IMA's response to 176th report of the Parliamentary Standing Committee on Affordability and Accessibility of Healthcare facilities in public and private sector.

Introduction: IMA compliments the exhaustive and in depth real time analysis of the Health status of the nation by the Parliamentary Standing Committee on Health under the leadership of Prof Ram Gopal Yadhav. This document shall stand as a beacon for all those who are concerned about Health and be a historical document for posterity. The sheer breadth of the document has not impacted its depth in content and language.

Prologue: IMA assesses that the Healthcare in India had four wrong turns which have sealed the fate of the system.

1. Allowing private share holder equity to set up For Profit Hospitals 1979-83
2. Passing of the Clinical Establishments Act and Rules decimating the small and medium hospitals especially the doctor owned institutions. 2010&12
3. Insurance panacea for the missing middle by the Niti Aayog 2021
4. Full FDI in Hospitals and Health insurance 2020 & 2025

IMA believes that the best part of Healthcare is already over in India and it is only question of time before our nation becomes another United States which is the most expensive albeit less efficient Healthcare in the world.

Core principles of IMA's point of view

1. **Government Leadership in Health**. Both the Centre and the States together should allocate 5% of GDP to Health. That amounts to 18 Lakh crores of rupees. The current allocated amount of all the Governments put together is 4.95 Lakh crores of which the Central Government share is 99,859 crores (one fourth). The leadership in Health today remains with the private sector which chips in 2.8 % of GDP ie around 9 Lakh crores of rupees.

2. **Tax funded Universal Healthcare** with basic package in primary, secondary and tertiary care for all citizens without intermediaries. There should be strategic purchase of care from private sector for BPL families**. (High power expert group: 11th five year plan 2011)**

3. The current Missing Middle concept of **NITI Aayog favoring the insurance industry** will lead the country to the US model where 18% Healthcare expenditure of a GDP of 30 trillion dollars has left 28 million Americans with no Healthcare. **(The Missing Middle- NITI AAYOG 2023)**

4. India has a **strong network of small and medium hospitals run by doctors**. These institutions are eminently accessible and affordable and are run by the profession (doctor entrepreneurs). These institutions are disappearing due to over regulation and policies as well as schemes favoring the *For Profit Corporate sector.* These professional institutions run by doctors deserve regulations and incentives different from the For Profit sector.

5. **India has done well in accessibility and affordability** of Healthcare. One needs to only look at what is in store in other countries. Accessibility and affordability achieved without quality and human dignity is unacceptable.

Clinician's perspective on accessibility and affordability

Availability of doctors (Modern Medicine) in 2025

	Population	Number of Doctors	Doctor Population Ratio
India	1,468,781,122	13,86,150	1:1060
Kerala	36,111,000	73,069	1:494
Uttar Pradesh	241,265,000	1,05,068	1:2296

Waiting time for Medical Emergency

NHS UK	4 hours and 46 minutes
US	16 minutes
India	15 minutes

Waiting time for appointment of a Cardiologist

NHS UK	17-19 weeks
US	33 days
India	Few hours

Consultation fee of a General Practitioner

UK	£ 69-£89 (INR 8023 to 10348)
US	$150 to $300 (INR 13310 to26622)
India	INR 50-200

Hospital charges for Caesarean section

NHS UK	£3,948 (INR 4,61,825)
US	$50,000 (INR 44,36,950)
India	Rs 50,000

Number of patients seen by a doctor in a day

UK	26-30
US	20-30
India	25-200 patients

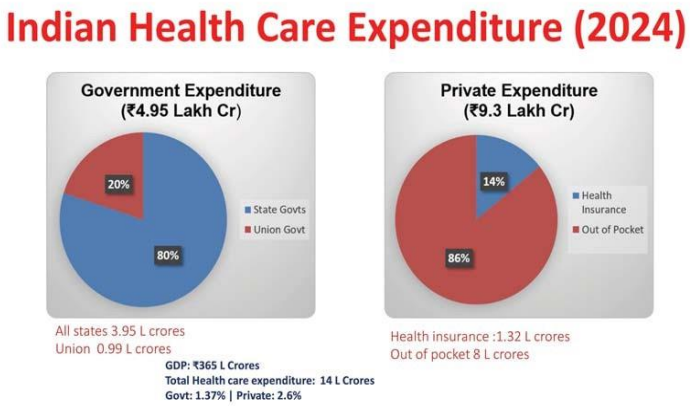
Comparison of cost of investigations in various countries

Si No	Country	MRI USD	X Ray USD	Blood Test Basic Panel USD
1	OMAN	$130 – 300	$10 – 30	$10-50
2	QATAR	$200 – 500	$50 – 100	$20 -100
3	THAILAND	$220 – 700	$17 – 42	$40 – 170
4	UAE	$400 – 800	$40 – 80	$55 – 135
5	SAUDI ARABIA	$100 - 300+	$15-40	$20-70
6	SINGAPORE	$600-2,000+	$40-150	$30-150
7	INDONESIA	$250 – 550	$15 – 40	$10-50
8	MALAYSIA	$340 – 700	$20 – 60	$25-100
9	VIETNAM	$70 – 250	$5 – 20	$5-30
10	INDIA	$70 – 300	$3 – 15	$5-30
11	PHILIPPINES	$140 – 450	$6-35	$10-60

Heath Funding : IMA's perspective

1. Tax funded universal healthcare with basic package for all citizens.
2. Direct funding of Government Hospitals and human resources with strategic purchase from private sector. Increase the investment in Public Hospitals, Public Health Infrastructure and Human resources.
3. 5% GDP resources to be allotted by the Governments to Health.
4. Direct patients transfer, co payment and reimbursement models will sustain Health insurance model.
5. New healthcare infrastructure (beds) creation: India's existing bed-to-population ratio is 1.3/1000 population (both private and public hospitals included), and there is a deficit of 1.7/1000 population with WHO prescribed norms. To cater to the existing population, an additional requirement of 2.4 million beds would be needed. Approximately 70% of current beds available are in private sector. Amongst private sector most of the hospitals which are serving currently are less than 50 bedded hospitals which are currently facing a dual challenge- at one end scarcity of capital to add beds/new projects and at the other end financial viability in current environment of third-party payor dominant system, over-regulations and price controls.

India Health expenditure 2024



Figures as calculated by IMA from available official sources

Budget 2025-26

States	Total Budget (Rs in crores of rupees)	GSDP (Rs in crore)	Allocation for Health (in Rs crore)
Andhra Pradesh	2,97,929	18.3lakh	19961.243
Arunachal Pradesh	38,809	47,823	1241.888
Assam	1,46,642	7,41,626	8945.162
Bihar	2,94,075	10.97lakh	19408.95
Chhattisgarh	1,65,000	6.35lakh	11220
Delhi	95,358	12.15 lakh	13826.91
Goa	25,639	1.39lakh	2025.481
Gujarat	3,32,150	29,82,032	23250.5
Haryana	1,69,229	13,47,486	9984.511
Himachal Pradesh	52,709	2,55,636	3320.667
Jammu and Kashmir	1,06,641	2,88,422	8851.203
Jharkhand	1,36,653	5,56,286	7652.568
Karnataka	3,83,075	30,70,103	18770.675
Kerala	1,98,582	14,27,145	10922.01
Meghalaya	27,598	66,645	2180.242
Maharashtra	7,00,020	49,39,355	31500.9
Mizoram	14,624	36,089	833.568
Madhya Pradesh	3,75,335	16,94,477	24021.44
Nagaland	20,096	45,020	1024.896
Odisha	2,66,800	10.63lakh	22944.8
Punjab	1,46,632	8,91,301	6745.072
Rajasthan	3,79,617	19,89,000	31887.828
Sikkim	15,535	57,000	776.75
Telangana	2,84,837	18,00,325	13672.176
Tamilnadu	4,39,293	35,67,818	21964.65
Tripura	31,412	1,00,795	1884.72
UttarPradesh	7,57,333	30.8lakh	49983.978
Uttarkhand	75,170	4,29,308	4810.88
WestBengal	3,41,462	20,31,805	21853.568
States		**Total**	**395467.236**
Union	**50.65lakh**	**365 lakhs (GDP)**	**99859**
		Total	**495326.236**

The out of pocket expenditure as calculated by IMA is 57 %

Figures as calculated by IMA from available official sources

176th Parliamentary report from the Rajya Sabha examines the current state of healthcare affordability and accessibility within India's dual public and private systems. It details a three-tiered public infrastructure focused on primary care, while noting that a rapidly expanding private sector dominates specialized and tertiary services. The committee expresses concern that low public investment in advanced care and high administrative overhead lead to excessive out-of-pocket expenses for citizens. To address these gaps, the document recommends regulatory reforms, including the uniform enforcement of the Clinical Establishments Act and mandatory price transparency. Furthermore, it suggests cross-subsidization policies and tax incentives to encourage private hospitals to expand into underserved rural regions. Ultimately, the report advocates for a technologically integrated healthcare model that balances commercial growth with equitable patient protections.

Strict regulatory reforms, while intended to improve affordability, often act as significant impediments to the delivery and expansion of advanced healthcare by threatening financial sustainability, stifling innovation, and imposing severe administrative burdens. Here is how these proposed regulations can negatively impact advanced medical care:

1. **Mandatory Pricing and Price Caps Threaten Financial Viability and Quality of Care**

Advanced tertiary care requires immense capital investment. Establishing a specialized 500-bed hospital, for example, typically requires an investment of around ₹1,000 crore and a gestation period of nearly four to eight years. Furthermore, advanced medical equipment is largely imported and attracts substantial customs duties and GST, making it nearly 35% costlier in India.

When the government mandates strict pricing or imposes package rates (such as those under Ayushman Bharat PM-JAY and CGHS), these rates are frequently based on marginal costing. They fail to account for heavy capital investments, rising medical inflation, the cost of specialized infrastructure, or a reasonable surplus for reinvestment. In some highly specialized fields like oncology, government package rates can be up to 70% lower than actual prevailing market costs.

Consequently, forcing an unviable financial model upon private hospitals continuously squeezes profit margins, threatens institutional revenue stability, and ultimately compromises the quality of patient care.

