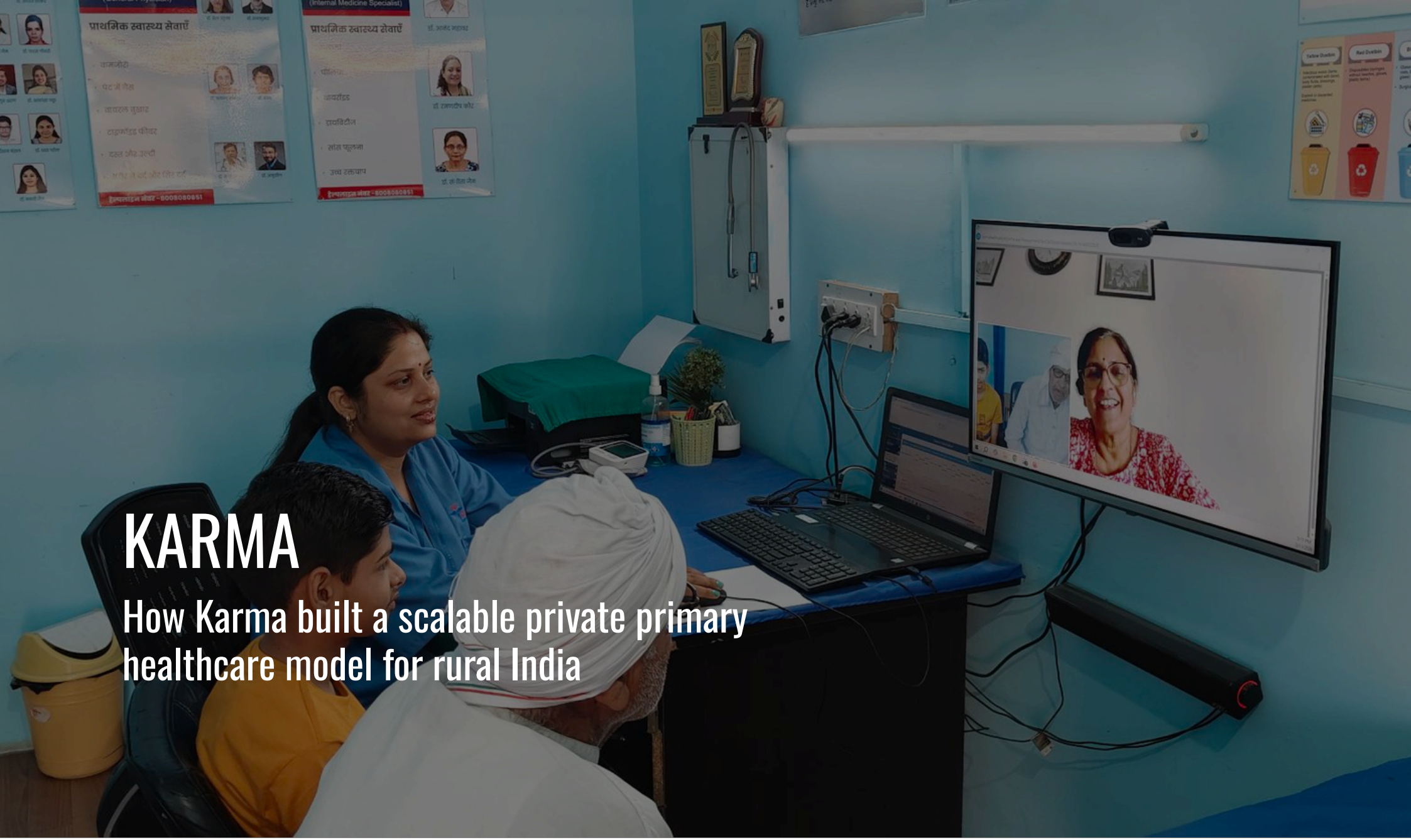


# KARMA

## How Karma built a scalable private primary healthcare model for rural India

Karma
Primary Healthcare

Grand Challenges Canada®
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SPRING
IMPACT

# SCALE BREAKTHROUGH

## Enabling 6.2 million+ health transactions across rural India

In Bhondsi, a town in the state of Haryana, India, 60-year-old Jagmala used to spend hours traveling to distant hospitals for diabetes and hypertension care. While there, she would experience long queues and high costs. After a Karma e-Doctor center opened minutes from her home, that reality changed. She now receives regular care nearby. Her health has stabilized and costs of treatment are lower.

