AHPI Response to the 176th Report of the Department-related Parliamentary Standing Committee on Health & Family Welfare on:

"Affordability and Accessibility of Healthcare Facilities in Public and Private Sector"

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FOREWORD

India stands at a defining moment in the evolution of its healthcare system. As our economy, technology and aspirations advance, every citizen must have access to healthcare that is **affordable, accessible, safe and of assured quality. The 176th Report of the Department-related Parliamentary Standing Committee on Health and Family Welfare on "Affordability and Accessibility of Healthcare Facilities in Public and Private Sector"** is therefore of considerable national importance. The Association of Healthcare Providers India (AHPI) commends the Committee for undertaking an extensive examination of one of the most complex challenges confronting Indian healthcare today.

AHPI **welcomes the overall intent and several important directions of the Report.** We particularly appreciate its emphasis on strengthening public healthcare infrastructure and human resources, expanding financial protection, addressing the needs of the uninsured and the "missing middle", improving transparency, strengthening patient grievance mechanisms, promoting digital health and NHCX, encouraging meaningful public-private partnerships, and moving towards outcome-based quality and accountability.

The Report also importantly recognises that the **public and private sectors are complementary pillars of India's healthcare delivery system.** The private sector has invested substantially in infrastructure, technology, specialist manpower and clinical capabilities and has played a critical role in expanding access to advanced healthcare across the country. Any national strategy for universal health coverage must therefore build upon the strengths of both sectors.

AHPI supports the Committee's call for greater transparency in treatment costs. We believe this should be accompanied by a robust national framework for **standardised costing, indicative treatment estimates, appropriate provisions for clinical uncertainty and complications, and effective financial counselling for patients.** AHPI stands ready to contribute constructively and transparently to this process.

Our collective objective must be clear: **a healthcare system in which no citizen is denied necessary care because of inability to pay, no provider is compelled to deliver quality care through an unsustainable financial model, and no compromise is made with patient safety or clinical quality.**

We respectfully submit this Executive Summary as AHPI's constructive response to the Report and as an expression of our commitment to work with the Government of India and all stakeholders in building a healthcare system that is **affordable, accessible, high-quality, patient-centred and sustainable.**

Dr. MI Sahadulla
President

Dr. Girdhar Gyani
Director General

ACKNOWLEDGEMENT

AHPI is privileged to represent vast majority of healthcare providers through 23-reginal chapters. AHPI gratefully acknowledges the valuable contribution of its members from across all the chapters and senior healthcare leaders who shared their insights, practical experience and considered perspectives during the preparation of this report. Their inputs have helped bring greater depth, balance and ground-level relevance to AHPI's response to the recommendations of the Parliamentary Standing Committee.

Special appreciation is due to the team of AHPI Chhattisgarh led by President **Dr. Rakesh Gupta and Secretary Mr. Atul Singhania** in going through complete report and summarising the key findings.

We particularly appreciate the time and constructive engagement of all members who contributed to the discussions and provided feedback on issues affecting healthcare delivery, affordability, quality, regulation and sustainability during our regular monthly meetings. **Their collective wisdom has strengthened this document and reflects AHPI's commitment to evidence-based, consultative and responsible policy advocacy.**

EXECUTIVE SUMMARY

AHPI's Overall Position:

The Association of Healthcare Providers India (AHPI) welcomes the Report of the Department-related Parliamentary Standing Committee on Health & Family Welfare on **"Affordability and Accessibility of Healthcare Facilities in Public and Private Sector."** The Report addresses one of the most important challenges facing Indian healthcare today—how to ensure that every citizen has access to **quality, timely and affordable healthcare without suffering financial hardship.**

AHPI particularly appreciates that the Committee has examined healthcare as a **mixed public-private ecosystem,** recognising that both sectors have complementary roles. The Report itself acknowledges that the private sector provides a substantial proportion of inpatient and outpatient care and has contributed significantly to specialist services, advanced technology, emergency care and patient responsiveness.

AHPI fully supports the objective of reducing out-of-pocket expenditure, improving transparency, protecting patients from financial distress, strengthening quality of care and expanding access to underserved populations.

At the same time, AHPI believes that **affordability cannot be achieved by regulating hospital prices alone.** Healthcare costs are the outcome of multiple factors—including infrastructure, manpower, technology, medicines, devices, consumables, insurance design, taxation, financing costs, regulatory compliance and the cost of maintaining 24×7 emergency and critical-care capability.

