REPORT NO.
176

PARLIAMENT OF INDIA
RAJYA SABHA

DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HEALTH AND FAMILY WELFARE

ONE HUNDRED SEVENTY SIXTH REPORT

ON

"AFFORDABILITY AND ACCESSIBILITY OF HEALTHCARE FACILITIES IN PUBLIC AND PRIVATE SECTOR"

PERTAINING TO

MINISTRY OF HEALTH AND FAMILY WELFARE

(*Presented to the Rajya Sabha on 7th August 2026*)
(*Laid on the Table of Lok Sabha on 7th August 2026*)

भारतीय संसद, राज्य सभा

PARLIAMENT OF INDIA,
RAJYA SABHA

Rajya Sabha Secretariat, New Delhi
August, 2026/ Shravan, 1948 (SAKA)

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CONTENTS

		Page Nos.
1.	COMPOSITION OF THE COMMITTEE	i-ii
2.	PREFACE	iii-iv
3.	ACRONYMS	v-xi
4.	**REPORT**	**1-222**
	Chapter -I Overview of Indian Healthcare System	**1 – 16**
	Chapter- II Assessment of Affordability and Accessibility	**17 – 52**
	Chapter- III Views of Stakeholders	**53 – 109**
	Chapter –IV Policy and Regulatory Framework	**110 – 148**
	Chapter –V Rationalization of Treatment Cost	**149 – 193**
	Chapter-VI Future Outlook of Healthcare Services	**194 – 222**
5.	RECOMMENDATIONS/OBSERVATIONS - AT A GLANCE	**223-346**
6.	MINUTES*	-

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**to be appended at later stage*

COMPOSITION OF THE COMMITTEE
(2024-25)

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Rajya Sabha

2. Shri Rajib Bhattacharjee
3. Dr. Ajeet Madhavrao Gopchade
4. Dr. Sikander Kumar
5. Shri Shambhu Sharan Patel
6. Shri B. Parthasaradhi Reddy
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27. Dr. Mahesh Sharma
28. Dr. Rani Srikumar
29. Shri Parimal Suklabaidya
30. Dr. Alok Kumar Suman
31. Mrs. Ruchi Vira

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6.	Shri Roshan Lal	Assistant Committee Officer

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PREFACE

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee to present the Report on its behalf, present this One Hundred Seventy-Sixth Report on the subject **"Affordability and Accessibility of Healthcare Facilities in Public and Private Sector."**

2. In pursuance of its constitutional mandate, the Committee, at its meeting held on 18th November, 2024, identified the subject "Affordability of Healthcare in Private Sector – A Study" for detailed examination. Subsequently, at its meeting held on 24th March, 2025, the Committee revised the title to "Affordability and Accessibility of Healthcare Facilities in Public and Private Sector" in order to expand the scope of the study to cover both the public and private healthcare sectors. The Committee selected the subject with a view to obtain a comprehensive understanding of the state of healthcare delivery in the country and examine the key challenges affecting equitable access to affordable, quality healthcare services. The primary objective of the examination was to assess the adequacy, efficiency and inclusiveness of the healthcare system and to evaluate the measures required to strengthen healthcare delivery across both public and private sectors at the rationalized affordable cost. The Report places particular emphasis on issues relating to quality of care, cost of treatment, patient satisfaction, grievance redressal mechanisms and the financial burden of healthcare on households.

3. As India advances on the path of development and progress, a robust and resilient healthcare system becomes indispensable for safeguarding the health and well-being of lower and middle class population of the country. Beyond its intrinsic value in preserving human life, a strong healthcare system serves as a catalyst for socio-economic development by promoting a productive workforce, reducing the burden of disease and strengthening resilience against public health emergencies. The public healthcare system is guided by the principles of equity, universal access and affordability in consonance with constitutional provision of socialistic pattern of society and welfare nature of the State. The private healthcare sector plays a complementary role to the public healthcare sector in service delivery, particularly in secondary and tertiary care. Both sectors possess distinct strengths and limitations in terms of accessibility, affordability, quality, efficiency, patient satisfaction and financial protection. The Committee has, therefore, endeavoured to undertake a holistic examination of the complementary roles of both sectors and to identify measures necessary for creating an affordable, accessible, equitable and patient-centric healthcare system.

4. The Committee held a meeting on the subject on 24th March, 2025 to hear the views of the Ministry of Health and Family Welfare. The Committee also sought comments and views from all State and Union Territory Governments on various aspects of the subject. Considering the significance and wide-ranging implications of the subject, the Committee invited suggestions and representations from stakeholders and the general public through a Press Communiqué. A total of 167 representations received in response thereto were forwarded to the Ministry of Health and Family Welfare for examination and comments. Subsequently, in its meetings held on 15th and 16th July, 2026, the Committee heard the views of the NITI Aayog, National Health Authority (NHA), Insurance Regulatory and Development Authority of India (IRDAI), AIIMS New Delhi, National Pharmaceutical Pricing Authority (NPPA), Quality Council of India (QCI), Andhra Pradesh MedTech Zone Visakhapatnam (AMTZ), Central Drugs Standard Control Organisation (CDSCO). During these deliberations, various dimensions relating to the affordability and accessibility of healthcare facilities in the country were examined in detail.

5. The Committee also undertook a study visit to Chennai, Bengaluru and Goa from 20th to 24th January, 2025 on the subject for in-depth study of the ground situation on affordability and accessibility of healthcare and the extent to which schemes of the Government are being efficiently implemented and the effectiveness of the scheme in enhancing affordability and accessibility.

6. During the drafting of the Report, the Committee relied upon, *inter-alia*, the following documents and materials:

(i) Background Notes on the subject received from the Department of Health and Family Welfare; the Department of Health Research and the Ministry of Ayush;
(ii) Background Notes and information received from the States and Union Territories;
(iii) Oral evidence tendered by the representatives of Department of Health & Family Welfare, NITI Aayog, NHA, IRDAI, AIIMS New Delhi, NPPA, QCI, AMTZ, CDSCO, and other stakeholders before the Committee;
(iv) Written submissions received from stakeholders and the general public in response to the press communiqué, along with the comments of the Ministry of Health and Family Welfare thereon;
(v) Replies to the questionnaires received from the Department of Health and Family Welfare, various Government and private hospitals, and other stakeholders; and
(vi) National Health Accounts Estimates 2022-23 and other relevant documents pertaining to the subject.

7. The Committee, in its meeting held on 06th August, 2026, considered and adopted the present Report.

8. For facility of reference and convenience, the observations and recommendations of the Committee have been highlighted in bold in the Report and have also been reproduced at the end of the Report under the heading **"Observations/Recommendations at a Glance."**

9. On behalf of the Committee and on my own behalf, I express my sincere gratitude to the Secretaries and officers of the Ministry of Health and Family Welfare, Ministry of Ayush, the NITI Aayog, NHA, IRDAI, AIIMS New Delhi, NPPA, QCI, AMTZ, CDSCO, UNEP and all other organisations and stakeholders who enlightened the Committee by furnishing valuable information and inputs on the subject. I also place on record the Committee's appreciation for the insightful contributions made by domain experts during the course of its deliberations.

10. The Committee further acknowledges with appreciation the dedicated efforts of the officers and staff of the Committee Section in compiling, analysing and assimilating the material and in facilitating the preparation of this significant Report.

New Delhi
06th August, 2026
Shravan, 1948 (Saka)

PROF. RAM GOPAL YADAV
Chairman,
Department-related Parliamentary Standing Committee on Health and Family Welfare

ACRONYMS

AAE	Auto-Adjudication Engine
AA-MMJAY	Ayushman Asom-Mukhya Mantri Jan Arogya Yojana
AAMs	Ayushman Arogya Mandirs
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
AB-HWCs	Ayushman Bharat Health and Wellness Centres
AB-PMJAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
ABR	Auditory Brainstem Response
ADS	Ayush Development Section
AEBAS	Aadhaar-enabled biometric attendance system
AETCOM	Attitude, Ethics, and Communication
AI	Artificial Intelligence
AI-ACIHR	Ayush–ICMR Advanced Centres for Integrative Health Research
AIIA	All India Institute of Ayurveda
AIIMS	All India Institute of Medical Sciences
AIMED	Association of Indian Medical Device Industry
ALL	Acute Lymphoblastic Leukaemia
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMC	Annual Maintenance Contract
AMR	Antimicrobial Resistance
AMRIT	Affordable Medicines and Reliable Implants for Treatment
AMTZ	Andhra Pradesh MedTech Zone
ANBAI	Association of National Board Accredited Institutions
ANMs	Auxiliary Nurse Midwives
ARPOB	Average Revenue Per Occupied Bed
ASHAs	Accredited Social Health Activists
ATACH	Alliance for Transformative Action on Climate and Health
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BCC	Behaviour Change Communication
BHASHINI	Basha Interface for India
BHISHM	Bharat Health Initiative for Sahyog, Hita, and Maitri
BHMS	Bachelor of Homeopathic Medicine and Surgery
BIS	Bureau of Indian Standards
BLS	Basic Life Support
BMET	Biomedical Equipment Technician
BMT	Bone Marrow Transplantation
BPCL	Bharat Petroleum Corporation Limited
BPHU	Block Public Health Units
BPL	Below Poverty Line
BSL	Bio-Safety Lab
BUMS	Bachelor of Unani Medicine and Surgery
CAPF	Central Armed Police Forces
CBAC	Community Based Assessment Checklist
CBHI	Central Bureau of Health Intelligence
CBME	Competency Based Medical Education
CBNAAT	Cartridge Based Nucleic Acid Amplification Test
CBT	Computer Based Testing
CCBs	Critical Care Blocks
CCEBDM	Certificate Course in Evidence Based Diabetes Management
CCRH	Central Council for Research in Homoeopathy

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CCRS	Central Council for Research in Siddha
CCRUM	Central Council for Research in Unani Medicine
CDB	Changing Diabetes Barometer
CDCs	Community Diabetes Centres
CDRI	Central Drug Research Institute
CDSCO	Central Drugs Standard Control Organization
CDSS	Clinical Decision Support System
CEA	Clinical Establishments Act
CGHS	Central Government Health Scheme
CHCs	Community Health Centres
CHE	Current Health Expenditure
CHOs	Community Health Officers
CHSI	Costing of Health Services in India
CII	Confederation of Indian Industry
CIRF	Centralized Instrumentation Research Facility
CME	Continuous Medical Education
CoE	Centres of Excellence
COPDs	Chronic Obstructive Pulmonary Diseases
CoPP	Certificate of Pharmaceutical Product
CPHC	Comprehensive Primary Health Care
CPSEs	Central Public Sector Enterprises
CREDO	Collaboration on Research Methods Development in Oncology
CRM	Customer Relationship Management
CSR	Corporate Social Responsibility
CSS	Centrally Sponsored Scheme
CT	Computed Tomography
CTT-IRT	Classical Test Theory and Item Response Theory
CVD	Cardiovascular Disease
CVTS	Cardiovascular and Thoracic Surgery
DCCCs	Day Care Cancer Centres
DDA	Delhi Development Authority
DDESS	Disease Development and Environmental Surveillance System
DDRS	Digital Drug Regulatory System
DGHS	Directorate General of Health Services
DHIS	Digital Health Incentive Scheme
DHR	Department of Health Research
DHs	District Hospitals
DISHA	Demography Integrated Surveillance for Health Assessment
DMHP	District Mental Health Programme
DNB	Diplomate of National Board
DPCO	Drugs Prices Control Order
DPS	Drug Policy Section
DRAs	District Regulatory Authorities
DRG	Diagnosis Related Grouping
DRP	District Residency Programme
DVDMS	Drugs and Vaccines Distribution & Management System
ECG	Electrocardiogram
EDL	Essential Diagnostics Lists
EHR	Electronic Health Record
EM	Emergency Medicine
EMRB	Ethics and Medical Registration Board
ENT	Ear, Nose & Throat

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EQAS	External Quality Assurance Schemes
ERR	Ethics, Rights & Responsibilities
ESIC	Employees' State Insurance Corporation
ESIS	Employees' State Insurance Scheme
eVIN	Electronic Vaccine Intelligence Network
EWS	Economically Weaker Section
FDCs	Fixed Dose Combinations
FDI	Foreign Direct Investment
FHCs	Family Health Centres
FLW	Front Line Health Workers
FSSAI	Food Safety and Standards Authority of India
GAIL	Gas Authority of India Limited
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GDP	Good Distribution Practices
GeM	Government e-Marketplace
GHE	Government Health Expenditure
GMCs	Government Medical Colleges
GMER	Graduate Medical Education Regulations
GMP	Good Manufacturing Practice
HBP	Health Benefit Packages
HEOCs	Health Emergency Operation Centres
HER2	Human Epidermal Growth Factor Receptor 2
HFR	Health Facility Registry
HFSS	High in Fat, Sugar, and Salt
HIE-CM	Health Information Exchange & Consent Manager
HLCE	High-Level Committee of Experts
HMIS	Hospital Management Information Systems
HPLC	High-Performance Liquid Chromatography
HPR	Healthcare Professionals Registry
HPSC	High-Powered Steering Committee
HR	Human Resource
HRD	Human Resource Development
HRP	Human Resource Planning
HTA	Health Technology Assessment
HTAIn	Health Technology Assessment in India
HTN	Hypertension
HWCs	Health and Wellness Centres
ICD	International Classification of Diseases
ICDs	Implantable Cardioverter Defibrillators
ICMR	Indian Council of Medical Research
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Programme
IEC	Information-Education-Communication
IEC	Information, Education and Communication
IGNOU	Indira Gandhi National Open University
IHAT	Indian Health Action Trust
IHIP	Integrated Health Information Platform
IHMI	India Hypertension Control Initiative
IITs	Indian Institutes of Technology
IKDRC	Institute of Kidney Diseases and Research Centre
IMPCL	Indian Medicines Pharmaceutical Corporation Limited

