Reflections on the Symposium: Delivering Health through Social Entrepreneurship

1st Singapore International Public Health Conference - Organised by the NUS Saw Swee Hock School of Public Health and the Chapter of Public Health and Occupational Physicians, Academy of Medicine Singapore. ACSEP co-organised a Symposium on social entrepreneurship and venture philanthropy in health delivery held in conjunction with the conference on 2nd October 2012.

Social entrepreneurs have a novel but instrumental role to play in the healthcare industry, especially in a day and age where new public health challenges are constantly being presented to conventional medicine and healthcare professionals. Innovation and creativity are increasingly becoming crucial assets to delivering healthcare.

I had the privilege of being introduced to the panellists by the session’s chairperson, also the Co-Director of the Asia Centre for Social Entrepreneurship and Philanthropy (ACSEP), A/Professor Audrey Chia, just before the session commenced. Sharing the stage with her that day was Mr Sadeesh Raghavan, Global Advisory Board Member of the Acumen Fund; Mr Amit Jain, President and CEO of HealthPoint Services Global Inc.; and Mr Timothy Ma, Senior Project Consultant (and former Executive Director) of the Senior Citizen Home Safety Association (SCHSA), Hong Kong. The remainder of the time before the session began saw Sadeesh and Amit in deep discussion with several healthcare professionals, and Timothy sociably making his rounds with members of the audience with helpful bilingual introductory-SCHSA pamphlets in hand. What followed for the audience was a rewarding time of absorbing and discussing what came quite obviously, from a rich stock of knowledge and experience.

Here are some of my main takeaways:

1) **Useful tips** on running a successful social enterprise (this is in no way comprehensive or ordered):

   A. Stay focused on one service; don’t diversify too much, too early
   B. Look for an unmet need, and fill in the gap
C. Competition is helpful as a benchmark: how you fare while sharing the same space can be indicative of how relevant your service or product is (E.g. in the presence of competition from government hospitals, traditional doctors, the large majority of the population goes to eHP in the areas they are situated in)

D. There is little point in running the extra mile alone when partnerships can easily fulfil what is needed

E. Be culturally sensitive while creating solutions

F. When growth plateaus, it’s time for change (scale up or adjust!)

2) There is no single working model of social entrepreneurship. And right there isn’t! If all social problems or any two societies were identical, a single model just maybe, could suffice. I personally tend to fall prey to assuming that single definitions sufficiently encapsulate all there is to know about a particular something – in this case, what social entrepreneurship is. But as Audrey’s presentation showed, it doesn’t. At the outset, she established the existence of at least three different models: A) the leveraged non-profit model, B) the hybrid non-profit model, and C) the social business model. Timothy’s SCHSA and Amit’s E-healthpoint Services exemplified the latter two respectively. At first glance, what differs between the three can be put down to the method of obtaining initial capital, and the expectations of investors and the organization on profit collection and return-on-investments. However what connects all these models (as asserted by the Schwab Foundation) is the common feature of having applied practical, innovative and sustainable approaches to benefit society in general, with an emphasis on those who are marginalized and poor. In case the slant of the session so far seems to be moving slightly out of context (you might be thinking: now what does this have to do with healthcare?), it would be good to assert at this point that the efforts of social enterprises generally aim to address a market or government failure, and are (arguably) less conventional solutions to widespread problems. In this vein, those from the public and private healthcare sectors ought not to see social enterprises as competitors but rather as playing a complementary role in delivering and improving public health. This is especially so in the arena of frugal innovation. The parallel between the practice of social entrepreneurship and conventional healthcare delivery is therefore this: social entrepreneurs share the same value space as individuals in public health, especially because there exists the same idealism and concern for the needs of the underserved.

