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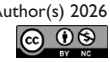

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Financialisation of the health sector: The case of public–private partnerships in India

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Abstract

This paper traces the evolution of public–private partnerships (PPPs) in India's health sector during the past four decades. These partnerships have been transformed because of their engagement with commercialisation and financialisation. Drawing on political economy frameworks and policy analysis, it argues that PPPs cannot be understood as technical instruments. They are institutional expressions of broader neoliberal reforms that reshape the role of the state and expand market influence in health systems. The paper identifies four phases of neoliberalism in India—pre-liberalisation, liberalisation, post-liberalisation, and more recently deepening of financialisation. In each of these phases there was a continuum of neoliberal ideas with introduction of new actors, organisational forms, and financial arrangements. While PPPs have expanded their outreach in some areas, it has led to fragmentation of the health services, widened inequities, and strengthened financial interests of the for-profit sector. The consolidation of financial interests has strengthened corporatisation of health services in India. The paper highlights the implications of this trajectory for universal health coverage and calls for renewed public stewardship to ensure equity and accountability in health service system delivery.

Keywords

public–private partnerships (PPPs), neoliberalism, health policy, commercialisation, financialisation, health system, health sector reforms

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Background and context

The growth of public–private partnerships (PPPs) in India, as in most lower- and middle-income countries (LMICs), has been witnessed since the early 1990s. PPPs have transformed from simple to complex forms over the past four decades. The health sector has transformed into a complex, multi-layered landscape in which multiple private actors (for-profit and non-profit) sit alongside the state as architects of how care is organised, financed, and delivered.

In this paper, we discuss the history of PPPs in India and how they have evolved over the past three decades across four phases of neoliberalism, using Fine's (2020) framework. There has been a shift from domestic non-profit actors to a mix of global and domestic non-profit and for-profit actors. These are no longer restricted to provisioning of health services but extend to private capital in financing, pharmaceuticals, and medical technology, deepening the scope and complexity of public–private interactions. While different forms of PPPs continue to shape the delivery and financing of health services and have evolved over the years, a new phenomenon has emerged alongside them. These are arrangements between private entities—corporate hospital chains tied to private equity firms—which operate outside the traditional PPP framework, yet have acquired state legitimacy through regulatory concessions, land grants, and insurance empanelment, and now profoundly shape the health system.

For the purposes of this paper, PPPs in India are understood as institutional arrangements through which the state mobilises public funds, public authority, or regulatory privileges to contract, subsidise, or partner with non-state actors—whether non-profit, for-profit, philanthropic, or financial—to deliver, manage, finance, or expand health services. PPPs are defined not by narrow typological categories but by their shared political–economic logic (Baru and Nundy, 2021; Chukwuma et al., 2025; Fine 2020, Romero and Van Waeyenberge, 2020).

Available studies show that there is a lack of conceptual clarity in the definition of PPPs (Baru and Nundy, 2021; Ravindran, 2011; Venkat Raman and Björkman, 2009; Wong et al., 2015). Romero and Van Waeyenberge (2020) argue that having no universal definition "fosters convenient ambiguities in defining the roles and expectations of each partner" and ultimately "permits the interests of the strongest partner to be served under the guise of serving the weak" (p. 40). However, typologies tend to treat each arrangement as sui generis, as a discrete "type" that can be meaningfully compared across contexts. This can lead to fragmentation in analysis and a failure to see PPPs as part of a broader systemic phenomenon. PPPs are increasingly about mobilising private finance, global capital, and long-term revenue models, not just contracting private providers. They highlight that PPPs now frequently involve complex financing mechanisms and must be understood as a part of larger processes of financialisation and globalisation of public services.

It is important to note that the expansion of PPPs in the health sector has been actively promoted by neoliberal actors on the grounds that private sector participation is essential for achieving Universal Health Coverage (UHC). It has been argued that public resources alone are insufficient to close the financing gap required to achieve UHC and Sustainable Development Goal 3 (SDG3), and that PPPs can mobilise additional private capital,

bring managerial efficiency, and extend coverage to underserved populations. This rationale has been used to justify PPPs across a wide range of health services and contexts, including in India. The assumption that PPPs are necessary vehicles for UHC has, however, been contested. Critics argue that rather than supplementing public resources, PPPs frequently redirect public funds towards private value chains and create accountability deficits that undermine the equity goals of UHC (Chukwuma et al., 2025). The Indian experience, traced in this paper, offers substantial evidence for the latter position.

The paper extends the existing body of work on PPPs in India in three respects: it provides a systematic longitudinal analysis of PPPs across four phases of neoliberal reform in India; it advances the theoretical framework from commercialisation to financialisation by adapting and extending Fine's (2020) periodisation and situating PPPs in the context of financialisation.

The paper proceeds as follows: the following section provides the analytical framework defining key concepts. The empirical section traces PPPs across four phases of neoliberal reform. The discussion draws out the implications for health equity and public stewardship.

Analytical framework

Concepts of commercialisation, privatisation, and financialisation are rooted in neoliberal reforms, each reshaping the role of the state and the organisation of public services in distinct ways. They have been applied systematically across multiple public service domains, including education, water supply, housing, and social protection. The same underlying logic has operated across sectors where markets are presented as more efficient and responsive than state provision, public assets and functions are transferred or contracted to private actors, and financial instruments are used to mobilise private capital for what were previously considered public responsibilities (Gideon and Unterhalter, 2020). The following definitions describe how each of these processes has operated specifically in health systems.

Commercialisation refers to the introduction of market norms, competitive incentives, and revenue-generating practices within public health institutions and market forces in the health services (Baru, 2005; Mackintosh and Koivusalo, 2005). It does not require a change in ownership; instead, it reconfigures public providers to operate under business-like logics. In India, this occurred early through user fees, hospital autonomy, and corporate management practices (Baru, 2005). Commercialisation establishes the ideological and institutional conditions for later reforms by weakening public values of universality and embedding internal markets within public health systems. Thus, PPPs can be seen as an outcome of commercialisation and a stepping stone towards privatisation.[1] Although PPPs are presented as alternatives to full-scale privatisation, they are conceptually inseparable from the continuum from commercialisation to privatisation. PPPs restructure state roles, decision-making authority, and control over health services.