2. **The Clinical Establishments Act Imposes Severe Compliance and Administrative Burdens**

While uniform enforcement of the Clinical Establishments Act is proposed to standardize care, it creates a severe burden of compliance for private healthcare providers. The regulatory landscape is highly decentralized, and varying compliance mandates create significant administrative bottlenecks that actively deter private healthcare investments, particularly in tier-2 and tier-3 cities.

Redundant and repetitive compliance requirements impose unnecessary administrative and financial overhead on healthcare providers, shifting resources away from patient care and toward bureaucratic paperwork. Blanket enforcement also ignores the operational realities of smaller or specialized facilities, which likely face proportionately higher compliance costs compared to large corporate hospitals.

3. **Cross-Subsidization Policies deter Investment in Cutting-Edge Technologies**

Proposed frameworks mandating that large corporate hospitals utilize revenues generated from international and high-net-worth patients to cross-subsidize advanced tertiary care for economically weaker domestic patients effectively shift the state's welfare burden onto private enterprises.

Private hospitals operate in a highly capital-intensive environment where super-specialist doctors command high compensation and world-class technology requires enormous capital outlays to install and maintain. Forcing private hospitals to cross-subsidize care restricts their ability to reinvest revenue into advanced medical infrastructure, robotic surgery, AI-powered diagnostics, and other modern technologies. Over time, this hampers the private sector's ability to maintain global standards of advanced healthcare.

4. **Price Controls on Drugs and Devices Stifle Medical Innovation**

Subjecting advanced medical devices and pharmaceuticals to aggressive price controls can have unintended negative consequences on patient outcomes. Extreme pricing pressures can lead to commercial unviability, inadvertently forcing critical formulations and advanced therapeutic devices off the market. When companies cannot recover the high costs of research, development, and scaling, they are discouraged from manufacturing or importing life-saving innovations.

Furthermore, novel and highly efficacious treatment modalities, such as immunotherapy, genomic therapies, and targeted therapies; are inherently expensive to develop and administer. Overly aggressive price regulation risks inadvertently stifling medical innovation and restricting the availability of these cutting-edge therapies, thereby compromising clinical outcomes for patients requiring advanced care.

5. Chronic Delays and Arbitrary Rejections in Government Claim Settlements

While the government pushes for greater private sector participation in health assurance schemes like Ayushman Bharat (PM-JAY), systemic and prolonged administrative delays in claim settlements actively threaten the financial sustainability of private hospitals. For example, the average time taken for bill settlement of government scheme patients can extend to 6 to 8 months. Furthermore, rigid procedural algorithms within government IT portals often generate avoidable, arbitrary claim rejections without transparent justifications. This chronic friction forces hospitals to suspend services, limits their ability to dedicate beds to economically weaker sections, and acts as a severe deterrent to scheme participation.

6. Unclaimable Embedded Taxes (GST) Inflate Operational Overheads

The current taxation structure inadvertently inflates the overall cost of medical treatment provided by the private sector. Although healthcare services are exempt from GST, private healthcare providers cannot claim Input Tax Credit (ITC) on the GST paid for procured goods, advanced medical equipment, specialized construction, and consumables. This unclaimable tax, combined with high import duties that make advanced medical equipment nearly 35% costlier in India; becomes an embedded operational cost. Expecting private hospitals to offer cheap healthcare while burdening them with embedded taxes and industrial-level utility tariffs creates an unviable financial environment.

7. Unrealistic Package Durations for Complex Critical Care

Government health schemes often rigidly impose predefined package durations that disproportionately penalize healthcare institutions handling complex and acute cases. High-cost specialties, such as Neurosurgery, Cardiovascular and Thoracic Surgery (CVTS), and Orthopaedics, frequently necessitate prolonged Intensive Care Unit (ICU) stays that exceed standard package parameters. Forcing private hospitals to absorb these outlier costs under bundled packages acts as a severe deterrent to admitting critically ill beneficiaries and restricts their access to advanced, life-saving procedures.

8. Lack of Infrastructure Support and High Institutional Licensing Costs

There is often an expectation that private hospitals should operate with public welfare motives, yet they do not receive the corresponding support required to lower capital expenses. Private hospitals face high institutional licensing costs, commercial utility tariffs, and operational fees because they are often categorized under an industrial category rather than an essential service. Unilateral rate-setting by the government for health schemes frequently fails to account for these practical realities, including the

massive real estate acquisition costs, specialized manpower compensation, and technology adoption required to maintain advanced healthcare facilities. Without targeted tax holidays, concessional land, or soft loans, capping prices stifles the private sector's ability to expand into Tier-2 and Tier-3 cities.

9. Customs Duties

To reduce customs duties on medical equipment and ensure that the resulting financial relief makes healthcare more affordable, the Committee recommends the following strategies:

Rationalizing tariff structure: The government should formulate a rationalized tariff structure to significantly reduce customs duties, cesses, and allied levies on advanced, life-saving medical equipment and their critical components. This rationalization should specifically target non-indigenously manufactured high-end radiation and diagnostic equipment.

Tying Exemptions to Capped Pricing: To guarantee that the financial relief from duty reductions translates into affordable patient care, tax exemptions on imported equipment must be strictly conditional. Importing healthcare facilities must be required to commit to standardized, capped pricing for the diagnostic tests and medical procedures that utilize the exempted machinery.

Incentivizing Domestic Manufacturing: Simultaneously, the government should provide targeted incentives under the 'Make in India' initiative to build indigenous manufacturing capabilities for advanced medical technology. By strengthening domestic production, India can sustainably reduce its dependence on expensive imported equipment.

IMA's perspective on recommendations

Recommendation 1

The Committee, therefore, recommends a systematic expansion of public sector capital investment in Community Health Centres (CHCs), District Hospitals, and state-run medical colleges. The Committee understands that the focus of such expansion should be on upgrading regional secondary-care facilities thereby reducing the referral burden on overstretched apex institutions.

IMA: Public sector capital investment is the right way to go. IMA recommends 50: 35:15 public health expenditure in primary: secondary: tertiary care institutions.

Recommendation 3

The Committee, therefore, recommends enforcing standardized, subsidized pricing models and expanding public insurance coverage for high-end tertiary procedures within public-private partnership (PPP) frameworks.

IMA: Public Private Partnership is a failed model. The Government should go for strategic purchase from private sector for marginalised communities in aspirational districts rather than chasing an utopian dream.

Recommendation 4

The Committee, therefore, recommends that the Ministry actively coordinate with State Governments to mandate the uniform adoption and strict enforcement of the Clinical Establishments Act nationwide. Furthermore, the Committee believes that relying solely on voluntary NABH accreditation is insufficient; hence, a mandatory quality-assurance and price-transparency framework must be implemented across the country for all private clinical establishments to ensure standardized treatment protocols and protect patients from monetarily exploitation.

IMA : The working group of 11th Five year Plan clearly identifies that the Health care sector is over regulated. It warns against creating a bureaucratic system especially for inspection.

(a) (Page 14 point 40 vi, vii) Report on the Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure For the 11th Five-Year Plan

(vi)As far as possible, registration should be done on the basis of documents certified by licensed professionals such as Chartered Accountants, approved valuators, assessors etc. The setting up of administrative paraphernalia for inspection is to be discouraged.
(vi)To the maximum extent possible, the responsibility of actual registration should be entrusted to Panchayati Raj Institutions (PRIs). There is already a multiplicity of licensing/inspector authorities under various health related legislations. These are, therefore, required to be consolidated.

It is exactly what the nation has ended up doing. The Plan identified accreditation as the route. The high handed CEA will eliminate the much needed small and medium doctor run enterprises. There is a strong case for reconsidering and withdrawing CEA on such institutions. However IMA supports a mandatory accreditation system for these hospitals from approved agencies and registration

under the state medical councils. This will satisfy the objectives of the Act namely registration and maintenance of standards.

IMA wishes to point out that standards of treatment and Standardised treatment protocols are two different things. Standards of treatment are in the interests of the patients while standardised treatment protocols are in the interests of the insurance industry. Standardised treatment protocols hamper clinical decision making and clinical autonomy affecting the patient care. Instead of prescribing standardised treatment protocols which are driven by the interest of the Health Insurance Industry individual hospitals can have their own protocols subject to the medical audit of the state medical councils.

Recommendation 5

The Committee notes the robust financial performance of corporate hospital chains, marked by a high Average Revenue per Occupied Bed (ARPOB) driven heavily by high-value treatments and an expanding medical tourism market. The Committee believes that while India's emergence as a premier, cost-effective global medical destination is commendable, the advanced medical infrastructure, often bolstered by government incentives such as 100% FDI, must simultaneously serve the domestic population equitably. Conversely, the Committee is of the view that India's significantly low private health insurance penetration, which remains well below the global average, forces domestic patients to bear debilitating out-of-pocket expenses for such services.The Committee, therefore, recommends the formulation of a structured cross-subsidization policy. Under the said framework, large corporate hospitals benefiting from government concessions should be required to utilize a portion of revenues generated from international and high-net-worth patients to provide cross-subsidized advanced tertiary care for economically weaker domestic patients as is the case inseveral countries. Additionally, these institutions must be mandated to allocate a defined quota of beds for empanelment under national health insurance schemes at standardized, regulated package rates.

IMA : The committee commits three faux pas in this recommendation.

a) **IMA feels 100% FDI in Hospitals is not an incentive. It is an open invitation to profit in an already commercial market place and is detrimental to the Health of our people. The Health care costs will further increase beyond everyone's reach.**

b) **No country in the world has provided UHC depending on private healthcare insurance industry which should be curtailed at a certain level.**

c) **Cross subsidisation will not work PMJAY has taken away the depreciation of the private hospitals. The cartel of 31 Health Insurance companies is batting for PMJAY/ CGHS rates under the benign watch of the IRDAI as well as the judicial over reach on the The Niti Aayog itself notes in its missing middle document that only 10% of the population can pay for their healthcare expenses. It will be interesting to watch if this 10% will be able to cross subsidise the 90%.**

Recommendation 6

The Committee believes that such small rural facilities are critical to decentralized healthcare delivery but require urgent systemic support to balance quality with affordability. The Committee, therefore, recommends that the government restructure its healthcare incentive frameworks, making tax benefits, land subsidies, and FDI facilitations strictly conditional upon private sector investment in underserved geographical regions.