Jagmala's experience reflects Karma Primary Healthcare's breakthrough. Rural India faces significant constraints to the delivery of primary healthcare, including persistent doctor shortages, low trust in formal care, and uneven quality in public facilities.

**Karma has built a healthcare model that overcomes these barriers.** Community-based centers staffed by trained paramedics use a digital platform to connect patients with remote doctors through real-time teleconsultations, while also linking care to patient records, prescriptions, diagnostics, follow-up, and referrals.

Together, these features bring more reliable and accessible care closer to underserved communities.

**The impact:**

- Karma's platform powers:
  - **76+** telemedicine centers, reaching 76,000+ people annually
  - **100+** partner-operated Mobile Medical Units across 16 states/Union Territories(UTs), enabling 6.2+ million transactions to date
- **95% of patients** could not find a good alternative to Karma; 79% report improved quality of life
- **65% of adolescent girls** treated by Karma reported better health compared to the previous year; 90.57% of caregivers accessed formal healthcare for their children.

**What enabled Karma to scale this model across rural India?**

# THE PROBLEM

Access to primary healthcare in rural India, home to over 800 million people, is shaped by a mixed delivery system in which public facilities operate alongside a large private and informal provider market.

**Access to reliable care is constrained by three challenges:**

**1. Uneven capacity and quality of public facilities**
Although India meets the WHO doctor-to-population norms nationally (1:811), doctor distribution is heavily skewed toward urban areas. Rural primary health centers are frequently understaffed or experience vacancies, or lack essential infrastructure and supplies. This results in inconsistent service availability and variable quality.

**2. Care is far and expensive**
In many areas, patients must travel more than 28 km[1] for outpatient care. In addition, over 39% of health expenditure is out-of-pocket[2], placing significant financial strain on rural households and delaying or deterring care-seeking.

**3. Low trust and reliance on unqualified providers**
Variability in availability and quality has contributed to limited confidence in public facilities, with only 32.5% of people seeking treatment for an illness in rural India using a public provider.[3] Care is often delayed until conditions worsen, with caste and gender bias further deterring access to formal providers, normalizing reliance on unqualified care.

To address these challenges, Karma needed to build a solution that could **expand access without relying on more doctors, while still delivering reliable and quality care.**

