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Aravind Eye Care System as Transformational Entrepreneurship: Spiritual Roots, Multi-Dimensional Impact

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Abstract Initiated almost four decades ago in the form of an 11-bed clinic in Madurai, Aravind Eye Care System with its large network of hospitals, vision centres and community outreach programs is now recognized in India and beyond as a major actor of health care. This paper upholds the view that Aravind's innovative characteristics call for the creation of a specific category: transformational entrepreneurship. It first clarifies what may be called the 'Aravind paradox': Aravind achieves compassion through Taylorism, providing free eye care to poor patients while expanding its robust entrepreneurial model. It then analyses the social, cultural and policy implications of Aravind's success, notably from the perspective of its contribution to the common good. Finally, the paper identifies the definitional components of transformational entrepreneurship.

Keywords Common good · Transformational entrepreneurship · Social business · Health care · Taylorism · Spirituality

Founded in 1976 by Dr. Govindappa Venkataswamy in Madurai (Tamil Nadu, South India), Aravind Eye Care System (AECS) is one of the largest providers of eye surgeries in the world. Often qualified as the greatest success story in health care, it has proposed an alternative model within the Indian health system. It is a success firstly because of its size: there are today 10 Aravind hospitals and more than 40 vision centers in India, along with a network of community outreach centers, factories, research and training institutes. Secondly, it is seen as a success for its performance: it resembles a large, efficient business enterprise. Yet, it is not

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a classic business success: its foundational principles and work ethics set it apart from other healthcare actors run on business lines, focusing on products and prices. Aravind is not only a business with a laudable social goal. Inspired primarily by the Indian spiritual master Aurobindo's philosophy of interconnectedness of human beings, it proposes a logic of entrepreneurial action and a management style based on the practice of compassionate care and the will to contribute to the common good. This paper starts by listing the innovative features that have worked successfully in Aravind, and clarifies what may be called the 'Aravind paradox': achieving compassion through Taylorism. It then explores the links between this success and its spiritual foundations, and analyses Aravind's social, cultural and policy implications. Finally, it identifies the definitional components of transformational entrepreneurship, before questioning the transferability of a model rooted in Indian socio-cultural and family business traditions.

The Aravind Paradox: Compassionate Taylorism

Aravind Eye Care System (AECS) stands out as an unusual healthcare organization that has opened up new possibilities and horizons in the field of eye care. Numerous articles, case studies and reports have examined its innovative style in the sector of public health hospital systems, its effectiveness in reaching out to the rural communities, its high quality care and its efficient business strategies (Mehta and Shenoy 2011; Shah and Murty 2005; Rangan 2009). Registered as a non-profit charitable trust (Govel trust), the Aravind eye hospital was founded with the mission of eliminating needless blindness in India by Dr. Venkataswamy as an 11-bed clinic in the provincial town of Madurai, South India. The Madurai hospital is now large enough to manage 330 paying patients and 920 free patients. In 1985 a second hospital was opened at Theni and a third in 1988 at Tirunelveli. Seven other Aravind eye hospitals have been created since then (Aravind Eye Care System 2013): Coimbatore (1997), Pondicherry (2003), Dindigul (2010), Tirupur (2010), Salem (2011), Turticorin (2012) and Udumalaipet (2012). In a country like India where more than half of blindness cases are caused by cataract, Aravind's success represents a significant transformation. Since its inception, Aravind has handled more than 35 million patients and realized 4 million eye surgeries. In the year ending in March 2014, Aravind treated 3.2 million outpatients and performed over 370,000 surgeries; in Madurai alone, it performed 145,000 eye surgeries (Aravind Eye Care System 2014). As compared to the British National Health Service, which does a little over half a million eye surgeries annually, Aravind does roughly 70 % of the UK total for one one-thousandth of the cost and less than half the complication rate of UK hospitals (Rosenberg 2013). It also proposes clinical training to postgraduates in ophthalmology, trains students in medical research and grants doctorate degrees (Shah and Murty 2005; Mehta and Shenoy 2011).

