



**National
Gender
Fellowship
2024**

Platforms of Techno-Corporate Care:
Narratives from Women Workers in New
Service Economies of Home Healthcare

Chiara Furtado

About IT for Change

Founded in 2000, IT for Change is a Southern, women-led NGO rooted in feminist principles and driven by a commitment to social justice. Recognized with Special Consultative Status by the Economic and Social Council of the United Nations. IT for Change is dedicated to democratizing digital technologies, enabling individuals and communities to harness their power for empowerment.



1371, First Floor, 31st "B" Cross,
Jayanagar 4th "T" Block, Bangalore,
Karnataka - 560041
www.itforchange.net

The views expressed in this publication are those of the authors and do not reflect the official stance of the commissioning or funding organizations.

Copyright © 2026 by IT for Change

For publications enquiries, please contact comms@itforchange.net

Licensed under a Creative Commons License Attribution–ShareAlike
4.0 International (CC BY–SA 4.0).



About the National Gender Fellowship

This paper was commissioned by IT for Change as part of the 2nd edition of the [National Gender Fellowship](#) under the project, '[Re-wiring India's Digitalising Economy for Women's Rights and Well-being](#),' supported by the European Commission and Friedrich-Ebert-Stiftung. The fellowship supports early career scholars, researchers, and practitioners, in the development of research studies that explore the multifaceted relationship between digital economy, gender, and inclusion in India, focusing on women's experiences.

About the Author

Chiara Furtado researches and writes on the intersections of informalized labor and digitalization. She is based in Bangalore, and has previously worked with Point of View and Centre for Internet and Society.

Credits

Managing Editors: Sadaf Wani & Natasha Susan Koshy

Editorial Review: Sadaf Wani, Natasha Susan Koshy, Susan Sreemala, Ammel Sharon, and Diya Deviah

Copyediting and Proofreading: Susan Sreemala and Sadaf Wani

Layout and Cover Design: Harikrishnan B.

Supported By



Contents

Abstract.....	5
Introduction: Nursing Labor and Platformization in Home Healthcare	6
Methodology.....	8
Findings and Analysis	9
Mobilization: Institutionalizing migration patterns and vulnerabilities	9
Productization: Legitimizing gender and caste hierarchies.....	16
A facade of formalization, an agenda of digital instrumentalization.....	23
Conclusion.....	25
References	26
Annexure	30

Abstract

The home healthcare sector in India is undergoing concurrent and convergent transformations of corporatization, commercialization, and productization. These transformations have manifested with platforms as the dominant model driven by rhetoric of digital transformation and disruption. Through a qualitative research approach, the paper draws on narratives of women nursing workers in home healthcare to unpack their everyday realities of laboring amidst transformations of corporatization and platformization.

The paper reveals key findings around the mobilization and productization strategies deployed by corporate home healthcare platforms and their impacts on nursing workers.

The mobilization of a vulnerable migrant workforce affords corporate platforms the conditions for greater labor disciplining. It widens power asymmetries, emerging from the ways in which platforms feed on vulnerabilities. Mobilization through formal training infrastructures provides corporate platforms access to a readily trained workforce, which they further leverage towards meeting strategic objectives around customer acquisition.

Corporate platforms deploy their institutional logics to enable productization through the selective visibilization and invisibilization of workers' and customers' identities. On the one hand, platforms hyper-visibilize and weaponize workers' gendered and socio-economic vulnerabilities. On the other hand, they invisibilize and legitimize customers' caste prejudice, privilege, and power. Productization fundamentally relies on the reinforcement and legitimization of gender and caste hierarchies encoded in corporatized notions of customer-centricity, customer retention, professionalized care, and continuity of care.

Finally, the paper exposes the facade of formalization in employment that corporate platforms enable, and reveal their agenda of the digital instrumentalization of nursing workers. It illustrates the ways in which platform institutional logics leverage workers themselves as instruments towards realizing promises of platformization for customers. Platform institutional forms have rapidly emerged across sectors, building a new precariat amidst socio-economic transformations of new service economies that cater to urban class and caste elites. The paper proposes an emphasis on a lens of 'digital instrumentalization' towards foregrounding workers' experiences within these broader transformations and tendencies.

Keywords: Nursing Workers, Home Healthcare, Informalized Labor, Caste Gender and Labor, New Service Economies, Platformized Labor, Adverse Incorporation

Introduction: Nursing Labor and Platformization in Home Healthcare

In the decade and a half since the emergence of labor platforms in India, differential trajectories of platformization have emerged across occupational sectors and institutional forms. Socio-historical contexts, market and regulatory practices, and socio-economic backgrounds of workers within specific sectors have been shown to contribute immensely towards platformization trajectories within the sector.

Emerging research shows that such differential trajectories are also present in the platformized home healthcare sector, particularly relating to nursing labor (ILO, 2023). Feminized sectors of the platform economy, such as domestic work and beauty work, diverge from the expected model of wholly automated on-demand platform work (Rathi and Tandon, 2021; Ghosh et al., 2021). Platformized home healthcare is distinctively built on the socio-historical contexts of the devaluation, segmentation, and hierarchization of nursing labor. On home healthcare platforms, workers in varying job roles within the professionalized hierarchy of nursing attendants, nursing assistants, and nurses are engaged in care arrangements spanning part-time/ live-out or full-time/ live-in placements in customers' households, as well as one-time or short-term home healthcare services.

The landscape of institutional forms in home healthcare in India is vast and highly fragmented. In a scoping review of home healthcare platforms, over 75 such small, medium, and large platforms were seen to be operating in Bengaluru alone.¹ While numerous offline placement agencies are in operation in Bengaluru, so are several small platforms that operate at a local scale within the city as sole proprietorships, partnerships, or small private companies. A handful of medium-large corporate platforms dominate the home healthcare sector and operate across tier 1 and tier 2 cities. These include Portea, HCAH, Nightingales (formerly), Apollo Homecare, and Life Circle Health Services (SEBI, 2022).

To understand the varying forms of platformization in home healthcare, it is useful to consider a continuum of institutional logics that labor platforms adopt, ranging from 'market logics' to 'corporation logics' (Immonen, 2023). Smaller home healthcare platforms tend to operate predominantly on market logics, and function as digital placement agencies or temporary employment platforms. These platforms offer medium to long term and part-time to full-time placements to healthcare workers in customers' households and/or transitory care centers (ILO, 2023). Similar to offline placement agencies, they maintain a digital database of healthcare workers who are screened, verified, and recruited by the platform. They also utilize data intensive digital tools for matching and other work processes.

¹ Scoping review of home healthcare platforms operating in Bengaluru (platforms operational as of May 2025), conducted as part of this research.

The model of ‘small’ home healthcare platforms bears strong resemblance to its ‘offline’ counterpart of a placement agency (Grover, 2022). However, the model of ‘corporatized’ home healthcare platforms is divergent across multiple dimensions. Medium-large platforms operate primarily on corporation logics of governance (Immonen, 2023). They are governed by strict rules of entry for nursing and other healthcare workers, close design and monitoring of work processes, and the involvement of external stakeholders such as venture capital investors and shareholders. They also feature a vast cross-functional managerial hierarchy, multiple layers of human-algorithmic managerial control, and a large capacity to deploy resources and processes towards digitalization, scale, and expansion.

The private healthcare sector in general, and the home healthcare sector in particular, is undergoing concurrent and convergent transformations of corporatization, commercialization, and productization towards building home healthcare ‘solutions’. These transformations have shaped healthcare workers’ experiences through shifts in their employment relations, and the introduction of metrics for labor disciplining (Chakravarthi et al., 2023; Marathe et al., 2020). Recent corporatization within home healthcare has manifested with platforms as the dominant model driven by rhetoric of digital transformation and disruption. The dual processes of platformization and corporatization in home healthcare occur alongside structural socio-economic transformations of new service economies consisting of a range of private actors and activities in urban economies, including in services such as retail, hospitality, and so on.