Financialisation refers to the growing dominance of financial actors, markets, instruments, motives, and logics in organising healthcare. The Structural Adjustment

Programmes (SAP) introduced financialisation of the public sector with the introduction of internal markets. Instruments such as user fees, concessional loans and subsidies, and the contracting-in of services were earlier forms of financialisation within the health system. In more recent years, these dynamics have intensified and consolidated, drawing global capital, investment actors, and increasingly sophisticated financial mechanisms into the core of health system financing, organisation, and governance. Epstein (2005) gives a comprehensive definition of financialisation as "the increasing role of financial motives, markets, actors, and institutions in the operation of the domestic and international economies" (p. 3). Neoliberalism today depends heavily on financialisation, which shapes how public and private sectors interact. Cordilha (2022) similarly shows how financialisation reshapes public health systems by embedding financial actors and instruments within governance structures. It alters the behaviour of the state, which increasingly acts to de-risk private investment rather than directly provide services. Financialisation began in the 1970s and has accelerated since the 1990s (Cordilha, 2022; Fine 2020). Hunter and Murray (2019) describe this shift as the transformation of health systems into sites of capital accumulation, where health facilities, insurance streams, and service contracts are structured as financial assets generating stable returns for investors. Fine (2020) argues that neoliberalism "by virtue of its dependence on financialization is inevitably variegated, and not homogenising (towards the market), by its very nature" (p. 26–27).

The paper uses "financialisation" as an umbrella term to describe the overall trajectory of increasing market and financial logic within the health system. The mechanisms comprising this trajectory are heterogeneous. They operate through different logics and produce different effects. These can be distinguished.

The first is financialisation in the narrow sense: the direct entry of financial actors—private equity firms, development finance institutions, and commercial investment funds—into healthcare markets as owners or creditors. These actors seek risk-adjusted financial returns. Their primary accountability is to investors, not to public health goals. The governance risks are significant: ownership concentration, profit-driven service prioritisation, and long-term contractual lock-ins that constrain public policy (Marriott, 2023; Taneja and Sarkar, 2023). These are mostly defined by partnerships between private players.

The second is commercialised public financing. Here, public funds are routed through market-structured arrangements without transferring ownership. Public health insurance schemes, viability gap funding, and performance-based financing are examples. The financial logic is embedded within state expenditure decisions rather than driven by external capital. The risks are different but real: public subsidies can be captured by private providers, accountability mechanisms are difficult to enforce, and reimbursement structures can skew services towards profitable rather than essential care (Chukwuma et al., 2025; Hunter and Murray, 2019). These are PPPs.

The third is philanthropic and corporate social responsibility (CSR) capital. These flows are driven by strategic and reputational motives rather than financial return. They do not seek ownership or profit in the conventional sense. However, they carry their own risks. CSR and philanthropic programmes tend to be selective, short-term, and aligned with corporate rather than public health priorities. They create parallel delivery channels

that fragment the health system and weaken the coherence of public provision (Baru and Kapilashrami, 2020; Birn, 2014). These could be PPPs.

All three forms therefore carry risks for public health systems, though of different kinds. All these forms can involve PPPs, though the nature of the partnership differs in each case. Private equity and Development Financial Institution (DFI) investment enters PPP arrangements when the state provides land, subsidies, or guaranteed patient flows to attract private capital. Commercialised public financing is perhaps the most direct expression of PPP logic: public funds are channelled through for-profit actors to deliver services. CSR and philanthropic capital become part of PPP arrangements when corporate foundations co-implement public health programmes alongside government agencies.

Chukwuma et al. (2025) argue that PPPs act as conduits for healthcare financialisation. The World Bank Group plays an influential role in promoting, normalising, and financing health PPPs in LMICs. They critique the normative assumption that PPPs inherently mobilise additional resources, revealing instead that they frequently redirect public funds into private value chains, particularly through payment guarantees, subsidies, and performance-based financing (Chukwuma et al., 2025).

Fine draws out three phases under neoliberalism to situate PPPs—the Washington consensus[2] (1980–1990), the post-Washington consensus (1990s–2000s), and the third phase (post-2008 after the global financial crisis) where the state is more receptive to collaborate with private capital and state's resources are used to promote private financing as well. In this paper, we further our argument using the framework of financialisaton as an accelerator of commercialisation to delineate the transformation of health systems under neoliberalism in the present context in India. We indicate four broad phases of neoliberalism and expand on Fine (2020). The phases include the pre-liberalisation period of the 1980s; the period following the Washington consensus and liberalisation in India (1990s); post-Washington consensus which is defined by the period of course correction (2005 onwards); and continuation towards greater financialisation over the past decade, since 2014 and the post-Covid era.

Four phases of PPP expansion in India and its implications

India's health system has evolved as a highly mixed, pluralistic arrangement shaped by federal political structures, historical underinvestment in public health, and the steady expansion of private provision since its independence. Public expenditure on health has remained low relative to other LMICs hovering around 0.9% to 1.1% gross domestic product (GDP) for most of the post-liberalisation period, resulting in limited infrastructural investment, workforce shortages, weak primary healthcare, and expansion of markets.

The public system is organised into a three-tiered structure of primary, secondary, and tertiary facilities. The public health system has also been dominated by vertical programmes for disease control and family planning concerns. The political space for market-oriented solutions was created, in significant part, by failures of the public health system itself. Decades of chronic underinvestment produced a public system

characterised by infrastructure deficits; workforce shortages and high absenteeism; and dysfunctional supply chains and services that were frequently unresponsive, inaccessible, or perceived as poor quality by the populations they were meant to serve. Household surveys consistently showed that large proportions of Indians, including those below the poverty line, turned to private providers not out of preference for private care but because public facilities were unavailable, unstaffed, or out of drugs resulting in high out-of-pocket expenditures (NSSO, 2004; Peters et al., 2002; Rao et al., 2011). This led to the weakening of the public sector and entrenched private sector dependency. India's policy environment has been conducive to PPP expansion, shaped by a long tradition of private medical practice, dual practice by public sector doctors, and successive national health policies from 1983 onwards that explicitly invited different forms of private sector participation. These are explained in the following sections.