The Committee itself recognises the financial pressures on private providers arising from rising costs, medical technology and regulated package rates, and recommends a **dynamic, consultative pricing mechanism** alongside regulation.

AHPI therefore recommends that implementation of the Report should follow a principle of:

"Affordability through greater financial protection, transparency, efficiency and evidence-based regulation—not through arbitrary price controls that may compromise quality, access or sustainability."

1. Recommendations AHPI Welcomes

A. Strengthening Public Healthcare

AHPI strongly supports the Committee's recommendation to substantially strengthen CHCs, District Hospitals and government medical colleges, including infrastructure, equipment, diagnostics, emergency services and specialist manpower.

Improving public-sector capacity is essential to reducing overcrowding, unnecessary referrals and the financial burden on patients. The Committee correctly observes that deficiencies in public secondary and tertiary care push patients towards private facilities.

AHPI recommends that this should become a major national priority, particularly in **Tier-II, Tier-III, rural, tribal, hilly and underserved areas.**

B. Greater Public-Private Partnership

AHPI welcomes the Committee's recognition that the private sector has a critical role in specialised and tertiary care and that PPP models, digital referral systems and outcome-based monitoring can bridge gaps in access.

AHPI recommends moving from fragmented PPP arrangements towards **long-term, outcome-based healthcare partnerships,** with clearly defined responsibilities, realistic tariffs and timely payments.

Considering that bulk of tertiary care beds are in private sector and that too are within, Tier-I and some in Tier-II towns, resulting very limited availability in Tier-III and rural areas, it is time that government comes with aggressive incentives for private sector to establish 100/200 bedded tertiary care hospitals in these regions. The incentives could be in the form of; concessional electricity tariffs, cheaper finance, making available build up structure/ land and above all single window clearance model for statutory compliances. Unless we work on it, accessibility of tertiary care will continue to be poor.

AHPI in the year 2023, came out with study, showing overall shortage of hospital beds and more importantly the vast disparity among the states. (refer annexure-A) This study can be the reference to focus on providing resources in building new hospitals either by government or in PPP mode or through incentivising private sector as mentioned above. We need to aim to achieve norm of 2.5-3 beds per 1000 population across all states including uniform spread within state by taking district as a unit. This will only ensure availability as well as accessibility.

C. Health Insurance and Financial Protection

AHPI strongly welcomes recommendations to expand health insurance beyond hospitalisation and address the **"missing middle."**

The Report recommends broader coverage for OPD care, chronic diseases, rehabilitation and other continuing healthcare needs.

This is particularly important because affordability should ultimately be addressed through **adequate risk pooling and financial protection,** rather than transferring the financial burden to healthcare providers.

AHPI also welcomes:

- Affordable insurance products for underserved populations
- Better coverage for senior citizens and chronic disease
- Faster cashless approvals
- Greater transparency in claims
- Reduction of insurance-related delays and disputes

D. NHCX and Digital Transformation

AHPI supports the proposed wider adoption of the National Health Claims Exchange (NHCX) and Public Insurance Registry.

A common digital platform can significantly improve:

- Claims transparency
- Standardisation
- Faster adjudication
- Reduction of disputes
- Fraud detection
- Patient convenience

The Committee recommends universal onboarding of private providers on NHCX and expedited deployment of the Public Insurance Registry.

AHPI recommends, however, that **NHCX should be genuinely interoperable, transparent and two-sided,** with defined turnaround times and an effective mechanism for hospitals to challenge erroneous claim denials.

E. Quality and Outcome-based Accreditation

AHPI strongly welcomes the shift towards outcome-based quality measurement.

The Committee recommends that accreditation should increasingly measure:

- Patient safety
- Clinical outcomes
- Infection rates
- Waiting time
- Patient satisfaction
- Grievance resolution

rather than relying only on infrastructure and documentation.

This is an important opportunity to move Indian healthcare from **input-based regulation to quality- and outcome-based regulation.**

F. Support for Small and Medium Healthcare Providers

AHPI particularly welcomes the Committee's recognition that smaller hospitals face a disproportionate compliance and technology burden.