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INTENT	Indian Clinical Trial and Education Network
IPC	Infection Prevention and Control
IPDMS	Integrated Pharmaceutical Database Management System
IPHLs	Integrated Public Health Labs
IPHS	Indian Public Health Standards
IRDAI	Insurance Regulatory and Development Authority of India
ISO	International Organization for Standardization
ITC	Input Tax Credit
ITRA	Institute of Teaching and Research in Ayurveda
JAK	Jan Aushadi Kendras
JAS	Jan Arogya Samiti
JIPMER	Jawaharlal Institute of Postgraduate Medical Education & Research
JNMC	Jawaharlal Nehru Medical College
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KPIs	Key Performance Indicators
LDCT	Low-Dose Computed Tomography
LIMS	Logistics Management Information System
LTOT	Long-Term Oxygen Therapy
MAFSU	Maharashtra Animal and Fishery Sciences University
MARB	Medical Assessment and Rating Board
MAS	Mahila Arogya Samiti
MBBS	Bachelor of Medicine and Bachelor of Surgery.
MCD	Municipal Corporation of Delhi
MCI	Medical Council of India
MCQs	Multiple Choice Questions
MDPRS	Medical Device Price Regulation Score
MDR	Medical Devices Rules
MDR-TB	Multidrug Resistant TB
MDTAG	Medical Device Technical Advisory Group
MEAs	Managed Entry Agreements
MESU	Mobile Eye Surgical Unit
MIDAC	Medical Innovations Development Acceleration Council
MIYCAN	Mother-Infant-Young Child-Adolescent Nutrition
MJPJAY	Mahatma Jyotirao Phule Jan Arogya Yojana
ML	Machine Learning
MMDP	Morbidity Management and Disability Prevention
MMUs	Mobile Medical Units
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoHUA	Ministry of Housing and Urban Affairs
MOOC	Massive Open Online Course
MRHRUs	Model Rural Health Research Units based
MRI	Magnetic Resonance Imaging
MRP	Maximum Retail Price
MRUs	Multidisciplinary Research Units
MSMER	Maintenance of Standards of Medical Education Regulations
MSMEs	Micro, Small, and Medium Enterprises
MSR	Minimum Standard Requirements
MUHS-CHAKRA	Maharashtra University of Health Science – Centre for Health, Applied Knowledge & Research Autonomy
MVT	Medical Value Travel

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NABFID	National Bank for Financing Infrastructure and Development
NABH	National Accreditation Board for Hospitals & Healthcare Providers.
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NAFU	National Anti-Fraud Unit
NAM	National Ayush Mission
NBEMS	National Board of Examinations in Medical Sciences
NCAHP	National Commission for Allied and Healthcare Professions
NCCE	National Council for Clinical Establishment
NCDC	National Centre for Disease Control
NCDs	Non-Communicable diseases
NCG	National Cancer Grid
NEET	National Eligibility-cum-Entrance Test
NEIAH	North Eastern Institute of Ayurveda and Homoeopathy
NEIGRIHS	North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences
NEML	National List of Essential Medicines
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHA	National Health Authority
NHCX	National Health Claims Exchange
NHM	National Health Mission
NHP	National Health Policy
NHRC	National Human Rights Commission
NHRP	National Health Research Priorities
NHSRC	National Health Systems Resource Centre
NICPR	National Institute of Cancer Prevention and Research
NIH	National Institute of Homoeopathy
NIMHANS	National Institute of Mental Health and Neurosciences
NIMR	National Institute of Malaria Research
NIN	National Institute of Nutrition
NIOH	National Institute of One Health
NISR	National Institute of Sowa-Rigpa
NITI Aayog	National Institution for Transforming India
NITM	National Institute of Traditional Medicine
NIV	National Institutes of Virology
NLEM	National List of Essential Medicines
NMC	National Medical Commission
NMDCFF	National Medical Device Component Financing Framework
NOTTO	National Organ and Tissue Transplant Organization
NPCCHH	National Programme on Climate Change and Human Health
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
NPPA	National Pharmaceutical Pricing Authority
NQAF	National Quality Assurance Framework
NQAS	National Quality Assurance Standards
NRA	National Regulatory Authority
NRHM	National Rural Health Mission
NSO	National Statistical Office
NSS	National Sample Survey
NTEP	National Tuberculosis Elimination Programme
NTMHP	National Tele Mental Health Programme
NUHM	National Urban Health Mission
NVR	Network Video Recorder

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OBC	Other Backward Class
ONGC	Oil and Natural Gas Corporation Limited
OOPE	Out of Pocket Expenditure
OPD	Outpatient department
OPEX	Operational Expenditure
ORF	Observer Research Foundation
PAPs	Patient Assistance Programmes
PED	pre-existing disease
PGIMER	Postgraduate Institute of Medical Education and Research
PGMEB	Post-Graduate Medical Education Board
PHCs	Primary Health Centres
PHFI	Public Health Foundation of India
PHR	Personal Health Record
PHSC	Punjab Health System Corporation
PIPs	Programme Implementation Plans
PLI	Production Linked Incentive
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PMBJP	Pradhan Mantri Bhartiya Janaushadhi Pariyojana
PM-JANMAN	Pradhan Mantri Janjati Adivasi Nyaya Maha Abhiyan
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMNDP	Pradhan Mantri National Dialysis Programme
PMR	Physical Medicine and Rehabilitation
PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
PNDT	Pre-Natal Diagnostic Techniques
PoC	Point-of-Care
POCUS	Point-of-Care Ultrasound
PoE	Points of Entry
POSHAN	Prime Minister's Overarching Scheme for Holistic Nourishment
PPP	Public Private Partnership
PPT	Pen-and-Paper Test
PRE	Patient Rights & Education
PROs	Public Relations Officers
PSUs	Public Sector Undertakings
PTD	Price To Distributor
PTR	Price To Retailers
PVHI	Private Voluntary Health Insurance
PVTGs	Particularly Vulnerable Tribal Groups
QALYs	Quality-Adjusted Life Years
QCI	Quality Council of India
QI	Quality Improvement
QMS	Quality Management System
RBI	Reserve Bank of India
RBSK	Rashtriya Bal Swasthya Karyakram
RCAs	Rate Contract Agreements
RCC	Regional Cancer Centre
RCH	Reproductive and Child Health
RGCIRC	Rajiv Gandhi Cancer Institute & Research Centre
RIMS	Regional Institute of Medical Sciences
RMNCHA	Reproductive, Maternal, Newborn, Child Health and Adolescents
RSBY	Rashtriya Swasthya Bima Yojana
RTAs	Road Traffic Accidents
SAAPs	State Annual Action Plans

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SASHAKT	Systematic Assessment of Health care providers Knowledge and Training,
SAST	Suvarna Arogya Suraksha Trust
SC	Scheduled Caste
SCI	State Cancer Institute
SCs	Sub-Centres
SDGs	Sustainable Development Goals
SDHs	Sub District Hospitals
SECC	Socio-Economic Caste Census
SeHAT	Services e-Health Assistance and Tele-consultation
SHAs	State Health Agencies
SHCs	Sub-Health Centres
SIDBI	Small Industries Development Bank of India
SLAs	Service Level Agreements
SNCM	Standing National Committee on Medicines
SOPs	Standard Operating Procedures
SRS	Sample Registration System
ST	Scheduled Tribe
STEMI	ST Elevation Myocardial Infarction
STGs	Standard Treatment Guidelines
STP	Standard Treatment Protocol
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TAC	Technical Advisory Committee
TAEI-SMART	TN-Stroke Mobilization and Rapid Treatment
TB	Tuberculosis
TB PPSA	Tuberculosis Patient Provider Support Agency
TCAM	Traditional, Complementary and Alternative Medicine
TCCs	Tertiary Care Cancer Centres
TCS	Tata Consultancy Services
Tele-MANAS	Tele Mental Health Assistance and Networking Across States
TEQ	Teachers Eligibility Qualification
THE	Total Health Expenditure
TMC	Tata Memorial Centre
TMR	Trade Margin Rationalization
TMR	trade margin rationalisation
TPAs	Third-Party Administrators
UGMEB	Under-Graduate Medical Education Board
UHC	Universal Health Coverage
UIP	Universal Immunization Programme
ULB	Urban Local Body
UNEP	United Nations Environment Programme
UPPCHAR	Understanding Pain and Palliative Care, Health and Rehabilitation
UWIN	Universal Immunization WIN
VCRC	Vector Control Research Centre
VHSNCs	Village Health Sanitation and Nutrition Committees
VHSNCs	Village Health, Sanitation and Nutrition Committees
VIA	visual inspection with acetic acid
VRDLs	Viral Research and Diagnostic Laboratories
VTT	Voice-to-Text
WHO	World Health Organization
WHO	World Health Organization
WISH	Wadhwani Initiative for Sustainable Healthcare
WPI	Wholesale Price Index

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CHAPTER I

OVERVIEW OF INDIAN HEALTHCARE SYSTEM

1.1.1 India's healthcare system is a vast, complex, and evolving landscape that reflects the country's demographic diversity, socio-economic disparities, and historical legacies. With a population exceeding 1.4 billion, India faces the dual challenge of addressing both communicable and non-communicable diseases, while striving to ensure equitable access to quality healthcare across various socio-economic segments of population in urban and rural regions. The system is characterized by a mixed model, where a large public sector coexists with a rapidly expanding and technologically advanced private sector. Over the decades, India has implemented a series of policy reforms and flagship schemes aimed at strengthening healthcare delivery, improving financial protection, and moving towards Universal Health Coverage (UHC). This report attempts to provide a comprehensive analysis of the Indian healthcare system, examining its current structure, public and private sector hierarchies, evaluating the impact of major government initiatives and policy framework on affordability and accessibility, with a focus on quality, cost, patient satisfaction, grievance redressal, and the financial burden of healthcare on households.

1.2 Evolution of the Healthcare System in India

1.2.1 The Constitution of the World Health Organization (WHO) defined health "as a state of complete physical, mental and social well being, not merely the absence of disease and infirmity". Though the notion of complete absence of disease is unimaginable, nevertheless in 2015, a total of 195 nations committed to the UN's Sustainable Development Goals (SDGs) including universal health coverage, financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (target 3.8 of Goal 3).

1.2.2 Health is central to well-being, influenced by cultural, socio-economic, and biomedical factors. India's rich public health tradition dates back to the Indus Valley civilization's concept of "Arogya" (holistic well-being). The roots of India's modern healthcare system can be traced to the colonial period, when British rule introduced Western medical practices. After independence in 1947, India embarked on an ambitious journey to build a public health system that would provide universal access to healthcare. The early decades saw the expansion of medical colleges, the establishment of a three-tiered system (primary, secondary, tertiary), and the launch of national health programs targeting communicable diseases, maternal and child health, and family planning.The economic reforms of the 1990s accelerated the growth of the private healthcare sector, leading to increased investment, technological advancement, and the emergence of corporate hospital chains.

1.2.3 As the nation traverses the path of development and progress, a robust healthcare system becomes indispensable, ensuring the health and vitality of its populace. Beyond the intrinsic value of safeguarding human lives, a flourishing healthcare sector catalyzes socio-economic advancement by fostering a productive workforce, mitigating the burden of disease, and bolstering resilience against unforeseen health crises.As India strives towards her aspiration of becoming a developed nation, the healthcare sector stands as a linchpin, underpinning the nation's aspirations for inclusive growth, sustainable development, and a brighter future for all.

1.2.4 While public health falls under the state list, the Government of India has been playing a critical role in shaping the sector through efforts of various Committees, National Health Policies, centrally sponsored schemes, central sector schemes, and institutions for research and development. Beginning with the Bhore Committee in 1946, which emphasized the importance of social orientation and community involvement in healthcare, and subsequent efforts such as of the Mudaliar Committee, the National Tuberculosis Program, and the Alma Ata Declaration, have significantly influenced public health in India. Policies like the National Health Policy of 1983 prioritized preventive, promotive and rehabilitative care, while the National Population Policy of 2000 focused on addressing reproductive and child health needs. Government initiatives have evolved to prioritize quality improvement, as evidenced by the National Health Policy of 2002, which emphasized comprehensive primary healthcare and the regulation of the private health sector. These policies and programs reflect the government's dedication toachieving universal health coverage and reducing disparities in healthcare delivery nationwide.

1.2.5 With the progression of new millennium, the concept of health has evolved from being an entity which was to be achieved with the advancement of healthcare technology, along with the Universal Coverage of Health, to be an achievement which is possible only when the human beings are in attune with their physical and mental environment. This new concept of "One Health" is an approach calling for the collaborative efforts of multiple disciplines integrating human, animal, and environmental health. The National Rural Health Mission (NRHM) was launched in 2005 to strengthen rural health infrastructure, followed by the National Urban Health Mission (NUHM) in 2013, both of which were later unified under the National Health Mission (NHM). These initiatives focused on improving maternal and child health, disease control, and the availability of essential drugs and diagnostics.

1.2.6 The National Health Policy 2017 marked a renewed commitment to increasing government health expenditure, strengthening primary care, and achieving UHC. The launch of Ayushman Bharat in 2018, with its two components—Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PMJAY)—represented a paradigm shift towards comprehensive primary care and financial protection for secondary and tertiary care. Digital health initiatives, telemedicine platforms like eSanjeevani, and the expansion of medical education and tertiary care institutions (such as new AIIMS campuses) have further transformed the landscape.