Figure 1 gives the different forms of PPPs across the health service system that have emerged over the decades.

Pre-liberalisation phase (1980s)

In 1983, the national health policy privileged private sector collaboration in the health services (Baru and Nundy, 2021; Hooda, 2020). In the latter half of the 1980s, several steps were taken to foster private sector growth in health. These included state subsidies on land and reduction of import duties on high technology medical equipment. During this period, PPPs were largely collaborations at the primary level with the non-profit sector, focused on national disease control and family planning programmes.

With respect to the hospital sector at the secondary level, public subsidies supported the establishment of mainly non-profit institutions, and after the 1980s, it shifted to the for-profit sector at the tertiary level. This was effected through access to concessional loans from public financial institutions and favourable industrial financing policies. The government also reduced import duties on medical technologies, incentivising private investment in diagnostics and high-end care (Baru, 2018; Prasad, 2018).

These measures effectively created the institutional and financial foundations for a liberalising health sector. By nurturing private hospital infrastructure, expanding the technological base of private providers, and establishing precedents for state–private collaboration, the pre-liberalisation era opened pathways for market-oriented reforms. As a result, the 1990s did not represent an abrupt shift but a continuation and intensification of earlier trends—transforming nascent forms of state-supported private participation into the more formalised PPPs and commercialisation that defined the post-liberalisation period (Baru, 2005).

Liberalisation (1990s–2005)

The 1990s marked the period of liberalisation of the Indian economy as a result of the Government of India opting for loans from the World Bank and the International Monetary Fund (IMF). With the liberalisation of markets and SAP in the 1990s, private sector participation increased in the health sector. The share of public expenditure in health fell to its lowest around this time. It was the conditionalities of the World Bank

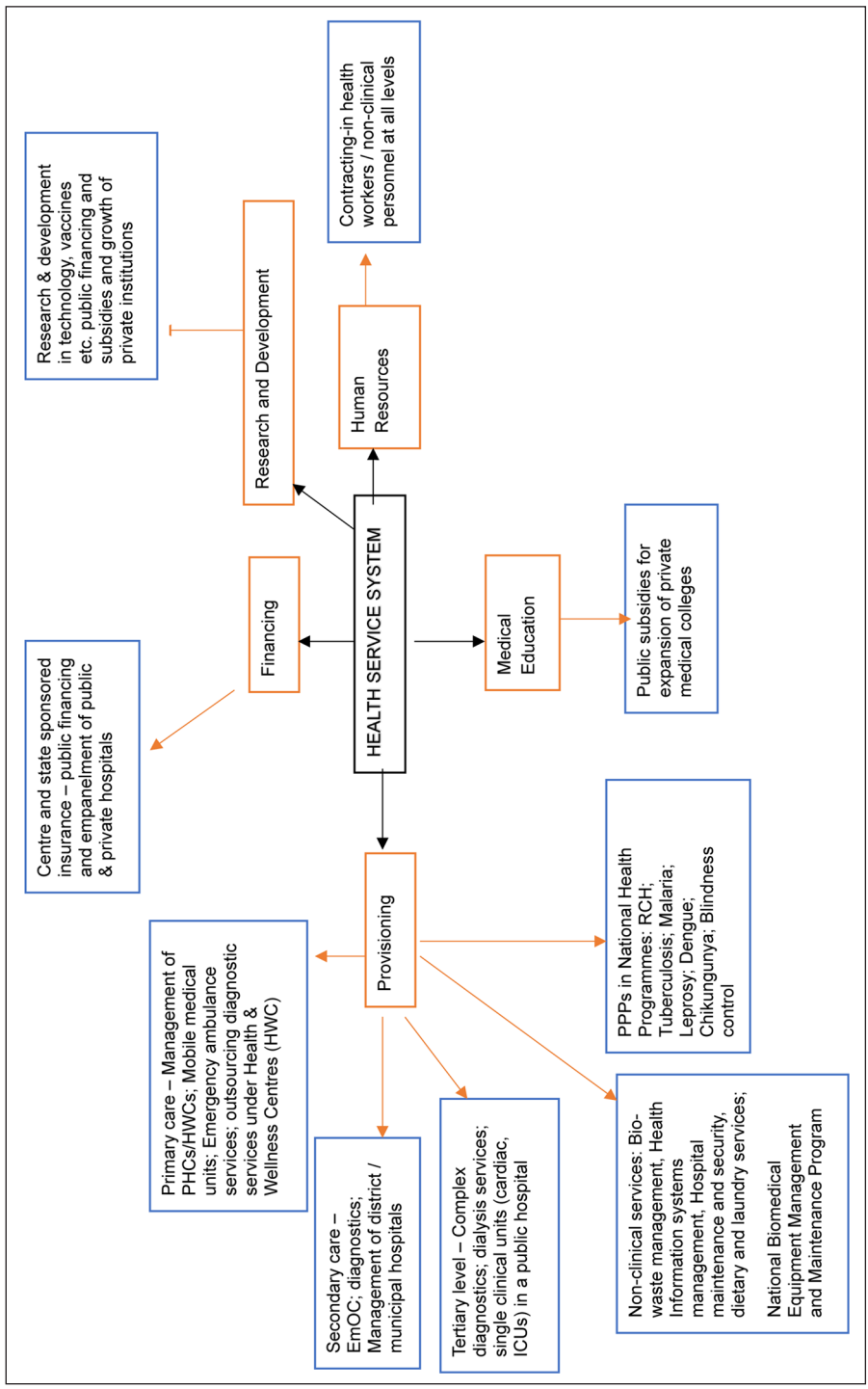

Figure 1. PPPs across health service components in India.
Source. Authors' representation.

that encouraged private participation and the role of internal markets in public provisioning (Baru and Nundy, 2021; Rao, 1999).

This period marked the beginning of a redefinition of the state's role from direct provider to purchaser, regulator, and facilitator. Thus, PPPs became an integral part of India's health sector reforms.

Primary care. The 1990s and early 2000s witnessed a proliferation of PPPs in the World Bank-supported vertical programmes—Reproductive and Child Health (RCH-I), Tuberculosis (TB) Control, Blindness Control, and Malaria. A complex constellation of multilateral and bilateral donor agencies (World Bank, DFID, USAID, GIZ) funded, designed, and structured PPP modalities.