Corporatized rhetoric of “digital transformation” and “disruption” feeds into platformization logics and practices, including the active mobilization of a large workforce and the productization of home healthcare (Portea, 2025a; HCAH, 2025a). In this paper, I term the form of care emerging from these transformations as ‘techno-corporate care’. While digital transformations have largely been visibilized on the customer end of operations on corporate platforms, these transformations instrumentalize nursing workers as key nodes of mediating platformization in home healthcare.

How do we understand platformization in the context of nursing labor that has historically been devalued, stigmatized, and hierarchized? Do platforms truly ‘disrupt’ informalized labor regimes as their rhetoric of digital transformation and inclusion suggests? Or do they leverage gender and caste hierarchies to build ‘techno-corporate care’ on the backs of marginalized workers? Drawing on narratives of women nursing workers in home healthcare, this paper unpacks their everyday realities of laboring amidst transformations of corporatization and platformization.

Methodology

For this paper, I adopt a qualitative research approach to understand everyday experiences of women nursing workers in home healthcare across institutional forms of offline agencies, small platforms, and medium-large corporate platforms. The paper draws on strands of scholarship around adverse incorporation (Hickey and du Toit, 2013) that I used as an implicit analytical frame. Frameworks around adverse incorporation allow for a critical exploration of intersecting structural inequalities that shape the everyday experiences of the nursing workers amidst broader socio-economic transformations of corporatization and platformization in the home healthcare sector.

The locational focus of this paper is Bengaluru. This location was selected as the primary research site since platform operations in home healthcare are relatively more widespread in tier 1 cities like Bengaluru, while still emerging in tier 2 cities. This allowed for an in-depth analysis of workers' experiences under varied institutional forms including major platforms as well as smaller platforms, and also offline agencies operational in the city.

Analysis for this paper includes both secondary and primary research. Secondary research includes a review of the literature around themes of informalized labor; nursing labor; intersections of caste, gender, and labor; new urban service economies; corporatization; and platformization. It also includes an analysis of major home healthcare platforms through a scoping review of business models; and a discourse analysis of dominant public-facing narratives and rhetoric mediated by these platforms. For this analysis, I relied on corporate documentation and communications material, corporate website and mobile app interfaces, news reportage around business models and strategies, and publicly available interviews with senior executives of major home healthcare platforms posted on social media platforms such as YouTube.

The initial plan for this research included conducting key informant interviews with senior platform executives to better understand work organization and management. However, the executives I contacted were either not responsive or not open to being interviewed. So I, instead, relied on the publicly available social media interviews to understand perspectives of senior platform executives. While this alternative approach did not allow space for in-depth conversations with platform executives, the publicly available interviews still provided useful insights into the rhetoric and dominant narratives that platforms employ around nursing labor. The interviews used for analysis include those with senior executives at four major platforms—Apollo Homecare, HCAH, Life Circle Health Services, and Portea.

For the primary research for this paper, I conducted in-depth semi-structured interviews with 16 women nursing workers across three job roles: 12 nursing attendants, three nursing assistants, and one nurse. The interviewed workers had been part of various agencies and platforms in the years that they worked in the home healthcare sector. Fourteen of them had work experience with offline agencies, six of them with small platforms, and four of them with medium-large corporate platforms.

I conducted two key informant interviews with labor researchers, each working on nursing labor and on platformized labor to understand intersections between these domains. I also conducted one key informant interview with a former nursing coordinator and team lead who worked for corporate home healthcare platforms to understand the form and function of their managerial hierarchies. The interviews with workers and with key informants were conducted between January and April 2025. All interviews were conducted telephonically; and in Hindi, Kannada, or English based on the preferred language of research participants. Details on interviews with workers and key informants are included in tables 1 and 2 of the Annexure. Hyperlinks to the publicly available social media interviews used for analysis are listed in table 3 of the Annexure.

Findings and Analysis

Mobilization: Institutionalizing migration patterns and vulnerabilities

In my interviews with the women nursing workers and in the social media interview recordings of senior platform executives, social identities and economic vulnerabilities of nursing workers within small and medium-large platforms largely overlapped with those of nursing workers with offline agencies. These overlaps exist particularly in relation to demographic workforce patterns around gender, income, and migrant status. Socio-historically embedded recruitment mechanisms used by home healthcare agencies and platforms to mobilize their nursing workforce have shaped similarities in social identities and economic vulnerabilities of workers across offline and platform institutional forms.

As research around nursing labor in India reveals: the composition of the nursing workforce in India is gendered, with a large proportion of women workers owing to socio-historical inequalities resulting from the stigmatization and devaluation of care labor (John, 2019; P. Ray, 2020; WHO, 2020). Specifically, nursing labor in the private sector is structured around job roles within professionalized hierarchies marked by social identities, with workers facing intersecting marginalities around gender, caste, and migrant status pushed to the bottom of these hierarchies (Basu, 2019; P. Ray, 2020). These structural factors also persist in the private home healthcare sector, where research finds continuities in a gendered workforce of nursing attendants, nursing assistants, and nurses (ICRW, 2018; Das, 2021; Gupta and Randhawa, 2023).

In my interviews with the women workers and in social media interview recordings of senior platform executives, it became clear that offline agencies, small platforms, and medium-large corporate platforms, all relied substantially on an inter-district and inter-state migrant nursing workforce. Of the workers interviewed, all were internal migrants who had migrated to Bengaluru solely to work in the home healthcare sector. These workers had migrated from small cities and towns, peri-urban areas, and villages across districts in Karnataka (including Dharwad, Koppala, Raichur, Tumakuru, and Vijayanagara districts), and across states (including Andhra Pradesh, Odisha, and Tamil Nadu). Internal migration, therefore, is an integral aspect shaping the nursing workforce across institutional forms within the home healthcare sector.

All the women workers interviewed were unmarried at the time of joining home healthcare work and had migrated from their natal households. A majority of these migrant women workers were part of daughter-only natal households, and some of them were from households where multiple daughters were engaged in home healthcare work. The workers were between 18 and 29 years old at the time of the interviews, with most having joined home healthcare work at a young age after completing secondary school. While the workers mentioned that both small and medium-large corporate platforms had ensured that they were at least 18 years old at the time of joining, a number of workers in offline agencies were not legal adults at the time of joining and had begun home healthcare work when they were 16–18 years old.

The distinct age and migration patterns of the women workers were primarily shaped by decisions taken on the workers' behalf by their natal households. These women workers were part of low-income households experiencing chronic poverty and income insecurity. As a result, natal households relied heavily on the women workers' engagement in paid work in order to sustain themselves. Hence, socio-economic vulnerabilities were crucial in determining why the women had entered the paid workforce, at what point in their working lives they did so, and on what terms they had begun working in home healthcare (as we see in the sections that follow).

In my interviews with the workers, they described how offline agencies and small platforms primarily rely on recruitment channels through kinship and community networks. The offline agencies and small platforms also rely on other channels of recruitment typical of the sector—such as third-party labor contractors or job advertisements—albeit to a lesser degree.

In contrast, medium-large corporate platforms leverage their capacities for network-building to forge strategic partnerships with formal healthcare training infrastructures for workforce mobilization. These platforms have identified key channels of migrant nursing labor recruitment through training institutions affiliated with the National Skill Development Corporation (NSDC), a public-private partnership of the Central Government's Ministry of Skill Development and Entrepreneurship (NSDC, 2025).

