FOREIGN PRIVATE EQUITY IN INDIAN HEALTHCARE: RETHINKING PPP MODELS FOR EQUITY, ACCESS, AND SUSTAINABILITY

By Rashi Vaidya[*] & Tanishka Gora[**]

ABSTRACT

Foreign private equity now in controls around 70 per cent of India's leading private hospital chains, a recent trend enabled by policies permitting 100 per cent FDI under the automatic route, which has triggered significant structural realignment within the hospital sector and raises critical questions for public health governance. The question that this paper will address is whether the current Public Private Partnership (PPP) architecture in India can provide affordability, fair access and long-term sustainability in service delivery where the offshore investors whose interests are largely financial are mediating service delivery. The main conflict is in balancing profit making interests with the sovereign welfare responsibilities of the State, a tussle that the current frameworks might not be in a good position to balance effectively.

Keywords: Foreign Direct Investment, Foreign Private Equity, Indian Healthcare, Public Private Partnership, Right to Health.

[*] 4th Year Student, B.A. LL.B. (Hons.), Department of Law, Prestige Institute of Management & Research, Indore. Email: goratanishka@gmail.com.

[**] 4th Year Student, B.A. LL.B. (Hons.), Department of Law, Prestige Institute of Management & Research, Indore. Email: rashivd23@gmail.com.

I. Introduction

Over the past decade, India's hospital sector has experienced one of the fastest ownership transformations of any major healthcare system in the world. By the end of fiscal year 2024–25, foreign private equity funds, sovereign wealth funds, and global healthcare operators controlled approximately 68–72 per cent of the country's top twenty private hospital chains when measured by revenue, EBITDA, or licensed beds (CRISIL, 2024). This is no longer a marginal phenomenon: the eight largest listed hospital platforms; Apollo, Fortis, Max, Narayana, Manipal, HCG, Aster DM, and Rainbow Children's, are either majority owned or significantly influenced by offshore institutional capital originating from Singapore, Malaysia, Abu Dhabi, Canada, and the United States.

This consolidation was made possible by a series of deliberate policy choices. The liberalisation of foreign direct investment in Greenfield hospitals began in 2000, but the decisive shift occurred in 2015 (Press Note 4 [2015], DPIIT) when the Department for Promotion of Industry and Internal Trade placed brownfield hospitals under the 100 per cent automatic route. Overnight, global private equity funds were granted the same freedom to acquire controlling stakes in existing Indian hospitals as they enjoyed in consumer goods or information technology.

The consequences have been profound. Average revenue per occupied bed in PE backed chains rose 42 per cent between 2019 and 2024, far outpacing medical inflation (CRISIL,2024; Sengupta,2023). Out of pocket expenditure as a percentage of total health spending, which had begun to decline after the launch of Ayushman Bharat, stabilised and in several states reversed (Sengupta,2023). Most importantly, the very architecture of Public Private Partnerships (PPPs) in healthcare, originally designed for domestic philanthropic trusts or family owned groups, now finds itself mediating service delivery through entities whose primary fiduciary obligation is to deliver 18–22 per cent internal rates of return within a five to seven year horizon.

This paper argues that the existing Indian PPP framework is constitutionally and structurally misaligned with a financialised, private equity dominated hospital ecosystem. The tension is not merely economic; it is constitutional. Beginning with *Paschim Banga Khet Mazdoor Samity v. State of West Bengal,* 1996 and on having reaffirmed repeatedly, the Supreme Court has held that Article 21 imposes positive, non-derogable obligations on the State to protect the right to

life and health. Financial incapacity is no excuse, and the State cannot contract away this duty even when it delegates service provision to private actors.

Yet current PPP concession agreements and FDI approvals contain almost no enforceable mechanisms to prevent value extraction practices, dividend recapitalisations, sale and leaseback transactions, aggressive management fees, or Operation company- Property company (OpCo-PropCo) separations that systematically reduce long term affordability and geographic equity. The result is a growing risk that India's constitutional right to health will be subordinated to the logic of global private capital.

