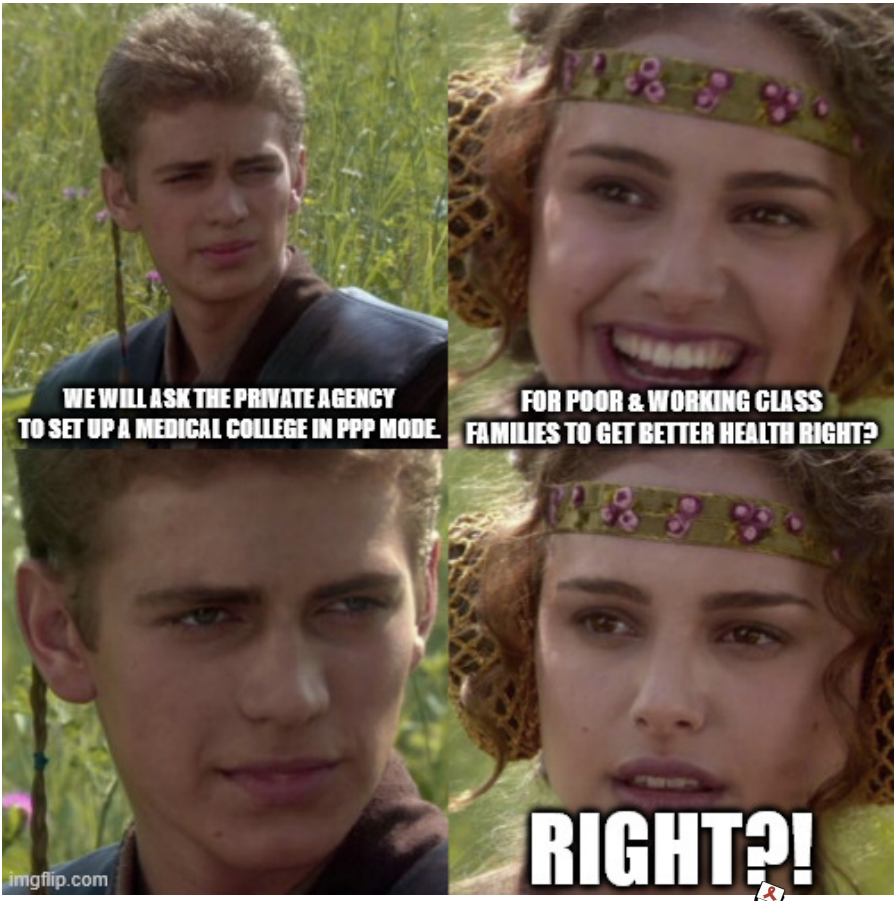
How we are losing our public health system

A Booklet on privatisation and its effects on the public health system

September, 2025



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SARVATRIKA AROGYA ANDOLANA KARNATAKA

Introduction

"The Karnataka government is planning to establish 11 new medical colleges under a Public-Private-Partnership (PPP) model in 11 districts that do not have government medical colleges at present" stated the article in The Hindu on Oct 20, 2024. The districts listed are - Tumakuru, Davangere, Chitradurga, Bagalkote, Kolar, Dakshina Kannada, Udupi, Bengaluru Rural, Vijayapura, Vijayanagara and Ramanagara districts. Previously in 2022, the state had mentioned the same for 9 districts and there was widespread protests and opposition from people in these districts against this and the decision was taken back. What has been key in pushing states including Karnataka to go in this direction is the NITI Aayog recommendation and guiding principles since 2019. NITI Aayog claims that "*it is practically not possible for the Central/State Government to bridge the gaps in the medical education with their limited resources and finances*" and with this justification, states are giving up the government district hospitals to private establishments.

