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Karnataka Janaarogya Chaluvali

Healthcare in Karnataka: Is a Health Bill the Need of the Hour?

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Background

In spite of being one of India's wealthiest state, Karnataka continues to perform poorly on key public health indicators compared to some of the other southern states (see Table 1) primarily because of structural and policy failures. However, it is no accident that the state continuous to be promoted as a 'model' for healthcare reforms, largely due to its aggressive adoption of **privatisation, public–private partnerships (PPPs), contracting out critical health care services and insurance-based healthcare**. The state has been quick to uptake the mandates of the Structural Adjustment Programs (SAPS) -economic reform packages pushed onto India by International Monetary Fund (IMF) and World Bank.

Table 1: Comparison of mortality indicators for Karnataka, Kerala and Tamil Nadu

Sr.	Indicator	Karnataka	Kerala	Tamil Nadu
1	Maternal Mortality ratio (per lakh live births)	68	30	35
2	Infant Mortality Rate (IMR) per 1000 live births	14	5	12
3	Neonatal Mortality Rate (NMR) per 1000 live births	12	4	8
4	Under 5 Mortality Rate (U5MR) per 1000 live births	21	8	14

Table 2: Health coverage indicators for Karnataka (NFHS-5)

1.	% all women (15-45 years) anaemic	48%
2.	% children age 6-59 months anaemic	65%
3.	% households with at least one person covered by any health insurance	28%
4.	% children with low weight for age	33%`
5.	% children stunted	35%

What should be a Public Health law look like?

When there is a failure of voluntary compliance to public health policies, laws may be required. However, laws in themselves may be inadequate unless there is a political and moral mandate by governments to protect populations from threats to health and even to healthcare systems themselves. Public health laws should:

- Set clear rules of behaviour for individuals, public bodies, and private actors
- Define powers, limitations, and duties
- Protect fundamental rights
- Apply universally and predictably under the rule of law
- Must be transparent, publicly debated, and widely understood.
- Embed principles of autonomy, privacy, transparency, accountability, and least harm.

- Include Collective Rights to Social Determinants of Health such as safe drinking water, sanitation, nutrition and housing at the very least.
- Explicitly provide right to universal, free health care services that includes free diagnostics, free treatment and free drugs for ALL citizens for ALL health conditions without any conditions or exceptions.
- Prevent any role of private/ corporate entities in planning, regulating, monitoring or provisioning of public health care services
- Explicitly list violations of citizens' health, health care and patient rights with clear redressal and enforcement mechanisms with proportionate penalties.
- Regulate unnecessary tests, procedures, referrals, bribes, negligence, and staff absenteeism.
- Clarify responsibility for service delivery failures.
- Prevent sabotage by regulated entities.
- Apply Siracusa principles to limit state power during emergencies
- Cap the costs of drugs and treatment in private/ corporate entities and enforce evidence based, standardised government protocols for treatment of diseases of public health importance.

How Karnataka government perceives health rights

A government draft **Karnataka Right to Health and Emergency Medical Services Bill 2025** has been circulating, without any due process of public consultation and mostly borrowed from the Rajasthan Right to Health Act (2022). Some activists in Karnataka have been clamoring for a replication of the Rajasthan Right to Health Act without investing too much thought into whether this is what Karnataka requires. This critique by Karnataka *Janaarogya Chaluvali* (KJC) illustrates that the draft Bill for Karnataka neither protects the public health system not citizens' health care rights. Instead, it seems to legitimise large scale privatisation with a predominant focus on empanelling hospitals for emergency medical care and outsourcing ambulance services to any entity that 'volunteers' to do so.

The Preamble of the draft Bill invokes Articles 47 and 21 of the Constitution claiming to commit to providing "*protection and fulfilment of rights and equity in health and well-being*", "*free accessible health care for all residents of the State with the progressive reduction in out of pocket expenditure in seeking, accessing or receiving health care*' and "*to provide for the people of Karnataka rights to health including emergency Health services with participation of stake holders and people for realization of people's right to health services*".