II. Identification of Statement of the Research Problem

This study therefore poses three interrelated questions:

1. How can India's investment laws (FEMA and FDI policy) and PPP concession designs be realigned with health sector regulation to protect public-interest outcomes and uphold the constitutional right to health?
2. What macro, contractual, and oversight reforms are required to recalibrate the balance between private capital and public good in a landscape dominated by private equity owned providers?
3. How can statutory frameworks, concession agreements, and investment conditions be deliberately engineered to hard-wire affordability, quality, geographic access, and long-term sustainability while preserving reasonable capital efficiency and investor returns?

The paper proceeds as follows: Chapter 2 briefs about the research methodology adopted. Chapter 3 reviews the relevant literature and identifies critical gaps. Chapter 4 maps the regulatory ecosystem and demonstrates the current misalignment. Chapter 5 presents empirical evidence from leading Private equity backed hospital chains. Chapters 6 and 7 propose a comprehensive reform architecture. Chapter 8 provides a concluding overview, synthesizing the arguments and insights presented throughout the paper.

III. Research Methodology

The paper takes a policy research approach of doctrinal and analytical approach. It integrates constitutional jurisprudence analysis, statutory interpretation of rules and regulations of the investment and health sector, and qualitative analysis of PPP concession rules with secondary empirical data extrapolated on the basis of financial disclosures, sectoral reports, and published

case studies of large chains of hospitals with private equity support. The methodology is mainly normative and analytical to determine whether the legal and contractual structures are sufficient to meet the needs of the protection of the imperatives of its public interest, and suggests different means of reform in line with the principles of constitutionality and sustainable investment.

IV. Analysis and Findings of the Research

A. *Three Streams and One Missing Link*

In Indian healthcare academic and policy writing on privatisation and foreign investment can be grouped into three broad streams.

1. *Corporatisation and Consolidation*

   The first, largely economic and sociological, documents the rapid corporatisation and consolidation of the hospital sector. These studies demonstrate how private equity has driven scale, introduced advanced clinical protocols, and simultaneously contributed to cost escalation and regional concentration in metropolitan clusters.

2. *Constitutional Right to Health*

   A second stream, predominantly legal-constitutional, has traced the evolution of the right to health jurisprudence from *Bandhua Mukti Morcha v. Union of India*, 1984 through *Paschim Banga*, 1996*, Consumer Education & Research Centre v. Union of India*, 1995. This literature firmly establishes that the State retains primary responsibility for health even when services are delivered through private entities.

3. *Public-Private Partnerships in Healthcare*

   The third stream evaluates India's two-decade experience with healthcare PPPs. Most analyses focus on early diagnostic or district-hospital models under Build Operate Transfer or annuity frameworks and conclude that modest free care obligations (10–20 per cent beds) and viability gap funding have delivered mixed results.

Remarkably, almost no scholarship bridges these three streams. There is no systematic examination of how the financialised ownership structures enabled by post 2015 Foreign Direct Investment policy interact with the constitutional obligations articulated in Paschim Banga and its progeny, nor with the contractual architecture of existing PPP concessions. This paper fills

that gap by treating the modern hospital PPP as an investor State contract in which global private equity is now the dominant counterparty.

B. *The Regulatory Ecosystem and Its Constitutional Misalignment*

India's current regulatory framework for foreign investment in hospitals is remarkably permissive. One hundred percent FDI is allowed under the automatic route for both Greenfield projects and brownfield acquisitions. The Foreign Exchange Management (Non-debt Instruments) Rules, 2019, and RBI Master Direction 17/2016–17 (as amended) impose no sector-specific restrictions on leverage, related party transactions, management fees, or dividend repatriation. Private equity funds may therefore legally push down acquisition debt into Indian operating companies, enter into high cost lease arrangements with sister entities, and extract value through special dividends long before clinical or geographic access obligations are fulfilled. This regulatory permissiveness creates a structural disconnect between investment governance and constitutional obligations.

PPP concession agreements fare little better. The Ministry of Health and family welfare's Model Concession Agreement for hospitals (2014, still in use with minor state level variations) contains only soft obligations: typically, 10 per cent free beds and 20 per cent at CGHS rates, with weak monitoring and no financial conduct covenants. There are no clauses restricting change of control without government consent, no debt service coverage or dividend lock up provisions, and no requirement to ring fence clinical revenue from real estate or related party outflows.

The Clinical Establishments (Registration and Regulation) Act, 2010, mandates 'reasonable' pricing and transparency but has been notified in only 12 states and lacks an effective enforcement mechanism. The National Health Policy 2017 and the Draft National Policy Framework on Healthcare PPPs articulate aspirational goals but remain non-binding.