1.3 Structure of the Indian Healthcare System

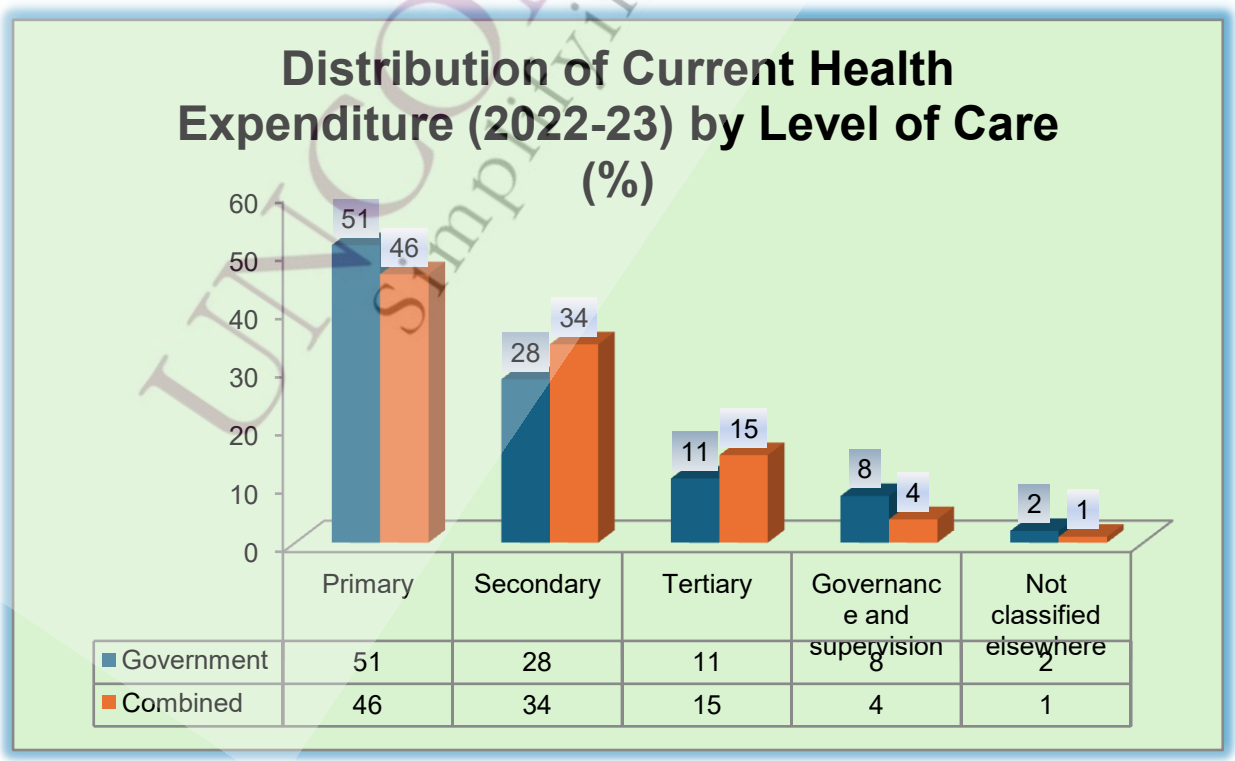
1.3.1 India follows a mixed healthcare delivery model in which public and private providers coexist and jointly contribute to healthcare service delivery. The public healthcare system is broadly organized into three levels, each with distinct roles and infrastructure:

(i) **Primary Care:**It is the foundational level care focusing on prevention, health promotion, and the treatment of common ailments delivered through Sub-Centres (SCs), Primary Health Centres (PHCs), and Health and Wellness Centres (HWCs). The primary care emphasizes immunization, maternal and child health, nutrition, and early diagnosis. SCs serve as the first point of contact in rural areas staffed by Auxiliary Nurse Midwives (ANMs), covering 3,000 to 5,000 people. Primary Health Centres (PHCs) serve as the first point of professional medical care, covering 20,000 to 30,000 people, staffed by doctors, nurses, and pharmacists. PHCs provide

outpatient care, minor surgeries, maternal and child health services, and implement national health programs.Health and Wellness Centres (HWCs) deliver expanded services including screening for non-communicable diseases (NCDs), mental health, oral health, and palliative care, staffed by Community Health Officers (CHOs), multipurpose workers, and Accredited Social Health Activists (ASHAs).

(ii) **Secondary Care:** The secondary care bridges the gap between primary and tertiary services. It is the referral level, providing specialized services such as obstetrics, gynecology, pediatrics, and emergency care delivered through Community Health Centres(CHCs), Sub-District Hospitals, and District Hospitals. CHCs function as block-level referral units consisting of 30-bedded hospitals, each covering 80,000-1,20,000 people, offering specialist services and emergency care. First Referral Units (FRUs) are designated CHCs or Sub-District Hospitals equipped to provide comprehensive emergency obstetric and newborn care, blood storage, and surgical interventions.District Hospitals serve as the apex secondary care facility in each district, offering a wide range of specialties, inpatient and outpatient services, diagnostics, and emergency care. Sub-District Hospitals are the intermediate facilities providing secondary care in larger districts.

(iii) **Tertiary Care:**Tertiary care is the highest level, offering super-specialized treatments, advanced diagnostics, and teaching/research functions, provided by medical colleges, apex institutions (e.g., AIIMS, PGIMER), and large corporate hospitals. Government initiatives like Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)have expanded the number of AIIMS campuses to improve regional access to tertiary care.



Source: National Health Accounts Estimates for India: 2022-23

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1.3.2 The data from *National Health Accounts Estimates for India: 2022-23* provides insights into India's healthcare financing pattern and service delivery structure. The Government allocates 51% of its health expenditure towards primary healthcare, compared to 46% in combined expenditure. In contrast, combined expenditure on secondary and tertiary care stands at 34% and 15%, respectively, against 28% and 11% in government spending. The public expenditure is primarily focused on preventive, promotive, and basic curative healthcare, while the private sector plays a larger role in specialized and advanced treatment services.

1.3.3 The Committee observes that the expenditure pattern reflects the Government's emphasis on positive trend of preventive and community-based healthcare, which helps reduce disease burden and long-term healthcare costs. However, relatively lower public spending on secondary and tertiary care indicates continued dependence on private healthcare for specialized treatment, contributing to higher out-of-pocket expenditure for households.Further, government expenditure on governance and supervision accounts for 8%, compared to 4% in combined expenditure, reflecting the larger administrative framework required for implementation and monitoring of public health programmes.Overall, the data highlights a healthcare financing structure where the Government mainly supports foundational healthcare services, while higher-level curative care continues to be substantially financed through private expenditure.

1.3.4 The Committee is of the view that while the current 51% allocation to primary healthcare establishes a vital preventive foundation, the disproportionately low spending on secondary (28%) and tertiary (11%) care drives citizens toward expensive private facilities, resulting in catastrophic out-of-pocket expenditure (OOPE). 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 to provide dependable, round-the-clock emergency, obstetric, and pediatric care, thereby reducing the referral burden on overstretched apex institutions. The Committee recommends for strengthening of the CHC infrastructure and facilities so that post-graduate doctors can work there in suitable conditions. Facilities like proper accommodation and salary incentives be extended to enable such doctors to work at CHC level. The Committee understands that there is overcrowding of patients but lack of facilities in public sector resulting into influx to private sector hospitals where exorbitant bill on the health expenditure is the real concern, therefore, there is lot of scope for improvement in public health sector by giving due impetus to preventive and community based healthcare.

1.3.5 The Committee observes that government expenditure on governance and supervision currently stands at 8%, double the combined expenditure (both government and private) of 4%. While an extensive administrative apparatus is necessary, the Committee believes that such high overhead costs signal systemic inefficiencies and operational duplication. The Committee, therefore, recommends an immediate administrative rationalization program utilizing digital health infrastructure, such as the Ayushman Bharat Digital Mission. By automating routine oversight and streamlining scheme delivery, the government can safely redirect these administrative funds directly into the procurement of medical equipment, diagnostics, and specialist

human resources and all vacancy position at CHC level be filled up on utmost priority basis.

1.3.6 The Committee is of the view that, given the significant role of the private sector in delivering specialized treatments, a balanced regulatory framework is imperative to protect patients from financial vulnerability. 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. The Committee believes that implementing digital referral systems, outcome-based monitoring, and robust public-private partnership (PPP) frameworks will bridge the equity gap in advanced curative care, improving transparency and accessibility while strictly regulating costs for rationalising out-of-pocket expenditure.

1.3.7 **Private Sector Healthcare Landscape:** The private healthcare sector in India is large, heterogeneous, and rapidly expanding. It includes individual clinics, nursing homes, diagnostic centers, specialty and multi-specialty hospitals, and corporate hospital chains. The sector accounts for over 60% of inpatient care and 70% of outpatient care, especially in urban areas.The private sector is segmented by ownership (individual, trust, corporate), type (general, specialty, multi-specialty), bed capacity, and geography (urban, tier-2/3, rural). Corporate hospital chains such as Apollo Hospitals, Fortis Healthcare, Max Healthcare, Narayana Health, and Manipal Hospitals dominate the urban tertiary care market, offering advanced treatments and global standards of care.

1.3.8 The key drivers of private sector growth includes rising incomes and a growing middle class, urbanization and increased demand for specialized care, technological advancements (robotic surgery, AI diagnostics, telemedicine), Medical tourism, with India attracting millions of foreign patients annually,Public-private partnerships and government incentives (e.g., 100% FDI in healthcare).Private hospitals are at the forefront of adopting advanced technologies, robotic surgery, AI-powered diagnostics, telemedicine, and electronic health records, enhancing efficiency, precision, and patient experience.

1.3.9 According to Brickwork Ratings, the Indian private hospital sector is recording strong financial performance, driven by robust demand, increased medical tourism, and aggressive expansion. Major hospital chains maintained a strong operational and credit profile with sustained growth in Average Revenue per Occupied Bed (ARPOB) ranging from Rs. 38,000 to over Rs. 74,000 bolstered by high-value treatments and better payer mixes. The private hospital sector is projected to almost double from USD 122.3 billion in 2025 to USD 202.5 billion by 2030, with medical tourism acting as a primary growth accelerator. India's medical tourism market is valued at USD 8.7 billion (2025) and is projected to reach USD 16.2 billion by 2030. India attracts around 2% of global health tourism and ranks 10thin the Medical Tourism Index among 46 destinations, attracting patients for cardiac surgery, oncology, orthopedics, and reproductive health, driven by cost-effectiveness and high-quality care.

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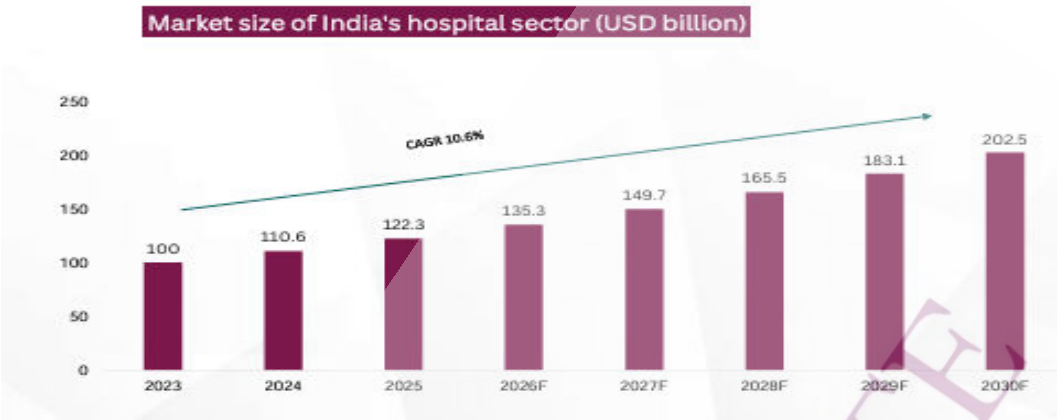

1.3.10 In addition to large hospitals, the private sector includes a vast network of small clinics, nursing homes, and diagnostic centers, many of which are unregulated and concentrated in urban and peri-urban areas. These facilities often fill gaps left by the public sector but vary widely in quality and cost.

1.3.11 The Committee observes that while the private sector accommodates over 60% of inpatient and 70% of outpatient care, it remains highly heterogeneous, with a vast network of small clinics, nursing homes, and diagnostic centres operating without regulations. The Committee is of the view that the unbridled growth of clinics, nursing homes and diagnostic centres and uneven implementation of the Clinical Establishments (Registration and Regulation) Act, 2010, across states creates glaring disparities in both the quality and cost of care in private sector, leaving patients vulnerable to arbitrary pricing and substandard practices. 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. Further, the NABH system be made user friendly and transparat for the small health establishment as NABH compliance in itself adds to the total cost for these health care providers in small towns.

1.3.12 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.

1.3.13 The Committee is of the view that the current private healthcare landscape is disproportionately concentrated in urban tertiary markets, leaving a significant void in tier-2, tier-3, and rural areas despite a growing demand for specialized care in rural, semi-urban, hilly and tribal areas. The Committee believes that market forces alone will not bridge this geographical divide, and that advanced technologies, such as robotic surgery, AI-diagnostics, and telemedicine, currently remain confined to metropolitan corporate chains. The Committee notes with concern that smaller hospitals in these regions severely lack access to modern infrastructure, advanced medical equipment, and emerging technologies. 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. By heavily incentivizing Public-Private Partnerships (PPPs) in non-urban areas, the government can ensure that the infrastructure, technological advancements, and high quality of care characteristic of the corporate private sector are made accessible and affordable to the broader rural and peri-urban population.

1.3.14 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.

1.4 Comparative Analysis: Strengths and Weaknesses of Public and Private Healthcare Sectors

1.4.1 India's healthcare system operates through a mixed model comprising both public and private healthcare providers. While the public healthcare system is guided by the principles of equity, universal access, and affordability, the private healthcare sector plays a dominant role in service delivery, particularly in secondary and tertiary care. Both sectors possess distinct strengths and limitations in terms of accessibility, affordability, quality, efficiency, patient satisfaction, and financial protection.

1.4.2 **Perceived Quality of Care:**In India, the quality of healthcare is perceived differently across the public and private sectors. Public healthcare infrastructure varies widely by state and level of care, with many facilities facing shortages of beds, equipment, and maintenance. Human resource gaps, particularly in rural and remote areas, further affect service delivery.

As a result, public perception is mixed, overcrowding, delays, and limited resources often undermine confidence, though premier government institutions and medical colleges continue to provide high-quality tertiary care. Standardization also remains uneven despite guidelines under NHM and IPHS.

1.4.3 By contrast, private healthcare is generally associated with modern infrastructure, advanced diagnostic facilities, and better amenities. Urban centers benefit from greater availability of specialists and support staff, and patients often perceive private institutions as more efficient, responsive, and patient-friendly, with shorter waiting times and personalized care. NABH-accredited hospitals maintain standardized practices, though quality can vary significantly between large corporate hospitals and smaller private clinics. Overall, while government institutions achieve excellent clinical outcomes in many cases, the private sector is more consistently linked with superior service delivery and patient experience.

1.4.4 **Cost Differences and Affordability:**Public healthcare in India is largely free or heavily subsidized, with essential medicines and diagnostics often provided under government schemes, though shortages of medicines and diagnostics can occur. This makes public facilities more affordable, especially for economically weaker sections, and less dependent on insurance coverage.

1.4.5 In contrast, private healthcare is substantially more expensive, with patients typically bearing the full cost of medicines, diagnostics, and procedures unless insured. Access to care in this sector often depends on household income or insurance coverage, leading to high out-of-pocket expenditure and financial distress for many families. Studies highlight that hospitalization expenses in private hospitals can vary by 2 to 20 times higher *vis-à-vis*government facilities. NSO estimates confirm that average out-of-pocket spending per hospitalization is several times greater in private institutions compared to public ones.

1.4.6 The latest National Statistical Office survey (80th round of the National Sample Survey January-December 2025) highlights India's deepening healthcare affordability crisis. The Committee notes with deep concern that treatment in private hospitals is often five to ten times costlier than in government facilities, with childbirth and serious illnesses like cancer, heart disease, and kidney failure reflecting the sharpest divides. The average cost of inpatient treatment for an illness in India is about Rs 37,858, while out-of-pocket expenditure is about Rs 34,064. The average cost of hospitalization is Rs. 6,631 in government hospitals compared to Rs. 50,508 in private hospitals. The gap widens further for serious illnesses such as cancer, heart disease and kidney failure.