Unfortunately the proposed solution of establishing medical colleges in PPP mode neither meets the gaps in healthcare nor the medical education in these districts. We will have to understand what this PPP will entail. If we just look one step ahead, it becomes clear that in the same arrangement, the district hospitals in these districts will be handed over to the private agency who agrees to establish the medical college. The reasoning being the set standards for a medical college to run with 150 MBBS seats annually, is that it should have a minimum of 300 beds teaching hospital (based on NMC). So the district hospitals would be handed over to the private agency to meet this criteria. What would "handing over" the district hospital mean? What more does this agreement between the state and the

private agencies be in terms of subsidies? Will people continue to access free services? Will the hospital continue to be a public asset that people can have a say in? Who would these private agencies be? Who would ultimately own the medical college and benefit from it? Answers to these questions not only reveal that this would make healthcare inaccessible to a large majority of population in these districts who are reliant on district hospitals resources, but also that the arrangement is just another dangerous form of privatisation and disinvestment in the public sector undertakings (PSU). Ultimately this is just large government subsidies and giving away public assets for private profits in the disguise of “partnership” and “development”.

In this context, this booklet outlines fundamentally how our public health system is being slowly dismembered, its vital parts handed over to private interests, until it no longer survives. We’ve structured this booklet by reviewing existing literature, evidence, government documents, and arguments in the public domain. So we’d like to acknowledge all the work that people have done in this domain so far and have referenced them at the end of the booklet.

Privatisation of public health system - a form of disinvestment

When gaining independence from the British, India resolved to ensure economic and social well-being of all its citizens, which was deliberately denied till then by the colonizing force of Britain. This resolve, expressed within fundamental rights, directive principles of state policy, and other sections of the Constitution, made India a "welfare-state". Unfortunately, in less than four generations, the Indian state seems to have forgotten this commitment and have fallen prey to an attitude of disinvestment wherein the state holds itself responsible only for "doing what it can" and over time keeps lowering the bar on "what it can" having unacceptable negative impact on health, education, and public utilities.

Whereas earlier the mandate for the state was to ensure welfare to its citizens, the mandate which the state now works towards is to prove its incapacity to do anything. The state actively disinvests and seeks intervention from outside and externalizes the task of welfare. It proudly claims that it is incompetent to build, run, or maintain public systems, including healthcare.

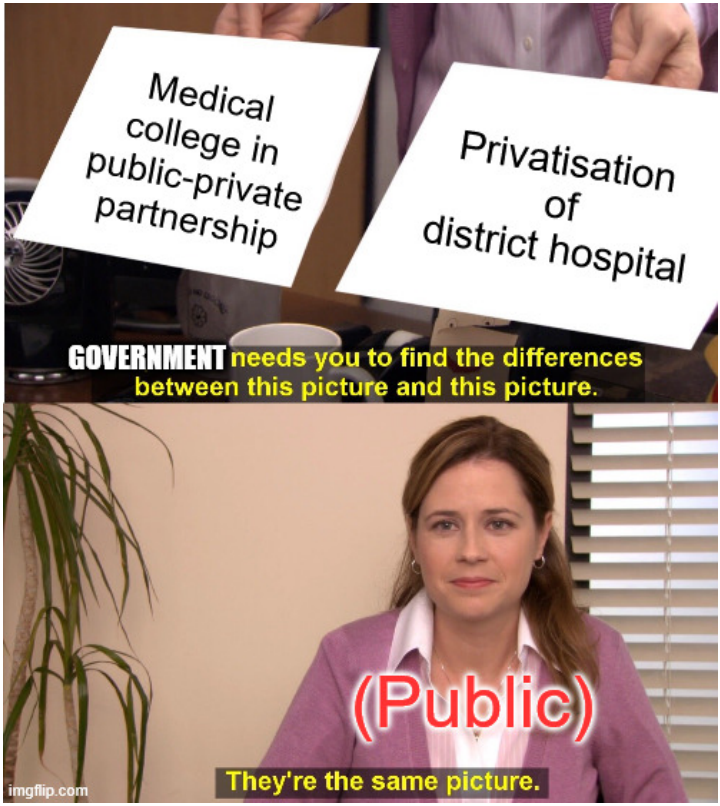
This serves the interest of the elite stakeholders:

- The government can abstain from responsibilities
- Private capital can make investments that return manyfold profit
- Public money can be diverted to sectors that benefit mostly the elite citizenry and make the rich richer
- And the politicians can claim credit for everything good while blaming others for everything that goes wrong

Unsurprisingly, this harms the interest of the majority of the population who have been disadvantaged for

generations and are unable to fulfil the full potential of their lives.