The Committee recommends making NABH more **user-friendly and transparent for small healthcare establishments**, recognising that compliance costs can add to healthcare costs in smaller towns.

AHPI recommends a tiered quality framework, proportionate to the size, complexity and clinical services of an establishment, exist by way of NABH Full Accreditation and Entry Level Certification for small hospitals. Need is to build capacity within small nursing homes to enable them to build culture of quality which enable them to continuously improve quality.

2. Arbitrary Price Caps on Private Healthcare

The most significant concern is the recommendation to establish mechanisms to **standardise and cap costs of essential treatments, diagnostics and routine procedures across all private hospitals.**

The Report further recommends a national statutory body to determine rigid caps on essential procedures and diagnostics.

AHPI believes that **uniform national price caps are unlikely to reflect the enormous diversity of Indian healthcare providers.**

Costs vary substantially according to:

- Geography
- Hospital size
- Level of care
- Case complexity
- Infrastructure
- Accreditation
- Human-resource costs
- Technology
- Emergency preparedness
- Teaching and research responsibilities
- Cost of capital

A tertiary/quaternary-care hospital cannot reasonably be benchmarked against a small nursing home simply because both perform the same procedure.

AHPI Recommendation

Replace rigid price caps with an **evidence-based National Healthcare Costing and Benchmarking Framework**, developed through independent costing studies and stakeholder consultation. AHPI suggest to get the activity-based costing of healthcare procedures through an independent entity like; Institute of Cost Accountants of India, which is statutory body under Act of Parliament. AHPI will actively support through wide network of hospitals, nursing homes and clinics. In fact, there is QCI document on grading of hospitals, which can be useful reference for costing exercise.

Tariff benchmarks (costing) should be:

- Procedure-specific
- Geography-sensitive
- Complexity-adjusted
- Periodically revised
- Linked to quality and outcomes

3. Hospital Room Rent – Major Concern

The Committee recommends that hospital room charges in large metropolitan cities should not exceed the average room tariff of a **three-star hotel in the vicinity,** with this benchmark becoming mandatory for private hospitals.

AHPI believes that the **hotel analogy is inappropriate.**

A hospital room is not simply an accommodation facility. Its cost includes the infrastructure and systems necessary for:

- 24×7 nursing
- Resident doctors
- Infection prevention
- Biomedical services
- Emergency response
- Oxygen and medical gases
- Biomedical equipment
- Fire and life safety
- Infection control
- Clinical waste management
- Regulatory compliance

The Report itself recognises that hospital room charges vary because of differences in infrastructure, service levels and operating costs.

AHPI Recommendation

AHPI supports **complete transparency of room tariffs,** but recommends that room pricing should be based on:

Actual cost of providing the service + reasonable and transparent margin, rather than comparison with hotel tariffs.

Room tariffs should be openly displayed and patients should receive clear information regarding inclusions and exclusions.

4. Upfront Treatment Estimates – Support with Safeguards

AHPI supports the principle of providing patients with upfront treatment estimates, particularly for elective and planned procedures.

The Committee recommends legally binding estimates for complex or prolonged treatment and deployment of financial navigators.

AHPI recommends that the estimate should be:

Transparent | Procedure-specific | Based on standard clinical pathways

Clearly divided into included and excluded components

However, it should **not be legally binding in situations where the patient's clinical condition changes,** complications arise, additional procedures become medically necessary, or treatment has to be escalated.

A clinically appropriate **"estimate with a defined contingency range"** would protect both patients and providers.

5. Cross-subsidisation – Need for a More Sustainable Model

The Committee recommends a structured cross-subsidisation policy under which large corporate hospitals benefiting from government concessions would use a portion of revenue from international and high-net-worth patients to subsidise advanced care for economically weaker domestic patients. It also proposes defined bed quotas for government insurance schemes.

AHPI fully supports the objective of ensuring that economically weaker patients receive appropriate care.

However, **mandatory cross-subsidisation without accounting for the actual financial economics of hospitals may become unsustainable.** The report has itself recognized that delayed reimbursement discourages private institutions from dedicating beds to economically weaker sections.

AHPI Recommendation

AHPI proposes a **government-supported Social Healthcare Responsibility Framework,** under which:

- Benefits received from Government should be transparently identified.
- Corresponding social obligations should be clearly defined.
- Free/subsidised treatment should be measurable.
- Government should provide appropriate fiscal incentives.
- CSR and philanthropic funding should be integrated into the framework.
- Social obligations should be linked to actual benefits/concessions received, rather than imposed uniformly on all hospitals.