Some non-governmental organisations (NGOs) in several states were given the contract to manage primary health centres in rural areas. Social franchising and social marketing models, vouchers, and conditional cash transfers were implemented by international NGOs and national NGOs, creating new quasi-market structures for reproductive health services (Baru and Nundy, 2008, 2009; Ravindran, 2011). These aligned with the recommendations of the International Conference on Population and Development (ICPD) 1994, and opened space for non-governmental and private sector involvement in reproductive health service delivery. The ICPD Programme of Action referred to increased involvement of the private sector, user fees, and social marketing, with its primary emphasis on securing public and official development assistance resources (United Nations, 1994; 120–121).

Secondary care. Contracting-in of private obstetricians was introduced for Emergency Obstetric Care (EmOC) for Below Poverty Line (BPL) women. Popular among this was the Chiranjeevi Scheme (De Costa et al., 2014; Iyer et al., 2017). In public hospitals, contracting-out of services became widespread for non-clinical services (cleaning, laundry, dietary), laboratory, and diagnostic services.

Tertiary care. At the tertiary level, select district hospitals experimented with PPP-based management by corporate entities—early signs of corporatisation trends. The management of Rajiv Gandhi Hospital in Karnataka was given to the Apollo hospital group,[3] which was the first experiment where a tertiary-level public hospital was handed to the corporate sector for management. After several years of the partnership, an evaluation showed that there was no increase in utilisation and the objective of improving access for BPL people failed (Karpagam et al., 2013).

Corporate hospital chains expanded rapidly, supported by a permissive regulatory environment and concessional financing in the early 2000s. Land was provided at subsidised rates and many old charitable hospitals that had received land from the government were taken over by the corporates with the condition that they would provide 15–20% free services for outpatient and inpatient services. The conditions were never completely fulfilled by the hospitals (Baru and Kapilashrami, 2020). Domestic capital and Foreign Direct Investments (FDIs) supported the growth of private hospital chains, with land acquisition and real estate development playing a critical role in their expansion. The FDIs were directed towards tertiary and specialist hospitals (Chanda, 2002; Hooda,

2017; Lefebvre, 2010). DFIs like International Finance Corporation (IFC) have been funding corporate hospital chains since 1997 (Marriott, 2023).[4] The establishment of the Insurance Regulatory and Development Authority of India (IRDAI) in 1999 opened the private health insurance market, drawing new domestic and global financial actors into healthcare (Mahal, 2002). Early state-sponsored insurance schemes like *Yeshasvini* in Karnataka launched in 2003, pioneered public–private purchasing models, combining state subsidies, private third-party administrators, and networks of private hospitals (Baru and Nundy, 2008). These paved the way for later public insurance schemes. Studies from Maharashtra document how corporatisation transformed the private hospital sector as a whole, not merely through the expansion of large chains but, through structural and behavioural changes across not-for-profit hospitals, small nursing homes, and medical professionals with consequences for professional accountability, clinical autonomy, and the terms on which private providers engage with public systems (Chakravarthi et al., 2023; Marathe et al., 2020).

The varied experiences of PPPs revealed a consistent pattern of adhocism in contract formation, erosion of public sector capacity through dependence on contracted providers, and donor-led agenda-setting that weakened democratic accountability in health policy (Baru and Nundy, 2008; Nundy et al., 2021; Qadeer and Baru, 2016). Weak regulatory frameworks and opportunistic behaviour by private actors further constrained public accountability, quality, and equity (Taneja and Sarkar, 2023), generating sustained resistance from civil society and academia throughout the 1990s and early 2000s (Qadeer et al., 2001; Rao, 1999). Arrangements that persisted tended to be those with limited, well-defined scope where private providers operated within clear contractual parameters without substituting for absent public capacity. By contrast, models requiring private actors to assume comprehensive service delivery, most notably the Apollo-managed Rajiv Gandhi Hospital in Karnataka, failed because the financial logic of private providers was incompatible with public access and equity mandates (Karpagam et al., 2013). PPPs worked where there was a strong public sector foundation, well-designed contracts with realistic remuneration, sustained political commitment, and non-profit partners with prior community trust. They failed where public oversight was weak, contracting was ad hoc, payments were delayed, and communities were uninformed. Context mattered greatly—PPPs did not substitute for weak governance, they required good governance to function at all (Nundy et al., 2021).

Post liberalisation: Phase of course correction (NRHM—2005–2014) and continuation of neoliberal policies

The period 2005–2014 marks a significant shift in India's health sector trajectory. Although global health policy continued to be shaped by neoliberal frameworks—including the World Health Organization (WHO, 2001) and the World Health Assembly's 2005 call for UHC—there was simultaneous recognition that market-led reforms had led to widening health inequities (Qadeer and Baru, 2016). During this period the formation of a coalition government supported by left-leaning parties and a commitment to a Government of India (2004) created the political space for selectively strengthening public health systems. Against this backdrop, the National Rural Health Mission (NRHM

2005)—later expanded into the National Health Mission (NHM, 2013)—was launched in a "mission-mode"[5] to strengthen public health systems, restore state stewardship, and rationalise PPPs that had proliferated during the 1990s. After a decade of fragmented PPP experimentation in the 1990s and early 2000s, the state reframed PPPs as a health system strengthening strategy, particularly for underserved rural areas.

Primary level. During this phase, PPPs became embedded within the governance structures of primary-level care and National Health Protection Schemes (NHPs). At the primary-care level, a few NGOs continued to manage primary health centres in remote areas, human resources were contracted to address staff shortages, and social franchising and marketing models for reproductive and child health were scaled-up under RCH-II. Diagnostics, mobile medical units, and emergency ambulance services also expanded through contractual partnerships. Disease control programmes such as the Revised National Tuberculosis Control Programme (RNTCP), Malaria, and Blindness control programmes continued to engage non-profit and for-profit providers for case finding, training, and service delivery.

The constellation of actors involved in PPPs during this period also shifted; while multilateral and bilateral donors remained influential in funding reproductive health and disease-control strategies. The central and state governments assumed a coordinating role through district health societies and integrated planning processes. International NGOs remained prominent in RCH-II interventions later (legacy of the erstwhile family planning programme), while domestic NGOs implemented contracts at community and facility levels.