Disinvestment can take several forms, constantly under funding or reducing funds - eg: India continues to budget less than 2% of GDP for the health sector, many staff like medical officers, nurses, CHOs, continue to be on contractual nature of employment instead of investing in regular employment and securing benefits. Disinvestment can also take the form of partial or complete handing over of responsibilities/ service delivery to private agencies or what can be termed “privatisation” so that the government need not invest its (financial, human, infrastructure, technical, managerial, and other) resources.



Establishing Medical college in PPP model: "partnership" or privatisation?

One of the arguments that the government officials make is that this form of arrangement where a medical college is established by a private agency with a government site and giving away the district hospital is not privatisation but a useful partnership with the private agencies in order to bring "better services". In fact the health Minister of Karnataka in a TV channel interview with citizens' questioning about this, said this will bring more staff into the hospital and increase speciality services. The same minister who had earlier in 2023 mentioned "*I don't think we should be giving out district hospitals on the PPP model. Ultimately, it is our premises, our doctors, our nurses, our staff... I don't want to encourage PPP. We should strengthen our own department, especially PHCs, district hospitals, etc. It should be under the government's ambit*" and also promised the citizen groups when he came in power that his government would not go in the direction of privatisation of district hospitals.

Privatisation as described by the World Bank "occurs when all or substantially all the interests of a government in a utility asset or a sector are transferred to the private sector". Some other definitions if we see or even just use common sense, it can mean - transfer of ownership of specific government operations or services to the private sector. Again privatisation can take various guises. Something that has widely occurred for example is where the staffing of group-D sanitation workers in the health facilities are outsourced to a private agency. We all know what that has led to - precarious working conditions for the workers, lack of safety including against sexual violence, no labour rights, and accountability falling through the cracks -

slipping both the hands of the state and the private agency. Similar to this, different parts of our hospital/ healthcare system is cut into pieces and given to private agencies like ancillary services (ambulance, food), diagnostics, medicines, IT etc. Going into all forms of privatisation is beyond the scope of this booklet. But one of the serious forms is where facilities/institutes are given en masse to the private agencies because the government entrusts the private entity more than itself to be efficient. Giving the facilities to either non-profit organisations or worse for-profit companies and businesses in the guise of "public-private partnership".

And it is clear that a dangerous form of this is what the NITI Aayog guidelines suggest for establishing medical colleges. One where the site is **transferred** for a very subsidised lease **for 99 years** to build a **private college** AND the district hospital is not only going to provide support but will be **transferred** to the same private agency for **around 60 years. (which may extend).** So at least for 60 - 99 years, the definition of transferring the ownership applies and thus IS a form of privatisation! Call it "public-private partnership", or "private sector participation", or "partial privatisation", or "development" to make it sound harmless, but it basically is privatisation of our district hospitals and handing over public money for private profits.

Rema Nagarajan while presenting such PPP arrangements throughout the country in an article in TOI wrote, "*Yet, Karnataka has announced its intention to start nine new medical colleges in PPP mode by which over 2,000 beds in nine district hospitals worth more than Rs 1,000 crore of public money invested in building these hospitals, and hundreds of acres of public land will be handed over to private players.*"

Evidence: Can the private agencies really meet the critical gaps?