In the case of Pt. Parmanand Katara vs Union of India & Ors on 28 August, 1989, the Supreme court has quoted the Constitutional mandate of the state to preserve life and obliging every doctor (government and medical institutions) to protect life. The Indian Medical Council Act (1860) and Indian Medical Council/Code of medical ethics also state the importance of immediate medical aid in all cases. No law or State action can intervene to avoid or delay these paramount obligations of the medical profession and all standards of care and quality must be upheld while doing so. Doctors cannot put the life of a patient at stake while waiting for fees to be paid. The Karnataka Private Medical Establishments (KPME) Act further reaffirms this mandate. Indeed, there can be no Right to health without the intrinsic right to emergency healthcare[1], so it is unclear why this has to be specified separately as the Karnataka Right to Health and Emergency Medical Services Bill 2025.

Vague definitions and commitments defeat the purpose of a law

The Karnataka draft bill and the Rajasthan Right to Health Act have failed to use standardised globally accepted definitions related to public health and therefore leave wide room for (mis)interpretation, going against the very principle of a good law. Defining public health as "*the health of the population, as a whole especially as monitored, regulated, and promoted by the Government*" is not only inadequate but also mischievous because it leaves out the crucial term term "provisioned" absolving the state from being primary provider.

"health care", taken verbatim from the watered down Rajasthan Health Act is defined as "*testing, treatment, care, procedures and any other service or intervention towards a preventative, promotive, therapeutic, diagnostic, nursing, rehabilitative, palliative, convalescent, research and/or other health related purpose or combinations thereof, including reproductive health care and emergency medical treatment, in any system of medicines, and also included any of these as a result of participation in a medical research program*". Including health research into the definition of healthcare has many implications. Similarly the term "government funded healthcare services" legalises handing over funds to NGOs and private entities further absolving the government from its own Constitutional responsibilities.

The draft further reduces public health to a scheme (Karnataka Scheme of Public Health) with the planned State Health Authority (SHA) being expected to ensure availability, not of comprehensive health care or health, but only "medical services" free of cost, not to all, but only to "eligible patients". Public health rights must include social determinants of health such as water, sanitation, nutrition, housing etc and include not just related to curative care services.

The SHA is expected to oversee medical, clinical, and social audits; hear all appeals against decision of District /city Health Authority; empanel private medical establishments and outsource ambulance services. It is not clear why a regulatory body should be carrying out executive functions like empanelment of private, placing the Suvarna Arogya Suraksha Trust (SAST) Executive Director as member-secretary of the SHA. SAST is an autonomous body with representatives of empanelled private hospitals on its Board and conflict of interest. Typically, the Director of Health and Family Welfare should be the member secretary of state level regulatory bodies.

Further, the corresponding District /city Health Authority includes the IMA as member. It is not clear what a member of the IMA is doing in a district level regulatory body which also hears people's grievances. IMA members also have their own hospitals in the district. How can a legislation allow such a conflict of interest?

Grievance redressal

An aggrieved person should first approach the concerned person within the health care institution. If their complaint does not get resolved or if the person is not satisfied with the action taken by the health care institution, then she may approach the District Health Authority. Finally, an appeal can be made to the SHA and the latter should look into the matter and resolve it. There don't seem to be any serious consequences of violating the provisions of the Bill apart from "*a fine up-to rupees ten thousand for the first contravention, and up-to rupees twenty-five thousand for the subsequent contraventions*". Thus, human life is reduced to a few thousand rupees on the pretext of grievance redressal!

Finance

As per Chapter 6 and 8 of the draft Bill, the SHA will receive INR 100 crores as token fund from the state government to be used as corpus fund. The SHA as well as the District/ City authority can to raise its own funds not only through government bodies but also receive "donations" from any "individuals or body". Isn't it obvious that if individuals or groups donate funds then they will have a stake in the functioning of this regulatory body? These bodies can also borrow money from the open market for carrying out its activities. So the government will set up a regulatory body which the government itself will be unable to fund? How is the government expected to have any kind of control over this regulatory body? Furthe, the accounts of these agenciesw ill be accounted by auditors appointed by themselves. While audited accounts have to be placed before the state legislature, it does not mention if it will be audited by the CAG. These provisions make the government's intent highly suspect and does not infuse any confidence that the government has citizens' interest in mind.