IMA welcomes this recommendation

Recommendation 7.

The Committee, further, recommends that the government restructure its healthcare incentive frameworks to explicitly protect and upgrade smaller healthcare providers. Alongside incentivizing corporate Public-Private Partnerships (PPPs) to expand into non-urban areas, the government must launch targeted financial assistance, technology-upgrade grants, and subsidized equipment procurement programs specifically for small and medium-sized rural and semi-urban hospitals. Leveling such technological playing field will ensure that high-quality, modern care is not exclusively confined to corporate urban centers but is made accessible and affordable throughout the rural, semi-urban, hilly and tribal landscape.

IMA welcomes this recommendation

Recommendation 9

Healthcare costs are not uniform across India, but vary significantly. Treatment costs are higher in the south and in some more developed states. In Telangana, the total cost of hospitalisation reaches about Rs 55,000, while in Tamil Nadu it is around Rs 52,000. In Kerala and Karnataka, the cost ranges between Rs 40,000 and Rs 45,000. Expenditure is also high in states such as West Bengal and Maharashtra, where total spending is recorded at or above Rs 40,000. In Uttar Pradesh and Haryana, the level also reaches about Rs 45,000. By contrast, spending in the north-east and some less developed states

is relatively low. In Odisha, it is around Rs 22,000, while in Mizoram and Meghalaya it is about Rs 25,000.

IMA: The committee would perhaps want to use the term price and pricing rather than cost to have clarity.

The Health Care cost determines the price. Both infrastructural and Human Resources costs are different in different states even between districts. It is natural the prices are different. Better availability of Government Healthcare services cannot push prices below cost in private sector.

The net profit margin (PAT) in private hospitals is 8-12 % after interest, depreciation , tax -beacause the hospitals are very capex heavy.

The net profit margin of small and medium hospitals (MSME) which are 65-75% of India Hospital market (30-150 beds) is 2-5% .

Recommendation 10

The Committee, therefore, recommends for an accelerated capacity-building initiative focused on expanding bed capacity and recruiting specialized medical personnel in public facilities.

IMA : Both the observation and the recommendation are correct. Capacity building in infrastructure especially the beds and Human Resources in the Public sector is the only way for the nation to go forward.

Recommendation 11

The Committee observes with concern the widening cost disparity between public and private healthcare, where the recent 80thNSO survey (2025) reveals private hospitalization averages Rs. 50,508 (as compared to Rs. 6,631 in public facilities. Such huge disparity has triggered a deepening affordability crisis. The Committee, therefore, recommends for the existing regulatory framework for immediate formulation of a mechanism to standardize and cap the costs of essential treatments, diagnostics, and routine procedures across all private hospitals.

IMA : An absolutely unacceptable and undefendable observation as well as equally harmful recommendation. Comparing apples with oranges is unfair. The committee should order an independent and transparent costing for both the sectors where IMA would be happy to participate. IMA also understands that DHR has a study on costing in Government sector which has never been placed in public domain. To be fair the responsibility to evaluate actual cost in both public and private sectors should be entrusted to The institute of Costing Accountants of India.

It is respectfully submitted that Rule 9(ii) of the 2012 Rules purports to empower the Central Government to determine the range of rates which can be charged by the Clinical establishments from their patients. It is respectfully submitted that the 2010 Act, neither in letter nor in spirit, confers any such jurisdiction upon the Central Government to frame rules for restricting / curtailing / determining the rates to be charged by clinical establishments. The provisions of Rule 9(ii) are ultra-vires the Act.

Any such Rule providing for curtailment / restriction on the rates to be charged by the Clinical establishments for the services rendered by the Medical professionals as well as associated / ancillary services towards medical treatments / procedures / facilities provided to any patient - would directly impinge upon the fundamental right to practice profession, trade, business, occupation as guaranteed under Article 19(1)(g) of the Constitutional of India. The Rule also suffers from manifest arbitrariness, is irrational, arbitrary and unreasonable, and violative of Articles 14 and 21 of the Constitution of India.

Recommendation 12

The Committee, however, believes that current insurance coverage remains insufficient, as it largely ignores outpatient costs (which are five times higher in private settings) and indirect expenses like transportation and wage loss. The Committee, therefore, recommends a targeted geographical reallocation of health infrastructure funds to establish advanced public tertiary centers in underserved rural areas and northeastern regions, reducing regional reliance on the private sector. Simultaneously, the government must broaden the scope of existing national health insurance schemes to include comprehensive coverage for outpatient treatments and diagnostics.

IMA welcomes relocation of Health infrastructure funds to establish tertiary care centres in underserved rural areas.

IMA welcomes broadening coverage for OP and diagnostics from not only National insurance schemes but also private Health Insurance.

Recommendation 13

(PMJAY) provides critical financial protection to over 500 million vulnerable citizens, Currently, a significant portion of PMJAY funds is absorbed by the private sector. By synergizing PM-ABHIM‘s infrastructure upgrades with PMJAY‘s financial coverage, the government can ensure that public hospitals capture a larger share of insured patients, thereby retaining public funds within the public healthcare ecosystem and guaranteeing high-quality, cashless tertiary care.

IMA had demanded way back in 2018 to re envision PMJAY .

IMA categorically feels that the vision of the Honourable Prime Minister has been considerably diluted in the current version of PMJAY.

The vision is to bring expensive clinical care especially the tertiary within the reach of everyone. The care in the Government Hospitals is already available to the marginalised free of cost. By diverting precious money to Government Hospitals the scheme actually buys care for patients for whom the care was anyway free. The patient doesn't gain any additional benefit and the Hospital and the staff get paid for rendering a service which in first place was mandated. This results only in shifting the data from one register to another. No new services have been provided. In the absence of PMJAY also these care were being provided in yesteryears.

On the other hand IMA firmly believes that the funds of PMJAY should be exclusively used for strategic purchase of services from Private Sector in underserved areas for the marginalised. The Government can decide which and where of these services. That will create additional services in realtime. Government Hospitals and services should be funded exclusively and directly from the budgets of the Governments.

If the Government and the Parliamentary Committee feel that the public funds should be retained in public hospitals then they should also explain what is the relevance of PMJAY and why should the funds be routed through PMJAY when they could have transferred them by a less cumbersome process directly. A comptroller General audit could find out if there is any additional services that has been provided in these hospitals because of PMJAY.

Recommendation 14

The Committee also acknowledges the severe burden of compliance faced by private providers. Rising operational costs for medical supplies, medications, and state-of-the-art equipment, combined with government price caps under schemes like Ayushman Bharat and CGHS, threaten financial sustainability. The Committee believes that forcing an unviable financial model upon hospitals ultimately compromises patient care. The Committee, therefore, recommends that the Ministry must institute a dynamic, consultative pricing mechanism. Package rates under government schemes must be periodically rationalized to reflect realistic, rising operational costs, ensuring that private facilities can maintain high-quality care without facing systemic revenue instability.

IMA welcomes the recommendation.

Recommendation 15

The Committee, therefore, recommends making ABDM compliance mandatory for all public healthcare facilities and private hospitals empanelled under PMJAY.

IMA: Before espousing mandatory ABDM compliance the Parliamentary Committee would do well to answer the questions posed by IMA to the Hospital Authority of India which remain unanswered.

Recommendation 16

The Committee, therefore, recommends the Government to establish Jan Aushadhi Kendras within the premises of all District Hospitals, CHCs, and large private hospitals empanelled under government schemes.

IMA welcomes the move to expand Jan Aushadhi Kendras.

Recommendation 17

The Committee, therefore, recommends that the Government heavily synchronize the expansion of financial protection frameworks, such as the Pradhan Mantri Jan Arogya Yojana (PM-JAY), with targeted infrastructural investments under the PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM).

IMA welcomes the move

Recommendation 18

The Committee, therefore, recommends the Ministry of Health and Family Welfare to embark upon the web-based Indian Public Health Standards (IPHS) Dashboard an active, real-time remediation tool.

IMA welcomes the initiative

Recommendation 20

The Committee, therefore, recommends that the Government should exponentially scale up its budgetary allocations to health, establishing a binding, time-bound roadmap to achieve the 2.5 per cent GDP threshold. This augmented funding must be strategically channeled into strengthening public healthcare infrastructure.

IMA welcomes increased budgetary allocation and strengthening of public health infrastructure

Recommendation 21

Unregulated costs for diagnostics, consumables, medicines, and intensive care , push vulnerable households into indebtedness. existing health insurance schemes inadequately address the immense financial burden of outpatient treatment, particularly the recurring cost of medicines. The Committee, therefore, recommends that the Government institute stringent regulatory mechanisms to standardize and cap pricing across private healthcare facilities, including retail pharmacies. Concurrently, it is imperative that the scope of existing public health insurance frameworks, such as PM-JAY, be broadened to comprehensively encompass outpatient consultations, diagnostic evaluations, medicine costs, and post-hospitalization care.

IMA: Consultation charges are the least of the expenditure. They shall remain the right of the profession. Regarding capping of the prices of drugs the Government can expand the list of essential drugs and also implement One Company One drug One price policy. Not only public health insurance even private health insurance should be made to include the out patient diagnostic cost, drugs and post hospitalisation care.

Recommendation 22

Committee, recommends the Government expand the uninterrupted provision of free essential medicines across all tiers of public health facilities. Actively work to bring pharmaceutical expenditure within the ambit of prepaid and insured health financing rather than leaving it as a direct household cost.

IMA welcomes the suggestion

Recommendation 23

The Committee, recommends the formulation of specialized financial support frameworks and enhanced insurance sub-limits explicitly targeted at chronic care management, with specific provision for recurring pharmaceutical costs.

IMA welcomes the suggestion

Recommendation 24

The Committee, recommends that the Ministry of Health and Family Welfare, in consultation with the Ministry of Finance, chalk out financial outlook depicting a year-wise, costed glide path, detailing how GHE will move forward from 1.43 per cent, to 2.5 per cent of GDP by a revised goal but with binding timeline.