Most critically, none of these instruments engages with the constitutional jurisprudence on the right to health. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, 1996, the Supreme Court held that 'the right to life includes the right to emergency medical treatment' and that 'financial constraints cannot justify denial of care.' The judgment explicitly imposed positive obligations on the State and, by necessary implication, prevents the State from entering into contracts that systematically undermine access.

Subsequent landmark judgements in *State of Punjab v. Ram Lubhaya Bagga*, 1998, *People's Union for Civil Liberties v. Union of India,* 2001, and the 2023 Common Cause directives, have extended the same rational to non emergency care and to situations where the State delegates functions to private parties. The State remains the ultimate guarantor. A PPP concession or FDI approval that permits systemic tariff escalation or geographic cherry-picking is therefore not merely poor policy; it is arguably unconstitutional.

While these judicial decisions articulate clear and non-derogable constitutional obligations, they operate at a level of legal abstraction. The practical question is how these obligations are mediated when healthcare delivery is channelled through private equity owned hospital systems operating under permissive investment and contractual regimes. The following section therefore examines empirical evidence from leading private hospital chains to assess how financialised ownership structures interact with, and often erode, the constitutional commitments described above.

C. *Empirical Evidence: Financial Engineering Meets Public-Interest Obligations*

Five recent transactions illustrate the real-world consequences:-

1. Manipal Health Enterprises was acquired by Temasek, TPG, and Manipal Education & Medical Group in multiple tranches between 2018 and 2023. Post acquisition, average revenue per occupied bed rose from ₹36,000 to ₹52,000 per day while utilisation of reserved free/subsidised beds in its Karnataka PPP facilities fell from 18 per cent to 8 per cent (CRISIL, 2024; PwC India & FICCI, 2024).
2. Fortis Healthcare, acquired by Malaysia's IHH Berhad in 2018, implemented an aggressive OpCo-PropCo separation. Annual rental outflows to real-estate investment trusts rose to 132 million dollars by FY24, contributing directly to a 28 per cent increase in patient tariffs between 2020 and 2024 well above medical CPI. In Delhi and Haryana PPP blocks, below poverty line patient footfalls declined sharply (CRISIL, 2024; PwC India & FICCI, 2024).
3. Max Healthcare, backed by KKR and later merged with Radiant Life, extracted 162 million dollar in special dividends between 2021 and 2023 while simultaneously receiving viability gap funding for its Uttar Pradesh super specialty projects. Capex to EBITDA ratios in tier 2 PPP locations fell below 12 per cent, threatening long term sustainability (CRISIL, 2024; PwC India & FICCI, 2024).

4. Apollo Hospitals Enterprise, with Temasek Holdings holding a significant stake (~35 per cent), has seen average revenue per occupied bed surge to ₹56,000–77,000 per day in high margin clusters like Karnataka and Hyderabad post expansion investments. In legacy PPP arrangements (e.g., Bilaspur/Chhattisgarh model), premium payer shifts reduced free bed utilisation, mirroring affordability pressures despite government land concessions (CRISIL, 2024; PwC India & FICCI, 2024).
5. CARE Hospitals (Quality Care India Ltd., Blackstone/TPG backed since 2023), now merging with Aster DM, and pursued debt-enabled expansion of approximately 3,500 beds by FY27. Rental escalations and related party synergies in Telangana and Andhra Pradesh PPP linked expansions prioritised EBITDA growth (target 21.7 per cent), side lining subsidized care quotas amid tariff hikes (CRISIL, 2024; PwC India & FICCI, 2024).

All five chains actively engage in PPPs with state governments, leveraging viability gap funding (VGF), land grants, or operational contracts in exchange for 10–25 per cent reserved EWS beds and CGHS rate services. Manipal operates Kasturba, Wenlock District PPP (Karnataka); Fortis manages Uttarakhand cardiac centres and Delhi-NCR blocks; Max secures Uttar Pradesh and Punjab super-specialty VGF; Apollo's Bilaspur partnership provided state land for multispecialty expansion; CARE/Aster leverages Telangana, Andhra Pradesh health missions, yet PE driven financialisation systematically undercuts these public obligations.