The Committee itself recognises the importance of a formal mechanism for supporting indigent patients and proposes a healthcare corpus fund for high-cost therapies. Other option is to introduce 'Co-Payment' a scheme prevalent in many countries. This becomes relevant as bulk of tertiary care beds are in private sector and reimbursement rates fixed in government welfare/ insurance schemes for most of procedures are well below the rack rates of these hospitals. In such a case, hospital will receive reimbursement from government and balance will be paid as co-payment by patient. This of course is done in transparent manner with consent of beneficiaries.

6. PM-JAY and Government Package Rates

AHPI recommends that affordability reforms should give equal attention to the **financial viability of government-funded healthcare programmes.**

Private hospitals are essential partners in PM-JAY and other publicly funded schemes. However, packages need to reflect:

- Current input costs
- Inflation
- Technology
- Drugs and consumables
- Implants
- ICU requirements
- Length of stay
- Specialist manpower
- Complication rates

The Report itself records concerns from hospitals that several PM-JAY packages, particularly in high-cost specialties, do not adequately cover implants and prolonged ICU stays.

AHPI Recommendation

As suggested vide para 3A, introduce a **scientific and dynamic costing mechanism for PM-JAY packages** by Institute of Cost Accountants of India with automatic periodic revision and additional payment mechanisms for:

- Complications
- Prolonged ICU stays
- High-cost implants
- Exceptional clinical circumstances

No healthcare programme can remain sustainable if the purchasing price is persistently below the cost of delivering safe and quality care.

7. Regulation Must Be Uniform, Proportionate and Risk-based

AHPI welcomes the Committee's recommendation for uniform implementation of the **Clinical Establishments Act.**

However, implementation must not result in multiple overlapping regulators and additional compliance burdens.

The Committee itself notes the heterogeneous nature of private healthcare and recommends a mandatory quality and price-transparency framework, while also asking that NABH be made more accessible to small providers.

AHPI Recommendation

India needs a **single, harmonised and risk-based regulatory architecture,** with:

- Single-window registration
- Common definitions
- Common minimum standards
- Digital compliance
- Risk-based inspections
- Third-party assessment wherever appropriate
- Time-bound approvals
- Appeal mechanisms
- No duplication between CEA, local authorities and accreditation systems

AHPI supports the principle of **"One Hospital – One Integrated Regulatory Framework."**

8. Medical Devices, Drugs and Consumables

AHPI welcomes the Committee's emphasis on domestic manufacturing, medical-device testing infrastructure, MedTech parks and reduction of import dependence.

The Committee recommends reducing the gap between landing cost and MRP and proposes a maximum 20% gap for drugs and medical devices, while simultaneously stressing quality, availability and prevention of shortages.

AHPI recommends that any price rationalisation must consider the complete supply chain and must avoid:

- Shortages
- Quality compromise
- Reduced innovation
- Withdrawal of essential products from the market

A cost-plus approach with quality and availability safeguards would be preferable to an arbitrary margin ceiling.

9. AHPI's Key Recommendations to Government

AHPI recommends that implementation of the Committee's Report should be built around **ten policy principles:**

1. Increase public healthcare capacity

Accelerate investment in CHCs, District Hospitals and medical colleges, particularly in underserved areas.

2. Move from price control to cost transparency

Create a national evidence-based healthcare costing and benchmarking system before introducing price ceilings

3. Make insurance the principal instrument of financial protection

Expand health insurance to cover OPD, chronic disease, rehabilitation and long-term care.

4. Rationalise PM-JAY and CGHS packages

Use transparent, scientific costing with periodic revision and additional payment for clinical complexity.

5. Establish a single-window regulatory system

Implement the Clinical Establishments Act uniformly while eliminating duplication of regulatory requirements.

6. Adopt risk-based quality regulation

Combine mandatory minimum standards with progressive accreditation and outcome-based assessment.

7. Support small and medium hospitals

Provide technology grants, affordable accreditation pathways, concessional financing and equipment-upgradation support, especially in Tier-II/III and rural areas.