Secondary and tertiary levels. An important initiative of PPPs was the emergence of the *Rashtriya Swasthya Bima Yojana* (RSBY)[6] (National Health Insurance Scheme) in 2008 for BPL and in-patient services. The arrangement included quasi-private[7] insurance companies, publicly subsidised insurance premiums, private third-party administrators, and a network of empanelled private and public hospitals into the health financing landscape. This signalled the beginning of a purchasing-based model of PPPs that would later expand considerably. In some states PPPs extended to the management of district hospitals, as well as to specific clinical departments, including dialysis units, blood banks, and diagnostic services. These arrangements varied considerably in their contractual terms, risk-sharing mechanisms, and degrees of public oversight (Nundy et al., 2021).

At the policy level, rather than promoting markets as a general organising principle, partnerships were framed as mechanisms to strengthen public service delivery, particularly in underserved rural districts, and to address long-standing gaps in human resources, diagnostics, referral transport, and programme implementation. In some disadvantaged regions, social franchising networks, community-based interventions, and emergency transport PPPs contributed to increased utilisation of maternal and reproductive health services. However, the reliance on contracted providers continued to expose weaknesses in regulatory capacity, and access remained uneven across states and social groups (Baru et al., 2010). Targeted insurance-based PPPs such as RSBY were limited by their focus on inpatient care, modest benefit packages, and challenges in monitoring provider

behaviour, resulting in no significant improvements for access (Baru, 2015; Dasgupta et al., 2013; Nandi et al., 2012).

At the systems level, this phase helped stabilise a public health system weakened during the liberalisation era, particularly through investments in infrastructure, building capacities of human resources, community health workers, and decentralised planning but PPPs faced challenges. Contract management capacities remained limited and service delivery continued to be fragmented across multiple actors. The RSBY experience exposed gaps in governance and regulatory oversight that would become more pronounced as insurance-based purchasing models expanded in the subsequent phase.

Table 1 gives the intersections between levels of care, across programmes of the NHM components and the dominant models of provisioning and financing that emerged from these partnerships. This is shown across two phases of the mission—NRHM (2005–2013) and NHM (2013–present).[8]

Overall, the phase represents an attempt to discipline and reorient PPPs after two decades of fragmented growth. The focus shifted from market-extension logics to mission-driven alignment; ad hoc contracting to programme-linked contracting; private-sector-led solutions while still relying on non-profit actors for primary-care delivery in difficult areas. Yet, this period did not tackle the deeper structural drivers of underfunding, inadequate governance, and fragmentation that had fuelled the earlier PPP expansion. As a result, PPPs stabilised but did not transform the public health system.

Deepening of financialisation (2014–present)

The continuity of PPPs in public health insurance schemes and NHPs is seen in the post-2014 period. The launch of *Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana* (PM-JAY—Prime Minister's Public Health Insurance Scheme)[9]—has expanded the role of for-profit hospitals through publicly financed purchasing arrangements that rely on large-scale empanelment and reimbursement flows. At the primary level, Health and Wellness Centres (HWCs) have incorporated NGO management, outsourced diagnostics, and private service contracts. Partnerships for non-communicable diseases remain uneven, but private providers play prominent roles in cataract surgery, diagnostics, and dialysis services through both outsourced and in-house PPP models (Nundy et al., 2021). In several states, corporate social arms, including those of major hospital chains, have become visible actors in primary care management.

The post-2014 period marks a decisive shift in the evolution of PPPs in India, characterised not only by the continuation of earlier forms of PPP but also by the emergence of new actors, instruments, and financial logics that push health systems further into the domain of capital markets. This phase also coincided with the rise of a conservative coalition government, which created a policy environment conducive to accelerated corporate sector expansion. While PPPs had long been promoted as mechanisms to fill public financing gaps—particularly in the context of global commitments to UHC and SDGs (Chukwuma et al., 2025), this phase is distinguished by a qualitative transformation. Given the decline of funding of developmental aid from multilaterals and bilaterals globally, domestic corporatised non-profits, global and domestic philanthropic foundations, and multinational corporations (domestic and foreign) now operate alongside traditional

Table 1. Findings from NHM across levels, phases of NHM, and programmes.

Levels of Care	Phase I of NRHM (2005–2013) Types of partnerships			Actors—financing and provisioning	Phase 2 of NHM (2013–present) Types of partnerships			Actors—financing and provisioning
Primary	**Programmatic components**				**Programmatic components**			
	RCH	**Communicable diseases**	**HSS**		**RMNCH + A**	**Communicable and NCDs**	**HSS**	
	RCH II programme was focused on family planning services and there were PPPs in delivery of these services through social franchising, contracting services to private especially non-profits and social marketing by non-profits. *Mostly in rural areas*	RNTCP—TB—monitoring of patients enrolled in the programme and partnerships in training private providers at the primary level to improve case detection and send patients to the programme. *These partnerships emerged before NRHM and were mostly in urban areas as the concentration of private providers are there.* Malaria—mostly Health promotion—*in rural* Only NPCB in NCD—dominated by partnering with private providers for cataract surgeries—*in rural and urban*	Management of some PHCs given to NGOs—mostly rural Emergency ambulance services—for rural Under communitisation component of NRHM, *Rogi Kalyan Samiti* had representatives from NGOs, PRIs, govt. in institutions at all levels	Multilaterals, bilateral organisations and international NGOs played an important role in Phase I of NHM (NRHM) especially in RCH-II component and defined design of PPPs—franchising, marketing and contracting-out. These were implemented through domestic NGOs at the primary level. *Mostly public financing and private provisioning based on generating demand*—supply by public and demand created by private.	In 2013, RCH was renamed RMNCH + A Within the NHM the main partnership component is still family planning services.	NTEP–PPSA (Patient Providing Support Agency). is an interface agency between the NTEP and the private-sector healthcare system. PPSA acts on behalf of the NTEP to liaise with laboratories, physicians, chemists and all other clinical/medical establishments, to ensure that all private-sector patients have access to services. Malaria, NPBC, NLEP in few states, Dengue and Chikungunya Very few partnerships in NCDs	Management of PHCs and newly established HWCs and partnerships in training for human resources—*rural and urban* Managing mobile health clinics Providing emergency ambulance services Pathology services (Hub and spoke model)*	Funding and services by CSR and foundations of big industries (pharma sector, food industry, diagnostic and medical device companies) *Public and private financing and private provisioning at the primary level*