In social media interviews, senior executives at medium-large corporate platforms such as Portea and Life Circle spoke of the importance of partnerships with NSDC training institutions as a key workforce mobilization mechanism. At Portea, while nursing colleges in city centers are targeted for recruiting nurses, recruitment for attendants and nursing assistants are oriented towards small towns and villages in states such as Jharkhand, Bihar, and Karnataka, where the platform targets workers looking to move to larger cities for employment.² Similarly, at Life Circle, the platform primarily works with NSDC training institutions to recruit nursing attendants and nursing assistants from small towns and villages.³

2 Social media interview with the co-founder and former CEO of Portea in: Radically Yours by Radhika. (2025, February 7). From 0 to 500 cr | How she became a MILLIONAIRE with multiple startups!? [Video]. YouTube. <https://www.youtube.com/watch?v=Eiie8wc66-U>

3 Social media interview with the co-founder and director of Life Circle Health Services in: Life Circle Health Services. (2024, February 19). Transforming senior care: Insights from CII Care Panel with Priya Anant | #CII #lifecircle #homecare [Video]. YouTube. <https://www.youtube.com/watch?v=o6HtTQthqQI>

Through these mobilization mechanisms, medium-large corporate platforms have institutionalized internal migration patterns of workers in home healthcare that were previously informal (and which continue to be the case for offline agencies and small platforms). This is particularly true for job roles of nursing attendants and nursing assistants where migration and recruitment had been otherwise centered around kinship and community networks.

Corporatization logics of medium-large platforms play a key role in institutionalizing and sustaining internal migration patterns of workers through the reliance on training infrastructures. These logics support platform objectives along two key strategic dimensions. First, mobilization of a socio-economically vulnerable migrant workforce affords corporate platforms the conditions for greater implicit managerial control for labor disciplining. It widens power asymmetries, emerging from the ways in which platforms feed on vulnerabilities and construct workers' economic dependence on platforms. Second, mobilization through formal training infrastructures affords medium-large corporate platforms access to a readily trained workforce, which they further leverage towards meeting their strategic objectives around customer acquisition.

Let us first look at how platforms have mobilized a vulnerable workforce towards their own strategic objectives of labor disciplining. NSDC training institutions under the Healthcare Sector Skill Council (HSSC) provide 6-month training programs for the General Duty Assistant (GDA) job role.

In my interviews with the nursing workers, they described how corporate platforms entered the recruitment process upon the workers' completion of the GDA training program. One of them, Aarti*⁴, was a former nursing assistant at Portea. Her journey as an inter-state migrant nursing worker began at an NSDC training institution in her home state. She shared the training and recruitment process:



There was training for nursing aides through the government in [my home state]. We completed training here and we were directly given a posting in Portea. They may have had a partnership with Portea, I don't know much about it. [...] Before selecting me, Portea had conducted an interview and asked questions on topics we had covered in the GDA course.

—Interview with Aarti*, a nursing assistant at Portea
(until 2024)

Aarti* also told me that this form of recruitment was a general practice at Portea. During her time with the platform, she had seen sizable cohorts of 20 to 25 nursing workers from states such as Bihar and Uttar Pradesh recruited by Portea upon completion of their GDA training program. Aarti* herself was part of a GDA training cohort of 21 nursing workers recruited by Portea.

4 Pseudonyms are used for names of all the nursing workers to protect the identity of interviewees, and are marked with an asterisk. In addition, information that may potentially be identifiable such as geographical locations and names of home healthcare agencies/platforms have been anonymized, where necessary.

The NSDC-mediated recruitment channel, therefore, affords corporate platforms access to a stable, recurring recruitment pool of workers as part of GDA training cohorts across a large number of training providers. According to 2025 data from the HSSC, over 170 training providers across several states were affiliated with the Council (HSSC, 2025). Considering corporate platforms' strategic emphasis around scale and expansion, a large pool of workers across training providers would be all the more critical for them.

In social media interviews, senior executives at corporate platforms highlighted how they target GDA training providers operating in small cities, towns, and villages to recruit workers in these regions.^{5, 6, 7} The platforms couch this targeted recruitment of socio-economically vulnerable migrant workers under a rhetoric of 'aspirational employment'. They claim to provide formal employment that promises high job satisfaction and dignity in large cities, implying that this is one of few means of aspiring towards dignified employment for workers from small towns and rural areas.⁸

Behind the facade of the 'aspirational employment' rhetoric lies platforms' goal of customer retention, and by extension, nursing workers' retention in home healthcare placements. For this, platforms would require not only a stable workforce, but also a 'compliant' workforce to enable labor disciplining.

The corporate platforms' targeting of migrant workers from geographic regions facing socio-economic disparities in income, employment, education, and other development indicators is in effect a targeting of workers with high socio-economic vulnerabilities, as we see with the intersecting vulnerabilities of the women workers interviewed.

These vulnerabilities are a function of the socio-economic inequalities that NSDC skilling infrastructures themselves target and perpetuate. The GDA program runs as a short-term training program under the Pradhan Mantri Kaushal Vikas Yojana (PMKVY), the flagship skilling scheme by the Central Government that primarily encourages targeting of socio-economically marginalized groups and geographical regions (MSDE, 2023). Field research on these skilling programs shows that, for the industry-oriented NSDC, short-term training has instead served to afford industry partners—such as corporate home healthcare platforms—a large pool of workers that can be routed into low-wage, informalized job placements (Ruthven, 2018; Maithreyi, 2019; Upadhyia and RoyChowdhury, 2024).

5 Social media interview with the co-founder and former CEO of Portea in: Radically Yours by Radhika. (2025, February 7). From 0 to 500 cr | How she became a MILLIONAIRE with multiple startups! [Video]. YouTube. <https://www.youtube.com/watch?v=Eiie8wc66-U>

6 Social media interview with the co-founder and director of Life Circle Health Services in: Life Circle Health Services. (2024, February 19). Transforming senior care: Insights from CII Care Panel with Priya Anant | #CII #lifecircle #homecare [Video]. YouTube. <https://www.youtube.com/watch?v=o6HtTQthqQI>

7 Social media interview with the co-founder and current CEO at Portea in: National Skills Network NSN. (2023, May 5). Skill development and jobs in Home Healthcare | Mr Vaibhav Tewari CEO Portea [Video]. YouTube. https://www.youtube.com/watch?v=_CEIDnFstq8

8 Social media interview with the co-founder and current CEO at Portea in: National Skills Network NSN. (2023, May 5). Skill development and jobs in Home Healthcare | Mr Vaibhav Tewari CEO Portea [Video]. YouTube. https://www.youtube.com/watch?v=_CEIDnFstq8

The industry- and target-driven nature of short-term NSDC training programs has enabled a symbiotic dynamic between training providers and their industry partners. This makes it so that training providers function as rural-to-urban labor intermediaries that source a 'compliant' workforce to place in insecure albeit corporatized jobs within new, high-demand, urban service economies (Ruthven, 2018; Upadhyaya and RoyChowdhury, 2024).

Training providers have been deploying their own mobilization teams to target potential workers, with the aim of having a readily 'compliant' and 'disciplined' workforce for their industry partners. These are 'desperate' workers from towns and villages facing chronic socio-economic vulnerabilities at both the level of the region and the households. According to training providers, these are workers who are more likely to be 'loyal' and equipped with 'soft skills' demanded by industry partners in new urban service economies (Upadhyaya and RoyChowdhury, 2024).

For GDA-relevant job roles, equivalent to nursing attendants and nursing assistants in home healthcare, this means having "humble and compassionate people, [who] must 'throw their egos out' before handling the patients" (see Iyer, 2019), essentially workers more likely to be subordinated by gender and caste hierarchies entrenched within nursing labor (Iyer, 2019). Moreover, migrant women nursing workers are especially seen as important to build this 'compliant' and 'disciplined' workforce, deemed by industry partners as less 'flighty' and more likely to remain engaged in 24-hour placements (Ruthven, 2018). This was the case for a majority of the women nursing workers interviewed who undertook 24-hour care arrangements, not out of compliance but out of compulsion. Deficits in support systems provided by platforms in the destination city meant that these migrant nursing workers were constrained to 24-hour care arrangements, since living and housing expenses were not sustainable alongside substantial financial burdens comprising remittances to their natal households.

Targeting and training for the GDA role has seen a reinforcement of gender and caste inequalities associated with nursing labor, with the job role being poorly defined and devalued by the HSSC as a squarely non-medical, relatively 'unskilled' healthcare role that is primarily concerned with the 'comfort' of the patient (Iyer, 2019). Further, the NSDC skilling programs function as a form of pedagogical segregation, where education for nursing attendants and assistants job roles has been excluded from general nursing education and restricted to the short-term GDA programs with little room for occupational mobility. Therefore, corporate platforms' targeted recruitment of nursing attendants and assistants through NSDC skilling infrastructures has institutionalized not only precarious migrant labor mobilization, but also a channel for platforms to weaponize workers' vulnerabilities and the structural devaluation of care labor towards labor disciplining.