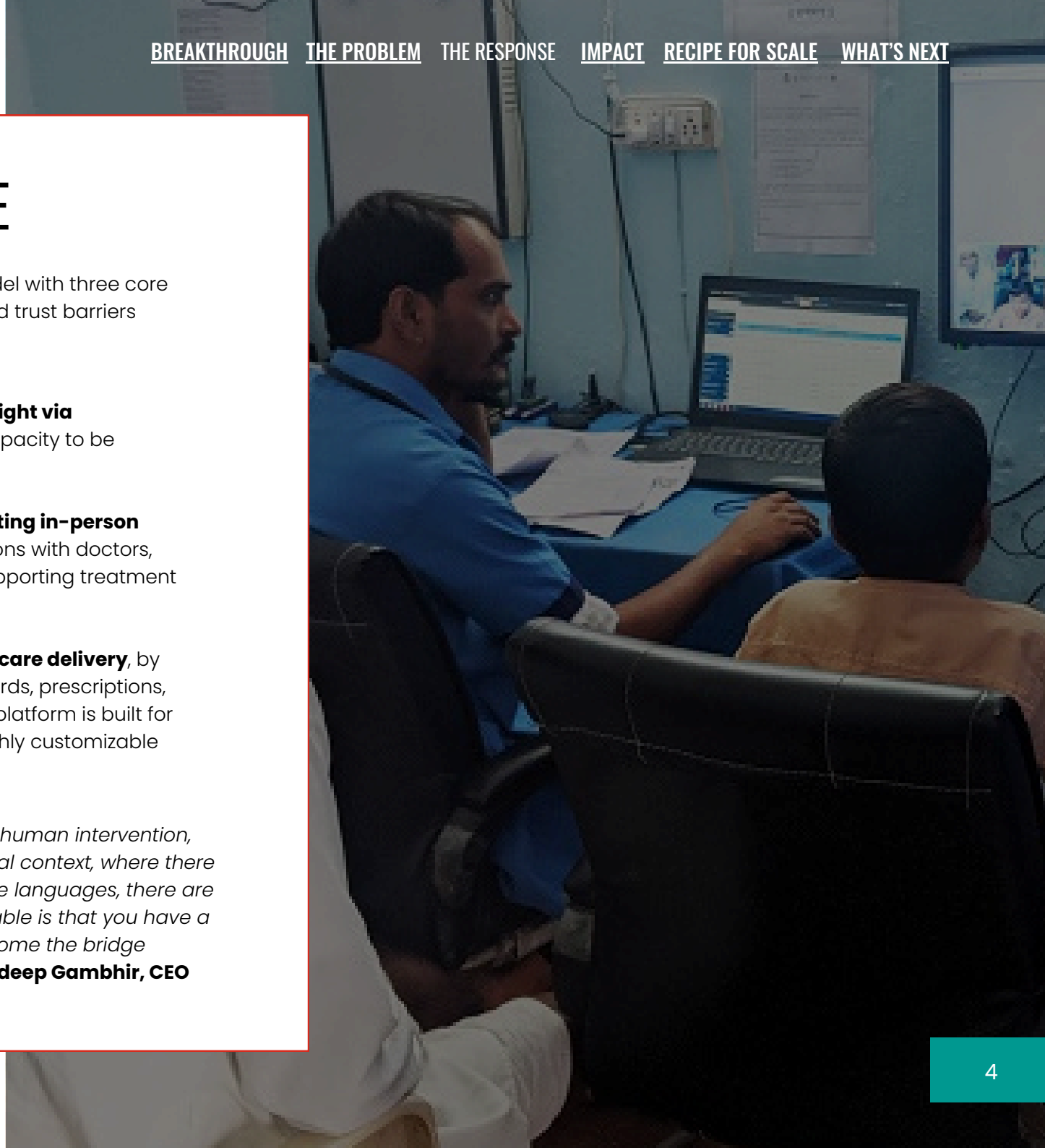
1. Misra et al., Distance to the Health Facility and Health Care Utilisation in India, based on Longitudinal Ageing Study in India (LASI) Wave 1 (2017–18), International Institute for Population Sciences & Ministry of Health and Family Welfare, Government of India
2. National Health Accounts Estimates 2021–22, Ministry of Health and Family Welfare, Government of India
3. Key Indicators of Social Consumption in India: Health (NSS 75th Round, 2017–18), National Statistical Office, Ministry of Statistics and Programme Implementation, Gov. of India, Page 50, Table A8

# KARMA'S RESPONSE

Karma designed a tech-enabled care model with three core features that address doctor shortages and trust barriers simultaneously:

- **Remote doctors providing clinical oversight via telemedicine**, enabling limited clinical capacity to be shared across multiple rural locations.
- **Community-based paramedics facilitating in-person care**, supporting real-time teleconsultations with doctors, translating, explaining diagnoses, and supporting treatment adherence.
- **A digital platform enabling end-to-end care delivery**, by linking teleconsultations with patient records, prescriptions, diagnostics, follow-up, and referrals. The platform is built for low-connectivity environments and is highly customizable based on the needs of the center.

*"There is a judicious mix of technology and human intervention, which I think is especially important in a rural context, where there are so many languages, and then within the languages, there are so many dialects. So how you make it scalable is that you have a paramedic assistant who can actually become the bridge between the patient and the doctor."* **– Jagdeep Gambhir, CEO**



# HOW THE SCALE MODEL WORKS

From the outset, Karma understood that the scale of the problem exceeded what any single organization could address.

They therefore designed the model to be delivered in two complementary ways:

**1. Direct delivery by Karma**
**2. Indirect adoption by others, extending reach without requiring new infrastructure.**

## 01 Direct Delivery through Karma-Operated Telemedicine Centers

Karma sets up and operates standardized primary care centers embedded in rural communities. Each center is designed as a repeatable delivery unit, typically serving around **30,000** people.

Karma deliberately designed centers to operate with **minimal infrastructure and staffing**. Each center is equipped with a **small, standardized digital and clinical setup**, including a laptop, a large-screen television, a web camera, internet connectivity, a printer, and basic medical devices. Clinical expertise, systems, and oversight are provided centrally across the network.

Centers use Karma's technology platform to provide access to a defined set of services, including remote specialist consultations, on-site pharmacy, lab-based diagnostics, and value-added services such as eye care, doorstep consultations, and family and health subscriptions.

**Each center operates with a lean cost structure and generates revenue** through standardized patient fees. Centers reach break-even at an average daily footfall of around eight patients, a threshold typically achieved within three years or earlier. Centralized technology and oversight costs are distributed across the center network, creating economies of scale as additional centers are added.