IMA welcomes the suggestion

Recommendation 25

The Committee is of the view that the prioritization of healthcare within the broader fiscal framework has regressed alarmingly post-pandemic. The data explicitly reveals that Government Health Expenditure (GHE) as a percentage of General Government Expenditure (GGE) plummeted from a peak of 6.12 per cent in 2021-22 to just 4.89 per cent in 2022-23, pulling back to a level even lower than the pre-pandemic baseline of 5.02 per cent in 2019-20. The Committee believes that treating health allocations as expendable once a public health emergency subsides fundamentally undermines the structural integrity and resilience of the healthcare system.The Committee, therefore, recommends that the Government should establish and adhere to a statutory minimum threshold for health allocations as a fixed proportion of total government spending. Such budgetary provision and allocation will guarantee that healthcare retains a permanently prioritized status in the national and state budgets, explicitly safeguarding public health investments from being crowded out or deprioritized in favor of other sectors during non-pandemic years.

IMA : Strong words. IMA supports every word.

Recommendation 26

The Committee, therefore, recommends the aggressive scaling up and deepening of insurance / pooled health financing mechanisms. This includes expanding PM-JAY coverage, strengthening state health assurance schemes, and improving primary and secondary care availability in public facilities to prevent patients from being pushed into the costly private sector. Furthermore, the Committee recommends the provision of a statutory target of enhancing Government Expenditure and capping on prices of medical drugs, diagnostics and devices to ensure reductions in OOPE as a percentage of THE, bringing OOPE below 30 per cent, tied to a specific target year.

IMA does not support scaling up of private Health Insurance or insurance by public sector companies.

IMA welcomes the rest of the recommendation

Recommendation 27

The Committee, however, believes that even at 13 per cent, capital allocation as percentage of the still remains critically insufficient relative to the infrastructure deficits in public healthcare (rural hospitals, diagnostic capacity, tertiary care, medical education seats). The Committee, therefore, recommends that the Government aggressively enhance the capital expenditure outlay within the health budget. This augmented funding must be strictly ring-fenced for the rapid infrastructure expansion, procurement

of advanced medical equipment, and the scaling up of training capacity for healthcare personnel, thereby shielding infrastructure development from fluctuations in current expenditure priorities and ensuring that long-term accessibility is not compromised.

IMA welcomes this recommendation

Recommendation 28

The Committee, therefore, recommends that the Ministry of Health and Family Welfare immediately invest in advanced digital systems and Artificial Intelligence-enabled data collection systems. Such technological overhauling must ensure that NHA estimates are published by the final quarter of the subsequent financial year.

IMA welcomes this recommendation

Recommendation 29

Low public expenditure on health has constrained the capacity and quality of healthcare services in the public sector, resulting in nearly two-thirds of healthcare utilisation taking place in the costlier private sector. Consequently, households remain vulnerable to catastrophic health expenditure and impoverishment due to medical expenses. The Committee therefore emphasizes that pre-payment and risk-pooling mechanisms through health insurance are indispensable instruments for protecting households against health shocks and reducing out-of-pocket expenditure.

IMA: It is a case of correct diagnosis and wrong prescription. Health insurance is a failed model and should not be pursued. Incomplete in penetration and coverage, high overhead costs (36%), the For profit nature and the unfriendly attitude towards the patients and the hospitals as well as the expensive nature of the US model should deter us from sliding further on this detrimental model. If any thing we should scale it back by positively pushing the public sector ahead.

Recommendation 30

The Committee is of the view that the "missing middle", constituting over 40 crore individuals or 30% of the population, presents a unique challenge.

IMA finds the word missing middle derogatory and unbecoming of Governments to describe neglected people. This word should be excluded summarily.

Recommendation 31

The Committee also observes that private health insurance penetration remains concentrated among urban and higher-income groups, with limited coverage in rural areas and among informal-sector workers. Concerns were also expressed regarding rising

insurance premiums, exclusions and waiting periods, co-payments, claim rejections and the limited coverage of outpatient care, diagnostics and chronic disease management. The Committee further noted that delays in claim settlements and inefficiencies in the functioning of Third-Party Administrators (TPAs) adversely affect public confidence in health insurance mechanisms. The Committee is concerned to note that insurance claims charges very steeply for the same procedure between various hospitals. The Committee strongly recommends for a transparent, well regulated health insurance sector where claim settlements date is integrated onto a common portal with open access. This will ensure transparency in the settlement of insurance claims.

IMA agrees with the honest appraisal of the committee on the private health insurance. It is again a case of correct diagnosis and wrong prescription.

The right way to go : a) direct benefit transfer b) co payment c) non cashless reimbursement of claims.

Recommendation 32

Achieving Universal Health Coverage would require enhanced public health expenditure, stronger primary healthcare systems, expansion of financial protection beyond hospitalisation, affordable insurance products for uncovered populations, wider availability of free medicines and diagnostics, greater adoption of generic medicines and a robust digital health insurance ecosystem to effectively protect households from catastrophic health expenditure and impoverishment.

IMA agrees with all the points except the ones on insurance sector

Recommendation 33

The Committee observes that employer-sponsored insurance currently proves significantly more effective in reducing out-of-pocket expenditure (OOPE) than government-funded schemes. The Committee believes this effectiveness stems directly from broader coverage limits that include routine OPD visits, fewer hidden costs for diagnostics and specific medicines, and seamless access to high-quality provider networks. The Committee is of the view that to prevent catastrophic and impoverishing health expenditures, government-funded schemes must emulate these structural advantages.

IMA agrees with the findings

Recommendation 35

The Committee recommends that State Health Agencies utilize the Indian Public Health Standards (IPHS) 2022 web-based dashboard to ensure 100% of healthcare facilities

IMA: a. Generic prescription by the medical profession will be commensurate with the quality assurance mechanism put in place by the Government. Testing less than 1-2% of the drugs in the market is unacceptable. 98 % of batches on shelf are never lab tested by the regulator-they rely on manufactures QC and GMP compliance. The Government will have to give an unadulterated guarantee regarding the quality of drugs to the nation before asking the doctors to comply. The clinicians' point of view regarding the welfare of the patient is being misinterpreted as being hand in glove with the pharmaceutical industry. The profession is not willing to play soft target in this game. The issue will be taken to the people to expose the facts about the quality assurance mechanism in the country.

b. IMA will support the Government if the Government is willing to ban all branded medicines and assure the quality of generic drugs.

c. The Government can for a beginning adopt a one drug one price policy. IMA informs the nation that the Governments have permitted three levels of pricing for the same molecule by a single pharmaceutical company in three different formats. First abolish this irrational practice. (Annexure 1)

d. Promote universal health check ups? How did this get into the recommendation? There may be individual parameters that might have to be screened for certain high risk patients. The committee is duty bound to show evidence for universal annual health check ups for the entire population. This is a corporate agenda and deserves to be deleted from the report.

Recommendation 36

Relying on refurbished diagnostic systems is highly unrealistic to long-term healthcare outcomes. The Committee recommends that the Ministry significantly expand financial and structural incentives under the "Make in India" initiative to guarantee **.**

IMA welcomes these recommendations

Recommendation 37

The Committee is of the view that the persistent financial burden on patients is severely exacerbated by retail pharmacy malpractices, wherein pharmacies exploit high Maximum Retail Price (MRP) margins, misuse GST refunds through fraudulent billing, and offer arbitrary discounts outside of prescription mandates. Unregulated, over-the-counter sale of antibiotics accelerates the critical threat of Antimicrobial Resistance (AMR) the Committee recommends that the Central Drugs Standard Control Organisation (CDSCO) comprehensively enforce the "Red Line" campaign and existing FSSAI and ICMR

guidelines to categorically prohibit the sale of antibiotics without a valid prescription, ensuring the rational use of medicines across the country.

IMA welcomes these recommendations

Recommendation 38

The Committee is of the view that the escalating threat of Antimicrobial Resistance (AMR) cannot be contained solely through clinical prescription guidelines, as the rampant misuse of antibiotics in veterinary and agricultural sectors heavily contaminates the human food chain.

IMA welcomes these recommendations

Recommendation 39

The Committee is of the view that the reported 33% gap in AB-PMJAY fund utilization highlights systemic bottlenecks. The Committee recommends the strategic induction of at least 4 lakh private hospital beds into the AB-PMJAY network. This must be achieved by streamlining paperless empanelment, reducing the administrative compliance burden for smaller hospitals, and ensuring predictable, monthly payment cycles, all while strictly upholding the minimum infrastructure and staffing benchmarks.

IMA welcomes these recommendations

Recommendation 40

The Committee observes that while the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has significantly enhanced financial protection and access to healthcare services, several operational and implementation challenges continue to affect its efficient functioning. The Committee recommends that the Ministry of Health and Family Welfare and the National Health Authority (NHA) undertake a comprehensive review of the Scheme's package architecture.

IMA welcomes these recommendations

Recommendation 41

The Committee highlights the need for strengthening the AB-PMJAY portal.

IMA welcomes these recommendations

Recommendation 42

The Committee believes that while the Employees' State Insurance Corporation (ESIC) remains a cornerstone of India's social security framework, The Committee is of the view that systemic inefficiencies, specifically unviable private hospital package rates, delayed

financial settlements, and cumbersome referral processes, severely restrict beneficiary access to critical tertiary healthcare.

IMA welcomes these recommendations

Recommendation 43

The Committee, further, recommends the phased inclusion of unorganized and platform workers via national databases like e-Shram,

IMA supports this suggestion

Recommendation 54

The Committee further believes that the quality of healthcare delivery is intrinsically linked to the physical safety, mental well-being, and continuous capacity building of medical professionals and frontline health workers. Persistent issues such as unregulated duty hours, inadequate service conditions, and acute mental health challenges among resident doctors demand urgent statutory intervention. Therefore, the Committee recommends the strict, time-bound execution of the short-, mid-, and long-term action plans formulated by the National Task Force, pursuant to the Hon'ble Supreme Court's directives. The Government must strictly enforce fixed duty hours and structured well-being programs for all resident doctors and nursing staff. The Committee recommends for suitable augmentation of the salary and allowances of resident doctors.

