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BIOMETRIC GOVERNMENTALITIES: THE RISE OF DATAFICATION AND THE UNIQUE HEALTH IDENTIFICATION PROJECT IN INDIA

Faheem Muhammed
Pondicherry University

Samarjit Kachari
Pondicherry University

Introduction

India's healthcare sector has undergone a remarkable transformation over the last decade, powered by the integration of technology and medicine. The Ministry of Health and Family Welfare released the National digital health blueprint in April 2019 under the vision of the National Health Policy, 2017. This policy is an action plan to digitalize health records at the district level, maintain registries for diseases and link primary healthcare services with referral care services (Dhingra & Dabas, 2020). The major shift in India's healthcare system has been marked by a turn towards digitalizing health information and creating a Unique Health Identification Number (UHID) at the national level. Though centralized digital programs have been implemented in different states across India for the digitalization of health information and the creation of UHID, the use and adoption of these technologies vary among many states in India. This study offers a close analysis of the Unique Health Identification project with a case study of the South Indian states of Kerala, Puducherry and Andhra Pradesh. The paper investigates the norms of governmentalities in datafication by looking into the requirements and conditions of enrolment into the databases for accessing healthcare.

The Making of Unique Health Identification

The Unique Health Identification (UHID), also known as the Ayushman Bharat Health account (ABHA), is a 14-digit identifier linked to Aadhaar (the world’s largest biometric system), designed to distinguish individuals within India's digital healthcare system. Linking of ABHA and Aadhaar facilitates enrolment in Personal Health Records (PHR), further streamlining health data sharing. By April 2023, 380 million ABHA numbers have been issued, and over 262 million health records have been linked with their ABHA

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(Raj, Dananjayan & Agarwal, 2023). A person can access their health records from admission to treatment and discharge through ABHA as it facilitates longitudinal digital health records of an individual with disease history and previous treatments. Though ABHA is supposed to work on voluntary consent-based linking and sharing of personal health records (PHR), ABHA numbers have been created for beneficiaries enrolled through the CoWIN platform who have provided Aadhaar as the ID proof at the vaccination site. When ABHA is auto-generated from Aadhaar data, it raises concerns about the consent frameworks in the UHID project and threatens citizen's right to voluntary enrolment. An interoperable digital health infrastructure with biometric authentication of beneficiaries or patients requires the linking of ABHA with Aadhaar. When linked with Aadhaar, the ABHA ID will feature the demographic and biometric data of the beneficiary on the national portal. Linking ABHA with Aadhar and an individual's mobile number makes it imperative to consider the data protection and privacy of users or beneficiaries, given multiple instances of data breaches in Aadhar. When ABHA is not a mandatory identity, some states in India made ABHA mandatory for enrolment into the public insurance scheme -Pradhan Mantri Jan Arogya Yojana (PM-JAY).

Digital Health and Biometric Welfare in India

In the last two decades, Indian governments have shown peculiar interest in shifting towards a biometric-based identity authentication system for verifying welfare beneficiaries. Information infrastructures are established and maintained to streamline access to health care and welfare. The state's move towards the digitalization of the health sector has serious implications for how health care is availed and experienced by the people, especially the poor. Ayushman Bharat PM-JAY is the largest public health insurance scheme in the world. The scheme aims at providing health cover of 500,000 INR (around 6,000 euros) per family a year for secondary and tertiary care hospitalization to over 12 crore poor and vulnerable families (approximately 55 crore beneficiaries) that form the bottom 40% of the Indian population (National Health Authority, nd). Though PMJAY functions as an independent scheme under the Ayushman Bharat Digital Mission, ABHA or UHID is now a prerequisite to access PM-JAY public insurance and different health services in many states of India. To enrol in the PMJAY scheme, citizens must provide their ABHA number. However, having a UHID does not guarantee people access to public insurance; rather, their Aadhaar should be updated with mobile numbers and would have to go through OTP (one-time password) verifications for Aadhaar, ABHA and PMJAY services. When biometric identity systems are put in place for authorization and verification, people are forced to meet the demands of technical systems for accessing healthcare. The datafication of health and welfare is often manifested in unequal power relations between citizens and the state in which citizen bodies have to prove themselves constantly.

Biometric Identification: For whom?

A biometric-based health identity system that stores and maintains health records of individuals poses a severe threat to marginal populations (gender, sexual, religious and caste minorities) who are already facing discrimination. The history of global data infrastructures reiterates how information systems have been transformed into

surveillance weapons against the marginalized (Arora, 201 9). The mandatory requirement of Aadhaar for antiretroviral therapy has prompted HIV-positive people to drop out of treatment programs across India (Rao, 2017), fearing privacy violations and abuse. The mandatory requirement of ABHA for availing public insurance and its opaque data protection policy pose severe threats of data abuse. Masiero & Shakti (2020) highlight the embeddedness of Aadhaar within wider techno-social formations, suggesting the massive potential of Aadhar technology to be linked with other identity systems and the portability as well as mobility (dataflows) of digitally stored biometric data. Whereas, enrolment into health identity systems becomes a condition for citizens' rights to access healthcare and welfare. When ABHA is championed as a model for biometric-based health identity systems, it places citizen bodies at the mercy of socio-technical systems for recognition, authorization and verification of identity. Mishaps in fingerprint reading, complexities in IRIS scanning, delayed OTPs, and server issues often complicate access to digital health and welfare. The mandatory requirement to be enrolled into public databases often formats citizen bodies into datasets. Navigating through multiple ID systems, including ABHA, Aadhaar, and PMJAY, often confuses people and places the burden of being updated (in the ID systems) for availing welfare and healthcare. In some cases, people are not even aware of what one particular ID is meant for, and they still keep enrolling in new ID schemes when asked by government authorities.

Conclusion

Examining India's UHID project ABHA, which records biometric and demographic data of patients, the paper place biometric identity within its governance implications, highlighting UHID's role in redefining the state-subject relation. The paper raises concerns about the challenges in authorization and verification and the misuse of personal data, underscoring the complex social implications of UHID implementation. Dwelling on how citizen bodies and identities are formed and (re)negotiated across multiple identity systems, it concludes that digital health and biometric welfare often make enrolment into health identity systems a condition for citizens' rights to healthcare. Furthermore, the costs of data/biometric-based approaches in health have altered the notion of welfare as well as care, where the most vulnerable strata of the Indian population are forced to navigate the biometric regime to access healthcare and welfare.

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