for high quality care and since opening it has had no difficulty attracting fully paying customers. Figures from 2004 reveal that around 60% of patients paid the full price for surgery.

Cardiac patients require access to a number of other specialties during the course of their care and the group found that it has been able to apply the low cost cardiac model to other non-cardiac specialties with little additional effort. Further, much of the equipment and facilities of the original cardiac hospital, such as blood banks and diagnostic apparatus, could be shared amongst a wide array of specialties yielding economies of scale (Khana and Bijlani 2011). Patients treated with the NH health cities are able to benefit from the multiple specialists housed on site and this wide range of expertise is believed to improve the quality of clinical health outcomes.

Having established 'health cities' in Kolkata and Ahmedabad, Shetty is working towards his goal to operate 30,000 beds within 7 years. This would put his group on a par with the largest for-profit hospital chain globally. Two notable projects amongst this expansion include a medical facility in the Cayman Islands and a low cost hospital in Mysore, India. The Cayman site opened its doors as a 104-bed tertiary care hospital offering cardiac and orthopedic services in February 2014. Over the next decade it is expected to grow into a 2,000 bed, multi-specialty health city, much like its Bangalore counterpart. It is marketed as a destination for medical tourists and cuts prices at comparable facilities in the Western hemisphere by up to 40%. Shetty envisages that it will serve Americans with limited access to healthcare.

The other initiative is India's first low-cost, no frills, multispecialty hospital in Mysore. The total cost of the build was estimated to be around \$4 million. Savings were made by building a pre-fabricated structure on just two floors, using thatched roofing and introducing training for family members to provide the basic nursing care. These savings allow for open-heart surgery to be offered 20% cheaper than at the main NH hospital in Bangalore. Further, Shetty believes that patients benefit not only from cost savings but also in this setting, they feel more comfortable with the environment that further aids their recovery process.

### **What and how do they contribute to the public good and how is it evaluated?**

Both the entrepreneurs and their services espouse social values related to the wellbeing of the populations they provide for. Their now well-established enterprises arose from a desire to meet a social need. Both have gained a very high personal standing in their communities and Dr Shetty's enterprise has also brought him personal wealth.

In order to compare not only these cases with each other but also their contributions relative to the other non-government contributions described in this volume, we now ask questions based on those raised in the book's Introduction.

### **What is the public good that these socially oriented entrepreneurs contribute?**

In all regions of India amongst both men and women circulatory disease has been the leading cause of death (Registrar General of India and Million Death Study 2009). 2.5 million heart surgeries are required each year in India but across the country only 90,000 are performed. Through his daily work in Kolkata, Shetty recognized that this huge gap existed and he started Narayana Hrudayalaya in order to address the vast unmet need. His services are designed to offer hope to some of the 2 million Indians that need, but cannot afford, heart

surgery. The difference between Dr Shetty's hospitals and other private facilities is that the NH group provides specialized services to patients across the socio-economic spectrum, regardless of the ability to pay. No patient is turned away for a lack of funds.

Dr Shetty's Narayana Hrudayalaya hospitals have met very substantially what has been an even more substantial unmet need. The impacts have been both on individuals and their communities. In terms of outcomes, the care is of international standards. For example, for coronary artery bypass graft (CABG) procedures the mortality rate is 1.27% and the infection rate 1%. These results are comparable with rates of 1.2% and 1% respectively in the United States. The goal of lowest cost has always been pursued alongside the principle of highest quality.

These results are achieved and sustained by a very challenging combination of managing social products with strict economic management of the enterprise. The NH model effectively utilizes economies of scale to achieve low prices in an attempt to make specialized surgery more affordable. Cross-subsidization is the other factor that has made services, once thought out of reach for millions, a possibility. Moreover, hospital funds are monitored daily. This enables administrative staff to gauge the affordability of free surgeries. If surgery is not deemed to be urgent it may be postponed depending on the financial position of the hospital.

To date the main cost saving by NH has been on staff salaries. This accounts for 22% of expenditure compared with 60% in the West. It is not that doctors are underpaid but they work much longer hours, typically 12 to 16 per day. This allows each doctor to perform more procedures. NH runs 56 postgraduate diploma programs for doctors and it is anticipated that this training may help to further drive down the cost of specialist time. Moreover, with expansion has come more buying power in the market. Shetty predicts that once the group reaches 15,000 beds it will be able to buy directly from the original equipment and pharmaceutical manufacturers.