Corporate platforms have further leveraged this 'compliant' nursing workforce towards meeting their strategic objectives around customer acquisition. These platforms have co-opted the ostensible value of the GDA training program and certification towards their own claims of offering value to customers via home healthcare delivered by a trained and certified workforce.

For instance, Portea assures prospective customers that their attendants are “well trained and their backgrounds are checked” (Portea, 2025b). In a similar vein, HCAH promises prospective customers access to a team of “highly trained home attendants that follow clinical protocols according to international standards” and lists “experienced and certified staff” as a key reason to choose their services (HCAH, 2025b). The promise of ‘professionalized’ and ‘quality’ home healthcare, therefore, is central to corporate platforms’ messaging towards prospective customers to signal key features of their services. This messaging is in line with the platforms’ larger claim of modernizing the home healthcare sector, implying that these features have been missing within informally organized offline agencies or even smaller platforms.

In social media interviews with senior executives of corporate platforms, they spoke of how their services—and by extension, their workers—are expected to embody platform-defined notions of care that seemingly distinguish platformized home healthcare services from those that are informally organized by offline agencies. A co-founder and current CEO of Portea, for instance, spoke of availability, reliability, and quality as central to the distinct value proposition that the platform offers: “We are taking this service to the market for the first time in an organized manner. When we started, each of these services were offered [offline] in some form or the other. But we thought of how each of these services can be taken to the market with the right availability, reliability, and quality.”⁹

Platforms have also differentiated their services in comparison with hospital settings by relying on gendered and casteist notions of care labor that is ‘ever-giving’ and ‘ever-available’. As the CEO of Apollo Homecare shared in a social media interview, homecare through platforms, according to him, offers customers varying benefits: “They receive one-on-one dedicated care where someone is always available. Sometimes people are wary of pressing the nursing call bell at hospitals but at home they have caregivers just by their side. They also develop a caregiver bond where they become part of the family in a way. So all caregivers are trained in these softer aspects on how to deliver care compassionately.”¹⁰ In another social media interview, the co-founder and current CEO of Portea similarly emphasized the importance of what he termed “core caregiving principles”, again drawing on gendered and casteist notions of care labor, and dual expectations for nursing workers to perform affective labor that unquestionably centers and privileges the demands of both the customer and the customer’s family over all else:

9 Social media interview with the co-founder and current CEO at Portea in: GIBS Business School, Bangalore. (2024, October 3). Revolutionizing healthcare: Mr. Vaibhav Tewari - Founder & CEO at Portea | GIBS IRE Talks Podcast [Video]. YouTube. <https://www.youtube.com/watch?v=GVpOv972tYE>

10 Social media interview with the current CEO at Apollo Homecare in: India Today. (2025, February 25). Can your home be turned into an ICU? | Health Wealth, Ep 84 [Video]. YouTube. https://www.youtube.com/watch?v=qgqpZzPKZ_Q



An important part of caregiving is to also have the right empathy and connect with the patients' families. So, training is not only needed from a medical perspective but from a core caregiving principles perspective as well. This has been a big focus area for us on how we can make sure that the patient is the center of our universe, and also at the center of our caregivers', nurses', and medical professionals' universe as well.

—Co-founder and current CEO at Portea, in a social media interview¹¹

'Soft skills' training has become an avenue for these gendered and casteist notions of care to be embedded within nursing labor on corporate platforms. Both the NSDC GDA training programs and platforms' in-house training programs lay emphasis on these 'soft skills'. In GDA training programs, modules stress on teaching trainees how to be 'well-groomed' and 'well-behaved' with customers in order to be employable in the healthcare sector (Iyer, 2019). My interview with Geetha* (a former nurse at Portea) sheds light on 'soft skills' training on platforms that similarly emphasize ways for workers to mold their professional identities to meet demands of patient/customer households. For Geetha*, this included training sessions on English and regional languages for communicating with patients and their families, reorienting care to the needs of patients and their families within their households, 'taking care' of all of the patients' medical and non-medical needs, and being mindful of 'ways to behave' with patients and their families.

In a key informant interview with Ritumoni Das, a researcher on labor in the home healthcare sector, she spoke of the strategic importance of 'soft skills' for organizations offering home healthcare services:



Organizations feel that it is essential to train their staff on 'soft skills' because they treat home healthcare as a customer-oriented service. So, they do train staff on how to communicate better or to show more respect to the customer. [...] It is an emerging need among organizations to ensure a 'good experience' for the patients.

—Key informant interview with Ritumoni Das, researcher on the home healthcare sector in India

Ritumoni's observations echo workers' experiences with training on corporate platforms. More broadly, this follows patterns of 'soft skills' training within new service economies that are central for corporate employers in constructing professional identities of workers that embody compliance with corporatization logics and demands; classed, gendered, and casteist norms; and customer-centricity aligned with consumption idiosyncrasies of urban elites (Kikon and Karlsson, 2020; A. Ray, 2024; Upadhyia and RoyChowdhury, 2024).

¹¹ Social media interview with the co-founder and current CEO at Portea in: National Skills Network NSN. (2023, May 5). Skill development and jobs in Home Healthcare | Mr Vaibhav Tewari CEO Portea [Video]. YouTube. https://www.youtube.com/watch?v=_CEIDnFstq8

Drawing from these embodied and affective manifestations of ‘soft skills’, corporate platforms construct professional identities of nursing workers to align with their strategies to productize home healthcare. As we will see in the following section, for nursing workers these constructed professional identities and corporatized notions of ‘professionalization’ and ‘core caregiving principles’ are experienced as platforms’ reinforcement of gender and caste hierarchies in service of their productization strategies. The mobilization of a precarious migrant workforce is weaponized to enable the control and devaluation of workers within the household-as-workplace. Platforms further leverage workers’ vulnerability and economic dependence through coercive managerial strategies that force workers to embody corporatized notions of care.

Productization: Legitimizing gender and caste hierarchies

Productization in home healthcare platforms is embedded within broader processes of corporatization. More generally, productization has been conceptualized by corporatized institutions as encompassing transformations of services and processes into systematized, standardized, and quantifiable ‘products’ (Harkonen et al., 2017). Corporatized institutions consider digitalization and platformization as key enablers of these productization processes, holding promise for scalability, cost reduction, and geographical reach. These transformations have become instrumental in realizing corporate strategic aims of centering the customer in productization processes: streamlining the customer experience, building trust with customers, and promising convenience and reliability through high quality standardized and/or modularized services (Ramiller et al., 2008; Surie, 2020).

In new service economies of home healthcare built around customer-centricity, strategies of service productization are just as instrumental in shaping the everyday work processes and pressures nursing workers face as they navigate demands to center the customer in everything they do. The corporatized emphasis on customer-centricity is in and of itself steeped in historical continuities that dictate caste and labor relations in contemporary economies. It echoes the caste-based division of labor and laborers that legitimizes the permanent and hereditary servitude of oppressed castes, and reinforces the notion of a ‘natural’ caste order in which oppressed castes are created by God for the service of oppressor castes (Bühler, 1886, as cited in Thorat et al., 2023). In the context of the gendered labor of home healthcare, narratives of workers show how platform productization processes fundamentally rely on the perpetuation of caste and gender hierarchies driving both the devaluation of labor and of laborers (Gopal, 2013). Even when corporatized demands are couched in modernized rhetoric of ‘customer-centricity’, the workers’ experiences illustrate how relations of labor are reconstituted in new service economies in ways that reinforce social hierarchies of servitude (Gopal, 2013).