IMA welcomes the recommendation

Recommendation 55

The Committee is of the view that addressing the critical deficit of 0.79 public sector beds per 1,000 population and persistent regional disparities requires a targeted, systematic overhaul of public health infrastructure. To effectively utilize the budgetary allocation and bridge the gap toward the World Health Organization norm, the Committee, therefore, recommends establishing a dedicated Healthcare Capital Expenditure (CAPEX) Fund

IMA welcomes the recommendation

Recommendation 56

The Committee, therefore, recommends formulating a comprehensive incentive framework, comprising targeted tax holidays, soft loans, subsidized land, and concessional electricity tariffs, explicitly designed to attract private investment for multi-specialty facilities in Tier-2, Tier-3, and rural zones. The Committee considers it essential that Corporate Social Responsibility (CSR) guidelines be immediately amended to

mandate the prioritization of corporate contributions toward healthcare infrastructure in underserved rural and Tier-2/3 towns.

IMA welcomes these suggestions

Recommendation 57

Committee recommends forging a strategic partnership with the Department of Posts to utilize its extensive rural logistics network for the rapid and secure transportation of diagnostic samples and essential medicines.

IMA welcomes these suggestions

Recommendation 58

Government must develop a standardized Health Facility Access Index to systematically measure spatial, temporal, and financial accessibility, ensuring that all future policy interventions are strictly equitable and data-driven.

IMA welcomes these suggestions

Recommendation 61

The Committee recommends extending the AB-PMJAY to all children below five years of age and all senior citizens aged 60 years and above. To operationalize this effectively, the Committee further recommends that the Ministry ensure adequate financial provisioning.

IMA welcomes these suggestions

Recommendation 64

The Committee is of the view that the lack of transparency in the pricing of healthcare services, escalating rates of Caesarean-section deliveries, and excessive diagnostic testing drive high out-of-pocket expenditure. The Committee, therefore, recommends that the Government formulate and execute a comprehensive, legally binding regulatory framework to standardize rates for common medical procedures and diagnostic tests across all private healthcare providers.

IMA :

a) **IMA has reasons to believe that the rising rates of Caesarian sections are fully justified. The WHO statement in this regard has been misused to authenticate this claim. (Annexure 2)**
b) **Any regulatory framework to standardise rates will be ultra vires the Constitution.**
c) **The hypocrisy of statements regarding generic drugs has been already exposed by IMA.**

Recommendation 65

The Committee, therefore, recommends that the Government advise and assist States in establishing a dedicated, specialized cadre of Hospital Administrators across all public secondary and tertiary institutions, effectively liberating doctors to focus exclusively on patient care.

IMA : There existed an Indian Medical Services in this country till 1948. Half of the administrative excesses during the Covid pandemic could have been avoided if IMS had remained. IMA proposes the alternative of restoring the IMS. (Annexure 3)

Recommendation 74

The rational interpretation of DHR data reveals that targeted cost-effectiveness analyses, such as the Costing of Health Services in India (CHSI) have vastly improved reimbursement efficiency

The Committee, therefore, recommends that the National Health Authority (NHA) strictly utilize DHR's CHSI data and evidence-based clinical guidelines to continuously recalibrate and revise the costings of all health benefit packages under AB-PMJAY. The Committee, further, recommends making adherence to these cost-effective, standardized clinical protocols mandatory for all private hospitals empanelled under government insurance schemes to curb inflated out-of-pocket expenditures for patients**.**

IMA supports this recommendation

Recommendations under AYUSH :

The regressive suggestions of integration sprinkled in these recommendations are a challenge in patient care and safety. IMA is of the strong opinion that this tendency should be taken no further. Let the mutually exclusive systems exist as verticals and let it be the wont of the patients to choose what they want. Apart from patient safety integrative medicine will decimate our traditional systems of medicine. The fact that Chinese Traditional system no longer exists in its pure form should be a lesson for us

SWOT Analysis of the National Health Mission

IMA is of the strong opinion that the establishment of National Health Mission has led to emergence of two power centers inside the Ministry. IMA is of the opinion that whatever functions have been allocated to NHM can be as well carried out by the Directorate. If further refining and expansion requires a framework Indian Medical Services (IMS) should be revived. The Human Resources handling by the NHM is

exploitative and by passes the legitimate rights of the Healthcare workers including doctors and nurses.

Recommendation 116

Address the acute disparities between contractual and permanent healthcare staff, establish hard-duty hardship allowances and career progression pathways to attract and retain doctors, specialists, and paramedics in rural and remote regions,

IMA deems this recommendation will mitigate atleast some of the grievances and should be fast tracked.

Recommendation 121

The Committee believes that financial protection cannot be achieved through insurance coverage alone; it requires stringent cost containment, elimination of defensive or predatory medical practices, and strict adherence to evidence-based medicine across both sectors. Private hospitals must strictly adhere to national Standard Treatment Guidelines (STGs) to eliminate unwarranted investigations, unnecessary hospitalizations, and polypharmacy**.**

IMA : Elimination of defensive practices will require exclusion of doctors and hospitals from the Consumer Protection Act and the criminal prosecution. The nation can not have both.

Evidence based medicine? Yes not only across sectors but also across the systems. The systemic bias in implementation has to be overcome.

The standard treatment guidelines are just that: Guidelines. The Government making it mandatory will handcuff science, arrest doctors in a virtual straight jacket and compromise patient care and safety in crucial situations. This is unacceptable to the clinicians of the country who are in the forefront of clinical care. Whatever it takes in a given situation will be done. The mandate of the profession is clear.

Recommendation125

The Committee, therefore, recommends that the Ministry, in consultation with State Governments and the National Medical Commission (NMC), formulate a dedicated cadre structure and transparent incentive framework—including financial bonuses, preferential postgraduate seats, and accelerated promotion pathways—for medical specialists serving in remote and rural district hospitals.

IMA supports these suggestions

Recommendation 129

The Committee believes that long-term affordability cannot be sustained without a firm fiscal commitment from the Union Government, alongside an aggressive pivot toward early detection and prevention of non-communicable diseases (NCDs). The Committee, therefore, recommends that the Ministry lay down a statutory, year-on-year roadmap to progressively scale public health expenditure to 2.5–3% of GDP within a defined timeframe, as envisaged under the National Health Policy.

IMA supports these suggestions

Recommendation 130

The Committee is of the view that public health procurement should shift toward "strategic purchasing,"

IMA: Strategic purchasing from the private sector means that the Government will buy care selectively for marginalised communities from private sector in districts where Government sector do not have those services. (High power expert Group-11th Five year plan-Planning Commission of India)

Recommendation 138

Ministry should formulate guidelines to systematically channel Corporate Social Responsibility (CSR) funds toward procuring capital-intensive medical infrastructure for public hospitals.

IMA supports CSR for the infrastructure of public hospitals.

Recommendation 155

The Committee, therefore, recommends that the Government must formulate statutory guidelines to mandate the integration of all private healthcare providers into the Ayushman Bharat Digital Mission (ABDM) ecosystem.

The committee could have studied if ABDM itself has a legal mandate. Except for the consent, the quality of which is doubtful ABDM does not have any statute backing its work. ABDM deserves a close legal scrutiny if it is violating privacy laws of the country. Predictably the Government has exempted itself from the DPDP Act 2023. The other concern is the data privacy and the breaches. IMA's questions to the National Health Authority are yet to be answered. (Annexure 4)

Recommendation 157

The Committee, therefore, recommends that the central regulatory councils institute a mandatory, independent annual audit framework to evaluate faculty adequacy, clinical exposure, and infrastructure viability across all newly established or upgraded medical and nursing institutions

IMA welcomes this suggestion

Recommendation 158

The Committee, therefore, recommends the formulation of a centralized, data-driven clinical audit authority tasked with periodically reviewing the treatment protocols, patient outcomes, and financial claims of all public and private facilities empanelled under central health assurance schemes.

IMA resents the recommendation of more and more of bureaucracy especially when the total funding of AB PMJAY has hardly crossed ₹10000 crores.

Recommendation 161

The Committee recommends the accelerated, nationwide adoption and stringent enforcement of the Clinical Establishments (Registration and Regulation) Act. Furthermore, the Committee recommends the formulation of a binding national charter of Standard Treatment Guidelines (STGs).

IMA

a. The Clinical Establishments Act is an aberration. IMA has lot of reservations regarding how it has been rolled out. It is a self defeating exercise.

b. Standard Treatment Guidelines are impractical and are a challenge in crucial situations. Professional autonomy is a right of the profession.

Recommendation 164

The Committee, recommends that the designated national medical and nursing regulatory commissions execute mandatory, bi-annual statutory audits of all newly approved and upgraded medical colleges to meticulously evaluate infrastructural compliance and faculty adequacy.

IMA welcomes the suggestion

Recommendation 166

The Committee, therefore, recommends a systemic overhaul of the existing regulatory framework to institute a "Single Window Clearance" mechanism for hospital registrations.

IMA welcomes the idea of single window clearance for hospitals.

Recommendation 174

The Committee, recommends the formal inclusion of advanced technical disciplines, specifically Critical Care, Respiratory & Cardiac Care, Molecular Diagnostics, Nuclear Medicine, Health Informatics, and Public Health Laboratory Sciences, into this national roadmap.

IMA supports the suggestion

Recommendation 183

The Committee, therefore, recommends that the Government, utilizing the multi-stakeholder Working Groups constituted by IRDAI and the Confederation of Indian Industry (CII), formalize a statutory framework to implement standardized treatment guidelines and cap arbitrary price variations. Specifically, the Committee recommends the elimination of room rent-linked inflation models for standard procedures across all private hospitals to protect citizens from catastrophic out-of-pocket expenses.

IMA : Neither IRDAI nor CII have the legitimacy to formalise a statutory framework for Standard Treatment Guidelines.