(continued)

Table 1. (continued)

Levels of Care	Phase 1 of NRHM (2005–2013) Types of partnerships			Actors—financing and provisioning	Phase 2 of NHM (2013–present) Types of partnerships			Actors—financing and provisioning
Secondary	**Programmatic components**			At the secondary and tertiary levels there were very few PPPs and were based on simple models. These were also mostly public financed and provisioning was by private sector. Different financing models were being experimented with—insurance model where the government financed but partnered with commercial insurance companies and empanelled private providers and used intermediaries (TPAs) to administer the scheme. *Public financing and private provisioning*	**Programmatic components**			*Private financing and public or private provisioning under CSR, other private financing*
	RCH component EmOC services	**Communicable diseases**	**HSS**		**RMNCH + A**	**Communicable diseases/NCDS**	**HSS**	
	Institutional delivery and Emergency Obstetric care services were outsourced to private providers in some districts of few states.	RNTCP—patients requiring hospitalisation referred to a charitable hospital (A PPP in AP)	Some district level secondary hospitals contracted-out drug stores; CT scan/MRI services and non-clinical services.		Institutional delivery under EmOC	NCD screening only through diagnostics	Simple Diagnostics like pathology as well as ultrasound Hub and spoke model	
Tertiary	**Programmatic components** **HSS** Contracting Out of Drug Store and Diagnostic Services at few Public Sector Tertiary Level. Contracting Management of Public Hospital at the Tertiary Level to a Corporate Entity The insurance component was introduced at the secondary and tertiary level for in-patient services				**Programmatic components** **HSS** Dialysis programme (In most instances dialysis services are contracted-in by State Health Society district/State Health Department at district hospitals level from private sector and in some other instances services are contracted-out to a private provider.) Complex Diagnostics (CT scan/MRI etc.) Hub and spoke model Private management of district hospitals and private finance to build district hospital infrastructure			

Source. Authors' compilation.

EmOC: Emergency and Obstetric Care; HSS: Health system strengthening; NCD: non-communicable diseases; NPCB: National Programme for Control of Blindness; NTEP: National Tuberculosis Elimination Programme; RNTCP/NTEP: Revised National Tuberculosis Programme was renamed as National TB Elimination Programme in 2020; RCH: Reproductive Child Health; RMNCH + A: Reproductive, Maternal, Neo-natal, Child Health + Adolescent Health.

*The hub-and-spoke model in PPPs for health diagnostics is an organisational structure where a central diagnostic laboratory (hub) coordinates with a network of smaller, local diagnostic or collection centres (spoke) to deliver a full range of diagnostic services across a wider geographic area.

development actors, creating dense and multilayered assemblages that link public programmes to global finance, private venture capital, and philanthropic investment portfolios. These arrangements consolidate the financialisation of India's health system, embedding market and investment imperatives into governance, delivery, and regulatory structures.

During this phase, the architecture of the health system expanded through "innovative" financing mechanisms. Rather than relying solely on contracting arrangements, the system increasingly drew upon blended finance, viability gap funding (VGF), impact bonds, CSR capital, and philanthropic investment portfolios. These instruments mobilised private capital while tying public budgets to long-term contractual payments, thereby shifting financial risk to the state and generating new revenue streams for private intermediaries. Such models reconfigure the state's role from direct provider to de-risker and guarantor of private returns and mark a move towards partnerships centred not on service delivery but on capital mobilisation, asset creation, and financial value extraction. This is the clearest expression of health sector financialisation in present times in India.

CSR. CSR-led partnerships have become more complex and consequential. Corporate foundations increasingly implement health programmes through multitiered arrangements that combine public resources, donor funds, and CSR capital. Initiatives such as Merck for Mothers (M4M) exemplify this model. M4M operates as a sophisticated PPP involving a pharmaceutical company (Merck), international NGOs (Jhpiego, Pathfinder), domestic NGOs (HLFPPT, Gram Vaani), professional associations (FOGSI), and global health agencies (Baru and Kapilashrami, 2020). These partnerships extend beyond product-based interventions, embedding corporate clinical and managerial practices within national maternal health programmes while generating significant reputational and strategic benefits for the parent company. Similar logics underpin Coca-Cola Foundation partnerships in WASH (water, sanitation, and hygiene), nutrition, and community health, where CSR investments align closely with the corporation's branding and market interests. Such partnerships blur boundaries between public health and corporate strategy, raising concerns about accountability, agenda-setting, and the diversion of public attention away from structural determinants of health (Baru and Kapilashrami, 2020).

Many domestic corporate foundations have extended their work at the primary level whether in health or education and work with state governments to deliver services. Corporate social arms of big domestic companies like Zydus Cadilla, Adani, Reliance, and Bajaj are playing an expanding role in India's health landscape by investing directly in healthcare infrastructure, education, and service delivery. For example, the Adani Foundation is committing substantial resources to build integrated health campuses, partner with educational institutions, and expand affordable healthcare and insurance outreach through community programmes, signalling a shift where domestic capital and foundation networks increasingly shape the organisation and financing of health services which was the public sector domain (EMR, 2025; PTI, 2022).

Blended financing. The expansion of blended finance and infrastructure PPPs, particularly those using Design-Build-Finance-Operate-Transfer (DBFOT) model through viability gap funding (VGF) are the newer forms of PPPs. In India, more recently, the Niti Ayog

(erstwhile Planning Commission of India) has assured the provision of VGF to build new medical colleges and to upgrade district hospitals to medical colleges with private capital in several states. Recent proposals to establish medical colleges in several states through PPPs involve attaching new privately managed colleges to existing public district hospitals under long-term lease arrangements, combined with public subsidies, VGF, and guaranteed patient flows through government insurance schemes. This proposal helps private partners gain access to public land, hospital infrastructure, and publicly financed service utilisation, while recovering investments through tuition fees, clinical revenues, and state reimbursements. Although framed as a means to expand medical education and tertiary care capacity, these PPPs transfer substantial financial and operational risk to the public sector, including exposure to delayed reimbursements, long-term loss of control over public hospitals, and limited recourse in the event of private partner failure. The asymmetry in risk-sharing is compounded by weak regulatory capacity, raising concerns that private operators may prioritise revenue-generating services, compromise on faculty and student recruitment and quality of care, and divert public hospital resources away from their service mandate. Over time, such arrangements risk deepening financialisation of medical education, exacerbating inequities in access, and entrenching long-term dependencies that are difficult to reverse within publicly funded health systems (Goyal et al., 2025; Rao, 2025).