Free Treatment for the Poor

The system has shown itself to be highly performing and exceptional in the field of health care. While offering high quality service, it privileges poor people who fall outside the usual health care structures because of lack of money, ignorance of available resources and difficult material access to health care structures in far off cities and villages. The Aravind network offers them free diagnosis at their doorstep in addition to free transport to the city hospital, free surgery and accommodation. Whilst providing free or very low-cost eye treatment to 45 % of

its outpatients and to 65 % of patients undergoing cataract surgery (Aravind Eye Care System 2013, p. 9), its ophthalmology hospitals also cater to rich patients who pay for services. Moreover, Aravind has expanded its capacities to integrate production with Aurolab, another non-profit organization founded in 1992, which manufactures intraocular lenses (IOLs) in a cost-effective way. Aurolab lowered their cost from around US$100 in rich countries to about US$2. Today, Aravind's manufacturing unit claims 7 % of intraocular lens sales worldwide and all benefits are reinvested in its eye care system.

Aravind is thus an economically healthy example of entrepreneurship and innovation in healthcare. Its three main sources of revenue are the sliding scale fee payment system, the sales of ophthalmic products, and the training of other public health professionals. Its first source of revenue comes from affluent patients – 55 % of outpatients and 35 % of patients undergoing cataract surgery – who pay for the surgery and to receive more amenities. A second substantial source of revenue comes from the sales of ophthalmic products. These two sources of income enable Aravind to support its benevolent practices of free eye care to the poor. A third source – Aravind's training activities – allows it to diffuse its work ideology and ethics to other systems and organizations. Whilst Aravind's business model is thus economically sound, financial self-sufficiency is not laid down as its primary imperative. AECS's income depends partly (10 %) on charity – but it neither depends on government subsidies nor on international aid.

Taylorian Principles

Another innovatory feature is Aravind's adoption of Taylorian management principles of economic efficiency and labor productivity. Dr. Venkataswamy's ethnographic observations of work organization systems in different situations (hotels, airport toilets, McDonald's restaurants) inspired him integrate the principles of standardized efficiency. The clinical staff does the diagnosis, nurses handle pre-op and post-op care, doctors prescribe and operate. Each doctor works alternately on two operating tables; while one patient gets operated on one table, nurses prepare the next patient so that the doctor can turn to the other table as soon as he has finished with one. Surgeons operate in a restricted space without losing time shifting from one operation room to another, thus avoiding delays and bottlenecks. This logically increases doctors' productivity. Surgical equipment is in operation 24 h a day, which further reduces surgical costs per patient. Consequently, Aravind's doctors perform more than 2,000 surgeries a year on average, as compared to 250 in other Indian hospitals and 125 in the U.S.

Such unprecedented performances have invited the paradoxical statement posted on the *New York Times* website: "*Aravind can practice compassion successfully because it is run like a McDonald's*" (Rosenberg 2013). Aravind has adopted the same factory like procedures, assembly-line efficiency, strict quality norms, standardization, consistency and systematic cost control as McDonald's restaurants. Like McDonald's, it works like clockwork. And it enjoys similar brand recognition. The 'Aravind paradox' consists of applying Taylorism to eminently humane ends. Its model of sustainable health care is based on wise, patient-centered utilization of advances in medical technology. It stands in contrast with other Indian health institutions which illustrate the limits of technological progress in promoting significant improvements in public health or health care delivery, except for high and middle-income segments. Such a situation suggests that a number of health organizations would benefit from drawing on Aravind's managerial principles and operational efficiency.

Aravind's Spiritual Foundations: From Ashoka to Aurobindo

The Aravind venture as a whole is based on spiritual foundations and has continuously been developed with a spiritual inspiration and finality. Management literature has shown keen interest in the potential offered by the Hindu, Christian, Buddhist or Confucian spiritual traditions for business management (Srinivasan 2003; Kale 2004; Danak 2010; Lépineux and Rosé 2010). Yet, translating spirituality at an operational level remains problematic (Thaker 2009). In Aravind's case, the founder's spiritual convictions and inspiration continue to impregnate the group's working practices. Aravind's philosophy of healthcare evokes Indian traditions of common good that can be traced back to the 3rd century B.C. (Alexander and Buckingham 2011) but are equally present in contemporary Gandhian ideals of *sarvodaya*. Even if Aravind's rhetoric privileges Aurobindo's views on the interconnectedness of human beings (Sri Aurobindo 1953), the idea of common good encapsulates the organization's approach and impact.