## 02 Indirect Delivery through Other Public Health Actors

Karma also provides their technology platform and network of doctors to enable public health organizations, non-profits, and CSR programs to deliver a higher level of care through existing facilities. Organizations pay for this either as a one-time licensing Software-as-a-Service (SaaS) fee and/or a recurring monthly subscription.

**This is possible because Karma's platform is designed as a plug-and-play solution,** allowing partners to integrate only the functions they need. It can be used across mobile medical units, fixed-site clinics, and partner-run centers, supporting replication without requiring significant new infrastructure or technical expertise.

**Examples of how other actors use the platform include:**

- **Smile Foundation,** which operates 100+ mobile medical units, uses Karma's platform to gain real-time visibility and analytics across operations.
- **Central Tibetan Administration**, which operates clinics in mountainous regions, uses Karma's platform and doctor network to offer a higher level of care than would otherwise be possible.

# IMPACT (1/2)

Karma's centers are making timely healthcare more accessible in parts of rural India, bringing care closer to home and reducing the need for long journeys, high costs, and delayed treatment.

A mother in Rajasthan no longer travels 40 km to consult a gynecologist. A daily wage worker in Gujarat can seek care without losing a full day's income. A teenage girl in Odisha receives an HPV vaccination without leaving her village or navigating social stigma.

**These experiences are not isolated cases, but reflect how Karma's care model operates at scale.**

## EVIDENCE OF IMPACT

- **An assessment by 60 Decibels in 2023**[4], based on interviews with 285 clients, found that:
  - 97% of patients said Karma's service is unique
  - 95% reported they could not find a good alternative
  - 79% said their quality of life had improved as a result of using Karma's services

- **An impact evaluation conducted in 2019 by Max Institute of Healthcare Management** at the Indian School of Business on Integrated Use of Digital Connectivity and Data to Improve Women and Child Health[5] found that:

  - 51% of women in intervention areas reported better health compared to the previous year
  - 65% of adolescent girls treated by Karma reported better health compared to the previous year

4. 60 Decibels (2023) Karma Healthcare Impact Performance Report. Available here.
5. Deo, S., Sachdeva, A. and Gupte, S. (2019) Integrated use of digital connectivity and data to improve women & child health. Max Institute of Healthcare Management, Indian School of Business.

# IMPACT (2/2)

## SCALE OF DELIVERY

### 76+ telemedicine centers

- **16** are self-financed, sustained through patient fees, and directly reach more than 16,000 people annually across 5 states
- **60+** are managed centers, initially funded through partnerships, and reach more than 60,000 people annually across 11 states/UTs

### 100+ partner-operated Mobile Medical Units

Across **16 states/UTs,** enabling more than 6.2 million transactions to date.

# KARMA'S SECRET SAUCE

Behind Karma's scale journey are a set of intentional design choices that form the 'secret sauce' that enables their model to perform consistently across geographies:

## FEASIBILITY-DRIVEN CENTER PLACEMENT

Before opening centers, Karma assesses public provision, informal providers, and unmet demand to identify clear service gaps. They also factor in village-level dynamics, such as location and proximity to informal providers, to avoid undermining uptake.

## STRUCTURED COMMUNITY ENGAGEMENT

Karma places strong emphasis on community outreach, designing acquisition strategies around village characteristics such as literacy levels, communication norms, and care seeking behavior.

## VALUE-ADDED SERVICES AND REFERRALS AS A SUSTAINABILITY LEVER

Recognizing limits to new patient volume, Karma expanded beyond primary care into higher-value services and referrals, increasing repeat visits, improving outcomes, and strengthening center viability through higher-margin revenue.

## INVESTING IN GENDER-INCLUSIVE TEAMS

Karma prioritises recruiting and retaining women in frontline roles to improve trust and access in rural communities. Venture advisory support from Grand Challenges Canada helped strengthen gender equality practices, improving staff retention, increasing the number of women working at centers, and therefore encouraging more women patients to seek care.

# LESSON 01
# Start with a tight core and expand scope with discipline

From the outset, Karma was deliberate about starting with a tightly defined core service model focused on primary healthcare consultations, medicines, and basic diagnostics. They focused on testing whether this could be delivered safely, consistently, and at scale across multiple rural locations.