The original and sustaining good intended by Sanjoy Hazarika's boat clinics was similarly directed at access to healthcare for the Indian poor. At the outset, the driver was the simply humanitarian aim of improving the health and well being of individuals, especially women and young children, and their families and communities. Now, under the Memorandum of Understanding with the National Rural Health Mission of the Assam state government, there is a clear overall public health emphasis on population (especially children) as well as individuals.

The clinics now provide general health checkups, routine immunisations, antenatal and postnatal care, nutritional and vitamin support, and family planning services. Between 2008 and 2012, over 10,300 health clinics were conducted providing health checks for 832,300 people, with over 44,300 women receiving antenatal care (Arora 2014; and data provided by CNES in 2013).

Awareness and use of these clinics has grown to high levels. In a survey "95.4 per cent of the respondents reported using boat clinic services and were aware of the services provided by boat clinic. General health check-ups and immunization services have gained popularity among the study population. 94.9 per cent of the respondents felt that boat clinic services have improved their health condition" (Bhattacharjya 2013).

The impacts of the boat clinics have been substantial. They have transformed and will continue to increase access to basic health care services for vulnerable communities and they have been associated with a reduction of about a fifth in rates of maternal and infant mortality between 2008 and 2012 (data provided by CNES in 2013).

For Sanjoy Hazarika this might be sufficient impact in itself; it was after all what the original initiative was deigned to achieve. They are what we might describe as direct impacts, being those "those that result immediately from the delivery of direct benefits to persons or groups" (Moore 1995). However, we may identify more systemic impacts (Moore 1995). Not

only the high performing interventions themselves but also the values employed and demonstrated in the way they perform have grown confidence and trust in the ability of external collective effort, including by governments, to improve the conditions in which communities live and work. “The C-NES Boat Clinic Project is an articulated socially inclusive intervention that has leveraged boat clinics in stepping up comprehensive healthcare services for hard-to-reach communities... belonging to different states, different caste groups, and divergent indigenous population” (Development Facilitators undated).

The recognition of the right to health care embodied in the enterprise has had a positive effect on the population. This we may describe as an enhancement of political and social capital both of the individual communities and the region in general in ways consistent with those depicted by Putnam in his work on social capital (1993, 2000). It is as though the boats have acted as a catalyst for community self organization with state agencies. It has provided the state government of Assam with a means of enhancing health care provision through the vehicle of a social enterprise that manages to have its own identity separate from government and appears to those who use its services to be “just and fair in the way in which its operated” and “leads to just and fair conditions in the society at large” (Moore 1995). These impacts may be less tangible than the mortality and morbidity statistics but have long-term significance for social and political integration in a hitherto deprived part of the world.

### **How do these enterprises achieve their impacts?**

There are two distinctive facets to the way socially oriented entrepreneurs and their enterprises achieve their impacts. The first is their governance. Chapter 1 defined governance as “the arrangements by which social entities provide for the allocation of authority and function, establish and maintain rights and obligations, and formulate and realize policies”. The Chapter also elaborated how the governance practices are founded on three modes of

relationship: command (the adherence to rules emanating from a sovereign body and delivered through a scalar chain of authority), communion (reference to common values and creeds) and contract (an agreed inducement-contribution exchange).

Our cases bring evidence of and interplay between these three distinct modes of governance. As the Narayana Health group grew, Shetty instituted a new management structure that was hierarchical in nature, with himself as Chairman and a CEO to manage day-to-day operations (Khanna and Bijlani 2011). Command is strong and staff follows the laid down processes of the organization as they carry out their daily duties. This is not, however, the only form of governance in effect. Dr Shetty's vision of bringing affordable healthcare to the masses along with his track record and celebrity status both inspire and motivate staff. Most share his vision and the values upon which the organization has been built. They regard it as an honor to work alongside Shetty in this internationally revered institution in pursuit of a common goal. Further, due to the sheer number of operations that are performed at each site, the surgical experience that can be gained is arguably unrivalled elsewhere in the country. Together, these factors help to explain the high demand to work here and the fierce loyalty that is observed (communion).

Yet contract is also observed. Doctors agree to a salary (a rarity elsewhere in Indian private health practice where practitioners charge fee for service or receive a proportion of the revenues they generate) and to a long workday (often 12 hours and upwards), during which time they are able to perform more procedures than doctors in other hospitals. Contracts are also used as a mechanism to ensure the best prices from the suppliers with long-term contracts explicitly avoided allowing responses to changing market conditions.