The notion of common good has been approached from various perspectives and disciplines: philosophy, political science, economics (mostly through the problem of the provision of public goods), the Christian social doctrine, and various religions or cultural traditions. A short list of the main general conceptions of this notion could read as follows: the utilitarian ideal of the greatest good for the greatest number; the teleological approach which envisions the common good as a finality; the relational model which emphasizes the importance of deliberation, cooperation and shared responsibilities between social actors; and the communitarian approach which highlights the complex social networks that sustain and support the individual (De Bettignies and Lépineux 2009; O'Brien 2009). In the Indian social and political tradition, the idea of common good can be traced back to two ancient traditions (Alexander and Buckingham 2011) and a more recent one.

Indian Traditions of Common Good

The earliest tradition of common good in ancient India is associated with the figure of Kautalya or Chanakya, political advisor to the emperor Chandragupta Maurya (340 B.C. – 298 B.C.). Author of a political treatise, the *Arthasastra* (4th century B.C. and 150 A.D.), Kautalya, in a set of 15 books outlined the art of statecraft and strategies of rule for the emperor, detailing the myriad practices for effective State control and rule. The work also emphasized the welfare of those crucial for the maintenance and continuity of the king's power and the ethics necessary for the cohesion of society. Kautalya is credited with the idea of the welfare State that governed and managed the daily life of its subjects, guaranteed a just and fair redistribution of resources and provided the infrastructure necessary to maintain discontent under control. In the *Arthasastra*, the common good is perceived as a principal duty of rulers in order to avoid a breakdown of consensus between ruler and subjects. Kautalya proposes a pragmatic approach, based on a selective, elitist understanding of the common good – that is it to say, it considers only those subjects who are important to the maintenance of the king's power.

A more egalitarian understanding of common good can be identified in a second political tradition that goes back to the 3rd century B.C., when it was developed into a State policy by the Mauryan emperor Ashoka. After his conversion to Buddhism (around 261 B.C.), Ashoka instituted a set of guidelines directed to meeting people's economic needs and welfare. This implied that the king held himself responsible for the well-being of all the different

communities within his kingdom. It engaged him in ensuring an adequate infrastructure of routes, rest houses or medical centers throughout his territory (Dhammika 1993). Here, the common good implied the greatest good for the largest number, and the reflection on the king's responsibility was further refined by the notion of *dharma* or right action. According to this notion rooted in the Hindu tradition and found equally in Buddhism and Jainism, the ruler's acts were to be guided by concern for the good of the community and the empire; but the *dharma* also imposed a respect for life and resources, and the protection of the weak and feeble or the minority religious groups. Common good and *dharma* thus served as a moral and ethical framework for the actions of the king as well as those of his subjects.

As the duties of the king and his administration were proclaimed through engravings on rocks and pillars across the kingdom, they were commonly shared and constituted a pool of duties, expectations and accountabilities for both rulers and ruled. The king's public proclamations included his entire population in the definition of common good, not simply a small group of literates and scholars, the wealthy or the powerful. His edicts also manifested an equal concern for all and reflected identification with all (Dhammika 1993, p. 11):

> "I consider the welfare of all to be my duty, and the root of this is exertion and the prompt despatch of business. There is no better work than promoting the welfare of all the people and whatever efforts I am making is to repay the debt I owe to all beings to assure their happiness in this life, and attain heaven in the next. Therefore this Dharma edict has been written to last long and that my sons, grandsons and great-grandsons might act in conformity with it for the welfare of the world."

In the later paternalist system developed by Indian princely rulers and the British colonial administration, a weaker version of this ideal can be found in the form of the '*ma-baap*', or the State as mother and father, committed to a benevolent protection of the subjects.

Finally, a third tradition of common good can be traced to the Gandhian idea of *sarvodaya*, or universal uplift or welfare of all. Developed in an anti-colonial framework, it has continued to inspire social movements of self-determination and equality for all strata of Indian society after independence. This social ideal is officially affirmed by the post-colonial State; though it has not pervaded working behaviors, it has remained the proclaimed ideal. The approach to health care not as a market commodity, but as an essential element of human empowerment and capacity of action infuses Aravind's work practices. Dr. Venkatswamy's emphasis on enhancing patients' autonomy and raising their capacity to contribute to the collectivity, from their family to society, laid down the direction for the group. Eye care is conceived as an essential common, public good, enhancing self-worth and dignity and of equal benefit to the community. It shifts the understanding of eye care from a language of private rights and interest to public and common interest.