As we will see, the rhythms, temporalities, and spatialities of work governed by logics of customer-centricity manifest as everyday forms of structural gender and caste violence for the workers. Customer households and managerial hierarchies at corporate platforms emerge as key perpetrators, mediators, and enablers of this violence. Drawing from my interviews with the women nursing workers, the experiences described below focus on nursing attendants and nursing assistants with 24-hour care arrangements and the customer household as their 24-hour workplace.

Particularly for the nursing workers with corporate platforms, the platforms' careful construction of professional identities and notions of 'professionalization' (discussed in the previous section) mediated the rhythms and temporalities of work, and brought with them the burden of affective labor that workers were expected to perform in compliance with corporatization logics and demands of customer-centricity aligned towards urban elites (Kikon and Karlsson, 2020; A. Ray, 2024; Upadhyaya and RoyChowdhury, 2024). Corporate platforms' demands for workers to embody value propositions of 'availability, reliability, and quality' and fulfil 'core caregiving principles' of centering the customer household has primed customer expectations of 'professionalized' behavior that workers are expected to maintain at all times. In a key informant interview, Chetna V M, a researcher on platformized labor, shared observations from her work. Platform pressures to perform affective labor and uphold notions of customer-centricity is revealing in terms of the caste hierarchies they reinforce:



Workers have been given this added responsibility of following certain etiquettes, or behaving a certain way to ensure that the customers are retained, and will remain long-term customers. Platforms are shirking off the responsibility [to ensure fair working conditions]. Rather, there's an added burden on the care worker that feeds into the caste dynamics of having a certain etiquette, or behaving a certain way, in order to ensure that the customer is happy at all times with the service provided.

—Key informant interview with Chetna V M, researcher on platformized labor in India

Across institutional forms of offline agencies, small platforms, and corporate platforms, the nursing workers' work time schedules were unclear, unpredictable, and variable. Moreover, their work time was almost entirely determined by customer households, aligning not only with the medical and non-medical needs of the patient, but also with schedules of the customer household, and with schedules demanded for additional unpaid work by members of the household. As Sowmya*, a former nursing assistant at Nightingales explained in my interview with her:



We have the doctor file for the patient, where the file has the doctor's suggestions and prescriptions, and we have to follow that only. But in the client's home, they say that you need to do this and that. We have to do the work according to how they do things and how things are at their home. If they ask to do some work at any time, then that is something we have to accept.

—Interview with Sowmya*, a former nursing assistant at Nightingales, currently working for an offline agency

When not engaged in tasks involving the medical and non-medical needs of patients, the workers were rebuked by members of the customer household for “sitting idle”. They were expected to always remain busy, and take on household and domestic work. According to customer households, this was in order to ‘justify’ the high fees that customers were paying agencies and platforms. In reality, these demands were steeped in ‘cultures of servitude’ within domestic spheres that expect workers’ time and labor to be wholly dictated by the household (Qayum and Ray, 2003). They echo labor disciplining regimes of contemporary care-domestic economies that normalize the total control and domination of workers within the household-as-workplace; and reproduce the routine devaluation and invisibility of care-domestic labor (Grover et al., 2018; Grover, 2022). In the case of the workers with corporate platforms, gendered and casteist rhetoric of offering care that is ‘ever-giving’ and ‘ever-available’ reinforces customer households’ temporal control over workers. Playing right into their value proposition of ‘continuous’ and ‘high quality’ care services, this temporal control is therefore left unchallenged by corporate platforms.

In my interview with Aarti*, the former nursing assistant at Portea, she spoke of the totalitarian work time regimes dictated by customer households:



Sometimes it was very difficult to manage schedules, when we had to work during the day and even at night. The company tells the patient home to give us rest times of 1-2 hours in the afternoon and 6-8 hours in the night to rest. But once we end up going to the patient's home, it's difficult to say anything.

She continued on about her experiences with customer households demanding unpaid work:



In some patients' homes, they may just say do this thing, or do that thing. So, the company people say no, and say that we should do only the patient's work. But later they also say, “Okay, if you want to do it then you can do some small work, only if you want to but nothing more than that.”



When I was on 24-hour duty, and if there was some small work and I refused, then the patient's family argued a lot with me. They used to say, "Why can't she do this work? We are paying so much money, but she has been sitting completely idle [yeh ekdum khaali baithi hai]."

—Interview with Aarti*, a nursing assistant at Portea (until 2024)

This temporal control over nursing workers is exacerbated through the customer households' further gendered control and moral impositions over their mobilities, forbidding workers from stepping out of the household and confining them within the household at all times. These restrictions on workers' mobilities subsumed the entirety of the workers' time within the customer household. From my interviews with the workers, Lasya's* experience as a nursing attendant was illustrative of women migrant nursing workers navigating these moral impositions:



In this work there is no such thing called freedom for us. Some customers don't allow you to step outside at all. The entire 24 hours you have to be inside the [customer's] house only. I can only see the outside world when I take leave to travel back home to my village. This is my life now.

—Interview with Lasya*, a nursing attendant who has worked at both offline agencies and small platforms

The workers' spatialities within customer households were markedly mediated by the households' imposition of caste hierarchies and practices. Here again, the devaluation of nursing labor and laborers shapes and is shaped by the everyday violence of segregation, stigmatization, coercion, and control imposed by customer households. Professionalized hierarchies in nursing labor relegate job roles of nursing attendants and assistants as menial-affective-corporeal labor (P. Ray, 2023). The corporeal labor of bedside caregiving is labor that requires contact with feces, blood, vomit, and other bodily fluids—marking workers in these job roles as 'impure' and 'polluting' bodies to be distanced (P. Ray, 2023). With the household-as-workplace, the domestic sphere of customer households in urban spaces become sites of subtle manifestations of caste and untouchability (Guru, 2009; Krishnan, 2023). Although modernized rhetoric has forced out untouchability as practice and as consciousness to descend to the bottom of the Brahminical mind, the domestic sphere still offers a stable site to unveil dynamics of untouchability by acting as both a space for physical and ritual purification and as a space for the oppressor to manifest their sovereignty as 'upper caste' (Guru, 2009).

As the workers' experiences showed, customer households sought to resolve caste anxieties and realize caste sovereignty by maintaining dimensions of untouchability relating to proximity, social and physical association, and commensality, which cause 'pollution' to oppressor castes. The workers' spatialities within the households were segregated, demarcated, and excluded from spaces associated with ritual purity.

They were only allowed to step foot in certain areas of the house away from the kitchen and dining areas, given days-old leftover and stale food, made to use separate plates and water bottles, and keep a newspaper sheet between their bodies and the floor while being forced to sit down and eat food. Purnima* and Sudha*, two former nursing assistants, shared the everyday forms of caste violence they faced during their assignments through both offline agencies and platforms:



This has happened to me many times. No matter how much we work, they [customer households] will not give proper food and only give yesterday's spoiled food. We can't sit here or there. Even if I was clean, they used to keep a newspaper where I had to sit. They used to tell me to keep clean when using the bathroom. In some places, they used to keep my plate and bottle separate.

They used to say, "We are paying you already, so why should we make you sit on our heads, and why should we take care of you?" If they think about us and value us, only then will they think that we are also human. But they don't have that thought.

—Interview with Purnima*, a former nursing attendant at offline agencies and small platforms



When we go for 24-hour duty, they [customer households] should at least give us a proper bed or room. We have to sleep next to the patient's bed on the floor, even when they are not well. There should be some respect for us. The work that a nurse does, we also do that. If someone calls them Sister, then we are also Sister. Nurse work at least has some respect and value.

—Interview with Sudha*, a former nursing assistant at Life Circle, currently working for an offline agency

As we have seen, nursing workers across institutional forms experienced everyday forms of structural violence. Even so, for nursing workers with corporate platforms, these experiences intersected with logics of productization in particular ways. The notion of customer-centricity is heightened in the context of corporate platforms, where work is hyper-commercialized, workers and services are personalized and expected to be 'ever-giving' and 'ever-available', and customer households are legitimized to wield often unbridled control over workers and subsumed within managerial processes. Therefore, productization within corporate platforms fundamentally relies on the reinforcement and legitimization of gender and caste hierarchies, encoded in corporatized notions of customer-centricity, customer retention, professionalized care, and continuity of care.