Early design decisions were guided by a clear principle: **even if a service could increase impact or revenue at a single center, it was not added unless it could be standardized**, quality-assured, and replicated across a distributed network.

As an example, Karma chose not to offer emergency or acute care through their centers. Doing so would have required costly specialized infrastructure, 24/7 staffing, and would have introduced clinical risk, limiting safe replication across a distributed rural network.

Only once the core model was operationally stable and could absorb additional complexity did Karma begin to layer in value-added services and referrals as a way to increase both impact and revenue. Karma took a phased approach by running pilots and assessing the feasibility, demand and the cost implications of each new service added.

### Takeaway

Scale is built on discipline: prove a simple, standardized core model first, then expand scope only when the core model is robust enough to carry it.

# LESSON 02
# Recognize and design for differences in adoption dynamics

Karma recognized that rural communities differ in their pace of adoption of new private healthcare services, and that a single financing approach would constrain expansion into lower-income areas. In these communities, adoption required more sustained awareness-building and early price incentives to encourage uptake.

Rather than changing the care model itself, Karma designed two financing pathways for the same center model:

**1. Self-financed centers**: In middle-income rural communities, centers are initially launched with equity investment and are designed to become financially self-sustaining through patient fees. Equity investors, including UBS Optimus Foundation, 1Crowd, and Innospark Ventures to date, have provided upfront capital to establish operations and supporting technology systems.

**2. Partner-funded centers**: In lower–income rural communities, centers are initially supported by CSR or grant funding. Patient fees are initially discounted to encourage adoption, gradually increasing to standard levels as utilization grows, generally within three years. Partner funding for the first three years covers both the fee subsidy and the additional community outreach required to build awareness and trust. To date, partners for these centers have included Grand Challenges Canada, Hyundai Motor India Foundation, Swiss Re Foundation, and Ujjivan Small Finance Bank.

### Takeaway

Scale is built on discipline: prove a simple, standardized core model first, then expand scope only when the core model is robust enough to carry it.

# LESSON 03
# Make the impact–profit tension explicit in the operating model

As Karma scaled, they faced recurring questions from investors, CSR partners, and internal stakeholders about whether the organization should optimize for profitability or for reaching lower-income communities. Instead of leaving this tension implicit, they built it into the operating model by distinguishing between two functional components, designed to reinforce one another:

- **Financial Engine:** Consultations, pharmacy sales, diagnostics and subscriptions form the model's commercial backbone. These services generate patient fees to fund center operations and create the margin required to scale sustainably.

- **Impact Engine:** Education, outreach, and community awareness are impact-led activities that are not expected to be financially self-sustaining. These activities are funded through grants and CSR partnerships.

**These are not parallel tracks**. Outreach and awareness lead to uptake and repeat visits, to enable centers to reach viable patient volumes. Similarly, without financially sustainable centers, outreach cannot convert into sustained care.

### Takeaway

Separating revenue-generating functions from access-building activities, and funding each appropriately, allows them to reinforce one another, supporting both sustainability and reach as organizations scale.

# WHAT'S NEXT

Karma has reached an inflection point. With their operating model proven across more than 76 centers and a growing patient base, Karma is now focused on scaling their depth of impact, as well as reach.

**Over the next three years, Karma plans to:**

- Grow their self-financed telemedicine centers from 16 to 50
- Expand their telemedicine centers funded by partners from 60+ to 80+
- Expand the number of mobile medical unit deployments from 100+ to 250+

Alongside this expansion, Karma plans to strengthen the model in three ways:

- **Grow their standardized value-added** and referral services, including diagnostics, chronic disease management and health packages, to improve the continuity and quality of patient care while generating additional revenue at the center level

- **Strengthen their data and technology platform** to support care management, follow-up, and service planning across the network; while creating potential monetization opportunities through aggregated, anonymized patient data

- **Integrate AI across operations:** this will include AI-enabled medicine forecasting, AI-powered doctor allocation and queue management, as well as AI-driven personalized care and retention tools

Karma estimates that these shifts will increase their core operating margin by **3.11 times** relative to their current base.

With the core model proven and the next phase of scale clearly defined, Karma is raising **USD $3 million** in equity to expand their center network, strengthen systems, and support scale-ready service delivery.

# GET IN TOUCH

## Want to explore a partnership with Karma or learn more?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**https://karmaprimaryhealthcare.in**

**Karma Primary Healthcare**



This case study was developed through a partnership between Grand Challenges Canada and Spring Impact.

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