Financialisation and the tertiary sector. There has been a shift in partnerships in the tertiary sector that includes outsourcing of entire district hospitals to corporate management, the contracting of specific clinical departments (such as cardiac units, dialysis services, and ICUs (Intensive Care Units)) to private operators, and the growing role of private entities in managing municipal hospital infrastructure (Marathe et al., 2025). These arrangements reflect an unwillingness of the state to invest in specialised human resources and infrastructure. Evidence from Maharashtra reveals that PPP decisions at the municipal corporation level are made entirely outside state health department oversight, with local political representatives actively shaping contract selection. This politicisation, documented across multiple cases, systematically diverts PPPs from public health objectives towards commercial interests, with consequences for quality of care, staff qualification, and contract compliance (Marathe et al., 2025).

Deepening of financialisation is evident in the growing prominence of consulting firms, DFIs, and private equity in health policy design and service expansion. Alongside other DFIs and private equity investors, the IFC has been financing corporate hospital chains in India since 1997, directing investment towards high-end urban facilities with no demonstrated improvement in access or equity (Economic Times, 2025; Hooda, 2017; Marriott, 2023; Taneja and Sarkar, 2023; Vivek, 2025). Consulting firms have played an increasing role in advising central and state governments on PPP framework design, though this dimension of health sector governance remains incompletely documented in the published literature. Beyond direct investment, the IFC has provided transaction advisory services to state governments to design and implement hospital PPPs—acting, by its own account, as the only multilateral organisation offering such advisory services globally—structuring concession agreements in states including Bihar, Odisha, Jharkhand, and Maharashtra (Taneja and Sarkar, 2023). These investments have fuelled

Table 2. PE investors investing in private hospitals in India.

Hospital/Chain	PE investor	PE stake in hospital (%)
Manipal Hospital	Temasek Holdings	59
Care Hospital	Blackstone	73
Kims Kerala	Blackstone	80
HCG	CVC Capital, KKR	60
Ujala Cygnus	General Atlantic	70
Sahyadri Hospitals	OTPP	100
Motherhood Hospitals	TPG Growth and GIC	98
Indra IVF	BBEA EQT, TA	60
Baby Memorial	KKR	70
Sterling Hospital	Arpwood Partners	100
Max Hospital	KKR, Abhay Soi	50
Maxivision Hospital	Quadria Capital	Minority
Rainbow Hospital	CDC Group	Minority
Apollo Hospital	Advent International	Minority

Source. Economic Times (2025).

the rise of large hospital chains and technology-driven service providers, enabling rapid expansion of tertiary superspecialties into metropolitan and tier-two cities. At the same time, private equity investments have transformed the corporate hospital sector, concentrating ownership and creating powerful actors (Table 2) whose priorities centre on profitability and risk management.[10] This consolidation exacerbates inequalities by directing investment towards high-end, urban markets while leaving primary healthcare underresourced (Marriott, 2023). While these private–private arrangements fall outside the traditional PPP framework, their inclusion here is analytically deliberate. They represent a point at a trajectory that is preceded by partnerships and other forms of commercialisation. This is the progressive legitimation of private capital in health services through state-facilitated pathways. Table 2 illustrates how global private equity firms have taken majority or controlling stakes across major corporate Indian hospital chains in recent times. Understanding this trajectory is essential to grasping the full implications of health sector financialisation in India. Private equity investment has become a structural necessity of the business model created by the for-profit sector. Corporate hospitals are technology and human resource-intensive: they require continuous investment in specialist talent, advanced equipment, and expanding infrastructure to remain competitive. Out-of-pocket revenues and insurance reimbursements, while significant, are insufficient to sustain this model at scale or to fund the rapid expansion into new markets that corporate chains require. Private equity therefore fills a structural gap providing the capital that the market alone cannot generate.

Discussion and conclusion

Over the past three decades, India's health sector has been shaped by a complex set of actors exercising multiple forms of authority. In the earlier phases, PPPs were largely

concentrated at the primary level and driven predominantly by multilateral and bilateral agencies, international donors, and NGOs. With the deepening of financialisation, however, partnerships have increasingly shifted towards secondary and tertiary levels of care. This shift has been accompanied by a marked transformation in the profile of actors involved. Alongside multilateral and bilateral agencies, one now sees the rise of domestic and foreign philanthropic foundations, pharmaceutical and technology companies, real estate companies, DFIs, and private equity firms. Together, these actors have fundamentally reconfigured authority and influence within the health system, with private capital increasingly able to shape policy in the direction of deeper financialisation.

PPPs have thus become central to the liberalisation-era health reforms, institutionalising the private sector as a legitimate actor in health systems. Despite their stated objectives of extending coverage and improving efficiency, PPPs frequently exacerbated inequities. The emergence of corporate hospitals and private insurance produced a dual health system, with perceived high-quality private care for the insured and underfunded public services for others. Out-of-pocket expenditure remained high and public spending stagnated (Baru and Nundy, 2021; Bhat, 1999; Roy and Gupta, 2011). Gender, caste, class, and regional inequities persisted in access (Qadeer et al., 2001). These studies show that rather than reducing inequities, many PPPs fragmented comprehensiveness of the health system and created spaces for deeper financialisation. System-wide impacts were significant as PPP-driven outsourcing led to fragmented service delivery with poor coordination among actors, weakening the systemic coherence that equitable health coverage requires.