Further, corporate platforms deploy their institutional logics and structures to enable strategies of productization through the selective visibilization and invisibilization of workers' and customers' identities. On the one hand, corporate platforms (and to a lesser extent, offline agencies and small platforms) hyper-visibilize and weaponize workers' gendered and socio-economic vulnerabilities. On the other hand, they utilize their digital and managerial structures to invisibilize and legitimize customers' caste prejudice, privilege and power.

In addition to customer households, restrictions on the migrant women workers' mobilities were also mediated by agencies and platforms. Natal household-mediated patriarchal norms restricting the mobility of women workers had now been transferred to and upheld by agencies and platforms. At their workplaces in the destination city, these norms morphed into a hyper-visibilization of perceived gendered vulnerabilities resulting in restrictions around stepping out of customer households or travelling at night, under the moral guise of 'safety' for the women workers.

Caste hierarchies and practices in the customer household were invisibilized through their legitimization and normalization by both agencies and platforms via a politics of 'adjusting', drawing on the ubiquity of customer-centricity imposed by platforms and the hyper-visibilization of workers' socio-economic vulnerabilities. Almost every nursing worker interviewed made repeated references of having to just "adjust" and continue on with their workday. The need to 'adjust', however, is strongly driven by agency and platform managers themselves attempting to convince the workers to 'adjust', and hyper-visibilizing the threat of unpredictability of earnings and jobs that workers would face if they fail to 'adjust' and raise complaints against customers instead. Although official platform policies and grievance mechanisms are in place, they offer little redress to the workers as compared to the immense risks of losing pay or work. On the contrary, when the workers do raise complaints, they are merely replaced with other nursing workers in the agency or platform, with customer households not facing any sanctions. Platforms limit their interventions to tokenistic work policies shared with customer households during onboarding, with no real means of monitoring or accountability. In essence, a politics of 'adjusting' necessarily means a deprivation of workers' rights and dignity. It is a politics where platforms strategically individualize the responsibility of 'adjusting' on to workers, while erasing everyday manifestations of structural violence and fabricating them as minor inconveniences that just require 'adjusting'.

This politics of 'adjusting' is intensified on corporate platforms, where middle managers facing corporatized platform targets are more likely to attempt to convince nursing workers to simply 'adjust' and remain in the assigned customer household. Business development targets imposed on senior and middle management of corporate platforms are oriented towards customer acquisition and retention. In a key informant interview with Manjunath*, who has been both a nursing coordinator and a team lead at corporate platforms, he described strict revenue targets assigned to coordinators and team leads, and intense pressures on these middle managers to achieve and maintain monthly sales revenue targets. Team leads are often provided revenue targets by regional managers.

They in turn assign revenue and customer targets to their teams of nursing and attendant coordinators. During his time as a nursing coordinator, Manjunath* was required to manage a minimum of 30–40 customers at any given time. The primary target imposed by the corporate platforms was to retain customers, failing which coordinators were required to swiftly acquire new customers and maintain revenue targets. These forms of business development and revenue targets for coordinators and team leads at corporate platforms ultimately mean that nursing workers themselves face implicit pressures to continue working at their assigned customer households, upholding customer–centricity even when subjected to the everyday structural violence.

Productization and the foregrounding of customer–centricity has meant that corporate platforms in particular are able to utilize their digital infrastructures and managerial hierarchies towards the linkage, quantification, and monitoring of nursing labor. This process reframes care work around customer–centricity and invisibilizes its associations with caste power by couching it in depoliticized corporatized language of neutral ‘performance metrics’:



We think of what all you can have in the process so that it delivers results [around customer-centricity]. We have institutionalized the process around KPIs [key performance indicators] of people, which means from the top to bottom, everyone is incentivized. Their KPIs have Net Promoter Scores¹² in them, so patient satisfaction scores are very critical to everyone’s KPI.

—Co-founder and current CEO at HCAH, in a public social media interview¹³

The co-founder and CEO at HCAH further narrated the importance the platform places on customer–centricity right from onboarding the customer, to using digital technologies towards continuous monitoring and communication with the customer, to deploying formal feedback processes that compute Net Promoter Scores for nursing workers and workers in the managerial hierarchy.¹⁴

¹² Net Promoter Score (NPS) is a market research metric commonly used by corporatized entities that measures how likely customers are to recommend a company’s products to their social networks.

¹³ Social media interview with the co-founder and current CEO at HCAH in: elets Tv. (2023, July 31). Innovation talk with Vivek Srivastava, Co-Founder & Chief Executive Officer, HCAH [Video]. YouTube. <https://www.youtube.com/watch?v=bcXdMXhqXFk>

¹⁴ Social media interview with the co-founder and current CEO at HCAH in: elets Tv. (2023, July 31). Innovation talk with Vivek Srivastava, Co-Founder & Chief Executive Officer, HCAH [Video]. YouTube. <https://www.youtube.com/watch?v=bcXdMXhqXFk>

Corporate platforms in particular maintain digitalized and managerial processes for regular ratings and feedback from customers. In the seven years that Aarti* was at Portea, the ratings and feedback system became increasingly digitalized, moving from a system where the customer wrote down their feedback that she then submitted to the platform office towards a system where the customer provided ratings and feedback digitally through email or the Portea app. As these systems became digitalized, they also became opaque to the workers. Workers now had no direct information on the feedback they received nor were they informed on feedback by their managers. These systems that reinforce caste hierarchies, veiled as customer-centricity, are further institutionalized on corporate platforms, where platforms engage several quality analysts and managers to datify and convert ratings and feedback, net promoter scores, and customer satisfaction scores into key 'metrics' of customer-led labor disciplining (Joblum, 2025). As sole metrics of 'performance evaluation' in invisibilized workplaces of customer households, corporate platforms entrench and invisibilize caste hierarchies by encoding ratings and feedback systems, net promoter scores, and customer satisfaction scores as central to their decision-making on workers.

As we will see in the following section, the entrenchment of social hierarchies by corporate platforms in their mobilization and productization strategies has only revealed their facade of formalization, and further revealed their agenda of leveraging workers as mere instruments towards corporatized platform strategies.

A facade of formalization, an agenda of digital instrumentalization

The institutional logics and practices of corporatization, professionalization, and productization in the platformization of home healthcare enable corporate platforms to claim that platformized home healthcare work can be aspirational, empowering, and lead to formalization of employment in the sector (Ganesh, 2020). These platforms also claim that home healthcare work offers the possibilities of training, upskilling, and professional development, with high job satisfaction.¹⁵

However, in my interviews with the nursing workers across institutional forms of offline agencies, small platforms, and medium-large corporate platforms, I find stigmatization and devaluation of labor and laborers persists across both non-platformized and platformized institutional settings. As we saw in the sections above, stigmatization and devaluation are deeply embedded in income, geography, migration, gender, and caste hierarchies, mediated by corporate platforms' varying strategies around expansion, customer acquisition, productization, customer retention, and customer-centricity. Workers' experiences emphasize the intersections of women's experiences with institutional forms, migration, gender, caste, and informality. Enduring structural inequalities mean that workers continue to navigate the capitalist-patriarchal-casteist nexus of domination, even in settings that claim to have been transformed through the dual forces of corporatization and platformization.

15 Social media interview with the co-founder and current CEO at Portea in: National Skills Network NSN. (2023, May 5). Skill development and jobs in Home Healthcare | Mr Vaibhav Tewari CEO Portea [Video]. YouTube. https://www.youtube.com/watch?v=_CEIDnFstq8

Workers' experiences bring to light the facade of formalization that corporate platforms have built, obscuring the realities of 'organized informality' characterized by the absence of formal contracts and labor protections, and the absence of occupational mobility (Gooptu, 2013). Nursing workers faced insecurity and instability in their employment in both the short and long term. Despite the purported formalization of their work, workers in both offline agencies and platforms did not receive living wages nor did they receive formal contracts and employment benefits such as ESI and PF. In corporate platforms, wages were only marginally better than with other institutional forms. If and when workers did receive both formal contracts and employment benefits, these were made available only to a minute fraction of nursing workers (SEBI, 2022).