Aravind's Primary Inspiration: the Philosophy of Sri Aurobindo

The very name 'Aravind' is a south Indian version of Aurobindo, the mystic saint philosopher, who abandoned his radical and at times revolutionary resistance to British colonialism in favor of spiritual introspection and yoga in 1910. Sri Aurobindo's integral yoga aims at the supramental transformation of the human being. It affirms the essential unity and wholeness of man, integrating the physical, the vital, the mental, and the spiritual planes. The human being, Aurobindo stated, is capable of being perfected and transformed to achieve the complete harmonization of these different aspects. This philosophy of integral yoga, which has inspired

Venkataswamy's actions, urges the evolution of human life to a divine life, albeit still active in the world – or to put it better: therefore more active in the world, with larger vision, greater efficiency, higher creativity, and visible results. Aurobindo's vision of an all-embracing reality personified by a supreme being (*Purusottama*) is both spiritual and pragmatic for it inspires action with a firm commitment to spiritual values such as love, devotion to truth, and selfless social service (Sri Aurobindo 1953, pp. 322–323). His view on the essential unity of man and the harmonization of its multiple facets through the practice of yoga was then extended to a broader scale in order to achieve a harmonious, unified world-order. This was inclusive of life and society in all its aspects, aspiring to a world in which unity and diversity, peace and justice, love and freedom may coexist harmoniously.

This vision of man's conscious cooperation with the creative energy toward a complete personal transformation that would then have a social and global impact can be found in Dr. Venkataswamy's approach of assuming responsibility for society's needs. In particular, the spiritual belief in the '*oneness of all*' lay behind Aravind's action. This essential idea has led Aravind to identify with the poor, to grow with them, give in order to transform their lives and to contribute to their dignity and well-being. This principle has become a hallmark and driving principle of Aravind and influences behaviors within the organization. Hindu sacred epics are full of statements in this vein that affirm the oneness of mankind and the importance of human solidarity, rooted in a belief of a common sharing of divine nature. One of the major Hindu sacred texts, the *Bhagavad Gita*, states (Radhakrishnan 1927, pp. 101–102):

> "He who knows himself in everything and everything in himself will not injure himself by himself. […] Every person around me is myself at a different point of space and time and at a different grade of being. […] You shall love your neighbour as yourselves because you are your neighbour".

This spiritual ethics emphasizes sameness in everything since the universe is built on the principle of the development of one seed into an infinite variety of forms and shapes (Sri Aurobindo 1953). On an essential plane, it sees no distinction between human beings. Dr Venkataswamy's journal entry in the 1980s exemplifies this idea (Mehta and Shenoy 2011):

> "Attachment to your village, your hospital, your State or country – that must go. You must live in your soul and face the universal consciousness. To have this vision and work with strength and wisdom all over the world. To see all as one."

This understanding lies at the heart of Aravind's business model which is articulated on the principles of compassionate service – not self-interest that is commonly the rationale behind business ventures. Service of the other as service to oneself was affirmed as the central motor of action by Dr. Venkataswamy. Instead of focusing on the ideas of social outcomes and social value that are central to social entrepreneurship, Aravind determines its actions according to the requirements of practical compassionate service. For instance when economic logic discouraged the setting up of another hospital in Pondicherry, the urge to propose their skills to larger groups drove them to do so in spite of economically well-founded reservations. Dr. Venkataswamy's spiritual approach to business has thus far endured. One of the most visible signs that Aravind is – still today – imbued with a spiritual aim and ideal resides in the fact that its employees respect and espouse the charismatic founders' values; even after his death, the model has continued to function and expand.

Transformational Implications: Social, Cultural, and Political Aspects

Firstly, Aravind's transformational impact may be identified through its focus on transforming people's lives. Aravind places emphasis on serving people, and seeks to help them thrive as human beings. The person with his/her needs is at the center of its model. Patients are not seen as clients or as consumers of health services. Aravind thus breaks away from the traditional logic of health care costs and reimbursement. An exceptional aspect in its hospitals is that those who cannot pay are not asked to supply proof of their poverty. Aravind works within the local cultural traditions, involving concerned communities in the planning and delivery of public health programs, respecting people's customs and showing cultural sensitivity. The individual is considered part of a family or community; the offer of eye care is built on this idea and care services are structured around it. Patients are accompanied by a relative when they come for surgery and Aravind takes charge of both. Thus, while family bonds are respected, the individual's autonomy is strengthened. This objective is translated in statistics: 85 % of men and 58 % of women find a job after undergoing eye surgery with AECS. It contributes to a healthy give and take in relationships, recognizes the dignity of each member of society and nourishes it. This is a radical shift from the competitive approach that pervades mainstream managerial culture, which is replaced by a spirit of compassion for the other and a desire to help him grow.