The equity implications of this trajectory deserves closer attention. PPP arrangements have consistently shown regressive distributional effects: benefits tend to accrue disproportionately to urban, insured, and higher-income populations, while rural, marginalised, and uninsured groups remain dependent on an under-resourced public system. The shift towards secondary and tertiary care PPPs has further distorted care-seeking patterns: as private facilities gain legitimacy and public infrastructure stagnates, households increasingly bypass primary care and seek specialist services from private providers, driving up medical costs, out-of-pocket expenditure, and delaying treatment for preventable conditions. Gender and caste dimensions compound these effects, as women, Dalit, and Adivasi populations face compounding barriers of distance, cost, and discrimination in accessing private empanelled facilities (Baru et al., 2010; Qadeer et al., 2001). These affordability concerns are concretely evidenced by rate comparisons from municipal hospital PPPs in Maharashtra, where services under PPP arrangements were priced 3–15 times higher than equivalent services in public hospitals with outpatient specialist consultations at 15 times the public rate and cardiac services ranging from 6 to 19 times (Marathe et al., 2025).

Recent analyses of the financialisation of health systems caution that once finance becomes embedded in health governance, it fundamentally reshapes priorities, risk allocation, accountability, and culture of institutions. Clarke (2025) argues that financialised health systems are characterised by long-term contractual lock-ins, public guarantees for private returns, and growing influence of financial intermediaries, which collectively reduce policy flexibility and weaken democratic oversight. Rather than enhancing resilience, such arrangements often amplify vulnerability during crises, as financial actors

prioritise capital protection over public health needs, as seen during COVID-19 (Clarke, 2025).

Across four phases, the evidence points to a structural asymmetry between the conditions required for PPPs to serve public health goals and the conditions that actually prevailed. PPP models performed closest to their stated objectives when the public sector retained sufficient capacity to define, monitor, and enforce the terms of partnership—and when private actors operated in delimited roles with clear accountability mechanisms and were not driven by profit motives. When these conditions were absent, as they were in much of the liberalisation and financialisation phases, the dynamics of private sector participation reflected commercial rather than public health logics. This asymmetry is not incidental: it reflects the paradox that PPPs are most frequently proposed as solutions in precisely the contexts—weak public sector capacity, inadequate infrastructure, fiscal constraint—in which the conditions for governing them effectively are absent.

The growing complexity of actors and financial arrangements in the health sector—marked by the entry of both domestic and foreign capital of for-profit companies—has fundamentally reshaped the organisation and priorities of health service delivery. As financialised partnerships expand, health systems have moved further away from foundational public health values of universality, comprehensiveness, and equity, towards fragmented arrangements that privilege financially viable and technologically intensive curative services over a comprehensive mix that includes preventive, promotive, curative, and rehabilitative services. Rather than supporting primary healthcare systems, financialisation incentivises vertical, profit-making interventions that fragment care pathways. This leaves us with a pressing question as financialisation deepens and private–private partnerships consolidate their market power, will traditional PPPs be rendered redundant, ultimately allowing private dominance to erode the foundational values of primary healthcare?

The COVID-19 pandemic exposed the limitations of commercialised public systems but there have not been any substantive efforts to strengthen the public sector. The evidence from the NRHM period (2005–2014) is instructive: when political commitment translated into increased public expenditure, mission-mode governance, and a reassertion of state stewardship, the public system demonstrated capacity for improvement. The limits of that period's achievements were not primarily technical but political and fiscal—chronic underfunding, fragmented governance, and the entrenched interests of the private sector remained unaddressed. This suggests that the alternative to financialisation requires a sustained political commitment to public health expenditure, alongside governance reforms that rebuild public sector accountability and responsiveness from within. Renewing public stewardship requires specific institutional changes, not rhetorical commitment. This does not require eliminating private sector involvement but reconstituting the state as a genuine steward of public health rather than a facilitator of private capital accumulation.

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None.

Notes

1. Privatisation involves the transfer of ownership, financing, or provisioning to private actors while commercialisation involves expansion of the market within and outside public services. Privatisation does not only mean the sale of public assets or the retreat of the state; it also includes the delegation, diffusion, and redistribution of public functions to private actors.
2. The Washington Consensus is a set of free-market economic policy prescriptions promoted by Washington, D.C.-based institutions (IMF, World Bank, US Treasury) for developing countries, starting in the late 1980s to combat debt crises, emphasising fiscal discipline, trade liberalisation, privatisation, and deregulation.
3. Founded in 1983, Apollo Hospitals pioneered corporate healthcare in India, It is one of the leading corporate hospital chains.
4. Development Financial Institutions (DFIs) have become important actors in India's health sector by financing private hospitals, diagnostics, medical education, and public–private partnerships (PPP)-based infrastructure, with the International Finance Corporation (IFC; private sector arm of the World Bank Group) playing a dominant role alongside other multilateral and bilateral DFIs such as the DEG (German financial institution), British International Investment (BII), and PROPARCO (French DFI).
5. In India, a "mission mode" programme is a focused, targeted initiative designed to achieve specific, clearly defined objectives within a strict timeframe and with measurable outcomes. In contrast, a regular government programme or scheme typically operates with a broader, less time-bound mandate and often faces typical bureaucratic hurdles.

6. The *Rashtriya Swasthya Bima Yojana* (RSBY) launched in 2008 by the Ministry of Labour and Employment, constituted PPP in health financing and service delivery. This was built on existing models of targeted public insurance schemes that were initiated in some of the southern states. It was designed with technical support from the German Agency for International Cooperation (GIZ).
7. India's four public health insurers act like private entities by competing fiercely for market share, innovating products, using similar sales tactics, facing performance pressures all while being government-owned, blurring lines as they vie for customers alongside private players in a liberalised market.
8. The National Rural Health Mission/National Health Mission (NRHM/NHM) programmatic components include RCH (since 2013 renamed as RMNCH + A); Communicable and non-communicable diseases; Health service strengthening (HSS) and; Infrastructure maintenance (mostly non-clinical services like laundry, dietary, and security services to equipment management and maintenance and bio-waste management in the later phases).
9. This was the expansion of the RSBY model to all states, expanding the coverage of services and premium amount limit for Below Poverty Line (BPL) population.
10. This was visible during the COVID-19 pandemic in India, wherein corporate hospitals demanded state support to treat patients.

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