One of the main arguments for PPP arrangements in healthcare in general is that they meet the critical gaps that exist within the public health system - either in terms of resources (financial, human etc) or in terms of techno-managerial aspects and make the service delivery more "efficient". This can only happen when the goals (and motives) of the state (public) and private entities are the same. But we know clearly that the motive of the state primarily as mentioned above is welfare, while that of the private in order to survive will have to prioritise profit-making. This we need to acknowledge not as a moral judgement but in terms of how the market system functions and so to ignore these innate differences in motive and expect to get better results in terms of meeting the needs don't fit logically however well intentioned the parties are.

There is enough evidence documented to also show the failure of such PPPs initiatives - in primary, secondary and tertiary care levels across states. A report, "*Public Private Partnerships Reflecting on 20 years of theory and practice*" produced by the people's health movement in India during their third National Health Assembly (2018) have systematically put together various case studies. These essentially show that by just shifting the ownership to private establishments, the existing gaps like retaining human resource, improving quality of care, governance issues etc don't get addressed. Rather newer problems emerge due to the perverse incentive of profit making - like prioritising high profit yielding services/ treatments/ specialists, prescription of unnecessary diagnostic and treatment modalities, higher OOPE for patients who can't

afford, unavailability of common facilities, further violation of labour laws for the human resources to name a few. "*Even with the best of the PPPs, all that we can assert is that they were able to survive*" states the report.

To state examples from Karnataka - Government of Karnataka went into an agreement with the Apollo Hospitals to provide management of the Rajiv Gandhi Super Speciality Hospital (RGSSH), Raichur and super-speciality clinical care services with free services for patients below poverty line. The 350 bedded hospital was built on 73 acres with financial aid of INR 60 crore from OPEC (Organization of Petroleum Exporting Companies) in 1997. The agreement came into effect in 2002 and an evaluation was carried out in 2011. Public health experts who have accessed this report through RTI have analysed the failure of this in their book chapter. It had failed to meet its responsibility to provide free care to BPL patients and only around 25 percent of the In-Patient (IP) services and 15 percent of the Out-Patient (OP) services had been utilized by the BPL patients over the period of 10 years. Services were limited and referrals were frequent. Out of the 350 beds, 154 were operational and among that only 40 were available for BPL patients. The community around the hospital reported harassment in the name of BPL card verification and were demanded INR 25,000 upfront. Employees didn't get their salaries for 3 months. This agreement was brought into effect despite citizens groups raising concerns and due to the failure, the contract had to be terminated in 2012 by the state government.

In 2016 the 70 bedded Government Maternity and Children Hospital in Udupi was handed over to industrialist BR Shetty (BRS Health Research Institute Private Limited) to develop into a multi-speciality hospital and manage the hospital for

30 years. This was done despite citizen groups' opposition and the history of the land being donated by Haji Abdullah Saheb with the condition of providing free healthcare. Due to poor management, failure to pay salaries to the staff, the state had to terminate the agreement and take the administration of the hospital (Kosamma Shambhu Shetty Memorial Haji Abdullah Government Mother and Child Hospital) back into Government's hands in 2022. Despite this failure, there seems to have been plans in 2024 to hand it over to another private agency in PPP and establishment of a medical college in PPP mode which continues to be opposed by various groups including the Haji Abdullah Trust.