Table 2.20: Out-of-pocket medical expenditure per hospitalization case (excluding childbirth) during the last 365-day period: All-India

Medical institution	Average out-of-pocket medical expenditure (₹)			Median out-of-pocket medical expenditure (₹)		
	Rural	Urban	Rural + Urban	Rural	Urban	Rural + Urban
Govt. hospital/Public health facilities	6,905	6,032	6,631	1,200	850	1,100
Charitable/ Trust/NGO run hospital	40,203	38,419	39,530	7,000	14,900	10,000
Private hospital (incl. Govt. empanelled)	47,710	54,999	50,508	23,500	25,000	24,000
All	**31,484**	**38,688**	**34,064**	**10,500**	**12,400**	**11,285**

Note: 1. Government hospitals/Public health facilities include AAMs/HSC/PHC/CHC etc.
2. Private hospitals empanelled under Government health financing scheme/insurance viz. AB-PMJAY, CGHS/ECHS/other Central Government health schemes (e.g., Railways etc.), State Health Insurance Schemes, State Government-supported medical reimbursement (for employees), ESIS/ESIC etc., have been considered in the 'Private hospital' category.

Medical Expenditure: *includes doctor's/ surgeon's fee, medicine, diagnostic tests, bed charges, other medical expenses (attendant charges, physio therapy, personal medical appliances, blood, oxygen, etc.)*

Non-medical expenditure: *includes transport for patient and other non-medical expenses incurred by the household (food, expenditure on escort, lodging charges if any, etc.).*

Out-of-pocket medical expenditure = (Total Medical expenditure) – (reimbursed amount (by insurance company or employer))

Table 2.26: Average and Median out-of-pocket medical expenditure (₹) per childbirth case during the last 365-day period by place of delivery

Place of delivery	Average out-of-pocket medical expenditure (₹)			Median out-of-pocket medical expenditure (₹)		
	Rural	Urban	Rural + Urban	Rural	Urban	Rural + Urban
Govt. hospital /Public health facilities	2,189	2,747	2,299	810	800	801
Charitable/ Trust/NGO run hospital	16,131	25,395	19,612	10,000	20,400	13,000
Private hospital (incl. Govt. empanelled)	33,979	43,580	37,630	30,000	36,000	32,000
All	**11,609**	**23,670**	**14,775**	**2,190**	**10,200**	**2,851**

Note: 1. Government hospitals/Public health facilities include AAMs/HSC/PHC/CHC etc.
2. Private hospitals empanelled under Government health financing scheme/insurance viz. AB-PMJAY, CGHS/ECHS/other Central Government health schemes (e.g., Railways etc.), State Health Insurance Schemes, State Government-supported medical reimbursement (for employees), ESIS/ESIC etc., have been considered in the 'Private hospital' category.

Table 2.25: Average out-of-pocket medical expenditure per treated spell of ailments during the last 15-day period and Median out-of-pocket medical expenditure, by healthcare service provider

Healthcare service provider	Average out-of-pocket medical expenditure (₹)			Median out-of-pocket medical expenditure (₹)		
	Rural	Urban	Rural+Urban	Rural	Urban	Rural+Urban
Govt. hospital/ Public health facilities	304	257	289	0	0	0
Charitable/Trust/ NGO run hospital	1,130	1,692	1,359	500	550	540
Private hospital	1,541	1,343	1,447	800	638	700
Private doctor/clinic	981	925	958	545	545	545
Informal health care provider	432	557	457	300	345	300
All	**847**	**884**	**861**	**395**	**420**	**400**

Note: Government hospitals/Public health facilities include AAMs/HSC/PHC/CHC etc.

1.4.7 The notion that only major treatments are expensive is challenged by the survey. Even the treatment of common illnesses varies sharply between public and private facilities. For

outpatient treatment during the 15 days covered by the survey, the average cost of a single treatment was Rs 861. In government hospitals, it was Rs 289. In private hospitals, the cost rose to Rs 1,447. Childbirth expenses illustrate the gap most starkly Rs. 2,299 in government hospitals against Rs. 30,000 to 40,000 in private hospitals, strikingly a difference of 10-15 times.

1.4.8 The Committee would like to highlight that, as per the 80th round of the National Sample Survey January-December 2025 conducted by National Statistics Office on Household Social Consumption: Health, state-wise data shows that 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. In areas such as Ladakh, spending is recorded at only about Rs 8,000. However, lower spending does not necessarily mean better conditions. It may also point to limited access to healthcare, lower use of services, or people being restricted to cheaper options. The state-wise data also shows that where government health services are stronger, public spending on treatment remains lower. But where the private sector has expanded, spending rises rapidly.For example, in southern Indian states, the role of private hospitals is greater and spending is also higher. In contrast, in the north-eastern states, there is greater reliance on government services, resulting in relatively lower expenditure.

1.4.9 **Accessibility and Geographical Reach:** India's public healthcare system, supported by the National Health Mission (NHM), remains the backbone of rural healthcare delivery. With its wide network of Sub-Centres, PHCs, CHCs, and Health and Wellness Centres, it ensures outreach to vulnerable and underserved populations and provides emergency coverage through referral systems and ambulance services. However, shortages of doctors, specialists, and equipment often limit effective accessibility.In contrast, private healthcare is concentrated mainly in urban and semi-urban areas, offering better emergency responsiveness and advanced facilities but remaining inaccessible to many low-income households due to high costs. Access in the private sector largely depends on affordability and insurance coverage, reinforcing inequities in healthcare reach across rural and urban India.

1.4.10 **Patient Load Management and Service Speed:**Public hospitals, particularly in metropolitan areas, face heavy patient inflows that result in overcrowding, high doctor-patient ratios, and long waiting times for consultations, investigations, and surgeries. The excessive workload often limits consultation time, straining healthcare personnel and reducing service efficiency.In contrast, private hospitals generally manage lower patient loads with better staffing patterns and resource availability. This allows them to offer faster appointments, quicker diagnostics, and more timely treatment procedures. Patients also benefit from longer and more personalized consultations, contributing to a perception of greater efficiency and responsiveness in private healthcare.

1.4.11 **Patient Satisfaction Levels:**Patient satisfaction in India's healthcare system varies significantly between the public and private sectors. In the public sector, satisfaction is largely driven by affordability, as subsidized or free services provide relief to low-income groups. However, delays, overcrowding, and administrative challenges often reduce service satisfaction. Trust in public institutions remains strong for affordability and specialized tertiary care offered by premier government hospitals.In contrast, private hospitals generally achieve higher satisfaction due to better amenities, communication, and responsiveness. Patients value the efficiency, personalized consultations, and service quality, though affordability remains a major barrier for economically weaker sections. As a result, private facilities are often preferred for specialized and emergency care when cost is not a constraint.

1.4.12 **Grievance Redressal Mechanisms:**In India, grievance redressal in healthcare differs across the public and private sectors. Public healthcare facilities rely on institutional mechanisms such as *Rogi Kalyan Samitis*, Village Health Sanitation and Nutrition Committees (VHSNCs), patient help desks, the helpline, and online grievance portals. These systems are guided by the National Health Mission (NHM) guidelines, the Patient Rights Charter, and public accountability frameworks. However, bureaucratic hierarchies and implementation gaps often slow down responses, reducing effectiveness.Private hospitals, on the other hand, use internal complaint cells, ombudsman systems, and customer care services. Large corporate hospitals tend to respond more quickly to grievances, though transparency and consistency remain uneven, especially in smaller facilities. Their accountability is shaped by the Clinical Establishments Act, NABH standards, and consumer protection laws.

1.4.13 **Common grievances:** In public facilities, patients often face long waiting times, overcrowding, staff shortages, delayed diagnostics and non-availability of medicines. In private hospitals, complaints typically involve high treatment charges, unnecessary diagnostics or procedures, lack of price transparency, excessive billing, and insurance claim disputes.

1.4.14 **Catastrophic Health Expenditure and Impoverishment:**Catastrophic health expenditure refers to healthcare spending that consumes a large share of household income, often pushing families into financial hardship. In India, the risk is relatively lower in the public sector due to subsidized services, though patients still face out-of-pocket costs for medicines and diagnostics not available in facilities. By contrast, private healthcare poses a significantly higher risk, as expensive hospitalization and diagnostic services are a major contributor to out-of-pocket expenditure (OOPE).

1.4.15 The Committee expresses deep concern over the financial consequences that are stark, while government schemes help reduce the burden in public facilities, private hospital costs often lead to indebtedness, asset sales, or delayed treatment. According to the National Health Accounts (2022–23), OOPE as a share of total health expenditure has declined over time, from 62.6% in 2014–15 to 39.4% in 2021–22, but it remains a major burden, particularly when care is sought from private hospitals. The NSO's 2025 Household Social Consumption Survey further confirms that hospitalization in private facilities can be 5 to 10 times costlier than in government hospitals, underscoring the link between private care and catastrophic spending.

1.4.16 The Committee takes into account the public vs. private healthcare facilities available in India highlighting comparative analysis that public healthcare offers greater affordability,

rural accessibility, and financial protection, though it suffers from infrastructure deficiencies, workforce shortages, and long waiting times. Private healthcare provides advanced technology, specialized care, and higher patient satisfaction, but its high costs and inequitable access limit affordability for large sections of the population.

1.4.17 The Committee is of the view that while the public healthcare system remains the crucial backbone for rural and low-income populations, with severe infrastructure deficiencies, workforce shortages, and extreme overcrowding that, in fact, erodes public trust and driving patients toward unaffordable private care. The Committee, however, notes with concern that excessive patient loads in government hospitals directly compromise consultation times and service efficiency. The Committee, nevertheless,believes that improving the perceived and actual quality of public healthcare is the most sustainable method to reduce the national burden of out-of-pocket expenditure (OOPE). The Committee, therefore, recommends for an accelerated capacity-building initiative focused on expanding bed capacity and recruiting specialized medical personnel in public facilities, particularly in high-demand metropolitan centers. Furthermore, the Ministry must strictly enforce Indian Public Health Standards (IPHS) to ensure that the availability of essential medicines, diagnostics, and modern amenities in government hospitals matches the responsiveness and patient satisfaction levels currently available exclusively to the private sector.

1.4.18 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 believes that the rampant commercialization of private healthcare, characterized by grievances of excessive billing, unnecessary diagnostics, and soaring costs for routine procedures like childbirth (average out-of-pocket medical expenditure of Rs. 37,630 in private as compared to Rs. 2,299 in public), is directly pushing vulnerable households into catastrophic debt and distress causing asset sales. 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. Additionally, the government must mandate absolute price transparency prior to admission and establish a unified, fast-track grievance redressal ombudsman specifically designed to audit excessive billing and resolve insurance claim disputes in the private sector.

1.4.19 The Committee is of the firm view that geographical inequities severely distort healthcare accessibility, with private tertiary care concentrated in urban centers and southern states, driving hospitalization costs above Rs. 50,000, while regions like the Northeast suffer from limited access to advanced care altogether. Although OOPE has declined to 43.4% (as per NHA Estimates 2022-23), 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, thereby shielding marginalized communities, the elderly, and women from the catastrophic financial impoverishment caused by private healthcare expenses.

1.5 Role of Major Government Schemes in Healthcare Delivery and Financial Protection

1.5.1 The Government of India has launched several healthcare schemes and initiatives to improve accessibility, affordability, financial protection, and quality of healthcare services, particularly for vulnerable and economically weaker populations. These initiatives aim to strengthen both preventive and curative healthcare systems while reducing out-of-pocket expenditure (OOPE) and ensuring equitable healthcare access across rural and urban areas.

1.5.2 **National Health Mission (NHM):**The National Health Mission (NHM), launched initially as the National Rural Health Mission (NRHM) in 2005 and later expanded to include the National Urban Health Mission (NUHM) in 2013, serves as the cornerstone of India's public healthcare system strengthening efforts.The Mission aims to ensure universal access to equitable, affordable, and quality healthcare services, with a focus on maternal and child health, communicable diseases, and strengthening public health infrastructure. NHM supports the recruitment of health workers, infrastructure upgrades, free drugs and diagnostics, and community engagement through ASHAs and VHSNCs.

1.5.3 **Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY):** Launched in 2018, PMJAY is the world's largest government-funded health insurance scheme, providing coverage of Rs. 5 lakh per family per year for secondary and tertiary hospitalization to over 500 million beneficiaries (bottom 40% of the population). The scheme operates through a large network of empanelled public and private hospitals and offers cashless and paperless treatment services across India.

1.5.4 **Ayushman Bharat Health and Wellness Centres (AB-HWCs):** The other pillar of Ayushman Bharat, HWCs aim to upgrade 150,000 SCs and PHCs to provide comprehensive primary care, including screening for NCDs, mental health, oral health, and palliative care. HWCs are staffed by CHOs, multipurpose workers, and ASHAs, and leverage telemedicine platforms like eSanjeevani to connect with higher-level facilities.The programme aims to

strengthen preventive, promotive, curative, rehabilitative, and palliative healthcare services at the community level.

1.5.5 **Ayushman Bharat Digital Mission (ABDM)**seeks to establish an integrated digital health ecosystem across the country.The initiative aims to enable citizens to create secure digital health IDs, store and access electronic health records, share medical records digitally across healthcare providers and improve continuity and coordination of healthcare services. ABDM promotes interoperability across healthcare institutions and supports data-driven healthcare governance. Digital health records and integrated healthcare platforms are expected to reduce duplication of tests, improve efficiency, and facilitate easier access to healthcare services.The initiative is particularly important for strengthening healthcare delivery in geographically dispersed and underserved populations.

1.5.6 **Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM):** The Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) focuses on strengthening India's public health infrastructure and improving preparedness for future public health emergencies. The mission emphasizes establishment and strengthening of Health and Wellness Centres, creation of critical care hospital blocks at district hospitals, development of Block Public Health Units, expansion of integrated public health laboratories, and strengthening disease surveillance systems. PM-ABHIM aims to address long-standing infrastructure deficiencies in the public healthcare system and improve resilience against pandemics and emerging health challenges.

1.5.7 **Teleconsultation and Telemedicine Services:** The Government of India has increasingly promoted telemedicine and digital consultation services to bridge geographical barriers and improve healthcare accessibility, especially in rural and remote areas. The eSanjeevani platform provides doctor-to-doctor and doctor-to-patient teleconsultation services. The key benefits include reduced travel costs for patients, faster specialist consultations, improved healthcare access in remote areas, and reduced burden on tertiary hospitals. Services e-Health Assistance and Teleconsultation (SeHAT) initiative provides free and easy access to video-based consultations between doctors and patients, particularly benefiting citizens residing in remote and underserved regions. Telemedicine initiatives such as eSanjeevani and SeHAT have become increasingly important in improving healthcare accessibility, particularly after the COVID-19 pandemic.