Alongside precarity and informality in employment, I also find through workers' experiences that the social and economic non-recognition and devaluation of nursing labor and laborers, especially with home healthcare, is deeply embedded within the broader private healthcare sector, contributing to chronic employment insecurity for nursing workers. Sowmya*, a nursing assistant, spoke of how home healthcare was still viewed as unskilled menial-affective- corporeal labor in institutional settings like hospitals and nursing homes. Workers' wages remain stagnant with little room for occupational mobility even in institutional settings, regardless of the years of work experience that they have in home healthcare. "Even if you have done 10 years in home care, they will still only take you as a fresher in hospitals.", she said.

The emergence and trajectories of corporatization and platformization in home healthcare reveal their insidious role in growing 'organized informality' and shifts towards new service economies of care, as part of broader tendencies of post-liberalization market-state collusion towards the systematic dismantling of workers' rights.

The nursing workers' narratives show us how in platformized yet informalized settings such as home healthcare platforms, it becomes crucial to look at adverse incorporation, which I adopted as an implicit analytical frame in this paper. The framework enables us to critically investigate intersecting structural socio-political inequalities that shape everyday experiences of work, amidst broader socio-economic transformations, and ultimately reveal ruptures between the rhetoric and the realities of 'inclusion' and 'empowerment' for workers within platformization (Hickey and du Toit, 2013).

Conclusion

This paper has illustrated, at multiple points, the ways in which platform institutional logics and practices leverage workers themselves as instruments towards realizing promises of platformization for customers. Platform institutional forms have rapidly emerged across sectors in India and shared global majority contexts, building a new precariat within new service economies that cater to consumerist urban class and caste elites. Amidst these socio-economic transformations, I propose an emphasis on developing a lens of 'digital instrumentalization' towards foregrounding workers' experiences within these broader transformations and tendencies.

In the paper, I primarily interrogate the institutional logics and practices of medium-large corporate home healthcare platforms. I argue that corporate platforms undertake strategies and practices that ultimately serve to utilize workers as instruments towards enabling 'techno-corporate' care for platform customers.

Looking at the workforce mobilization strategies of corporate platforms, the targeted mobilization of platforms affords them greater labor disciplining power, and also affords them a trained workforce to leverage towards strategic objectives of customer acquisition. The corporate platforms' productization strategies fundamentally rely on gender and caste hierarchies encoded in corporatized notions of customer-centricity, customer retention, and continuity of care. Finally, I dismantle the facade of formalization in employment that corporate platforms enable, and reveal their agenda of the digital instrumentalization of nursing workers.

References

- Basu, H. (2019). Mode of work organization in nursing: Management practices in private healthcare in India. *Management and Labour Studies*, 44(4), 433–454. <https://doi.org/10.1177/0258042X19870935>
- Chakravarthi, I., Hunter, B., Marathe, S., & Murray, S. F. (2023). Corporatisation in private hospitals sector in India—A case study from Maharashtra. *Economic and Political Weekly*, 58(11). <https://www.epw.in/journal/2023/11/special-articles/corporatisation-private-hospitals-sector-india.html>
- Das, R. (2021). Home health care industry in India; an account of genderised labour in commercial health care economy. *Women's Studies International Forum*, 88, 102497. <https://doi.org/10.1016/j.wsif.2021.102497>
- elets Tv. (2023, July 31). *Innovation Talk with Vivek Srivastava, Co-Founder & Chief Executive Officer, HCAH* [Video]. YouTube. <https://www.youtube.com/watch?v=bcXdMXhqXFk>
- Ganesh, M. (2020, February 24). Home health care and patient safety in India—ET HealthWorld. *ETHealthworld.Com*. <https://health.economictimes.indiatimes.com/news/industry/home-health-care-and-patient-safety-in-india/74285193>
- Ghosh, A., Ramachandran, R., & Zaidi, M. (2021). *Women workers in the gig economy in India: An exploratory study*. Institute of Social Studies Trust. <https://isstdigitallibrary.jivesna.com/jspui/handle/123456789/1608>
- GIBS Business School, Bangalore. (2024, October 3). *Revolutionizing healthcare: Mr. Vaibhav Tewari - Founder & CEO at Portea | GIBS IRE Talks Podcast* [Video]. YouTube. <https://www.youtube.com/watch?v=GVpOv972tYE>
- Gooptu, N. (2013). Servile sentinels of the city: Private security guards, organized informality, and labour in interactive services in globalized India. *International Review of Social History*, 58(1), 9–38. <https://doi.org/10.1017/S0020859012000788>
- Gopal, M. (2013). Ruptures and reproduction in caste/gender/labour. *Economic and Political Weekly*, 48(18), 91–97. <https://www.epw.in/journal/2013/18/review-womens-studies-review-issues/ruptures-and-reproduction-castegenderlabour.html>
- Grover, S., Chambers, T., & Jeffery, P. (2018). Portraits of women's paid domestic-care labour: Ethnographic studies from globalizing India. *Journal of South Asian Development*, 13(2) <https://doi.org/10.1177/0973174118793782>
- Grover, S. (2022). Placement agencies for care-domestic labour: Everyday mediation, regimes of punishment, civilizing missions, and training in globalized India. *Modern Asian Studies*, 56(6), 1901–1929. <https://doi.org/10.1017/S0026749X21000585>
- Gupta, P., & Randhawa, S. (2023). *Home healthcare emerging phenomenon in India*. Health Systems Transformation Platform (HSTP). <https://web.archive.org/web/20241012030746/https://www.hstp.org.in/kc/home-healthcare--emerging-phenomenon-in-india>

- Guru, G. (2009). Archaeology of untouchability. *Economic and Political Weekly*, 44(37), 49–56. <https://www.epw.in/journal/2009/37/special-articles/archaeology-untouchability.html>
- Harkonen, J., Tolonen, A., & Haapasalo, H. (2017). Service productisation: Systematising and defining an offering. *Journal of Service Management*, 28(5), 936–971. <https://doi.org/10.1108/JOSM-09-2016-0263>
- HCAH. (2025, March 1). *HCAH – India's trusted out-of-hospital care partner*. <https://hcah.in>
- HCAH. (2025, May 2). *Home attendant services | Female & male attendant for patient & Elderly–HCAH*. HCAH – Home Care – In Patient Rehabilitation Center. <https://www.hcah.in/home-attendant-services/>
- Healthcare Sector Skill Council (HSSC). (2025, May 2). *Healthcare Sector Skill Council (HSSC): Homepage*. <https://web.archive.org/web/20240919062337/https://www.healthcare-ssc.in/list-of-affiliated-training-providers.html>
- Hickey, S., & du Toit, A. (2013). Adverse incorporation, social exclusion and chronic poverty. In *Chronic Poverty. Rethinking International Development Series*. Palgrave Macmillan, London. https://doi.org/10.1057/9781137316707_7
- Immonen, J. (2023). HRM models of online labor platforms: Strategies of market and corporate logics. *Frontiers in Sociology*, 7. <https://doi.org/10.3389/fsoc.2022.980301>
- India Today. (2025, February 25). *Can your home be turned into an ICU? | Health Wealth*, Ep 84 [Video]. YouTube. https://www.youtube.com/watch?v=qgqpZzPKZ_Q
- International Center for Research on Women (ICRW). (2018). *Gender-smart Investing: Healthcare Case Study – Portea*. International Center for Research on Women (ICRW). https://www.icrw.org/wp-content/uploads/2018/12/ICRW_Portea_CaseStudy_2.pdf
- International Labour Organization. (2023). *Understanding and improving women's work on digital labour platforms: Stakeholder consultation workshop in India*. International Labour Organization. <https://www.ilo.org/publications/understanding-and-improving-womens-work-digital-labour-platforms>
- Iyer, A. (2019). Chapter 5: Marginalizing youth through skilling—Understanding the vocational subject of healthcare. In R. Maithreyi, K. Prabha, A. Iyer, S. R. Prasad, & J. Jha, *A Critical Sociological Analysis of the Skills Development Initiative of India*. Centre for Budget and Policy Studies (CBPS). https://cbps.in/wp-content/uploads/2024/12/Report_A-Critical-Sociological-Analysis-of-the-Skills-Development-Initiative-of-India_2019.pdf
- Joblum. (2025, March 1). *Job: Quality analyst at Portea Medical India*. <https://web.archive.org/web/20250301022136/https://in.joblum.com/job/quality-analyst/6545751>
- John, M. (2019). *Nurses in India: Migration, precarious employment conditions and resistance*. Centre for Women's Development Studies (CWDS). <https://www.cwds.ac.in/wp-content/uploads/2025/02/Working-Paper-101.pdf>