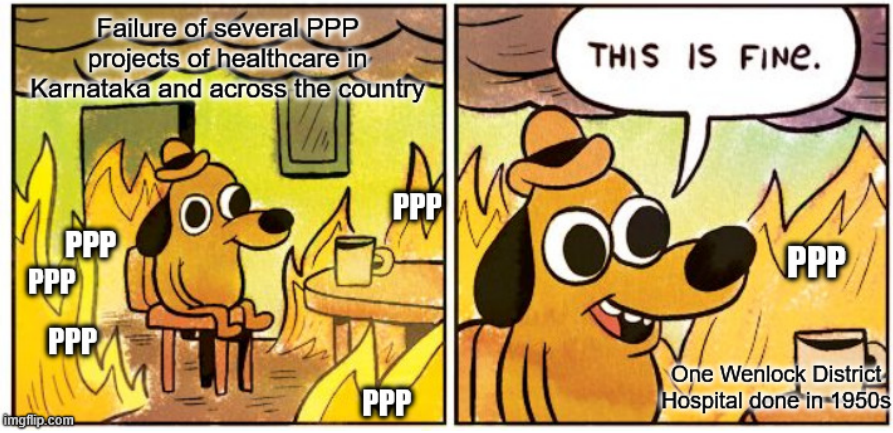
Even the Arogya Bandhu scheme in 2011-12 which had pushed for partnership with NGOs and charitable trusts and medical colleges to run PHCs in Karnataka had to be reversed. The state government passed an order in 2016 to scrap after evaluation showed non-compliance with rules, misuse of funds, lack of accountability, and failure to provide quality service to patients.

Usually when vouching for PPP, the officials in Karnataka give the only example of Wenlock's hospital. But one has to question the context and time when this partnership came into being - in the 1950s just post independence. The state can't look away from all the remaining evidence within Karnataka and other states that time and again shows that such initiatives not only fail to meet the gaps and deliver but also drain the resources from public funds.

Similar evidence from Maharashtra was published recently describing PPP projects in secondary and tertiary care hospitals that showed such models end up prioritising commercial interests over public health goals. They noted that many hospitals had low utilisation rates and were

unaffordable for the majority, with costs 3 to 15 times higher than those in government hospitals.

Despite these learnings and growing evidence over decades and resistance from various people's movements, every government (whichever party is in ruling) has buried their head in sand and continues to push for PPP or privatisation of health care with enthusiasm in Karnataka and other states. This naturally raises the question of what it is in it for them. There are enough instances of conflict of interest among people in power. Example: Banas Medical College, Gujarat; Parul Institute of Medical Science and Research, Vadodara; GCS Medical College and Research Center, Ahmedabad; Zydus Medical College and Hospital, Dahod; in Gujarat, GK General Hospital was given to Adani in 2009.



Is it really about "limited resources"?

The major argument or logic that the state governments and NITI Aayog recommendations present are "**limited resources and finances**". That is to say - to meet the gaps in healthcare or medical education - the state doesn't have enough resources and so we invite private participation to meet these needs. But this underlying thought process can be challenged. Prabhat Patnaik argues that the state is not a private individual to have this resource limiting mind set. If basic essentials and welfare of the people are prioritised, then the state has the authority and responsibility to raise adequate resources (through taxation and loans) to meet these standards.

Karnataka is spending 4% of the total budget on health (national budget - 6.4% of the total budget - which is also inadequate). India's tax-GDP ratio is also very low, among the lowest in the world. This shows where the priority of the state is - in globalised markets and neo-liberal agenda. Additionally, even though private establishments enter into agreements to meet these ends, we know from previous examples that such agreements still involve large government investments and draining of public resources. All of which is mostly going to benefit the private entities and we end up losing whatever resources we own as well. This arrangement inevitably results in private entities increasing the prices - and the government having to pay more and more. The government budget is drained, private profits increase and the government system is not strengthened, instead it continues to starve and die. **Hence the argument of limited resources is like selling the well because there isn't enough water in it.**

Who are these medical colleges for?

If we look at who these medical colleges established through PPP mode serve - it is clear that these are going to be private medical colleges that are mostly going to be affordable to class and caste-privileged students only and unaffordable to a vast majority of students. The fee to study in such medical colleges will be at par with usual private medical colleges that range from 1.5 lakh to 20 lakh annually with very few state quota seats. The PPP arrangement doesn't promise any higher number of state quota seats. So the promise that more students will have access to medical education is a deeply exclusionary and wrong one. Ensuring the representation of students from caste- and class-marginalised backgrounds in medical education is not only about fairness in access, but has the power to transform the health system to be more equitable, inclusive, and respond better to marginalised communities. So the solution to having enough doctors to cater to the public health system cannot be just a number issue where we produce doctors by hook or crook. We need to look into who and how these doctors are being trained in order for them to actually meaningfully contribute to the health needs of the majority of the population. Moreover, we need to concentrate on the quality of medical education that builds good doctors who are willing to work in districts/ regions where doctors are in shortage and not simply focus on increasing the numbers. Otherwise the medical colleges built in this mode will neither be for the well deserving vast majority of students nor for the betterment of overall healthcare in these districts.