1.5.8 **RashtriyaSwasthyaBima Yojana (RSBY):**Launched in 2008, RSBY provided health insurance to below poverty line (BPL) families for hospitalization expenses. It was a precursor to PMJAY and has since been subsumed under Ayushman Bharat. RSBY improved access to private sector care but had limited impact on reducing OOPE, especially in private facilities.

1.5.9 **Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK):**Janani Suraksha Yojana is a safe motherhood intervention implemented under NHM to promote institutional deliveries among pregnant women, particularly in low-performing states and economically weaker households.The scheme provides conditional cash assistance to pregnant women and incentivizes ASHAs for mobilizing beneficiaries towards institutional healthcare services.JSSK was introduced to eliminate out-of-pocket expenditure for pregnant women and sick newborns accessing public health institutions by providing free entitlements

(drugs, diagnostics, transport) for pregnant women and sick newborns in public health facilities.

1.5.10 **Mission Indradhanush:**Mission Indradhanush aims to achieve full immunization coverage among children and pregnant women against vaccine-preventable diseases.The initiative has significantly improved immunization coverage in high-focus districts and underserved populations, thereby reducing child mortality and preventable diseases.

1.5.11 **Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP)**The Jan Aushadhi Scheme promotes affordable access to quality generic medicines through Jan AushadhiKendras established across the country.Since medicines constitute a major component of household healthcare expenditure, the scheme plays an important role in reducing financial burden on families.

1.5.12 The Committee is of the view that while the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) provides critical financial protection to over 500 million vulnerable citizens, its success heavily depends on the availability of robust medical infrastructure. Currently, a significant portion of PMJAY funds is absorbed by the private sector due to enduring deficiencies in public tertiary care. The Committee believes that to build long-term systemic resilience and reduce dependency on private facilities, the public sector's absorptive capacity must be drastically improved to enable public sector hospitals as tertiary care providers. The Committee, therefore, recommends the aggressive, fast-tracked execution of the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). The government must urgently prioritize the establishment of critical care hospital blocks and integrated public health laboratories at the district level. 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.

1.5.13 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 rational government price caps under schemes like Ayushman Bharat and CGHS, continuously squeeze profit margins and threaten financial sustainability. The Committee believes that forcing an unviable financial model upon hospitals ultimately compromises patient care. The Committee, therefore, recommends that while the Ministry must aggressively mandate the uniform adoption of the Clinical Establishments Act and enforce a tiered quality-assurance framework, it must simultaneously 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.

1.5.14 The Committee observes that digital initiatives, particularly the Ayushman Bharat Digital Mission (ABDM) and teleconsultation platforms like eSanjeevani and SeHAT, are transformative in bridging the geographical healthcare divide. However, the Committee is of the view that voluntary or fragmented adoption of these digital tools limits their potential to reduce diagnostic duplications and streamline patient referrals. The Committee believes that a seamless digital continuum is necessary to lower the

financial and travel burdens on rural populations seeking specialist care. The Committee, therefore, recommends making ABDM compliance mandatory for all public healthcare facilities and private hospitals empanelled under PMJAY. Furthermore, the capacity of Ayushman Bharat Health and Wellness Centres (AB-HWCs) must be systematically augmented with uninterrupted high-speed digital connectivity to ensure that every rural citizen has seamless, reliable access to doctor-to-patient teleconsultations, effectively reducing the referral burden on higher-level urban hospitals.

1.5.15 The Committee notes with deep concern that despite free treatment entitlements, outpatient expenditures and the cost of medicines continue to drive significant out-of-pocket expenditure (OOPE) for households. The Committee is, therefore, of the considered view that while schemes like the Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP) have successfully provided affordable generic medicines, their physical footprint remains inadequate compared to the overall population's need. The Committee believes that mitigating such specific limitation is the most direct way to protect the patients of economically weaker sections from financial distress. 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 to ensure accessibility and availability of medicines at affordable costs. Concurrently, the Ministry must implement rigorous, technology-enabled audits through the National Health Mission (NHM) to ensure zero out-of-pocket expenditure for pregnant women and neonates under JSSK, explicitly penalizing medical centres that fail to provide complete free entitlements for drugs, diagnostics, and transport.

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CHAPTER II

ASSESSMENT OF AFFORDABILITY AND ACCESSIBILITY

2.1 Definition and Indicators of Affordability and Accessibility

2.1.1 Affordability and accessibility constitute the two fundamental dimensions for assessing the performance of a healthcare system.Together, these dimensions determine the extent to which healthcare services are equitable, inclusive and responsive to the needs of the population.While Chapter I provided an overview of the structure of India's healthcare system, this chapter delves into the performance of both public and private sectors through these twin dimensions, utilizing a framework of defined indicators, financial implications, geographical realities, infrastructural capacities, and the differentiated experiences of vulnerable populations.

2.1.2 Affordability in healthcare broadly refers to the ability of individuals and households to access healthcare services without experiencing financial hardship. Affordability extends beyond the cost of medical treatment and encompasses the financial capacity of households to meet healthcare expenses without compromising their standard of living.Key indicators of affordability include Out-of-Pocket Expenditure (OOPE) as a proportion of Total Health Expenditure (THE), catastrophic health expenditure, incidence of impoverishment due to medical expenses, insurance coverage, availability of free medicines and diagnostics, and public expenditure on health.

2.1.3 Accessibility refers to the timely availability of quality healthcare services irrespective of geographical, social or economic barriers. Accessibility encompasses the physical, geographical and functional availability of healthcare services. It is assessed through indicators such as the availability and distribution of healthcare facilities, doctor-population ratio, hospital bed density, availability of specialists and healthcare professionals, travel time to healthcare facilities, access to essential medicines and diagnostics, emergency transport services, and digital health services including telemedicine. Accessibility also includes the quality of healthcare services, as timely access to inadequately staffed or poorly equipped facilities cannot ensure effective healthcare delivery.

2.1.4 The Indian Public Health Standards (IPHS) provide the benchmark for assessing the functional readiness of public healthcare facilities by prescribing minimum standards for infrastructure, human resources, equipment, drugs and essential services at different levels of care. To strengthen monitoring, the Ministry has introduced a web-based IPHS Dashboard for self-assessment and real-time monitoring of compliance. As informed by the Ministry, nearly all public healthcare facilities have been assessed under the IPHS framework, enabling evidence-based identification of infrastructure and service gaps. The National Quality Assurance Standards (NQAS) and the Kayakalp initiative further complement these standards by promoting quality improvement and patient safety in public healthcare institutions.

2.1.5 The Committee was further apprised by the Ministry of Health and Family Welfare that the Government has adopted a comprehensive approach towards improving affordability and accessibility through the four pillars of Ayushman Bharat, namely: (i) Ayushman Arogya Mandirs providing comprehensive primary healthcare; (ii) Pradhan Mantri Jan Arogya Yojana (PM-JAY) providing financial protection against secondary and tertiary hospitalization; (iii) PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM)

strengthening public health infrastructure; and (iv) Ayushman Bharat Digital Mission (ABDM) facilitating continuity of care through interoperable digital health records and digital health services. The Ministry informed that approximately 1.76 lakh Ayushman Arogya Mandirs had become operational across the country and that telemedicine services through eSanjeevani and other digital platforms were improving access to healthcare, particularly in rural, remote and underserved areas.

2.1.6 The Committee is of the view that affordability and accessibility are intrinsically interlinked.Affordable healthcare holds limited value if facilities remain unavailable or inaccessible, just as accessible infrastructure fails equitability tests if it imposes catastrophic financial burdens on households.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). Immediate financial allocations must be directed toward eliminating Out-of-Pocket Expenditure (OOPE) by guaranteeing the uninterrupted supply of free essential medicines, diagnostic services, and emergency transport across all operational Ayushman Arogya Mandirs.

2.1.7 The Committee believes that the mere physical availability of healthcare centers does not equate to genuine accessibility if such facilities suffer from inadequate staffing, a deficit of specialists, or substandard equipment.The Committee, therefore, recommends the Ministry of Health and Family Welfare to embark upon the web-based Indian Public Health Standards (IPHS) Dashboard *i.e.,*from a passive self-assessment mechanism into an active, real-time remediation tool. Statutory, time-bound interventions must be mandated to rectify any identified infrastructure and human resource gaps, specifically optimizing doctor-population ratios and hospital bed density, ensuring absolute compliance with both the IPHS and National Quality Assurance Standards (NQAS).

2.1.8 The Committee is of the view that digital health innovations, particularly telemedicine platforms and the Ayushman Bharat Digital Mission (ABDM), act as crucial equalizers for populations facing severe geographical barriers/gaps.The Committee, therefore, recommends the rapid acceleration of digital health interoperability across the public and private sectors. This expansion must be aggressively supported by upgraded broadband connectivity and digital infrastructure at all rural healthcare facilities to maximize the functional reach of platforms like eSanjeevani. This will ensure seamless continuity of care and immediate access to specialized consultations, effectively bypassing the traditional barrier of physical travel time.

2.2 OUT-OF-POCKET EXPENDITURE AND FINANCIAL PROTECTION

2.2.1 Out-of-Pocket Expenditure (OOPE) is the expenditure directly made by households at the point of receiving healthcare. OOPEremains one of the most significant indicators of affordability in healthcare system, as it reflects the direct financial burden borne by households while accessing healthcare services.Total Health Expenditure (THE) constitutes current and capital expenditures incurred by Government and Private Sources, including External funds. THE as a percentage of GDP indicates health spending relative to the

country's economic development. Current Health Expenditure (CHE) constitutes only recurrent expenditures for healthcare purposes, net of all capital expenditures. CHE as percent of THE indicate the operational expenditures on healthcare that impact the health outcomes of the population in that particular year. Government Health Expenditure (GHE) constitutes spending under all schemes funded and managed by Union, State and local Governments, including quasi-Governmental organisations and donors in case funds are channelled through Government organisations. It has an important bearing on the health system, as low Government health expenditures may mean high dependence on household out of pocket expenditures.

2.2.2 During the course of examination, the Committee noted that despite substantial improvements in public health financing and expansion of government-funded health assurance schemes, households continue to incur considerable expenditure on outpatient consultations, medicines, diagnostics and hospitalization, particularly when public healthcare facilities are either unavailable or inadequately equipped. High medical expenses continue to push many families, especially those belonging to economically weaker sections, into financial distress.

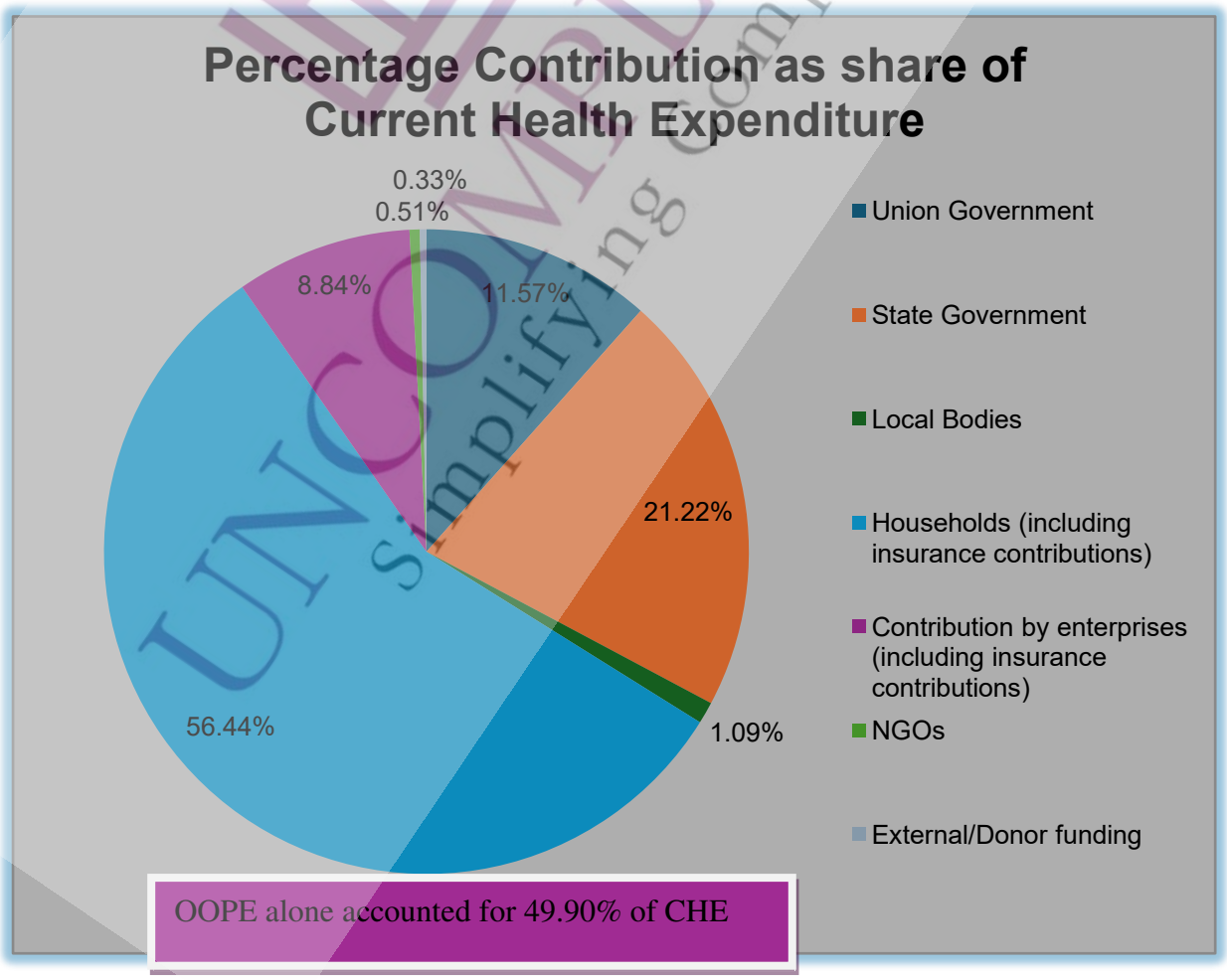
2.2.3 As per the National Health Accounts (NHA) Estimates 2022-23, India has witnessed a gradual improvement in financial protection in healthcare over the past decade. Government Health Expenditure (GHE) increased from about 1.15 per cent of GDP in 2013-14 to 1.43 per cent in 2022-23, while its share in THE rose from 28.6 per cent to 43.72 per cent during the same period, reflecting a public commitment to health financing. Correspondingly, the share of Out-of-Pocket Expenditure (OOPE) in Total Health Expenditure (THE)has declined from 64.2 per cent in 2013-14 to 39.4 per cent in 2021-22 but with an upward inclination to 43.4 per cent in 2022-23.The Ministry of Health and Family Welfare attributes this decline in OOPE to increased public investment in health, expansion of government-funded health insurance schemes, and the provision of free medicines and diagnostics under the National Health Mission. Since OOPE remains a major cause of catastrophic health expenditure and impoverishment, particularly among households dealing with non-communicable diseases (NCDs) and other chronic conditions, the declining trend indicates an improvement in financial protection and access to healthcare services.