8. Create a genuine PPP framework

Use private-sector capacity strategically for diagnostics, emergency care, tertiary services and specialist care where public capacity is inadequate.

9. Strengthen NHCX—but protect both sides

Ensure that NHCX provides transparent, time-bound claims processing for hospitals as well as patients, with an effective dispute-resolution mechanism.

10. Measure outcomes, not merely expenditure

Create the proposed **National Healthcare Affordability Dashboard,** but include clinical quality, patient outcomes, infection rates, waiting times, patient experience and financial protection alongside treatment prices.

The Committee itself proposes a district-level dashboard covering treatment costs, waiting times, specialist vacancies, diagnostics, medicines and grievances, and recommends outcome-based hospital accreditation.

10. AHPI's Proposed Way Forward

AHPI believes that the Report provides an important opportunity to undertake **fundamental reform of India's healthcare financing and delivery architecture.**

The objective should not be to create an adversarial relationship between Government and private healthcare providers. Rather, the Government should recognise private healthcare as a **strategic partner in achieving Universal Health Coverage.**

India's healthcare challenge cannot be solved by either the public sector or private sector alone.

A sustainable model should therefore combine:

Strong Public Healthcare + Responsible Private Healthcare + Universal Financial Protection

Evidence-based Regulation + Quality and Outcome Measurement

Digital Health Infrastructure + Strategic Public-Private Partnerships

AHPI proposes that the Government establish a National Stakeholder Working Group, comprising MoHFW, NHA, IRDAI, NITI Aayog, QCI/NABH, State Governments, private hospitals, insurers and patient representatives, to develop an implementation roadmap for the Committee's recommendations.

The Working Group should undertake **scientific costing and impact assessment before introducing any mandatory tariff or pricing regulation.**

11. Concluding AHPI Position

AHPI shares the Committee's fundamental objective of ensuring that **no Indian family is forced into poverty because of the cost of healthcare.**

The private healthcare sector is willing to accept greater transparency, accountability, quality measurement, patient protection and social responsibility. At the same time, healthcare providers must remain financially sustainable if they are to maintain infrastructure, attract skilled professionals, invest in technology and provide safe 24×7 care.

The appropriate policy response is therefore not simply to **cap what hospitals can charge,** but to address the entire healthcare financing ecosystem.

AHPI recommends a transition:

From Price Regulation → to Cost Transparency

From Out-of-Pocket Payment → to Universal Financial Protection

From Input-based Regulation → to Outcome-based Quality

From Fragmented Compliance → to Single-window Regulation

From Adversarial Regulation → to Strategic Public-Private Partnership

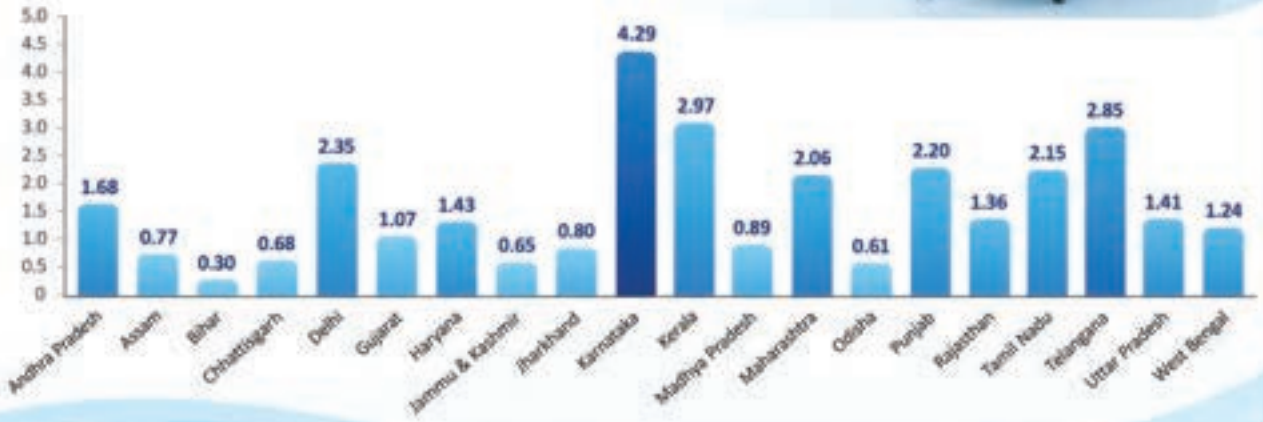
This approach would preserve the legitimate concerns of the Parliamentary Committee while ensuring that affordability reforms do not inadvertently reduce **quality, availability, investment or access to advanced healthcare.**

AHPI stands ready to work with the Government, Parliament, regulators, insurers, patients and other stakeholders to translate the objectives of the Report into a practical, sustainable and patient-centric healthcare reform agenda for India.