Now that the political context, historical evidence and practical limitations of privatisation is set, let's see what the NITI Aayog guidelines say.

Key Provisions in this arrangement and what can be expected?

Below summarises key points from the NITI Aayog Public Private Partnership in Medical Education Concession agreement - Guiding Principles, for a detailed understanding please refer to the document here.

1. Basic agreements between the private establishment and the state authority -

- The private establishment will construct the Medical College on the site given by the government. The site will be given for lease to the private establishment for 99 years at payment of a subsidised lease. Eg: 8% of the circle rate of the land.
- The government district hospital is handed over to the private establishment for 60 years (which may extend) and the private establishment will have all the rights to operate and maintain the hospital.
- The private hospital is also expected to augment or develop the district hospital further with grant funds from the government.

2. Which private establishments will the government give to?

- Whichever private establishment asks for the lowest grant/funds for development of district hospital or offers the highest amount to pay the government as "premium" in the bidding process - will enter the contract.
- In past such arrangements in India in health and other sectors, we have seen how these are often given to the corporate giants who may be favoured by the political/ ruling parties. Eg: in Gujarat, GK General Hospital was given to Adani in 2009. So the intention of the private establishment is very clear - one of profit making and not ensuring health of the majority of people dependent on

the district hospitals.

3. What does handing over the district hospital mean? Will people continue to get free treatment? - This will be dangerously compromised!

- **Managing board will be left to the private establishment with only one member from ARS (Arogya Raksha Samiti)**
- **People will end up paying a lot for their care**: Patients and beds - are said to be divided into "**paid patients**" and "**free patients**" where the private establishment is supposed to provide care for free for "free patients" and can charge as they will (based on market rates) for the "paid patients". So we can only imagine where the interest of the private establishment will be - to develop more beds for the "paid" category from where profits can be made.
- But in order to be eligible as a "free patient", one needs to get an authorization certificate which can become a huge barrier to get access to care. People will have to roam around and be at the mercy of the private establishment to get admitted to the beds that should be rightfully theirs.
- The existing beds and those that the private establishment will further develop will get divided into "paid" and "free" categories. Already people are struggling to get beds in government hospitals for their care and this will further snatch the beds away from people for profit making. Eg: Davanagere district hospital has 930 beds. Among this, it might be possible that 300 beds would be allotted as "free beds" and remaining allotted as "paid beds" for those who can pay high charges for care.
- Further for diagnostic tests - even "free patients" might be charged high rates as per the CGHS (Central Government Health Scheme) rates. Eg: a simple blood test of complete blood count can be as high as ₹140.
- **Denial of care**: It is said that patients shouldn't be

denied admission under “free beds” but if there is a reason like bed non-availability they can be denied. This will definitely lead to denial of care and people will have to fall back on private hospitals and spend huge amounts for their care.

• **Ancillary services**: the private establishment is free to charge any amount for cafeteria, lodging facilities, vehicle facilities etc. Moreover there is no mention if the food will be provided free for the patients.

4. Is the private establishment paying for the care for “free patients” - NOT entirely.

• It is not even that a private establishment is paying for the care of “free patients”. It can get reimbursements from the government for the care provided under Ayushman Bharat and various insurance schemes. Further governments might also under this agreement provide fund support for the operations/running costs of the district hospital. So it is almost like the government is providing the district hospital, paying for its development and paying for the patient care also and letting the corporations make profits.