2.2.4 OOPE as a percent of THE indicates the extent of financial protection available for households towards healthcare payments. Despite the gainsin terms of decline in OOPE, India's OOPE remains high by global standards. Nearly 60 per cent of all hospitalisations and about 70 per cent of outpatient services are still delivered by the private sector, according to the National Sample Survey Office 75th Round Survey on Social Consumption: Health (2017-18). This dependence on private healthcare presents a stark paradox. While India is widely recognised as the 'pharmacy of the world' because of its robust generic pharmaceutical industry, its citizens continue to bear one of the highest healthcare-related financial burdens globally. Private healthcare accounts for nearly 60 per cent of total health expenditure, often pushing vulnerable households into poverty and indebtedness.

2.2.5 As per the National Health Accounts (NHA) Estimates for 2022-23, India's Total Health Expenditure (THE) is estimated at ₹8,81,359 crore, equivalent to 3.37 per cent of GDP (based on the new series of GDP estimates with base year 2022-23) and ₹6,373 per capita. Thecomprises both current and capital expenditures incurred by government and private

sources, including external donor funds. Current Health Expenditure (CHE) amounted to ₹7,66,814 crore (87.0 per cent of THE), while capital expenditure stood at ₹1,14,545 crore (13.0 per cent of THE).Government Health Expenditure (GHE), including capital expenditure, was estimated at ₹3,85,332 crore, accounting for 43.72 per cent of THE, 1.48 per cent of GDP (based on the new series of GDP estimates with base year 2022-23), and ₹2,786 per capita. Of this, the Union Government contributed 36.3 per cent, while State Governments accounted for 63.7 per cent.

2.2.6 As per the National Health Accounts (NHA) Estimates 2022-23, households' Out-of-Pocket Expenditure (OOPE) on health was estimated at ₹3,82,629 crore, representing 43.41 per cent of THE, 1.47 per cent of GDP, and ₹2,767 per capita. Private Health Insurance expenditure amounted to ₹81,012 crore or 9.19 per cent of THE.Household health expenditures constitute both direct expenditures (OOPE) and indirect expenditures (prepayments as health insurance contributions or premiums). This indicates the dependence of households on their income/savings to meet healthcare expenditures.Within Current Health Expenditure, the Union Government's contribution was ₹88,721 crore (11.57 per cent of CHE), while State Governments contributed ₹1,62,752 crore (21.22 per cent of CHE). Local bodies accounted for ₹8,345 crore (1.09 per cent of CHE), whereas households, including insurance contributions, spent approximately ₹4,32,747 crore, constituting 56.44 per cent of CHE, of which OOPE alone accounted for 49.90 per cent.



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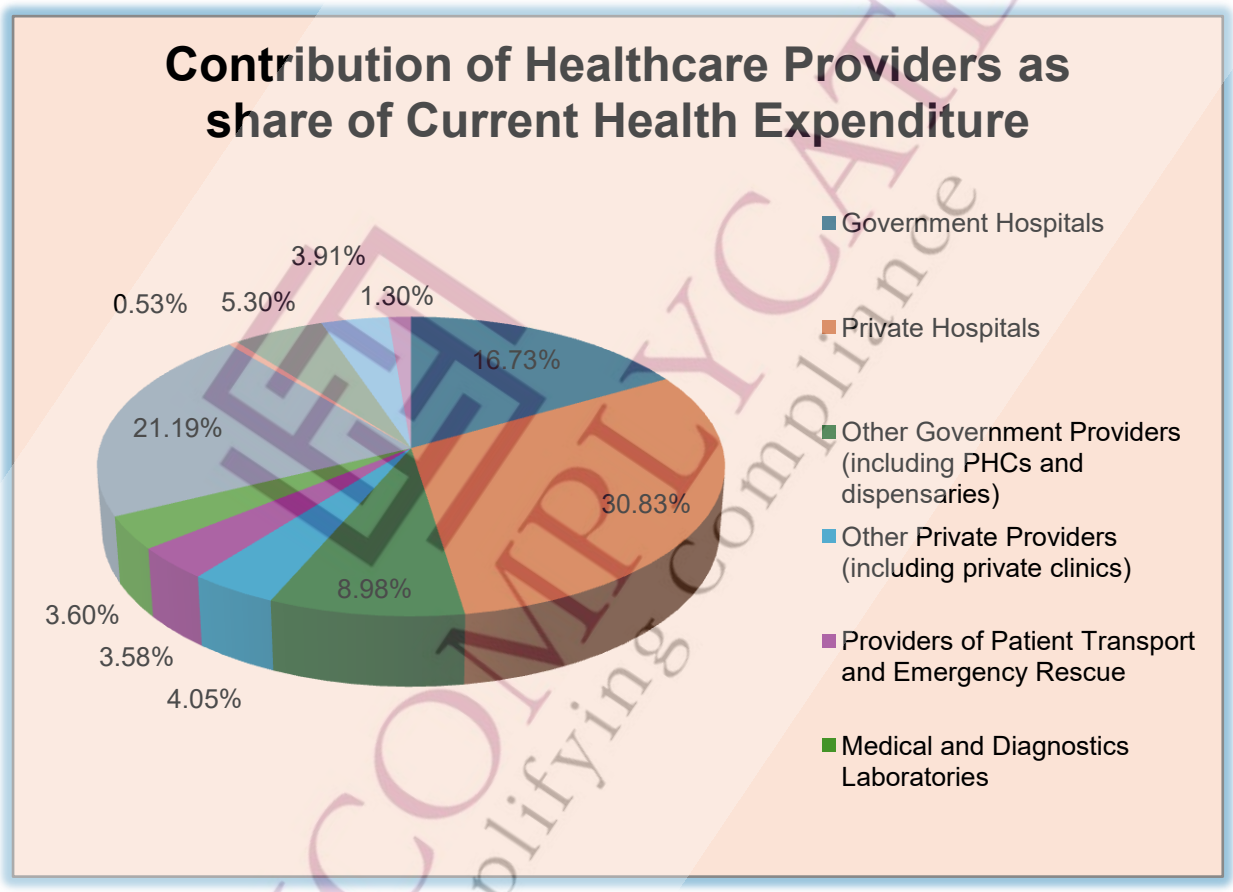
2.2.7 By healthcare provider, Government Hospitals accounted for ₹1,28,298 crore (16.73 per cent of CHE) and Private Hospitals for ₹2,36,410 crore (30.83 per cent of CHE). Other Government Providers, including Primary Health Centres, dispensaries and family planning centres, accounted for ₹68,833 crore (8.98 per cent), while Other Private Providers, including private clinics, accounted for ₹31,067 crore (4.05 per cent). Expenditure on patient transport and emergency rescue services was ₹27,440 crore (3.58 per cent), medical and diagnostic laboratories ₹27,578 crore (3.60 per cent), pharmacies ₹1,62,511 crore (21.19 per cent), and preventive care providers ₹40,622 crore (5.30 per cent). Expenditure on health system administration and financing amounted to ₹30,048 crore (3.91 per cent of CHE).



2.2.8 Pharmaceutical Expenditures includes spending on prescription medicines during a health system contact and self-medication (often referred to as over the-counter products) and the expenditure on pharmaceuticals as part of inpatient and outpatient care from prescribing physicians. Pharmaceutical Expenditures as a percent of CHE indicates the share of pharmaceutical expenditures in the current health Expenditure.Notably, Total Pharmaceutical Expenditure constituted 29.64 per cent of CHE, covering prescribed medicines, over-the-counter drugs, and medicines provided during inpatient and outpatient care. Expenditure on Traditional, Complementary and Alternative Medicine (TCAM) accounted for 3.52 per cent of CHE.

2.2.9 The Committee is of the view that despite the recent reduction in Out-of-Pocket Expenditure (OOPE) over the past decade, the current Government Health Expenditure (GHE) of 1.43 per cent of GDP remains inadequate to ensure universal financial protection. The Committee believes that persisting below the 2.5 per cent of GDP target envisaged in the National Health Policy, 2017, severely hinders the mitigation of catastrophic health expenditures and medical impoverishment. 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 to progressively reduce the populace's disproportionate reliance on costly private healthcare financing.

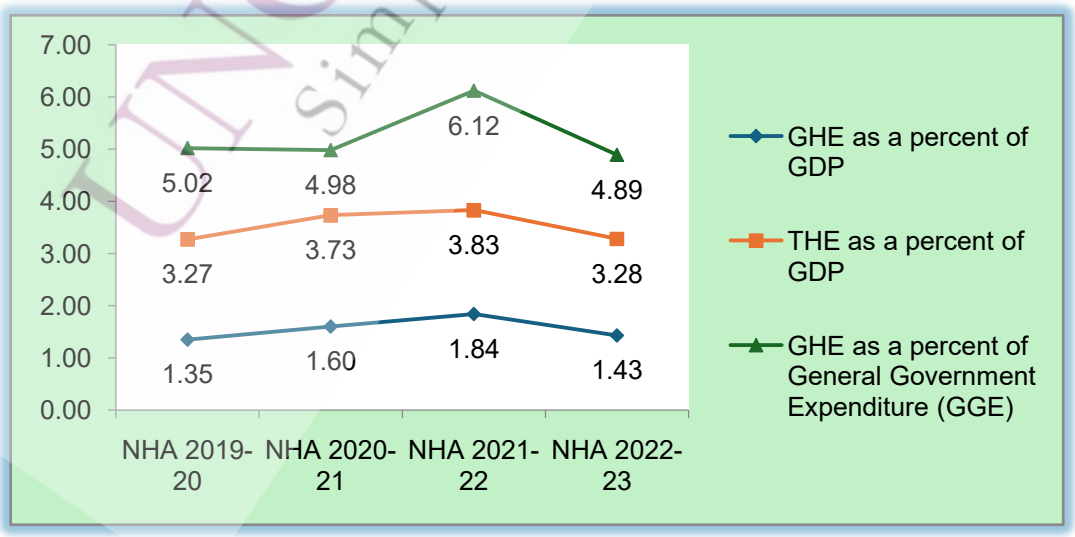
2.2.10 The Committee believes that the heavy reliance on the private sector, which currently delivers nearly 60 per cent of hospitalisations and 70 per cent of outpatient services, creates an environment where unregulated costs for diagnostics, consumables, medicines, and intensive care persistently push vulnerable households into indebtedness. The Committee further notes that outpatient treatment, being predominantly composed of consultation and medicine costs, remains the segment least protected by existing insurance architecture, which is overwhelmingly weighted towards hospitalization. Consequently, the Committee is of the view that 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.

2.2.11 The Committee is of the view that a stark paradox exists wherein India, globally recognized as the 'pharmacy of the world' for its robust generic pharmaceutical industry, still leaves its citizens to bear massive financial burdens for medicines. The Committee notes with concern that Total Pharmaceutical Expenditure constitutes nearly 30 per cent of Current Health Expenditure, with pharmacies alone accounting for over 21 per cent of CHE by provider, making medicines the single largest identifiable component of the nation's healthcare spending. The Committee is of the view that since such pharmaceutical expenditure is disproportionately financed directly by households rather than through insurance or government schemes, thereby constituting one of the foremost structural drivers of India's persistently high OOPE. The Committee believes such compulsion of patient is a major driver of impoverishment, particularly for households managing chronic illnesses. The Committee, therefore, recommends the Government to aggressively expand and strictly monitor initiatives ensuring the uninterrupted provision of free essential medicines across all tiers of public health facilities. Additionally, the Government must consider to enforce more rigorous price controls on life-saving drugs and over-the-counter medicines in the open market to shield consumers from exploitative pricing, and must actively work to bring pharmaceutical expenditure within the ambit of prepaid and insured health financing rather than leaving it as a direct household cost.

2.2.12 The Committee finds that the prolonged, recurring nature of treatments for non-communicable diseases (NCDs) consistently drives low-income families into catastrophic health expenditure, effectively neutralizing broader systemic gains in financial protection. The Committee believes that such chronic care is inherently medicine-intensive, requiring sustained and often lifelong pharmaceutical therapy, and that this recurring medicine expenditure, being largely excluded from episodic hospitalization-

based insurance coverage, is a principal reason why OOPE remains elevated among NCD-afflicted households, given their limited inclusion under existing public financing and insurance mechanisms, translates directly into household out-of-pocket payments. The Committee, therefore, 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. These safety nets must guarantee lifelong, heavily subsidized access to required diagnostics, therapeutics, essential medicines, and medical consultations for patients suffering from long-term ailments.