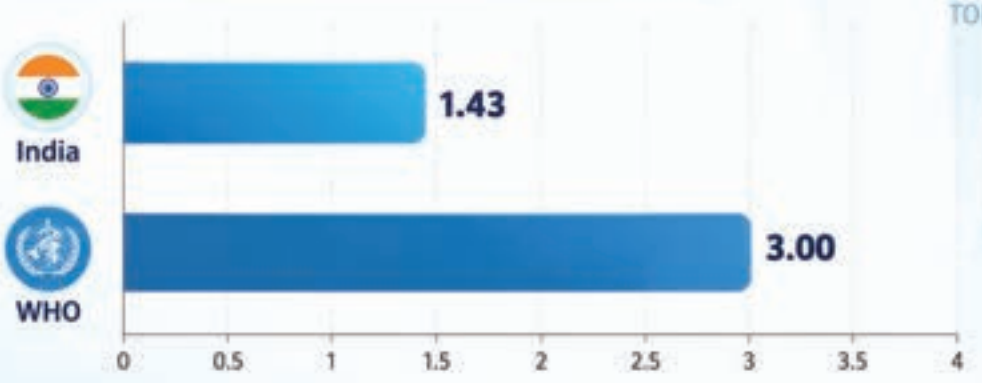
Annexure 1

NUMBER OF BEDS PER 1000 POPULATION

The graph shows the bed ratio per 1000 population in 20 most populated states in India.



BED RATIO PER 1000 POPULATION



Graph shows the comparison of bed availability in India and the WHO suggested.

Annexure 2

Hospital Beds In North

States	No. of beds in public sector	No. of beds in private sector	Population	No of beds/ 1000
Delhi	24,383	15,072	16,787,941	2.35
Himachal Pradesh	12,399	3,641	6,864,602	2.34
Uttar Pradesh	76,260	2,05,142	199,812,341	1.41
Punjab	17,933	43,064	27,743,338	2.19
J&K	7,291	704	12,267,032	0.65
Haryana	11,240	24,901	25,351,462	1.43
Chhattisgarh	9,412	8,018	25,545,198	0.68
Total	1,58,918	3,00,542	314,371,914	1.5

Hospital Beds In South

States	No. of beds in public sector	No. of beds in private sector	Population	No of beds/ 1000
Kerala	38,004	61,223	33,406,061	2.97
Karnataka	69,721	1,92,388	61,095,297	4.2
Tamil Nadu	77,532	77,843	72,147,030	2.15
Andhra Pradesh	23,138	60,092	49,577,103	1.67
Telangana	20,983	78,936	35,003,674	2.85
Total	2,29,378	4,70,482	25,12,29,165	2.78

Hospital Beds In East

States	No. of beds in public sector	No. of beds in private sector	Population	No of beds/ 1000
Bihar	11,664	19,193	104,099,452	0.29
Jharkhand	10,784	15,712	32,988,134	0.80
Chhattisgarh	9,412	8,018	25,545,198	0.68
West Bengal	78,566	34,969	91,276,115	1.24
Odisha	18,519	7,131	41,974,219	0.61
Assam	17,142	7,036	31,205,576	0.77
Manipur	1,427	363	2,570,390	0.70
Sikkim	1,560	392	610,577	3.20
Total	1,49,074	92,814	330,269,661	0.73

Hospital Beds In West

States	No. of beds in public sector	No. of beds in private sector	Population	No of beds/ 1000
Rajasthan	47,054	46,122	68,548,437	1.35
Madhya Pradesh	31,106	33,833	72,626,809	0.89
Gujarat	20,172	44,690	60,439,692	1.07
Maharashtra	51,446	1,80,293	112,374,333	2.06
Goa	3,012	1,572	1,458,545	3.14
Total	1,52,790	3,06,510	315,447,816	1.4

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