• Further the medical college seems to be completely of private establishment owned and will have high fees that will become their revenue.

What next now?

When we see the inherent contradictions in privatisation or PPP arrangements for a service that should be a public good, it becomes clear that the market can't meet the healthcare needs of our country. Such an arrangement is unconstitutional and in opposition to the welfare state. Healthcare is and should remain the government's accountability to ensure welfare of the people. Privatisation will have detrimental consequences to people's health and also to the working conditions and labour rights of the staff - doctors, nurses, health workers.

As per the TOI article states of Chhattisgarh, Goa, Haryana, Himachal Pradesh, Jammu & Kashmir, Kerala, Manipur, Mizoram, Nagaland, Puducherry, Punjab, Tamil Nadu, Telangana, Tripura have not opted for PPP. Karnataka should save their public hospitals by progressively ruling out the PPP model for public hospitals like their neighbouring states of Tamil Nadu, Kerala and Telangana.

There has been on-going resistance to various kinds of privatisation including the establishment of medical colleges in PPP mode across the country over years. In Karnataka too in 2022, such a move was opposed and the government had to take back the proposal due to widespread protests of various progressive people's groups in Davanagere. Campaign against privatisation (PPP) of district public hospitals in Karnataka also led a protest rally in Kolar in June, 2025. A signature campaign in Karnataka launched on Independence day this year is in progress and several people's organisations including Sarvatrika Arogya Andolana Karnataka have extended their solidarity. In September, widespread indefinite sit-in protests are on-going in Bijapur district. Across the country this opposition is only growing stronger. Protests in Madhya Pradesh have

forced the government to put the plan on hold. Tribal communities have staged protests in large numbers to save their district hospital in Gujarat. The fight continues in other states as well - Maharashtra, Andhra Pradesh, Jharkhand.

Such resistance needs more and more solidarity across collectives, individuals, citizens in general. You can also be part of this -

- Read about the fights that each state is putting to resist privatisation of healthcare in India. JSA in its blog - "Health on the Frontlines" has been publishing experiences from various states
- Sign the letter written to the officials to NOT Privatise District Hospitals in Karnataka in the name of PPP
- Talk to people around you about the issue
- Join the local campaigns in your region.
- Talk to your MLA/MP about the issue and appeal to them to oppose PPP or privatisation of district hospitals and healthcare
- If you'd like to be part of the campaign in Karnataka contact us
- File RTIs in your districts regarding the documents related to PPP arrangements proposed or on-going projects.
- Engage in research that can contribute to the campaign for eg: documenting the details of such arrangements in your region.

Acknowledgements

We gratefully acknowledge the contributions of all activists, collectives, researchers, public health practitioners, and groups who have carried forward the struggle against privatisation over the years across the country, many of whose work is listed in the resources below. Special thanks to Padmavathi, Navya MS, Akash Kudligi, and Savinitha Prakash for their creative support in making relevant memes, and to Pushpa V for carefully proofreading the Kannada version of this booklet. We thank all SAAK members for their support and inputs for the booklet.

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Contact us

Sarvatrika Arogya Andolana Karnataka

SAAK, a people's campaign for Universal Health Systems, Karnataka is a state-level collective of various trade unions, people's organizations, civil society organizations, networks and individuals working on public health and nutrition issues, including beedi workers, construction workers, garment workers, domestic workers, sex workers, sanitation workers, manual scavengers, migrant workers, unorganised workers, women, gender and sexual minorities, tribals, Dalits, farmers, elderly, people with disability, urban and rural poor, people living with HIV, and others. We are working together to ensure a Universal health system based on the right to health in Karnataka.

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Action for Equity

ACTION FOR EQUITY

Action for Equity strives for a just and equitable health system that enables people to live dignified lives. We believe that a society becomes equitable by a continuous process of questioning and dismantling existing power and oppressive structures and that collective action with hope and rationality is the way forward to bring about such social change.

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