Sanjoy Hazarika's boat clinic program displays a different blend of the modes of governance. This is a program with a strong moral mission and is evident in the strength of communion governance that underpins the boat and clinical teams and notably the discretion

they exercise to maximize the program values including when responding to unprogrammed activity (such as being flagged down along the river). Although Professor Hazarika has a much more reserved public personality than Dr Shetty, he is revered by his staff and feted by the media with whom he has excellent relations. In common with many enterprises built up by social entrepreneurs, the program has made extensive use of informal contacts, including personal relationships. As the program has grown and especially with the inflow of external funding first from the World Bank and then the state government of Assam, these contracts necessarily become more formalized. This formalization exemplified also more traditional elements of command style public service governance for the allocation of authority and function, establishing rights and obligations, and making policies.

Our second interest in the way these enterprises achieve their impacts is in the modes of reasoning or rationality that underpin their decisions and actions. Chapter 1 drew on Diesing (1962) to define rationality as the way in which the enterprise ‘takes account of the possibilities and limitations of a given situation and recognizes it so as to produce, or increase, or preserve, some good’. That chapter also elaborated Diesing’s distinct types of reasoning as technical, economic, legal, social, political and ecological.

In most government organizations the dominant forms of reasoning are legal, social and political. Doctrines such as acting within and only within the powers specifically allocated are central to government bodies in which means and ends are often ambiguous and evenly prioritized - especially where it may be easier to forge agreement on means than ends or where means have values that are themselves prized including legally. From this perspective the central purpose in opening up public service provision to more entrepreneurial entities has been to foster more technical and economic reasoning.

What do are cases reveal? All the Narayana Hrudayalaya hospital activities are based upon the visions of one man, a progressive unfolding of Dr Shetty’s dream. Thus the



rationalities evident are those underpinning Shetty's program, rather than the wider body of people that work at NH. It is a program **explicitly designed to solve a social problem and build social cohesion. He has taken on a role within the social system through which he is helping others. Diesing would consider this as socially rational.**

**Yet it is not through engaging in and building social relationships that Shetty has achieved his objectives and social goals. Rather it is through an underlying business model that seeks to maximize the input-output ratio, i.e. technical rationality, as part of a multi-million dollar for-profit business (revenues of \$119 million were expected in 2014). Economizing (economic rationality) is consistently evident as the basis of the business model and the utility sought by the enterprise. Thus, there is an explicit financial utility within which the humanitarian utility is set, suggesting an accommodation of two modes of reasoning often conceptualized as mutually exclusive. However,** Diesing recognized that socially rational organizations must be to some extent economically rational in order to be sustained. It is this economic rationality that allows the NH model to be sustainable by adopting a facilities strategy that is consistent with the long term capacity of the local society and its culture (ecological rationality).

If political rationality has not been important historically for NH decisions, in recent years the firm has received external investment that now amounts to a 25% stake in the entity. Despite remaining 75% family-owned Shetty must ensure his major investors (JP Morgan and PineBridge) are accommodated, always a challenging time for the political structure of entrepreneur-led organizations.

Sanjoy Hazarika's boat clinics display a different blend of rationalities in use. The program employs technical rationality both in making choices that are consistent with the ends and in adopting criteria for choice selection that are derived from those ends. But economic rationality is evident only in the sense that economizing is employed to maximize

the chosen utility. In Diesing's terms, this is a 'unique utility' in that there are no competitive utilities – it is non-negotiable (1962; 63). As with Dr Shetty's hospitals, the clinical program is consciously adopting social rationality: it is explicitly employing criteria derived from social integration and inclusion to inform its decisions and actions. And the philosophy of the program's development has evidenced consistency with sustainability (ecological rationality).

Only in limited senses are legal and political rationalities evidenced in NH. It remains a private organization and keeps its decisions and actions consistent with that position. But, as we have suggested above, its impacts have consequences for the political system more widely especially through its contribution to economic and social development. In contrast, as the boat clinic program has developed more formally with the support of the state government so legal rationality has become more pronounced. The Memorandum of Understanding with the National Rural Health Mission sets out a service delivery structure to the targeted population and assigns duties and responsibilities to each category of staff. With continued state government support for the program's extension so legal rationality is more evident as the basis for the program's decisions and actions.

### **What are the arrangements and challenges for evaluation of their contributions?**

In its survey of 27 existing UK health spin-out social enterprises (i.e. enterprises developed out of public sector health providers) Social Enterprise UK observed, "the respondents were not very strong in articulating their social impact. Some of the organizations surveyed are known to have produced relatively robust social impact reports but this did not come through in the survey for the spin-outs as a whole" (Social Enterprise UK 2013b: p18). This implies that the enterprises had capacities for self-evaluation but had not proactively managed this as part of its relationship with external stakeholders.