Transforming Society and Culture: From Entitlement to Responsibility

By its elaboration of eye care as public good, not market good, Aravind upholds the values of common good. In present day India, the liberalization of the service sector, from education to hospitals to water and transport, has transformed public services and goods hitherto dispensed by the State into marketable products purchased at a price. This evolution has furthered a climate of individual withdrawal and self-sufficiency, undermining the notions of community service and collective resources. It has dealt a blow to the idea of common good understood as the sharing of resources that all people need. Social movements or groups organizing actions for collective interests have attempted to redress this situation in favor of communities. Navdanya's campaign in defense of rural farmers' right to use indigenous seeds is one such example; WWF India's Sundarban program which strives to blend conservation with sustainable development is another. Aravind shows how entrepreneurial efforts can redress an unbalanced distribution of state resources and develop community welfare, particularly in perverse conditions of poverty. Its determination to promote human well-being focuses primarily on giving; this understanding of common good places it beyond a matter of human rights or collective action. Aravind exemplifies the will of a health actor to contribute to the common good at the individual, community and society levels.

Aravind's guiding principles and work ethic contrast with widespread attitudes in healthcare that businesses must act as businesses. In recent years, whilst pharmaceutical companies have shifted to offering low-cost generic medicines, to making vaccines and medicines available to the poorest in the world, thus becoming actors of 'global health', they still remain primarily wedded to the business of healthcare. For example, Novartis' *Arogya Parivar* rural healthcare initiative targets very low-income groups. Although it provides healthcare to the poor, profitability remains a priority: it targets the bottom-of-the-pyramid market, with the dual objective of delivering social value to rural patients and economic value

to investors. In contrast, Aravind shifts attention to 'attitudes of care' by privileging service and caring, by prioritizing humane attitudes in work.

Aravind has proved to be transformational in the ways it has affected social structures and cultural behavioral patterns in India. It has transformed the relationship between service providers and patients in different ways: It encourages patients' involvement and engagement in the process of healthcare delivery. It motivates actors to heighten their commitment and responsibility. Whereas it proposes services well beyond the act of free surgery (e.g. free transport for the person accompanying the patient, free meals and accommodation in the city), it also delegates responsibilities to local people: when setting up eye camps in rural areas, it lets village chiefs or notables take over material aspects. Eye care is thus not conceived as a top-down process, something to be handed out as aid or a philanthropic gesture. Nor is it seen in terms of attempting to induce rural populations into changing their habits through educational classes, propaganda or social workers' interventions. Such a change of habits does take place, but gradually, by building a relationship of confidence between doctors and patients. By building trust, by showing the results of cooperation and solidarity, Aravind encourages responsibility amongst patients – not only for themselves and for their family, but also for their community. It transforms patients into actors engaged in reciprocal ties of solidarity.

A Breakthrough Innovation for the Politics of Healthcare

How has Aravind contributed to modifying the socio-political regime of healthcare provision in India? In the context of a largely inegalitarian national system, the model it has built is democratic. Aravind's egalitarian healthcare approach has achieved this remarkable result that richer people, who in the Indian hierarchical social system would tend to withdraw from any popular service available to all, have continued to favor Aravind hospitals. This social consequence of Aravind's high quality care and attention cannot be underestimated. In the first five decades after independence, India's government hospitals were conceived to offer low-cost service to all citizens. But their reputation for indifferent service and the absence of accountability to citizens alienated the richer groups who opted for private hospitals and clinics, which offered them better care and facilities, though at a higher price. The divide between richer people who turn to private services (health clinics) and poor people who are forced to go to government institutions for lack of money has grown in the last few decades. By standing for transparency in its work methods and dedication to community service, Aravind has effectively shattered this pattern. For the first time in India's post-independence years, Aravind's actions have engendered a democratic institution and quality of healthcare that attracts rich and poor patients alike. In a hierarchical society like India, this is no mean transformation.