Key Health Financing Indicators for India-National Health Accounts Estimates					
Sl. No.	**Indicator**	**NHA 2019-20**	**NHA 2020-21**	**NHA 2021-22**	**NHA 2022-23**
1	GHE as a percent of GDP	1.35	1.60	1.84	1.43
2	THE as a percent of GDP	3.27	3.73	3.83	3.28
3	GHE as a percent of THE	41.40	42.80	48.00	43.72
4	GHE as a percent of General Government Expenditure (GGE)	5.02	4.98	6.12	4.89
5	Current Health Expenditure as a percent of THE	90.50	89.70	87.30	87.00
6	Capital Health Expenditure as a percent of THE	9.50	10.30	12.70	13.00
7	Household Health Expenditure (incl. insurance contributions) as a percent of THE	53.60	51.20	44.10	49.10
8	OOPE as a percent of THE	47.10	44.40	39.40	43.40
9	Pharmaceutical expenditures as a percent of CHE	35.10	29.20	30.80	29.60



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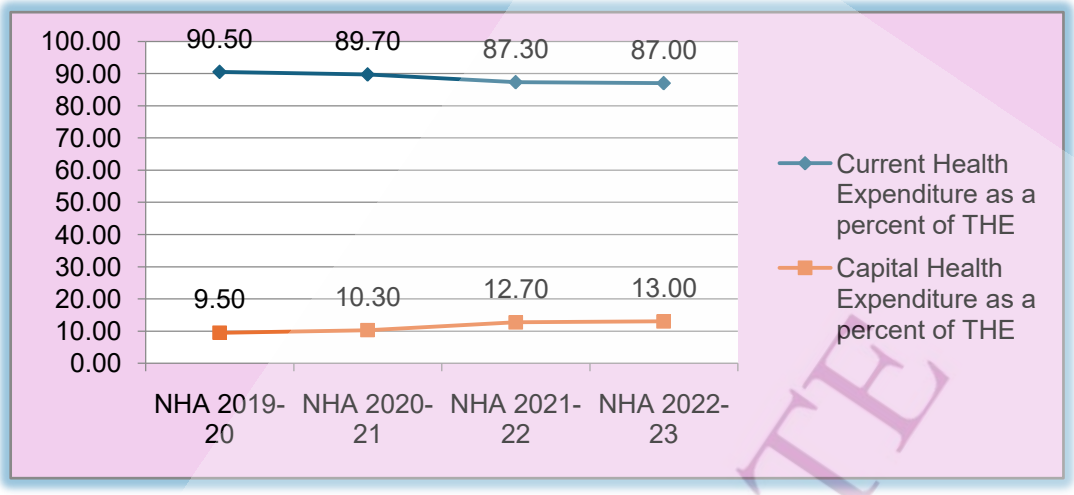

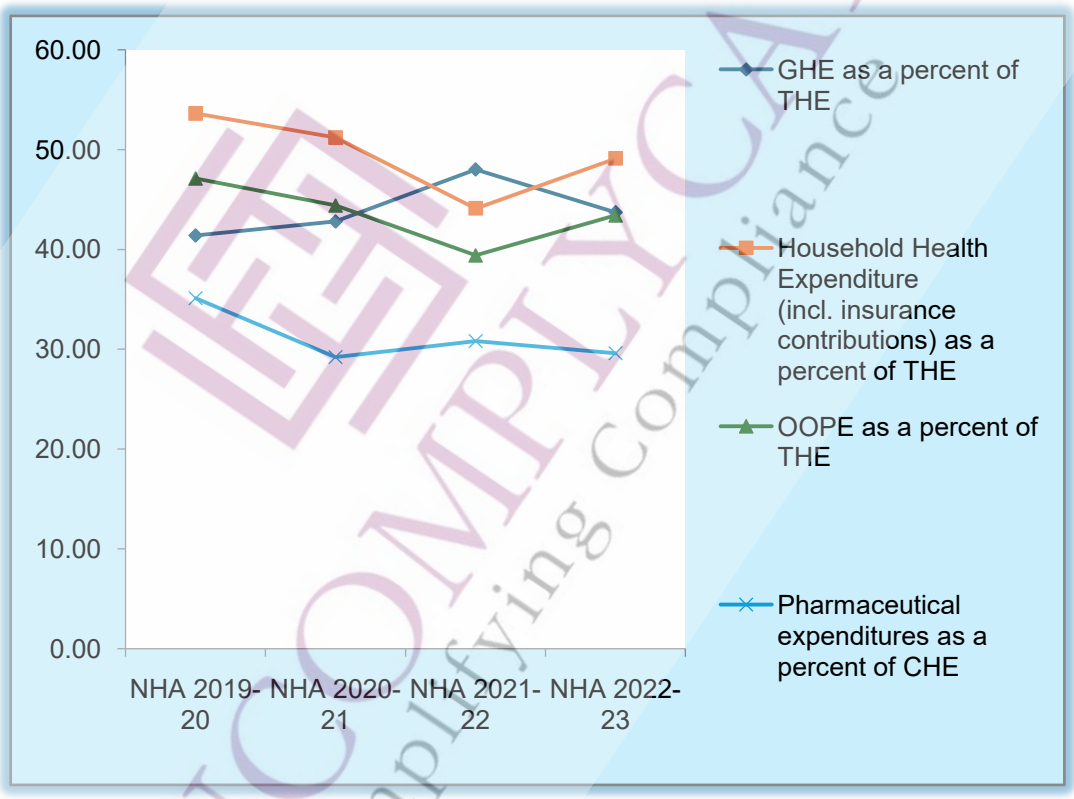

2.2.13 The Committee is of the view that the apparent progress in Government Health Expenditure (GHE), which peaked at 1.84 per cent of GDP in 2021-22, was an anomaly driven by one-off COVID relief and vaccination spending. Relying on this pandemic-year figure created a misleading impression of advancement toward the 2.5 per cent target, a distortion only corrected when the delayed 2022-23 estimates revealed a sharp reversion to 1.43 per cent, perilously close to the pre-pandemic baseline. The Committee believes that the statutory target envisaged under the National Health Policy 2017 must be insulated from emergency fiscal cycles. The Committee, therefore, 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, moving beyond a mere aspirational target, detailing how GHE will move forward from the current levels, *i.e.*, 1.43 per cent, to 2.5 per cent of GDP by a revised goal but with binding timeline. This glide path must be secured by ring-fenced, multi-year budgetary

commitments rather than single-year allocations that are vulnerable to cutbacks, with progress strictly reported to Parliament on an annual basis.

2.2.14 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.

2.2.15 The Committee is of the view that the financial protection gains witnessed during the pandemic were fundamentally non-structural. The reduction of Out-of-Pocket Expenditure (OOPE) to 39.4 per cent of Total Health Expenditure (THE) in 2021-22 was highly dependent on emergency-level public spending crowding out private costs; consequently, OOPE rebounded to 43.4 per cent in 2022-23 as government spending receded. The Household health expenditure, as a percent of THE, followed the same reversing pattern from 44.10 in 2021-22 to 49.10 in 2022-23. The Committee believes that genuine affordability requires shielding citizens from these fluctuating cycles exposing to volatile out-of-pocket costs, particularly in the unorganized private sector. 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.

2.2.16 The Committee takes into account that Capital Health Expenditure is the sole metric demonstrating sustained, consistent improvement, rising steadily from 9.5 per cent to 13.0 per cent of THE, reflecting investment in hospitals, equipment, research and development, and medical education/training. The robust investments in medical education, physical infrastructure, and research and development are the bedrock of long-term healthcare accessibility. 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.

2.2.17 The Committee notes from the National Health Accounts Estimates for India 2022-23 that the National Health Accounts (NHA) Estimates have certain limitations arising from incomplete and insufficiently disaggregated data, particularly in the private sector. Expenditures on dental, long-term and rehabilitative care, as well as spending by universities, autonomous bodies, MPLADS and on import/export of health services, are not fully captured, which may lead to underestimation of actual health expenditure. Further, the evolving nature of India's health financing and insurance schemes does not always align with the System of Health Accounts (SHA) 2011 framework, requiring context-specific adaptations. In addition, expenditure estimates for enterprises and firms in NHA 2022-23 continue to be extrapolated from the 2013-14 survey due to the absence of updated data.

2.2.18 The Committee believes that effective policy formulation is fundamentally compromised by delayed and insufficiently disaggregated data, as evidenced by the delayed release of the 2022-23 NHA estimates in May 2026 and the continued reliance on 2013-14 survey extrapolations for enterprise expenditures. The Committee is of the view that such time lags create misleading fiscal impressions regarding the true state of healthcare affordability. Furthermore, the Committee finds that the current methodology (National Health Accounting & Practice) fails to adequately capture private-sector, dental, and rehabilitative care spending. 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 to automate healthcare data collection. Such technological overhauling must ensure that NHA estimates are published by the final quarter of the subsequent financial year. Furthermore, comprehensive, updated surveys must be commissioned to accurately capture expenditures in the private sector, dental care, rehabilitative care, and by autonomous bodies.

Insurance Penetration and Financial Protection

2.2.19 Insurance coverage and financial protection have emerged as critical determinants of healthcare affordability and progress towards Universal Health Coverage (UHC) in India. The Committee noted that, notwithstanding significant improvements in public health insurance coverage over the past decade, high out-of-pocket expenditure (OOPE) continues to impose a substantial financial burden on households, often resulting in catastrophic health expenditure and pushing families into poverty.

2.2.20 The Committee was informed that the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), one of the world's largest government-funded health assurance schemes, provides an annual health cover of ₹5 lakh per family for secondary and tertiary hospitalisation. Initially designed to cover 10.74 crore poor and vulnerable families, representing the bottom 40 per cent of the population, the scheme was expanded to cover 12 crore families in 2022 in response to population growth and emerging social needs. A significant step towards gender equity was the decision to extend coverage to more than 37 lakh Accredited Social Health Activists (ASHAs), Anganwadi Workers and Anganwadi Helpers and their families, a workforce predominantly comprising women. The Committee

noted with satisfaction that women account for nearly 49 per cent of Ayushman Card creation and utilisation under the scheme.

2.2.21 In a major stride towards universal health coverage, the Union Government has further extended AB-PMJAY to all senior citizens aged 70 years and above, irrespective of income or socio-economic status. This expansion is expected to benefit approximately 4.5 crore families and nearly six crore elderly persons. More than 42 crore Ayushman Cards and over 86 lakh Ayushman Vay Vandana Cards have already been issued, while nearly 30,000 public and private hospitals have been empanelled under the scheme.

2.2.22 According to the National Family Health Survey (NFHS-5), health insurance coverage in the country increased to around 41 per cent in 2021, reflecting significant progress in financial protection. Further, the report titled *Health Insurance for India's Missing Middle* published by the NITI Aayog estimated that nearly 70 per cent of India's population is covered under various health insurance arrangements, including PM-JAY, State-sponsored schemes, social health insurance programmes such as the Central Government Health Scheme (CGHS) and the Employees' State Insurance Scheme (ESIS), and private health insurance products.Despite this progress, nearly 30 per cent of the population, estimated at over 40 crore individuals, continues to remain outside the ambit of financial protection. This segment, commonly referred to as the "missing middle", comprises households that are not poor enough to qualify for Government-funded insurance schemes but are unable to afford existing private insurance products. The Committee observes that this group largely consists of workers in the informal sector, self-employed individuals and households with unstable incomes and limited social security benefits.

2.2.23 The "missing middle" is not a homogeneous category but comprises multiple socio-economic groups spread across both rural and urban areas and across different expenditure quintiles. A substantial proportion of this population possesses the capacity to pay modest insurance premiums; however, the current health insurance market offers limited products that are affordable and tailored to their specific needs. The Committee feels that most private voluntary health insurance products are designed for higher-income groups and remain beyond the affordability threshold of the missing middle. It was suggested that the development of a low-cost, appropriately designed and contributory insurance product, including outpatient benefits, could significantly accelerate India's progress towards Universal Health Coverage while expanding the market for voluntary health insurance.

2.2.24 Several challenges continue to constrain the expansion of health insurance coverage in the country. These include low awareness regarding health insurance, difficulties in identifying and reaching the missing middle population, high distribution costs and the absence of sufficiently large risk pools necessary to keep premiums affordable and prevent adverse selection. The Committee is of the view that expanding insurance coverage to middle class segment would require concerted efforts by both the Government and the private sector, including the development of affordable and standardised insurance products, simplification of enrolment and claim procedures and innovative mechanisms to increase insurance penetration among informal-sector workers and self-employed households.

2.2.25 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.

2.2.26 The Committee is of the view that the "missing middle", constituting over 40 crore individuals or 30% of the population, presents a unique challenge, as they possess the financial capacity to pay nominal premiums but remain excluded by both fully subsidized government schemes and prohibitively expensive private products. The Committee believes that relying solely on existing frameworks will not suffice for this demographic, which predominantly comprises informal sector and self-employed workers. The Committee, therefore, recommends the introduction of a well-designed, voluntary, and contributory insurance model through a collaborative effort between the Government and the private sector. Specifically, the Committee recommends developing a modified, highly standardized product building upon the Aarogya Sanjeevani plan, structurally priced between Rs. 4,000 to Rs. 6,000 per family annually. To ensure widespread uptake, this product must strictly minimize waiting periods for disease coverage and explicitly include out-patient (OPD) benefits.

2.2.27 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.

2.2.28 During its deliberations, the Committee invited views and suggestions from stakeholders and the general public regarding health assurance initiatives. Stakeholders broadly emphasised that all health assurance initiatives should align with the Government's broader vision of Universal Health Coverage under Ayushman Bharat and should be guided by evidence-based policies to ensure equitable access to healthcare. Suggestions were received for universalisation of PM-JAY, expansion of coverage to the urban poor, gig and informal workers, women and vulnerable occupational groups and provision of free healthcare for all senior citizens.

2.2.29 Several stakeholders, on opinion being invited, suggested expanding insurance coverage beyond hospitalisation to include outpatient consultations, diagnostics, infertility treatment, rehabilitation services, long-term care, assistive devices, hearing aids, mental health services, non-communicable diseases, AYUSH services and key imaging diagnostics. Suggestions were also received for increasing the availability of private hospital beds under AB-PMJAY, encouraging greater participation of small and medium hospitals by reducing compliance burdens and ensuring that PM-JAY does not divert critical resources from

primary and secondary healthcare services.Concerns were also expressed regarding delays in payments to hospitals, restrictive package rates, differential pricing practices, selective acceptance of treatment packages by hospitals and the need for greater transparency in empanelment and de-empanelment processes. Stakeholders further advocated standardised reimbursement mechanisms, regular consultations with medical associations and healthcare providers, prevention of insurance fraud and malpractice and the establishment of a unified digital platform integrating insurers, TPAs, hospitals, banks and regulators.

2.2.30 The Committee was informed that AB-PMJAY seeks to address concerns relating to affordability and arbitrary pricing through a system of fixed and bundled package rates covering 1,961 treatment packages across 27 specialties. The Health Benefit Package has been substantially expanded from 1,393 to 1,961 packages, with the addition of 365 new procedures and upward revision of rates for 832 packages. The package rates cover diagnostics, medicines, surgeries, hospitalisation, intensive care and complications, thereby ensuring cashless treatment without out-of-pocket expenditure for eligible beneficiaries. Differential pricing has also been introduced to account for regional cost variations, and States have been provided flexibility to customise package rates and include State-specific procedures.