Kikon, D., & Karlsson, B. G. (2020). Light skin and soft skills: Training indigenous migrants for the hospitality sector in India. *Ethnos*, 85(2), 258–275. <https://doi.org/10.1080/00141844.2018.1543717>

Krishnan, S. (2023). Caste, class and space: Inequalities in India. In D. Bartmanski, H. Füller, J. Hoerning, & G. Weidenhaus (Eds.), *Considering space: A critical concept for the social sciences*. Routledge. ISBN: 9781003361152.

Life Circle Health Services. (2024, February 19). *Transforming senior care: Insights from CII Care Panel with Priya Anant* [#CII #lifecircle #homecare] [Video]. YouTube. <https://www.youtube.com/watch?v=o6HtTQthqQI>

Maithreyi, R. (2019). Conclusion. In R. Maithreyi, K. Prabha, A. Iyer, S. R. Prasad, & J. Jha, *A critical sociological analysis of the skills development initiative of India*. Centre for Budget and Policy Studies (CBPS). https://cbps.in/wp-content/uploads/2024/12/Report_A-Critical-Sociological-Analysis-of-the-Skills-Development-Initiative-of-India_2019.pdf

Marathe, S., Hunter, B. M., Chakravarthi, I., Shukla, A., & Murray, S. F. (2020). The impacts of corporatisation of healthcare on medical practice and professionals in Maharashtra, India. *BMJ Global Health*, 5(2). <https://doi.org/10.1136/bmjgh-2019-002026>

Ministry of Skill Development and Entrepreneurship (MSDE). (2023). *Guidelines for प्रधान मंत्री कौशल विकास योजना 4.0*. Ministry of Skill Development and Entrepreneurship (MSDE), Government of India. https://www.msde.gov.in/static/uploads/2024/02/PMKVY-4.0-Guidelines_final-copy.pdf

National Skill Development Corporation (NSDC). (2025, April 25). *General Duty Assistant* / National Skill Development Corporation (NSDC). <https://nsdcindia.org/general-duty-assistant>

National Skills Network NSN. (2023, May 5). *Skill development and jobs in home healthcare* | Mr Vaibhav Tewari CEO Portea [Video]. YouTube. https://www.youtube.com/watch?v=_CEIDnFstq8

Portea. (2025, March 1). *Healthcare at home: India's #1 home care services*. <https://www.portea.com/>

Portea. (2025b, May 2). *Nursing attendant* | Trained attendants in home care | Portea. <https://www.portea.com/trained-attendants/>

Qayum, S., & Ray, R. (2003). Grappling with modernity: India's respectable classes and the culture of domestic servitude. *Ethnography*, 4(4), 520–555. <https://doi.org/10.1177/146613810344002>

Radically Yours by Radhika. (2025, February 7). From 0 to 500 cr | *How she became a MILLIONAIRE with multiple startups!?* [Video]. YouTube. <https://www.youtube.com/watch?v=Eiie8wc66-U>

- Ramiller, N. C., Davidson, E., Wagner, E. L., & Sawyer, S. (2008). Turning products into services and services into products: Contradictory implications of information technology in the service economy. In M. Barrett, E. Davidson, C. Middleton, & J. I. DeGross (Eds.), *Information technology in the service economy: Challenges and possibilities for the 21st Century* (pp. 343–348). Springer US. https://doi.org/10.1007/978-0-387-09768-8_25
- Rathi, A., & Tandon, A. (2021). *Platforms, power, and politics: Perspectives from domestic and care work in India*. Centre for Internet and Society. <https://cis-india.org/raw/platforms-power-and-politics-pdf>
- Ray, A. (2024). Professionalism as a soft skill: The social construction of worker identity in India's new services economy. *Third World Quarterly*, 45(4), 790–809. <https://doi.org/10.1080/01436597.2023.2223133>
- Ray, P. (2020). Nursing in Kolkata: Everyday politics of labour, power and subjectivities. *South Asia Research*, 40(1), 40–57. <https://doi.org/10.1177/0262728019894117>
- Ray, P. (2023). Institutionalizing feminine caste-based labour: Nurses and nursing aides in Kolkata. In C. Wichterich & M. John (Eds.), *Who cares?: Care extraction and the struggles of Indian health workers*. Zubaan. ISBN: 9789390514038.
- Ruthven, O. (2018). Getting dividend from demography: Skills policy and labour management in contemporary Indian industry. *Journal of South Asian Development*, 13(3), 315–336. <https://doi.org/10.1177/0973174118822398>
- Securities and Exchange Board of India (SEBI). (2022, January 7). SEBI | *Healthvista India limited—Draft red herring prospectus*. https://www.sebi.gov.in/filings/public-issues/jul-2022/healthvista-india-limited-drrhp_60506.html
- Surie, A. (2020). On-demand platforms and pricing: How platforms can impact the informal urban economy, evidence from Bengaluru, India. *Work Organisation, Labour & Globalisation*, 14, 83–100. <https://doi.org/10.13169/workorglaboglob.14.1.0083>
- Thorat, S., Madheswaran, S., & Vani, B. P. (2023). Caste and unequal labour market outcomes. In S. Thorat, S. Madheswaran, & B. P. Vani, *Scheduled castes in the Indian labour market: Employment discrimination and its impact on poverty*. Oxford University Press. ISBN: 9780198872252.
- Upadhyay, C., & RoyChowdhury, S. (2024). Crafting new service workers: Skill training, migration and employment in Bengaluru, India. *Third World Quarterly*, 45(4), 753–770. <https://doi.org/10.1080/01436597.2022.2077184>
- World Health Organization (WHO). (2020). *State of the world's nursing 2020*. World Health Organization. <https://apps.who.int/nhwportal/Sown/Files?name=IND>

Annexure

Table 1 In-depth interviews with women nursing workers in home healthcare		
By type of home healthcare job role		
Nursing attendant	Nursing assistant	Nurse
12	3	1
By type of home healthcare entity*		
Offline agency	Small platform	Medium-large corporate platform
14	6	4
* The interviewed workers have been part of various agencies and platforms in the years that they have worked in the home healthcare sector.		

Table 2 Key informant interviews with researchers and platform middle management	
Manjunath* (pseudonym)	Former nursing coordinator at small and medium-large corporate home healthcare platforms
Chetna V M	Researcher on platformized labor
Ritumoni Das	Researcher on home healthcare labor

Table 3 Publicly available social media interviews with senior corporate platform executives		
Meena Ganesh	December 2021 (see here)	Co-founder and former Chief Executive Officer at Portea (as of May 2025)
	August 2022 (see here)	
	February 2025 (see here)	
Priya Anant	February 2024 (see here)	Co-founder and current Director at Life Circle (as of May 2025)
Vaibhav Tewari	May 2023 (see here)	Co-founder and current Chief Executive Officer at Portea (as of May 2025)
	October 2024 (see here)	
Vishal Lathwal	February 2025 (see here)	Current Chief Executive Officer at Apollo Homecare (as of May 2025)
Vivek Srivastava	July 2023 (see here)	Co-founder and current Chief Executive Officer at HCAH (as of May 2025)
	July 2023 (see here)	