3) “Small is beautiful, and for less, deliver much” said the angel investor, Sadeesh. He was talking to those who were looking to venture into the vast and ready fields at the bottom of the pyramid (BoP).
Coming from the standpoint of having established that the BoP offers boundless market opportunities, and that there are those who have and will attempt to capitalize on it, he notes that the difficulty many social entrepreneurs face in this arena: containing the diversity of services offered. The opportunity is enormous, and there is an infinite number of possible service configurations. Many fall prey to scaling laterally. But his counsel is to stay small and simple, and to scale up. This is lifesaving advice for social entrepreneurs. The idealism that motivates can turn against the motivated: it is easy to be overwhelmed by the surrounding societal problems and to then attempt to adopt the role of The Fix-it Guy. The business that tries to adopt that role becomes limited in scalability from an investment point-of-view, and interested investors will be few and far between. In this manner (and as a side point), listening to Sadeesh speak was such a privilege! For potential investment-seekers, there is really no better person to seek for advice, than an angel investor himself. Sadeesh cited the example of VisionSpring, the social enterprise that offers affordable reading glasses for the poor. From a pilot project in India, the reach of VisionSpring has expanded to four nations (India, Bangladesh, South Africa, and El Salvador), and is impacting the poor in need of vision care by the hundreds of thousands. They stayed simple in their mission and execution and scaled up, not sideways. Another mistake Sadeesh mentioned – which also is indicative of the market’s failure – was where it was demanded the poor population pay much in exchange for little. A social enterprise that could turn that around to offering more for less (and this does not mean a compromise in profitability) could potentially reach a much larger market than its commercial counterparts! Amit’s thriving e-HealthPoint is a testament to that. But of course, like any balanced counsel, the challenges that closely accompany opportunities to succeed as a social enterprise in the BoP world were not left unmentioned. Sadeesh emphasised that patience and perseverance are key traits required of one to stomach longer gestation periods\(^1\) and the inertia to starting out in India.

4) **Customize first world solutions to third world problems.** Copying and pasting does not work at the BoP. I imagine if a shiny new hospital from a first world cosmopolitan city were to appear in the middle of a cluster of remote villages, the management would have an immense headache from attempting to attract and retain manpower, or to even to meet its bottom line. However, that is not to say that social entrepreneurs cannot leverage on the knowledge and technology available in the first worlds they come from. They should! And that’s exactly what the founders of e-HealthPoint (eHP) did. To address the problem of the last mile healthcare gap – where many in the rural setting are plagued with the problems

\(^1\) Note that he also was quick to assert that profitability and size was in no way a compromise for long gestation periods. Where there is scale, there ought to be reasonable profitability, perhaps even more than a commercial enterprise!
of contaminated water, understaffed clinics, lack of reliable diagnostics, and a lack of access to quality drugs – Amit and his co-founders set up eHPs which supply safe water, qualified consulting doctors (over webcam), reliable diagnostic tools, and heavily discounted quality medicine dispensed by (physically present) licensed pharmacists. They adapt developed technologies and services to rural settings in order to reach those who have limited access to affordable, quality healthcare. Webcams, computers, wireless broadband, quality drugs, reliable diagnostic tests (e.g. for HIV, kidney failure, pregnancy), water purification systems – these are but some of the effective and efficient instruments used in the telemedicine ecosystem set up at each rural eHP. The failure of government hospitals (in part through the challenge of retaining quality staff) has thrown light on the difficulties faced in engaging medical personnel willing to base themselves primarily in a rural setting. Hence eHP’s innovative technological solution not only solves the problem of hiring quality manpower, but also that of unreliable medical diagnoses. Social entrepreneurs delivering healthcare to the BoP need to bring first world solutions to solve third world issues. But they must also not be so eager to implement change and consequently forget that replication in its exact form is rarely useful; every setting has a different mould that solutions must be customised to fit into. I liked the story Amit shared to illustrate eHP’s success. A man had on previous occasions approached a government doctor with shoulder and neck pain but was turned away with prescriptions for Vitamin A and aspirin. However the pain persisted to a point where he was unable to work, and he finally came to eHP for medical attention. At eHP, the attending doctor uncovered a history of seizures and referred him to a specialist who confirmed the hypothesis of epilepsy. The man received the appropriate treatment and was eventually able to return to work!