So we may ask how socially-oriented entrepreneur providers of public goods and services self-evaluate their contributions, how governments, international organizations, and other funding principals (those who commission or fund the goods and services) evaluate the entrepreneurial contributions, and what challenges and opportunities these entrepreneurial contributions present when evaluating public policy.

Here our cases diverge. NH is operating as a business in a market place. As a corporate entity in search of external investment it is subject to formal audit and to the assessments made externally by its investors. But it is also running a charitable foundation with charitable purposes and a micro insurance scheme through which it is able to open up its health treatments to those who would otherwise not be able to afford them. This involves considerable cross-subsidization. In practice, both dimensions of the enterprise demand effective internal management of performance (especially of costs), clinical service outcomes, and disciplinary development. Thus there is a coincidence of interest here: both the hospitals themselves and the Foundation share the aim of a profitable hospital enterprise. Thus self-evaluation and external evaluation by the market are key instruments for sustaining its viability.

In contrast, the boat clinic program has a generally stable funding stream and a similarly stable pattern of externally generated evaluations familiar to a public policy context. Funders, including UNICEF, the World Bank and more significantly of late the Assam State Government through the National Rural Health Mission, have established a regular series of evaluations on which they have based their continued funding support (Bhattacharjya 2013; Forrey et al 2008). These comprise a mix of commissioner conducted ex-ante appraisals, program monitoring, and ex-post evaluations. Their function is in part compliance and assurance audit within the accountability arrangements established with the funders (especially the NRHM). But they are also in part ex-ante assessments to inform future

funding and program developments. In these they appear to have followed a general philosophy of evaluation associated with the approach of realistic Evaluation (Pawson and Tilley 1997): that is, asking what works for whom in what circumstances?

Both the NH hospitals and the boat clinic program bring their own challenges to evaluating their contributions to public goods and services. Technically and organizationally, the challenges presented by NH hospitals appear similar to those in other independently provided healthcare service. However, the enterprise has been developed outside the commissioning arrangements of Indian health care policy and thus its rationing and allocation arrangements remain outside the influences of public policy, at least formally. This contrasts with the boat clinic program whose development has led to greater partnership with organs of government and thus has been brought increasingly within the general community of publicly funded health care provision and its policy goals.

In a recent essay on the development of social enterprise in India, Meera Vijayann argued that without strong government support, Indian social enterprises find it difficult to engage with society (Vijayann 2013). The CNES boat clinic program has apparently accepted this proposition and engaged increasingly with government. NH hospitals clearly have followed a strategy of distance through a more commercial-charitable model. Thus the two enterprises - while in origin similarly embodying a response to unmet social need through innovation, mobilization, systematisation and brokerage of support that have made life-changing and sustainable benefits to their populations - have become distinct.

## **Conclusions**

We are wary of drawing too firm a conclusion from this exploration of only two cases. They are, it is true, compelling stories of the differences that can be made by the vision, drive and organizing ability of a singleton mobilizing support into an effective collective endeavor that

makes a difference to disadvantaged lives. Some readers may wish to see more differences than similarities. But that may miss some important pointers for we observe:

- Social entrepreneur innovations can enhance public as well as private values, for example, by meeting needs unmet by statutory providers, linking up services with other providers, fitting user capacities and the way they live their lives (rather than expecting patients to fit into the service). It may be telling that it takes entrepreneurs to serve these values rather than the traditional so-called *public* services.
- For public healthcare policy, social entrepreneurs present heterogeneous and non-standardized alternative models to statutory healthcare provision in what they purport to contribute, the rationalities and governance they employ, and the impacts they bring. These characteristics may make them difficult for government commissioners to manage and reconcile with public policy goals.
- As a potential policy transfer from less developed to more developed economies, they are challenging as they have some critically distinctive contexts, sustaining factors, and undermining factors. UK governments in particular have been attracted to new schemes that are associated with quick gains. But the ventures described are distinctive to time and place and any implications for harnessing social entrepreneurs require careful analysis.
- Although Nicholls and Young argued that “academic work within the field of social movements tells us that permanent, systemic, social change ultimately comes from a realignment of wider societal cognitive frames of reference, rather than isolated private ventures” (Nicholls and young 2008: xviii), the enterprises reported here suggest that such “isolated private ventures” may instead be catalysts in realigning societal frames of reference.

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Figure 1: The Social Entrepreneurial Sector

(source: Leadbeater 1997)