These are not isolated aberrations; they are predictable outcomes of an incentive structure that treats hospitals as yield generating real estate intensive assets rather than public goods with constitutional overlays.

These empirical patterns are not the result of isolated managerial failures, but of incentive structures embedded in India's investment policy and PPP design. They underscore the need for targeted reforms at multiple levels investment regulation, contractual architecture, and institutional oversight to realign private capital with public health objectives.

D. *Macro and Contractual Reforms: Recalibrating Incentives*

Successful realignment involves changes that act concurrently in the macro-policy arena, in the context of PPP contract design, and with enhanced institutional control.

The level of the first is macro policy, which is Acquisitions of existing hospitals: foreign ownership (more than 49%) need to be shifted through the automatic channel to a government

approval channel. Such approval should conditional with the addition of the binding commitments of the FDI sanction letter, requirements applying to reserved bed capacity, tariff ceilings and minimum rates of reinvestment.

Second, contractual redesign of PPP concessions:

- Financial-conduct covenants limiting total debt to 2.5× EBITDA
- Mandatory escrow of 15–20 per cent of free cash flow for capex and technology renewal
- Prohibition on sale-and-leaseback transactions during the concession period
- Change-of-control clauses requiring government consent and public interest impact assessment

Financial leverage caps restrict total debt to 2.5× EBITDA, assist blocking the aggressive borrowing often used to fuel acquisitions. Second, a mandatory capex escrow locks 15–20 per cent of free cash flow exclusively for infrastructure and technology upgrades, ensuring profits aren't drained before maintenance needs are met. Third, a prohibition on sale and leaseback transactions prevents operators from selling hospital land to REITs (Real Estate Investment Trust) to generate quick cash at the cost of soaring future rents. Finally, change of control clauses require government consent for ownership transfers, contingent on a rigorous public interest impact assessment.

Third, oversight: creation of an independent Healthcare Investment Regulatory Authority under the Ministry of Health with powers to review related party transactions, impose windfall profit levies when tariff inflation exceeds medical CPI by more than 10 per cent, and enforce geographic coverage obligations.

E. *Designing Resilient Frameworks: Hard Wiring Public Interest*

The following concrete mechanisms can be embedded in every future PPP concession and brownfield FDI approval:

1. Mandatory Equity & Access Schedule
   - 25 per cent beds reserved for EWS/BPL patients at CGHS + 20 per cent rates
   - Minimum one satellite outreach centre per 100 km radius in catchment area
2. Performance linked payments, Viability gap funding and annuity streams tied to a composite index comprising:

- Affordability (real tariff growth ≤ medical CPI + 3 per cent)
- Equity (EWS patient share ≥ 22 per cent)
- Quality (NABH + Kayakalp score)
- Sustainability (capex ≥ 18 per cent of EBITDA)

Performance linked payments make public funding contingent on the hospital's measured performance on core public interest indicators, rather than being guaranteed irrespective of outcomes. In this design, both viability gap funding and annuity payments are released according to a composite index that tracks whether tariffs remain broadly affordable (prices growing no faster than medical inflation plus a small margin), whether a minimum share of care actually reaches economically weaker sections, whether clinical and hygiene standards are maintained as reflected in accreditation and quality scores, and whether a specified proportion of operating surpluses is reinvested into infrastructure and equipment. Together, these conditions convert government support into an outcome based instrument that structurally rewards affordability, equity, quality, and long term stewardship of assets, while correcting purely extractive financial behaviour.

3. State 'Golden Share' in concession holding companies, conferring veto rights over excessive leverage and change of control. This mechanism would grant the government a non-economic but strategic equity stake (a 'Golden Share') in the Special Purpose Vehicle (SPV) or operating company running the PPP hospital. This share does not carry dividend rights therefore avoiding conflicts with profit motives but rather confers specific veto powers over critical decisions that affect public interest at large.
4. The new structure does not allow the foreign investors to exercise a controlling interest on the prevailing PPP have hospital property not less than ten years and imposes gradual penalty in case of non-compliance having access privileged obligations. To deal with the instability of short-run private equity investment horizons, the regime has a ten-year lock in time frame in which the investor behaviour in the utilization and PPP assets can be monitored in terms of their management. By matching the investment time horizons with the long run nature of the healthcare infrastructure, the strategy does not encourage quick deals which focus on valuation multiples continuity and stability of over services. It is also an incentive that compels investors to internalize social objectives as central performance criteria as opposed to them being auxiliary corporate social responsibility commitments.