By privileging the individual as a person instead of a consumer of health services, by building its model around service to persons, Aravind breaks free from mainstream economic logic and dominant managerial techniques. It applies what economist Amartya Sen and philosopher Martha Nussbaum have defined as the development of capabilities (Sen 2009; Nussbaum 2011). The capabilities approach provides an alternative to contemporary theories of justice, in particular to Rawls' theory (Rawls 1971); it is directly related to the question of the common good (Mulligan 2010). Sen focuses on enhancing the individual's capability and freedom to choose the life he/she values through the eradication of unfreedoms, that is to say the fight against all the injustices (social, economic and political) that prevent personal fulfillment (Sen 1999). Nussbaum emphasizes the achievement of substantive freedoms, which

enable each individual to develop his/her potential as a human being through active engagement in society (Nussbaum 2011). Aravind contributes to build capabilities in both ways. It combats the injustice of poor eye care that leads to blindness, dependence and a loss of dignity and economic power. Also, by restoring eyesight Aravind furthers personal freedom and develops creativity, making the poor key actors of change.

Finally, Aravind's success and growth have had an impact on government: the State doctrine regarding the provision of health services has evolved. Government healthcare policy has been criticized for looking at the problem through the lens of early post-independent India, imposing schemes conceived far from rural realities, and falling into the trap of accepting technological answers to problems that are fundamentally social (Gangolli et al. 2005). Initially, Aravind's entry into the intraocular lens market was not supported by international organizations (the World Health Organization or the World Bank that funded eye programs), which insisted that the domestic production and implantation of lenses in developing countries was not viable because of the costs of production and the inability to monitor post-surgical complications. The Indian government also thought that the setting up of Aurolab would sabotage its national eye program. However in 1994, India implemented funding for eye hospitals to purchase intra-ocular lenses and this helped increase the demand for Aravind's lenses. Moreover, in 2001, Aravind's performance led the State to launch an ambitious national program termed 'Vision 2020' to prevent blindness due to cataract.

Recently, as Mr Thulasiraj, executive director at Aravind acknowledges, the Indian government has explicitly manifested interest in Aravind's philosophy, quality of care and cost effectiveness (Tabary 2013):

> "The general healthcare system is increasingly interested in replicating our approach. The government and the Centre for Innovation and Public Services reached out to us to help them improve public services. In a way, we work as consultants for the national prevention of blindness; for example, we collaborate with several hospitals to improve their productivity and quality of care."

The successful development of the Aravind group clearly holds policy implications at the national level, as it has inspired governmental action over the past two decades and is now considered as an essential lever for innovation to improve the Indian healthcare system.

Defining Transformational Entrepreneurship

The scope of Aravind's transformational implications is broad, as it ranges from social and cultural change to policy implications. Aravind has led patients to change their relationship to healthcare institutions by encouraging their involvement, commitment and responsibility to community welfare. Its eye camps in villages are one example of how public health interventions can promote solidarity among the population. It has instituted a platform of healthcare that attracts both the rich and the poor and works as a democratic system. It promotes the development of human capacity for action, thus furthering the common good. It has a multi-dimensional, multi-level impact. These characteristics lead us to consider it as a role model for transformational entrepreneurship.

In their study of Navdanya – the Indian NGO and network of farmers promoting organic agriculture and the use of indigenous seeds, Virmani and Lépineux (2015) have singled out some elements that constitute transformational entrepreneurship – a notion still in its developmental stage. The spiritual principles that Navdanya acknowledges as its foundational base

lead it to work for a shift in values whereby food is viewed not purely as a commodity or a means to profit but as life itself. This changeover appeared as a distinctive feature of transformational entrepreneurship. Similar spiritual orientations and emphasis on essential values are also in evidence in Aravind, which places persons at the center of its model.

The above analysis of the transformational implications of Aravind's actions, combined with the investigation of its business model and spiritual foundations, leads us to propose a characterization of transformational entrepreneurship in the following terms. Transformational entrepreneurship involves an *innovation stage* that proposes something decisively new and creates a *ripple effect*: like a stone thrown into the water, it generates waves from the center, affects people, institutions, communities and the state. Transformational enterprises draw their strength from firm *spiritual foundations, orientation* and *finalities. Values* of life, dignity, solidarity, human well-being, community welfare, the oneness of mankind converge to *transform the lives* of those who participate in the venture – enhancing their substantive freedoms and developing their capabilities. Transformational enterprises thus *impact other organizations*; their model is imitated, adopted, replicated. They *further the common good* through their *multi-dimensional*, *multi-level impact*. Multi-dimensional impact refers to the economic, social, cultural and political dimensions. Multi-level impact concerns individuals, organizations, communities and society. Transformational enterprises *act as a lever for systemic change*. Put differently, they *make the transition happen* in the field in which they operate – the transition from the multifaceted global crisis, towards a livable, humane, sustainable world-system. These are the distinctive features which, in our view, characterize transformational entrepreneurship.