Recommendation 184

The Committee, therefore, recommends that the Government mandate the universal onboarding and participation of all private hospitals and healthcare providers onto the National Health Claims Exchange (NHCX) platform developed by the National Health Authority (NHA).

IMA: The committee presumes that all private institutions would want to participate in an insurance driven Health system. Then it wants to onboard everyone to prevent fraudulent practices. Somewhere along the line the committee has relegated the fact individuals and institutions in a democratic country have their own rights to exist and operate with independence. This tendency to introduce an overarching Government mandate strikes at the basis of our Constitution itself.

Recommendation 186

The Committee, therefore, recommends that the Insurance Regulatory and Development Authority of India (IRDAI) mandate the integration of comprehensive Outpatient Department (OPD) coverage into standard health insurance frameworks.

IMA welcomes the suggestion

Recommendation 187

The Committee recommends that the multi-stakeholder Working Groups explicitly prioritize the standardization of maternity and childbirth treatment protocols across empanelled private hospitals.

How many child births take place in corporate hospitals? The committee 's obsession regarding standardisation of treatment protocols is to only favour the insurance industry to make profit and not in the interests of the patients. The profession will retain the right to set standards irrespective of the insurance industry and do whatever is necessary for the patient. Standardisation is a camouflaged word euphemistically resembling standard treatment yet it is a Trojan Horse of the insurance industry for cost cutting leaving the patient and the physician in a limbo.

Recommendation 189

The Committee, therefore, recommends that the regulatory authorities institute a stringent pricing and coverage framework to standardize all private health insurance policies nationwide. The Committee believes that private insurance providers must be statutorily mandated to align their reimbursement structures and package caps with government-approved clinical protocols. By legally curbing arbitrary premium escalations and mandating the inclusion of comprehensive outpatient department (OPD) care, the catastrophic financial burden on the middle-class demographic can be sustainably contained.

Regulations on the Healthcare Insurance Industry is long overdue. Instead of aligning them on their trade practices IRDAI has ended up cartelising them for pecuniary benefit. IRDAI has acted as a stakeholder rather than a regulator and are a problem than a solution.

a. IMA welcomes inclusion of OPD care and NCD care in insurance.

b. The committee should have commented on the self serving and profit oriented approach of these companies with an administrative cost of 36 percent comparing poorly with their counterparts elsewhere. The international norm is around 10%.

c. The Third party payer system is inefficient and expensive upfront. The insurance companies should pay their clients directly. The direct benefit transfer will eliminate the middleman and provide more money for patient care.

d. Co payments will enhance the transparency and sustainability of the healthcare insurance industry as a solution.

e. The cashless is a severe strain on the hospitals. The reimbursement models will circumvent avoidable claim rejections as well as help in financial prudence.

Recommendation 194

The Committee is of the view that pharmaceutical expenditures continue to constitute a massive proportion of out-of-pocket health spending for the general public, forcing an unsustainable reliance on expensive, branded, or patented foreign pharmaceuticals. The Committee recommends that the regulatory machinery focus on rapidly approving high-quality, low-cost bio-equivalents to flood the public and private markets, effectively disrupting monopolies held by expensive foreign brands.

The observation and recommendation are correct

The committee will do well to study the impact of the Delhi High Court division bench judgement in Vifor vs Dr Reddy's (2024 SCC online Del 784)

Recommendation 199

The Committee, in concise, recommends that all existing vacancies of Drugs Controllers be filled on a time-bound basis, so that vacancy in CDSCO vis-à-vis sanctioned regulatory strength is not allowed to remain a bottleneck to approval timelines.

IMA welcomes these suggestions

Recommendation 206

The Committee, therefore, recommends that the Ministry of Health and Family Welfare stringently enforce the NMC guidelines regarding the regulation of fees and all other charges for 50% of the seats in private medical colleges and deemed universities.

IMA welcomes these suggestions. IMA also points out that before NMC came into existence there were Fee Fixing committees in all the states duly constituted by the respective state governments which fixed the rates for 3 categories in private medical colleges a. 50% of the seats Government quota at Government rates b. 35% of the seats were payment seats at an enhanced rates albeit reasonable c. 15% NRI quota with an exorbitant rates

The original NMC Bill provided for only 40% of the seats were to be rate fixed by NMC. It was the stiff resistance from IMA which necessitated upgrading it to 50%. However what did the nation gain by changing the previous system which was much more reasonable and affordable? Now 50% of seats are auctioned to the highest bidder.

With number of private medical colleges ahead of the Government ones where does this leave the people and the profession?

Recommendation 207

The Committee, therefore, recommends that the MARB fully execute its multi-pronged strategic reforms for enhancing the quality and clinical exposure of the post graduate students by ensuring that the clinical requirement is not reduced.

IMA welcomes these suggestions

Recommendation 208

To ensure quality, the Committee recommends for an Exit examination for both graduate and post-graduate students.

IMA : All recommendations except the one on NExT are welcome.

NExT is an injustice and a cut and paste job not well thought out and not suitable for medical education in India. The right way to go is to regulate the medical colleges in real time on infrastructure and Human Resources. It is wrong to put the onus on the medical students. (Annexure 5)

Recommendation 212

The Committee, recommends that the Ethics and Medical Registration Board (EMRB) rigidly enforce the professional conduct codes that mandate all registered medical practitioners to prescribe affordable generic molecules rather than high-cost brand names.

IMA : Once again a right diagnosis with a wrong prescription. IMA is for generic drugs provided

a. If the Government ensures quality assurance of every batch of the generic generic drugs produced

b. bans production and marketing of branded generic and patented drugs

Trying to take a high moral ground without accompanying responsibility will be resisted and there is no way but to take the case directly to the people.

Recommendation 213

The Committee is of the view that the National Testing Agency (NTA) operates as a critical, upstream regulatory anchor in India's healthcare ecosystem.

IMA feels that NTA itself is an anomaly and has to be disbanded forthwith. Trying to impose a centrally controlled examination system on multiple streams of education in diverse country with varying levels of literacy and socio economic status is a disaster. The merit based system is elitist and only has helped the coaching industry.

The testing process should be delegated to the states with common minimum standards.

Recommendation 215

The Committee is of the considered view that alternative medicine (AYUSH) and nursing practitioners serve as the absolute first line of clinical defense across rural and semi-urban India.

a. IMA has no opposition to AYUSH practitioners practising their own system of medicine anywhere.

b. India is neither a sub Saharan state nor a developed nation not coping up with an expensive healthcare system. There are 847 medical colleges and 1,39,213 MBBS graduates are available for deployment every year. A Nurse Practitioner is neither a solution nor a patient friendly option.

Recommendation 216

The Committee recommends that the National Medical Commission (NMC) and the National Commission for Indian System of Medicine closely align with the NTA to continually refine the technical and psychometric vetting of entrance examinations. The Committee recommends the Ministry of Education to roll out its comprehensive Guidelines for Regulation of Coaching Centres. By actively reducing student dependency on hyper-commercialized test-preparation institutes.

IMA:

a. The aptitude and temperament required for various systems of medicine are different. Accordingly such vetting should be verticals dedicated to individual systems.

b. The existence of the coaching centers is because of the existence of a centralised NEET UG. Decentralised to states they would dissolve into oblivion.

Recommendation 217

In order to strengthen rural health care, the Committee recommends the Government to consider for giving incentives for rural postings and additional NEET PG marks for verified rural service. The Committee desires that structural incentives must comprehensively encompass financial hardship allowances alongside essential non-financial benefits such as housing, accelerated career progression, and preferential opportunities for higher medical education.

IMA welcomes the suggestion

Recommendation 218

The Committee firmly opines that optimizing the existing workforce is critical; thus, the Committee stands for the rapid formalization of task-shifting protocols. Appropriately trained nurses, mid-level healthcare providers, and community health workers must be clinically and functionally enabled.

IMA: Lack of clarity and ambiguity will be misinterpreted as purposeful.

‘ Task shifting’ ‘ clinically enabled’ deserve proper elucidation. Dilution of the professional and clinical work will certainly hamper patient care and safety

Recommendation 219

The Committee, in this connection, recommends the complete elimination of the requirement for obtaining an Essentiality Certificate from the State government to establish a new medical college.

IMA: State Government essentiality certificates are desirable

Recommendation 222

The Committee is of the view that the Government should formulate comprehensive regulatory guidelines, in consultation with hospital management and relevant

medical stakeholders, to standardize and rationalize overall treatment and procedural charges across the country. In this regard, the Committee, thoroughly, understands that the rate of the art and innate skill of medical professionals can not be precisely capped but can be humanly rationalized in the interest of the lower and middle class people.

IMA: The committee gets philosophical here. The only reason for mushrooming of For Profit Corporate Hospitals is the policy failure of the Governments and their lack of investment in Government Health infrastructure and Human Resources.

To standardise does not mean standards. To standardise is to ensure profit for the insurance industry. To uphold standards is the responsibility of the profession.

The tongue in check statement regarding the skills of the medical professionals is in conflict with the hard line taken by the report elsewhere and sounds hollow.

Recommendation 225

The Committee, therefore, recommends that the Government should exponentially scale up the well-spread, low-cost Jan-Aushadhi pharmacy chain programme.

IMA welcomes this suggestion

Recommendation 226

The Committee, therefore, recommends that the National Pharmaceutical Pricing Authority (NPPA) should institute an evidence-based monitoring and audit framework to scrutinize the justification of these WPI-linked price hikes by pharmaceutical companies.

IMA welcomes this suggestion

Recommendation 227

The Committee appreciates that, as a not-for-profit institution, Sankara Nethralaya follows a transparent and standardized pricing policy for all treatments and services.

IMA upholds the right of every individual hospital to determine its pricing of procedures as per their cost and nature.

Recommendation 228

The Committee is of the view that the prevailing practice of variable, demand-based, or urgency-based pricing in many private hospitals severely compromises healthcare

affordability and leads to financial distress for patients. The Committee, therefore, recommends that the Government should strictly mandate all private and public healthcare institutions to formulate and publicly display fixed, unified package rates for all standard surgical and medical procedures.