No real commitment to Right to Health or Emergency services

In this draft Bill, the government primarily commits to a Right to Information, a right to free OPD services and IPD consultations at public health institutions "*accordantly to their level of health care as may be prescribed by rules made under this Act*" and "*emergency treatment and care for accidental emergency, emergency due to snake bite/animal bite and any other emergency decided by State Health Authority under prescribed emergency circumstances, without prepayment of requisite fee or charges including prompt and necessary emergency medical treatment and critical care, emergency obstetric treatment and care, by any public health institution, health care establishment and empanelled health care centres, qualified to provide such care or treatment accordantly to their level of health care, promptly as prescribed or as per guidelines and in a case of medico-legal nature of case, no health care provider or health care establishment shall delay treatment merely on the grounds of receiving police clearance or a police report*"

Further it states that "*Provided that after proper emergency care, stabilisation and transfer of patient, if patient does not pay requisite charges, healthcare provider shall be entitled to receive requisite fee and charges or proper reimbursement from State Government in prescribed manner as the case may be*". The statement '*if the patient does not pay*' implies that payment by the patient is the first option and only if that does not happen, there will be reimbursement by the State.

The clause in the Act that emergency medical services means "*any reasonable measure to render first-aid, advise or assistance to an injured person of an accident or incident of crime or any other emergency*" is alarming. A private entity no matter how well equipped is now (by definition) allowed to wash its hands off by simply providing first aid, advice or assistance. This is no more than what anyone on the street can do if trained in basic first aid. It absolves private medical professionals and institutions from any kind of moral or ethical obligation to a patient in an emergency.
The bill says that to "stabilise" means the "*rendering of any immediate emergency care of the injured person as may be necessary to assure within reasonable medical probability, that no material deterioration of*

the condition of such injured person is likely to result from or occurred during the transfer of such injured person from one hospital to another, where such appropriate facilities are available to render the requisite treatment" goes against the Supreme court directive in the case of Pt. Parmanand Katara vs Union Of India & Ors on 28 August, 1989 where preserving life by the health professional and the State is overarching. Terms like '*as maybe necessary to assure within reasonable medical probability*' will not hold up in a court of law and will allow negligence to be absolved. Further emergencies happen to anyone in the state – visitor or resident. The language of "*eligible individual and eligible households*" being brought into emergency services is concerning. Are people now expected to carry identification documents or money for healthcare emergencies everywhere they go?

Other Provisions in the Bill

Karnataka Bill has two chapters dedicated to Empanelled Hospitals (Chapter 9) and Requirements of Ambulances (Chapter 10). Chapter 9 is about empanelling private hospitals for *"providing or directing the life support system or limited life support system and pre-hospital care system to provide Health care facility and treatment under Government Funded Scheme".* It is not clear what the terms "directing life support", "life- support system", "limited life support system" and "pre-hospital care" even mean. With funds from the government, empanelled hospitals will set up emergency departments in their respective facilities without clearly stating what their commitments and accountability mechanisms will be. using government funds. District/ City Authority are expected to ensure availability of ambulances, ensure easy access to medical emergency services as also handing over ambulance services to "persons voluntarily registered".

Conclusion

With the spate of new privatisation friendly healthcare policies, the state has moved further and further away from its core commitments. If the government of Karnataka is seriously invested in the health care, it needs to commit to sustained direct investment into government health care facilities at all levels (primary, secondary, tertiary and super-specialty); strengthened district and government medical colleges as the final referral point; a permanent and well-supported health workforce; strict regulation of private providers; transparent data reporting; and, accessible and enforceable grievance redressal mechanisms. Instead the government breezes over all of these in its draft Bill and instead undermine citizens' health rights, public accountability, and the core principles of public health.

In the **Karnataka State Integrated Health Policy in** 2004 and later again in 2017, the state had committed to quality healthcare with a focus on equity, accountability, community participation to improve health and well-being of ALL the people of Karnataka and reducing health disparities. The vision foregrounded the social determinants of health and Constitutional mandates thus foregrounding health within which healthcare is situated.

Any law that legalises privatisation (public private partnerships, health insurance, contracting) will only further drain public resources will leaving patients at the mercy of market vagaries. Unless there is a core commitment by the government to revisit these mandates, a law can only be toothless and an ineffective band aid for optics. It is time that the citizens of the state play a more informed role in demanding for our health rights.