*If you’d like to find out more comprehensively about the work e-HealthPoint is doing, this is where you can do so: [http://ehealthpoint.com/](http://ehealthpoint.com/)*

5) **See a need? Meet it, by sharing resources.** In a span of a few days in 1996, over 100 elderly people died of cold-related illnesses in a first world country. Sound strange? The founders of Senior Citizen Home Safety Association (SCHSA) thought so too. What was the problem? 13% of Hong Kong’s population was elderly, 40% of this group effectively live alone, 70% have 1-2 chronic diseases, and 25% live on social security. These statistics showed that there was potentially quite a large group living relatively isolated from the rest of society with little access to ready medical help, resulting in the high number of cold-related deaths. This loophole needed to be filled, and that was the need that sparked the birth of SCHSA and its 24 hour Personal Emergency (PE) Link Service. In a nutshell, this is the service it provides: 1) the user alerts SCHSA through the hotline, 2) if there is a medical emergency, the staff will
call the ambulance directly (bypassing the usual mandatory call to the police, who will only call the ambulance after eliciting a lengthy explanation from the caller), 3) the staff will inform the user’s emergency contact person to report the latest status of the emergency user, and 4) fax the electronic patient records to the relevant A&E department to speed up the rescue process. There is obviously a wide network of stakeholders involved in this operation, including both governmental and private bodies. The general public, the Hospital Authority, the telephone company, Ambulance Control Centre, Social Welfare Department, Housing Department, the media, and volunteers are but some examples of these. Through cooperation and leveraging on each other’s resources, it is possible to meet needs in an efficient way! Today, SCHSA does not just serve the elderly, but also children in need of periodic emergency medical attention. They have even expanded to include services such as an EldeRing Hotline Service that meets the emotional needs of their clients. SCHSA is a classic example of how non-health professionals can enter this public health space and contribute effectively by standing in the gap between the providers and recipients of healthcare services in a complementary way.

*If you’d like to find out more comprehensively about the work SCHSA is doing, this is where you can do so:* [http://www.schsa.org.hk/eng/service/pel.php](http://www.schsa.org.hk/eng/service/pel.php)

6) **Change is the name of the game.** A need truly met should see resulting life transformation. Amit’s eHP sells drinking water for a low price of US$1.50 for a month’s supply. They needed to convince villagers (it was not previously a common practice) of the necessity of purchasing this safe water for consumption because it reduces the transmission of water-borne diseases and is thereby a preventive health tool. It was a need prospective customers did not then know they had! Success therefore took on the form of customer purchases because it indicates a change in consumption habits. The social entrepreneur cannot be motivated by the prospect of breaking even or bringing in profit alone – he has to be concerned primarily with the impact on the lives of his clients; whether there is improvement in their quality of life. Look at SCHSA: the services provided by the social enterprise are integrated into daily life, potentially solving an emotional need. Take the Mobile Link Safety Phone (help activation system) for instance. Users keep it close to their bodies all the time as a security blanket; they can activate the “Help” button any time they require assistance, and there will be without fail, help dispensed promptly. By minimizing the alienation they experience mentally, it helps to alleviate some of the anxiety they might feel, thereby enhancing their quality of life as well.
The hope is that the world will never be short of social entrepreneurs ready to take on the next set of challenges in the public health sphere. With such developments and partnerships with public health professionals, perhaps society will not face a public health challenge too daunting to overcome.

Authored by Jessica Fong, Research Assistant at the Asia Centre for Social Entrepreneurship and Philanthropy, NUS Business School. Her thoughts and takeaways from the 1st Singapore International Public Health Conference’s session on Delivering Health through Social Entrepreneurship.