IMA: Having let the share holders to invest for profit and allowing 100% FDI in Hospitals and Health Insurance the Government and the law makers have no case against variable pricing. These are the consequences of policy decisions which were deliberate. Having let the horse bolt trying to lock the stable is a futile attempt.

The word package rates is an invention of the Corporate Hospital industry in collusion with the Insurance industry. It is anathema to the medical profession and its institutions.

Recommendation 229

The Committee, therefore, recommends the immediate overhaul and automation of the reimbursement architecture. The government must institute a strict, statutory timeframe for the processing and clearing of hospital dues under all state and central health schemes.

IMA welcomes the suggestion

Recommendation 231

The Committee strongly believes in *prevention is always better than cure*. The Committee is of the opinion that non-communicable diseases can easily be controlled through preventive health care. The Committee, furthermore, recommends that the government drastically increase financial allocations for preventive screening initiatives, such as school health programs, community outreach camps and cardiac screening

IMA: While School Health Programmes and community outreach camps are in order, the provision of cardiac screening is liable for misuse. This should be strictly restricted to the High Risk individuals only.

Recommendation 232

The Committee has been given to understand that the current taxation structure inadvertently inflates the overall cost of medical treatment. While healthcare services are exempt from GST, private healthcare providers are unable to claim Input Tax Credit (ITC) on the GST paid for procured goods, medical consumables, and auxiliary services. This unclaimable tax becomes an embedded operational cost that is

ultimately passed on to the patient. The Committee, therefore, recommends that the Ministry of Finance should comprehensively review the GST framework applicable to the healthcare sector. The government should evaluate the feasibility of "zero-rating" critical healthcare services or introducing a specialized refund/rebate mechanism that allows healthcare providers to claim ITC. The Committee believes that neutralizing this embedded tax burden will instantly reduce the operational overheads of private hospitals, providing immediate fiscal space to lower the capped costs of patient treatments.

IMA welcomes this suggestion

Recommendation 233

The Committee, therefore, recommends the formulation of a rationalized tariff structure to significantly reduce or eliminate customs duties, cesses, and allied levies on advanced, life-saving medical equipment and their critical components.

IMA welcomes this suggestion

Recommendation 235

The Committee, therefore, recommends the establishment of a permanent, statutory Consultative Pricing Board comprising representatives from both the National Health Authority and major private healthcare consortiums tasked with jointly developing the scientific, evidence-based costing models used to determine package rates.

IMA welcomes this suggestion

Recommendation 236

The Committee is of the view that the rigid imposition of predefined package durations disproportionately penalizes healthcare institutions handling complex, acute cases. The Committee, therefore, recommends the immediate unbundling of prolonged critical care from standard surgical packages. For hospital stays extending beyond the prescribed package duration due to medical necessity, hospitals must be permitted to transition to an open, itemized billing system subject to a predefined daily ceiling, ensuring fair compensation while maintaining a cap on overall expenditure.

IMA welcomes this suggestion

Recommendation 239

The Committee, therefore, recommends that the Government should pro-actively expand the Production Linked Incentive (PLI) Scheme to strictly target the domestic

manufacturing of high-cost surgical implants, stents, and specialized critical care consumables. The Committee recommends reclassifying hospitals under an essential service category rather than an industrial category for the purpose of statutory licenses, utility tariffs, and operational fees, thereby facilitating a direct reduction in the overhead costs passed on to patients.

IMA welcomes the PLI scheme expansion

Reclassifying the hospitals as essential services is an excellent suggestion and is long overdue. Parliament has the power to change the way that hospitals are being governed. IMA also suggests that the institutions run by doctors as single/ couple/ group may be classified separately within the category. For example under pollution control laws hospitals are under industries and a fee equivalent to the investment is collected from as if they are polluting industrial units.

Recommendation 240

The Committee believes that a standardized, evidence-based approach is urgently required to determine fair institutional compensation. The Committee, therefore, recommends that the Government may constitute an independent, multi-disciplinary Health Technology Assessment and Costing Board.

IMA welcomes the suggestions

Recommendation 245

The Committee hence recommends that the room charges for a hospital should not exceed the average room tariffs prevailing in three star hotels in the peripheral area or vicinity of the hospital.

Perhaps the most impractical suggestion of the report. The committee will do well to review this suggestion.

Recommendation 247

The Committee, therefore, recommends the establishment of a highly regulated, centralized National/State Healthcare Corpus Fund. This fund must systematically aggregate CSR contributions, philanthropic donations, and charitable grants from across the corporate sector.

IMA : Health care corpus fund is an excellent suggestion. IMA had forward this suggestion to the MPs in 2025

Recommendation 266

The Committee, therefore, recommends the urgent formulation of a standardized, evidence-based treatment protocol mandate across all secondary and tertiary care hospitals.

When the committee makes such recommendations it should examine its legality as well as its impact on patient care and safety.

Recommendation 267

Policies should be framed to mandate that a fixed percentage of revenue generated from standard or premium paying categories is legally earmarked to subsidize care for economically weaker sections.

IMA : Cross subsidisation model will not work in INDIA. 10% of the people can pay for their care as per the Niti Aayog missing middle document. 35 to 40 % coverage under PMJAY which prices below cost.

The rest 45 to 50 percent have been thrown to Health insurance. Cartelisation of 31 Health Insurance companies along with IRDA are negotiating skin to bone rates with hospitals. There is an indirect support of the courts also.

So only 10 % are left to cross subsidise their 90% of the people. The system will collapse.

Recommendation 268

It should be made legally binding for practitioners across both sectors to prioritize the prescription and dispensation of high-quality generic medicines wherever clinically appropriate, thereby instantly driving down out-of-pocket expenditures for patients.

IMA:

The report has been returning to this again and again.

1. **Ban all formulations other than the Generic Generic.**
2. **Ensure batch level drug testing and assurance of quality.**
3. **Where is the need to regulate the doctors?**

Recommendation 275

The Committee, therefore, recommends the accelerated, nationwide adoption of interoperable, specialty-specific Electronic Medical Records (EMRs)

IMA : It is not clear who benefits from nationwide interoperability of data and what should be its priority where basic sanitation and drinking water are a luxury.

The quality of consent in ADHM in a poor illiterate population and lack of a legal mandate to obtain patient's data sans the consent from a person who has no idea of what its implications are, are areas one would have expected the Parliamentarians to address.

Recommendation 276

The Committee, therefore, recommends the immediate deployment of a standardized National Cost Accounting System

IMA welcomes the suggestion

Recommendation 277

The Committee firmly opines that rate setting must become dynamic. The pricing structures must incorporate predefined, empirical adjustments for variables such as the severity of the patient's condition, the geographical location of the facility, and the institutional tier of the hospital.

IMA welcomes the suggestion

Recommendation 291

The Committee recommends, to ease the financial burden on medical students, rationalizing medical education fees, particularly in private institutions, so that graduates are not forced into years of loan repayment that shapes their later career choices. The Committee also calls for strict enforcement of the mandatory rural, tribal, and hilly service requirement for graduating doctors.

a. IMA welcomes the suggestion

b. Medical students being tied to a slavery system of mandatory posting by Governments is no longer acceptable. There are 849 medical colleges and 139369 MBBS doctors are graduating every year. Governments neither give them a posting nor relieve them. This injustice should be immediately stopped. It is heartening to note that NMC and the MOH hold a view to discontinue this practice.

Recommendation 303

A significant proportion of patients bypass primary care to seek specialist consultation for manageable conditions. The Committee believes that tertiary care institutions must operate as true referral centres, evaluating non-emergency patients strictly upon referral. The Committee is of the view that Family Medicine training must be expanded, effectively establishing family physicians as the first point of contact within the healthcare system.

IMA welcomes this suggestion

Recommendation 305

The Committee is of the view that uniform competency-based standards for postgraduate education must be implemented across all institutions, focusing on clinical exposure and case mix rather than institutional ownership. The Committee recommends developing a national framework for faculty sharing to utilize expertise through visiting appointments and tele-education.

IMA welcomes this suggestion

Recommendation 309

The Committee, therefore, recommends that the Government must deploy the economic tool of Health Savings Accounts (HSAs)

IMA welcomes the suggestion

Recommendation 311

The Committee, therefore, views that the Government must transit from an import-dependent market to a global manufacturing hub for medical devices.

IMA welcomes the suggestion

Recommendation 313

Ensuring Availability of Clinical Specialties in Tier-II & Tier-III Cities and Rural Areas

The Committee is of the view that to resolve the acute shortage of clinical specialists in Tier-2, Tier-3, and rural regions, the National Medical Commission (NMC) must shift away from rigid, legacy pedagogical structures and optimize the available medical talent pool. Tens of thousands of MBBS graduates spend their most productive clinical years isolated in libraries, rote-learning multiple-choice questions (MCQs) to crack the hyper-competitive NEET-PG exam. Concurrently, patients in smaller towns reject basic MBBS practitioners, demanding specialists doctors. Distribution from Tier-I cities to Tier-II and Tier-III has to be increased by balancing regional distribution through affirmative action and incentives.

IMA welcomes the suggestion

Recommendation 315

Ensuring availability of Point-of-Care Ultrasound (POCUS)

The Committee observes that the Pre-Conception and Pre-Natal Diagnostic Techniques (PNDT) Act, while vital for preventing female foeticide, has created an operational crisis. The law strictly penalizes any practitioner outside of a registered radiologist or gynecologist who operates an ultrasound machine, however, now–a-days, point-of-care ultrasound (POCUS) is a critical diagnostic tool- effectively the modern stethoscope-essential for triaging trauma, cardiac events, and acute abdominal crises. The Committee recommends for easing out the regulating mechanism for point of care devices.

IMA welcomes the suggestion

Recommendation 316

The Committee, therefore, recommends that Government must operationalize the Supreme Court direction given from 14 years ago, which permitted MBBS doctors with a six-month structured training certification to perform and interpret general ultrasound scans. The Committee recommends for introduction of a six month course for MBBS doctors in radiology so that they can interpret scans at the CHC level.

IMA welcomes the suggestion

Recommendation 317

The Committee, therefore, recommends provisioning an affordable annual diagnostic package for every citizen over the age of 40.