Conclusion

Over the past four decades, Aravind's outreach to poor people cut off from healthcare structures has been a breakthrough in a country with 15 million blind people, the majority from cataract. Aravind's spiritual-based business model, its expansion pattern, its national and international reputation, its popularity amongst both poor and rich patients testify that more than new legislation, regulation or medical education, a holistic health care approach can have a greater long-term social impact on attitudes towards health. It stands for a new type of health care business structured on compassionate care and enthusiastic service. Aravind points to a new level of action that is not exclusively about growth, quantity or markets. It is about high quality care for all. By focusing on the dignity of the individual and how to enhance it, Aravind places the common good at the heart of its actions. Its premise that what really counts are people, constitutes a radical break from the dominant reasoning of mainstream business management, for it implies a clear acknowledgement that human fulfillment cannot be reached through higher incomes, more products or more material comfort – instead, it can only be pursued if people are able to live with dignity and respect. Aravind claims to contribute not only to better eye care, but to the individual's capacity to act. Therefore, it invites us to rethink the anthropological and ontological foundations of management.

Eventually, the question of the transferability of the Aravind model deserves to be posed – in the form of two sub-questions. Would the model work in another area than eye care? Could it work in other parts of India and in other countries? Aravind has initiated a degree of change in current practices in the health sector by inviting other health professionals to adopt its methods. About 900 young ophthalmic assistants are trained every year in its hospitals.

Aravind also functions as a training center for employees in various community care organizations and hospitals across India and in the world. Some of these include the *Prasad Project* non-governmental organization based in the Tansa Valley, Maharashtra, which holds rural eye camps, and the *Jaipur foot* organization, which provides the disabled with prosthetic limbs in its numerous branches throughout India.

Aravind can practice free care because it is charging some patients and because eye care is on a very large scale. Cataract affects everyone; it is a one-time problem and there is a cure for it. Aravind's economic logic can work because a huge number of interventions can be practiced, i.e. for diseases affecting the majority of the population, thereby permitting economies of scale. The question whether its cost effective approach would work for less common health care problems is an open one. The founding of a low cost cardiology care system under *Narayana Health* by Dr. Devi Shetty in Bangalore in 2001 absorbs some of the principles of the Aravind model. A case study of this organization could provide interesting answers as to the transferability of Aravind's eye care approach to other fields of healthcare.

The Aravind model is rooted in Indian historical and spiritual traditions of common good and national anti-colonial struggles. It echoes Hindu spiritual ethos that upholds values of compassion and oneness with the cosmos, and in particular adheres to Aurobindo's philosophy. Can this model be transplanted outside the tight-knit family system of southern India? How replicable is it in other parts of India and other countries? Several examples can be quoted to illustrate the fact that Aravind's approach and methods are widely replicated. About 300 hospitals in India and other countries have been entirely or partially inspired by AECS, which has emerged as a model for other eye care organizations that aspire to be cost effective and reach rural populations. Two examples are *Sankara Eye Care Foundation*, set up in 1985 in Coimbatore, Tamil Nadu, which has 11 hospitals today, and *Ranjini Eye Care*, set up in 2004 in Ernakulum, Kerala. Both are on a smaller scale but indicate the relevance of the Aravind model for eye care organizations.

Outside India, the *Lumbini Eye Institute* in Nepal, as well as Muhammad Yunus' replication of the Aravind model in the form of a social business in Bangladesh – the *Grameen Green Children Eye Care Hospital* –, illustrate Aravind's potential for spreading internationally. With the financial support of the Berkeley-based *Seva Foundation*, Aravind works to set up eye hospitals in other countries and improve their efficiency, in developing countries but also in Britain where the British National Health Service needs ideas to cope with fund shortfalls. A *sui generis* business model at the outset, Aravind represents a breakthrough innovation which, as it was replicated, has inspired some changes in healthcare functioning. The Aravind model has impacted a number of health and third sector organizations throughout India and internationally, showing that the values embraced by Aravind are not exclusive to Indian philosophical and social traditions and the possibilities of humanizing the global market of healthcare.

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