These are not investor friendly mechanisms that have attractive returns that are risk adjusted. Internal rate of with a network that is well managed, it has been demonstrated through return (IRR) modelling that a IRR of 16-19% can be obtained even on these terms constraint which is much higher than the cost of capital on long term infrastructure funds.

V. Conclusion

India's Unregulated foreign private equity has brought capital, technology, clinical excellence, however, it has revealed the weaknesses of the protection of public interest that was created in a pre financialisation age. Instead of being a hindrance, the constitutional right to health gives the most powerful justification to reform.

Here, strong leadership in the legal field and deliberate regulatory design is of critical relevance. Reformed PPP models based on constitutional responsibility, investment discipline and performance-based public funds can transform private capital into a lasting stakeholder as opposed to a systemic risk. The State can secure that development of healthcare infrastructure results in equal access and sustainable service delivery instead of financial expropriation by aligning the interest of the investors with the long term health outcomes.

The proposals put forward here, brownfield investments reclassification, financial conduct covenants, performance based payments, a Healthcare Investment Regulatory Authority are politically viable, legally sound, financially viable and substantively supportive of the constitutional Article 21 guarantee of right to health. They provide a way to save the merits of private capital and prevent its excess, as in the next decade of healthcare development in India, the growth will be measured not only in the multiples of the EBITDA but in the number of lives that were reasonably served.

To conclude, the transformational change is anchored by resilient leadership in legal affairs based on the invariable interpretation of Article 21 to give in positive, non-derogative obligations on the State in the case of the Supreme Court. Combined with intentionally revamped PPP models that incorporate the notions of affordability, equity, quality, and reinvestment requirement directly into the investment approvals and concession deals, the reforms will spur sustainable development in the healthcare sector in India. India can use the leverage of a privatised incentive to the foreign private equity to achieve long-term results in the public interest in a systematic recalibration of their incentives to make them responsive to increasing access, clinical excellence, and equitable, sustainable health systems in the future.

References

1. Baru, R. V. & Nundy, M. (2020). Commercialisation and consolidation in Indian healthcare. Economic & Political Weekly, 55(42), 36–44.
2. Bhat, R., Menon, R. & Rajgopal, V. (2019). Public–private partnerships in Indian healthcare. *IIM Ahmedabad Working Paper* No. 2019-03-02.
3. Chakravarthi, I. (2022). Corporate takeover of Indian healthcare. New Delhi: Sage.
4. CRISIL (2024). Healthcare sector update: Private equity dominance.
5. Department for Promotion of Industry and Internal Trade. (2015). *Press Note No. 4 (2015 Series): Review of Foreign Direct Investment policy on various sectors*. Government of India.
6. Gupta, A. & Fischer, A. (2023). Right to health as a constitutional imperative. Indian Law Review, 7(1), 45–68.
7. Hooda, S. K. (2024). Financialisation of Indian healthcare. Economic & Political Weekly, 59(11), 52–61.
8. Kane, S. & Ravindran, T. K. S. (2023). Public–private partnerships and equity. Health Policy and Planning, 38(4), 492–508.
9. Ministry of Health and Family Welfare (2014). Model Concession Agreement for PPP in hospitals.
10. Ministry of Health and Family Welfare (2017). National Health Policy 2017.
11. NITI Aayog (2021). Draft National Policy Framework on Healthcare PPPs.
12. Paschim Banga Khet Mazdoor Samity v. State of West Bengal, AIR 1996 SC 2426.
13. PwC India & FICCI (2024). India healthcare outlook 2030.
14. Qadeer, I. & Baru, R. V. (2022). Privatisation and the right to health. In Health justice in India. Singapore: Springer.
15. Ramani, K. V. & Moola, D. (2021). PPP models in secondary and tertiary healthcare. IIM Bangalore Research Paper No. 642.
16. Reserve Bank of India. (2024). *Master Direction—Foreign Investment in India* (updated through March 2024).
17. Sengupta, A. (2023). Foreign private equity and rising out-of-pocket expenditure. Social Science & Medicine, 318, 115602.

****