IMA : This is an extraordinary suggestion. Such mass surveillance will only benefit the corporate sector. It will not serve any public Health purpose.

Recommendation 319

The Committee, therefore, recommends the introduction of a certified Nurse Practitioner (NP) framework

IMA : The committee has the ability to make correct observations yet has a penchant for wrong recommendations. India is neither a sub Saharan state short in Human Resources nor the so called developed nations where Human Resources are ridiculously expensive. Our strength is Human Resources available in good numbers and in quality. In a country where MBBS doctors are available for deployment and are being exploited by NHM for ad hoc salaries as low as 30000₹ this will be an extraordinary myopia.

1.Publish the list of OTC drugs without any further delay

2.Already the privilege and protection exists under Drugs and Cosmetic Act for nurses in Public sector to handle drugs under the National Health Programmes.

3.Nursing profession has its unique and dedicated mandate. Independent practice of medicine is not one of them.

4.To treat our rural and marginalised communities as second class citizens and expose them to nurse practitioners instead of doctors is an injustice and constitutional impropriety

5.The correct approach is to recruit as many MBBS doctors as required and deploy them as a Rural Services or reactivate the extinct IMS

Recommendation 320

The Committee, therefore, recommends a full GST waiver on low-cost group health insurance premiums. Strengthening Healthcare Delivery through Integrated Medical Education and Rationalisation of Regulatory Norms.

IMA welcomes the suggestion

Recommendation 321

The regulatory framework governing medical education should, therefore, facilitate integration, efficient utilisation of resources and uniform standards while maintaining the quality of medical education.

IMA supports vertical and horizontal integration within the parameters of modern medicine. This recommendation should not hold brief for Mixopathy.

Recommendation 322

The Committee, therefore, recommends harmonisation of statutory standards applicable to Government and Private Medical Colleges.

IMA welcomes the suggestion

Recommendation 327

The Committee, recommends that the National Medical Commission undertake a comprehensive review of the existing regulatory framework relating to faculty and bed norms with a view to promoting integrated medical education.

IMA feels that the committee is deliberately ambiguous in talking about integrated medical education without defining what it is.

Mixopathy in education, clinical practice, research, as well as public health and administration is unacceptable at all levels.

Recommendation 334

The Committee, therefore, recommends the strict enforcement of mandatory Standard Treatment Guidelines (STGs) across both public and private sectors.

IMA : The medical profession is independent and shall do whatever it takes to save a patient. Huge volume of scientific knowledge and expertise lies outside Government and even WHO led bench marks.

Uniform protocols will be rejected.

Recommendation 335

The Committee strongly recommends that the National Council for Clinical Establishment State Councils and District Regulatory Authorities must remain alert and at work all the time to implement the provision of the Clinical Establishment Act, 2010 to ensure compliance with prescribed Standard Treatment Protocol (STP) at ground level.

IMA considers CEA as an aberration which entered into statute by back door. IMA calls for withdrawal of this Black Act. Exemption of doctor/ s run small and medium hospitals could be the first step.

Recommendation 343

The Committee, therefore, recommends that dedicated Emergency Medicine (EM) departments, staffed exclusively by specifically trained physicians, be made mandatory across all district hospitals, medical colleges, and public tertiary centers.

IMA welcomes this suggestion. IMA points out that removing emergency care discipline from undergraduate MBBS curriculum has done great disservice to this recommendation.

Recommendation 347

Committee feels that there is urgent need to control the quality of a generic medicine and making the public aware that the quality of generic medicine at cheaper rate is equally effective. The Committee strongly recommends for complet ban on spurious medicine.

IMA welcomes the recommendation to ensure the quality of generic generic drugs

The committee is requested to redraft the sentence on spurious drugs. Currently the sentence admits spurious drugs are partially allowed.

Recommendation 349

The Committee believes that healthcare must urgently be prioritized as a foundational pillar for socio-economic development, demanding aggressive and sustained investment in public health infrastructure, preventive care, and equitable service delivery. The Committee, therefore, reiterates its recommendation in 172nd Report that a strategic revision of the NHP target, mandating a rapid escalation of government health expenditure to 5% of GDP over the next five years to ensure robust and comprehensive healthcare expansion.

IMA welcomes the suggestion

Recommendation 350

The Committee, therefore, recommends the following immediate interventions:

d) Scientific Costing Revision: The NHA must immediately undertake comprehensive, localized scientific studies to revise and rationalize health benefit package rates. These metrics must accurately reflect current clinical operational costs to ensure the active empanelment and participation of premier private healthcare providers.

IMA welcomes the suggestion

Recommendation 351

To systematically encourage and stimulate medical graduates to serve in rural government hospitals and Taluka facilities, the Committee recommends instituting a mandatory one-year rural service policy. Furthermore, to make this retention strategy effective, the Committee recommends awarding weighted incentive marks (such as an additional 10 to 20 marks) in the NEET-PG examinations for doctors who complete extended rural service, alongside the implementation of targeted rural reservation quotas. However, the Committee is of the considered view that deploying young doctors to rural PHCs and CHCs must be matched by immediate infrastructural upgrades. The Committee, therefore, urges the Ministry to ensure that adequate residential quarters, modern facilities, and secure infrastructure are provided on-site to make rural postings viable and sustainable.

IMA welcomes the suggestion

Recommendation 354

The Committee, therefore, recommends the immediate enforcement of a strict, time-bound financial settlement mechanism to clear all pending hospital arrears and stabilize the cashless healthcare ecosystem.

IMA welcomes the suggestion

Recommendation 360

The Committee, therefore, recommends the strategic establishment of autonomous, efficiently managed public sector multispeciality hospitals in every revenue division across the States to ensure equitable access.

IMA welcomes the suggestion

Recommendation 361

The Committee observes with serious concern the accelerating trend of substantial Foreign Direct Investment (FDI), often exceeding 51%, in the operational management of private hospital chains. The Committee is of the view that this unchecked influx of foreign capital is facilitating the monopolistic acquisition of cost-effective, mid-sized hospitals by large corporate entities. The Committee believes that this aggressive corporatization is fundamentally transforming healthcare from a public service sector into a purely capitalistic enterprise, artificially inflating the cost of medical procedures and triggering a cascading effect of price hikes across the entire healthcare ecosystem. The Committee, therefore, recommends that the Government strictly review and rationalize Foreign Direct Investment limits concerning the operational management and acquisition of existing healthcare facilities to protect affordable mid-sized hospitals from predatory corporate buyouts.

IMA welcomes the suggestion

IMA's overall take on the Parliamentary Committee's Report

1. The deliberate omission of the third dimension of the so called iron triangle 'QUALITY' from even the caption of this document has eliminated both the patients and the physicians from the reckoning, leaving the non medical and the non clinical community to determine what the Health Care in this country should be Hence the report remains highly controversial and coloured with systemic bias.

2. The inability of the Committee to differentiate the medical practitioners from the Hospital industry is deliberate. Sweeping everything under ' the private sector or the private providers' is to remain blind on purpose.

3. The Niti Aayog has said that 10% of citizens afford to pay for care meaning the private corporate care .The committee itself says 30 % of outpatient services and 40 % of the inpatient care is taken care of by the Government. So there is a large middle sector which is taking care of the rest of the people. IMA has shown Indian Healthcare is the most inexpensive and accessible amongst all nations. The For Profit Hospitals are naturally not the reason for this affordability and accessibility. Then who is responsible for the low Healthcare costs and the high access. It is the doctors of this country who have put together an unique system in place. Doctors of this country run clinics, Nursing Homes and Hospitals. There are individual, couple and group practices. It is the availability of these doctors in every corner of the country that has made the difference. It is their sacrifice to run these institutions amongst one of the most over regulated sectors in the world that has protected our people. The current Indian Healthcare scenario is the best in the world. The committee should consider whether such a low cost high quality easily accessible care is available anywhere else in the world. The views of the Indian diaspora and the Indians going abroad for work and leisure should be ascertained what the countries in West and East have to offer to their citizens and compared. Then the committee would perhaps have a different perspective. The inability of the committee to understand acknowledge, and accept the reality brings down the credibility of the Report.

4. The private doctors as individuals or couples or groups running clinics, nursing homes and hospitals are an important dedicated group who have not been captured by the Committee report. The committee may note that this middle sector does not exist in many countries. This professional group of doctor entrepreneurs deserves dedicated friendly laws and incentives. They should not be clubbed with the For Profit Corporate Hospitals. These institutions should be exempted from the Clinical Establishments Act and should be allowed to be registered under the medical councils. The oversight should be provided by the medical councils themselves. These institutions shall abide by the medical ethics and etiquette.

5. It is a disappointment that every major report in the fast 30 years has advocated higher public health expenditure. They have specifically quoted 5% of GDP. Health care has received step motherly treatment from all the Governments till date. IMA

is cynical in this regard. How many more Parliaments it will take to invest a decent percentage of GDP on Health .

6. The committee is driving the country into an insurance driven US model. Many of the observations of the committee are correct. However the colored template and the recommendations therefore are aligning towards a pro insurance tilt which is evident throughout.

7. Mindless digitalisation by NDHM without any checks and balances with little regard to propriety, confidentiality and privacy is pushing the patients to mere numbers. Unfortunately the committee has had little time to study the legality of NDHM and for whom the bell tolls.
8. The committee has not acknowledged even the presence of private doctors and their institutions as contributors at national level. This major blind spot will prove costly.
9. Indian Health Care at this rate will end up as a two sector phenomenon. In 30 years from now only the Government sector and the For Profit corporates will remain. The most affordable and accessible sector constituted by the doctors run small Hospitals would have disappeared. To that extent this committee has failed to provide an insight into what is happening currently and prophesy the fallout of For Profit industries and FDI in what is easily the most affordable and most accessible Healthcare model in the world.

Annexures

1. **One drug one price policy**
2. **Statement on Caesarean rates**
3. **Report on Indian Medical Services prepared by IMA**
4. **IMA's questions to the National Health authority**
5. **NEXT**
   a) **Critical appraisal of the proposed scheme of National Exit Test (NEXT)**
   b) **Reconsider NEXT-IMA**