2.2.31 The Committee was further informed that the scheme presently covers major non-communicable diseases, including cancer, diabetes, hypertension, cardiovascular diseases and stroke, and also provides coverage for mental health conditions through 22 defined procedures, including treatment for schizophrenia, autism spectrum disorders and substance use disorders.The Ministry informed the Committee that the National Health Authority has established a transparent and paperless hospital empanelment framework based on infrastructure and equipment standards, availability of specialist and nursing staff, service quality benchmarks and compliance with State regulations and the Clinical Establishments Act, 2010. Fast-track empanelment has been introduced for accredited hospitals, while mechanisms for de-empanelment of non-compliant facilities have also been instituted.

2.2.32 The Ayushman Bharat Digital Mission (ABDM) and the National Health Claims Exchange (NHCX) are being developed as a unified digital health ecosystem integrating insurers, TPAs, hospitals, regulators, banks and beneficiaries to facilitate real-time and standardised claims processing, improve efficiency and reduce fraud. The Committee was also informed that AB-PMJAY is supported by a centralised digital claims management system, a three-tier grievance redressal mechanism and an AI-driven anti-fraud framework based on prevention, detection and deterrence. State Health Agencies retain the authority to review and overturn unjustified claim rejections, and periodic audits of rejected claims are undertaken to ensure fairness and accountability.

2.2.33 The Committee further notes that achieving Universal Health Coverage would require a balanced public-private partnership model. While public hospitals provide foundational infrastructure and ensure access in underserved regions, private hospitals contribute specialist expertise, advanced technologies and expanded geographical reach. Greater participation of private hospitals under AB-PMJAY is therefore essential for improving accessibility, reducing waiting times and extending quality healthcare to Tier-II and Tier-III cities.

2.2.34 With regard to the Central Government Health Scheme (CGHS), the Committee was informed that package rates have recently been revised scientifically, taking into account all

treatment-related costs, including surgeon fees, anaesthesia, operation theatre charges, room rent, medicines and consumables. The new empanelment cycle will permit inclusion of State Government hospitals and will be accompanied by regular audits, city-level anti-fraud cells and empanelment disciplinary committees. The Ministry also stated that alternative mechanisms for delivery of medicines to senior citizens are being explored in light of the challenges encountered during the pilot project undertaken in Delhi.

2.2.35 The Committee is of the considered view that, while India has made significant progress in expanding health insurance coverage and reducing out-of-pocket expenditure through initiatives such as AB-PMJAY, increased public investment and affordable medicines programmes, however, substantial gaps in financial protection persist. The continued burden of expenditure on medicines, diagnostics and outpatient care, inadequate insurance penetration among informal-sector workers and the "missing middle", and concerns relating to claim management and private healthcare costs underscore the need for sustained policy interventions. 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.

2.2.36 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. The Committee, therefore, recommends an evidence-based expansion of Health Benefit Packages (HBP) under public Insurance schemes to formally encompass comprehensive OPD services, psychiatric disorders, chronic non-communicable disease (NCD) management, and rehabilitation, thereby preventing the systemic diversion of patients to costlier private care avenues.

2.2.37 The Committee emphasizes that the current private insurance market is heavily skewed toward high-income groups, with unacceptably low penetration in rural and informal sectors, and a rigid focus on inpatient care. Furthermore, widespread inefficiencies, such as slow claim settlements and selective denial of services, severely undermine public trust. The Committee believes that arbitrary pricing and claim manipulation by insurers or empanelled hospitals must be met with stringent regulatory penalties. The Committee, therefore, recommends the mandatory integration of all stakeholders-insurers, TPAs, and healthcare providers-into the National Health Claims Exchange (NHCX) to guarantee real-time, transparent claims processing. Furthermore, the Committee recommends that the National Anti-Fraud Unit (NAFU) continuously leverage AI-driven triggers to heavily penalize deliberate delays and ensure that all private insurance products align with the broader vision of Universal Health Coverage.

2.2.38 The Committee is of the view that the foundation of affordable healthcare relies on fully functional public infrastructure and the strict regulation of pharmaceutical costs. The Committee believes that the exorbitant OOPE driven by branded medicines, pharmacy malpractices, and irrational antibiotic use requires aggressive, sustained intervention. The Committee, therefore, recommends the immediate execution of a national audit utilizing the Drugs and Vaccines Distribution & Management System (DVDMS) to assess the availability of National List of Essential Medicines (NLEM) drugs and the user costs of diagnostics at all central institutes. Concurrently, the Committee recommends that State Health Agencies utilize the Indian Public Health Standards (IPHS) 2022 web-based dashboard to ensure 100% of healthcare facilities comply with essential service delivery benchmarks, while strictly monitoring the mandate for generic prescribing across all clinical establishments. The Committee recommends that the Governemnt should make provision for upgrading and strengthening infrastructure to meet IPHS standards, maintenance, ensure availability of medicines at these centres, strengthen the diagnostic servies wherever required through PPP mode also, promote universal annual health check-ups, strengthen the AYUSH based arms, ARogya Mandirs.

2.2.39 The Committee is of the view that while there is a pressing need to equip Health and Wellness Centres (HWCs), Community Health Centres (CHCs), and district hospitals in tribal and rural areas with advance affordable medical equipment. 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 the uninterrupted supply of safe, novel, and affordable indigenous medical technology to all tier-2 and tier-3 public health facilities all across the country.

2.2.40 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. Furthermore, the Committee believes that the unregulated, over-the-counter sale of antibiotics driven by these profit motives accelerates the critical threat of Antimicrobial Resistance (AMR). The Committee, therefore, recommends the deployment of strict, multi-sectoral audits targeting retail pharmacy supply chains to cap unjustified trade margins and penalize fake billing practices. Concurrently, 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.

2.2.41 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. The Committee, therefore, recommends the rigorous, coordinated enforcement of Food Safety and Standards Authority of India (FSSAI) notifications that prohibit the use of 19 specified antibiotics across all stages of meat, poultry, and seafood processing. Furthermore, the Committee recommends strict

national audits to ensure total compliance with Rule 97 of the Drugs and Cosmetics Rules, 1945, which mandates explicit labeling of withdrawal periods for drugs administered to food-producing animals. In addition to regulating pharmaceutical contents, the Committee believes that the physical integrity of medicines is equally vital. The Committee, therefore, recommends that the Central Drugs Standard Control Organisation (CDSCO) strictly enforce statutory standards for primary packaging, specifically promoting and regulating the use of glass bottle containers to ensure the chemical stability and safety of dispensed drugs.

2.2.42 The Committee is of the view that the reported 33% gap in AB-PMJAY fund utilization highlights systemic bottlenecks that restrict the scheme's potential to deliver Universal Health Coverage. Furthermore, the Committee believes that constrained public health expenditure inevitably diverts approximately two-thirds of individuals to seek treatment in the private sector. The Committee, therefore, recommends the Government to grant greater budget flexibility to State Health Agencies, enabling them to adapt benefit packages to localized epidemiological needs and accelerate fund deployment. Concurrently, 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 mandated by the Clinical Establishments Act, 2010.

2.2.43 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 and IT platform to address all the issues. The Committee specifically recommends provision for simultaneous application of multiple packages in emergency and multi-speciality cases, introduction of appropriate package codes for critically ill ICU patients requiring surgical intervention, bilateral procedures and patients with concurrent medical and surgical conditions. The Committee also recommends that annual utilization limits for high-cost investigations such as MRI and CT scans be displayed transparently on the portal and that the pending implementation of the 2022 package revisions across all States and Union Territories be expedited to ensure uniformity in reimbursement and service delivery.

2.2.44 The Committee highlights the need for strengthening the AB-PMJAY portal by enhancing file attachment capacity for complex cases, establishing a robust query management system with real-time tracking and detailed reasons for claim rejections, and designating nodal officers for addressing inter-State and out-of-State beneficiary-related issues. Considering the increasing burden of outstanding payments and delays in claim settlements, the Committee urges the Government to institute a time-bound mechanism for claim processing and reimbursement to safeguard the financial sustainability of empanelled hospitals. The Committee believes that greater transparency through real-time display of package eligibility, utilization limits, claim

status and query resolution would significantly improve administrative efficiency, reduce disputes and further strengthen the effective implementation and inclusiveness of the Scheme.

2.2.45 The Committee believes that while the Employees' State Insurance Corporation (ESIC) remains a cornerstone of India's social security framework, the rapid proliferation of the gig economy and informal labor necessitates an immediate, comprehensive modernization. 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. To rectify these structural deficits and transition toward a technology-driven, patient-centric ecosystem, the Committee, therefore, recommends the immediate execution of strategic administrative and digital reforms to restore stakeholder trust and reduce out-of-pocket expenditures.

2.2.46 The Committee, further, recommends the phased inclusion of unorganized and platform workers via national databases like e-Shram, supported by flexible contribution structures. Furthermore, the Committee is of the view that the Corporation must implement an end-to-end digital architecture for automated, time-bound claim processing, establish interoperable electronic health records with AI-driven fraud detection, and mandate market-aligned treatment package rates to incentivize premier private healthcare providers. Through enhanced administrative autonomy, robust multilingual grievance redressal, and total transparency in performance metrics, these interventions will decisively align the Corporation with India's universal health coverage objectives.

2.3 GEOGRAPHICAL DISTRIBUTION OF FACILITIES AND REGIONAL DISPARITIES

2.3.1 The Committee observes that equitable geographical distribution of healthcare facilities is a critical determinant of healthcare accessibility. Despite the expansion of the public healthcare network, significant regional disparities continue to persist in the availability of healthcare infrastructure, specialist services and emergency care. Rural, tribal, hilly and remote areas continue to face shortages of healthcare institutions, qualified medical professionals, diagnostic facilities and referral services, thereby limiting timely access to quality healthcare.

2.3.2 The Committee also invited views and suggestions from stakeholders and the general public on regional healthcare needs, and the representations received were forwarded to the Ministry of Health for examination and their comments. These observations were noted: (i) Adequate healthcare system for Urban Slum and migratory population; (ii) Incentives to private sector to establish tertiary care hospitals in deficit regions such as Providing low interest loans for hospitals setting up in Tier2/3 cities; (iii) Reduce Disparities of hospital beds between urban and rural areas and regional disparities; (iv) Health care facilities as per local requirements; (v) Increase medical college seats and train professionals for rural areas to address shortages; (vi) Regional disparity may be taken care of in public health care strengthening; (vii) Provisioning for tribal and remote areas through geographically sensitive planning, including mobile health units and community outreach; (viii) Improve the

infrastructure in rural areas to reduce disproportionate patient and doctors ratio; (ix) Prioritize government hospitals in urban areas to counter corporate monopolies; (x) Bridge Rural–Urban Divide in Healthcare Infrastructure; and (xi) Managing overcrowding of Urban Health facilities by proving adequate infrastructure in rural healthcare system.

2.3.3 The Ministry of Health and Family Welfare, in its submission, stated that PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) is a Centrally Sponsored Scheme (CSS) with some Central Sector Components (CS) which has an outlay of Rs. 64,180 Crores for the scheme period (2021-22 to 2025-26). The mission has two components: Central Sector Components which aim to strengthen public health response capacity for any health emergency, and Centrally Sponsored Components which focus on augmenting the existing systems at the subnational level. Activities under the CS Component include strengthening surveillance of infectious diseases and outbreak response under NCDC, strengthening surveillance capacity of Points of Entry, strengthening disaster and epidemic preparedness including establishment of Health Emergency Operation Centres (HEOCs) and procurement of BHISHM Cubes, and biosecurity preparedness and strengthening pandemic research. Under the CSS components, support is provisioned to States/UTs for construction of 17,788 building-less Sub-Centres as Ayushman Arogya Mandirs, establishment of 11,024 Urban Ayushman Arogya Mandirs, establishment of 3,382 Block Public Health Units, establishment of 730 District Integrated Public Health Labs, and establishing 602 Critical Care Hospital Blocks in districts with population more than 5 lakhs.

2.3.4 With regard to prioritizing government hospitals in urban areas, the Ministry stated that the National Urban Health Mission (NUHM) aims to provide equitable and quality primary health care services to the urban population with special focus on the slum and vulnerable population. Urban Primary Health Centres (U-PHCs) are established for an approximate population of 30,000 to 50,000, preferably located near slum clusters. Urban Community Health Centres (U-CHCs) are set up for every 2.5 lakh population in non-metro cities and for every 5 lakh population in metro cities, functioning as 30–50 bedded secondary-level facilities. Urban Sub-Health Centres (USHCs) serve populations of 15,000–20,000, and Polyclinics serve populations of 2.5 to 5 lakh in urban areas to further strengthen specialist and diagnostic services. As of 30th September 2025, a total of 7,998 USHCs, 5,401 UPHCs, 1,373 Polyclinics, and 240 UCHCs are operational in urban areas.

2.3.5 To bridge the rural-urban divide in healthcare infrastructure, the National Health Mission (NHM) serves as India's flagship initiative addressing regional disparities through both the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). NHM targets "high focus" and "aspirational" districts with extra financial and technical support for infrastructure, maternal and child health, communicable diseases, and human resource augmentation. As of April 2025, NHM has filled nearly 5.23 lakh health human resource gaps, deploying doctors, nurses, ANMs, and allied health professionals, especially in under-served states and tribal regions. More than 1.80 lakh Ayushman Arogya Mandirs (AAMs) have been operationalized throughout the country. There has been a significant increase in Medical Colleges from 387 to 818, UG seats from 51,348 to 1,28,875 and PG seats from 31,185 to 82,059 from 2014 to the present date, contributing to the long-term strengthening of healthcare infrastructure and human resources across the country.

2.3.6 The Committee notes that many Sub-Health Centres (SHCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) continue to function with inadequate infrastructure and vacant specialist positions. Long travel distances, poor transport connectivity and delays in accessing secondary and tertiary healthcare facilities further increase the financial and physical burden on patients, particularly in remote and aspirational districts.India's healthcare system continues to exhibit a pronounced urban-rural asymmetry. According to the National Health Profile, Urban areas account for highly skewed majority of all hospital beds, although only about one-third of India's population resides there. Rural populations continue to remain largely dependent on under-resourced public health facilities and face shortages of specialist, diagnostic services and emergency care.

2.3.7 The Ministry informed the Committee that several initiatives are being implemented to strengthen healthcare infrastructure in underserved regions. Under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), with an outlay of ₹64,180 crore for the period 2021-22 to 2025-26, investments are being made across the continuum of care through Ayushman Arogya Mandirs, Block Public Health Units, Integrated Public Health Laboratories and Critical Care Hospital Blocks. Administrative approvals amounting to ₹33,081.82 crore have been accorded for strengthening over 10,600 Ayushman Arogya Mandirs, 5,456 Urban Ayushman Arogya Mandirs, 2,151 Block Public Health Units, 744 Integrated Public Health Laboratories and 621 Critical Care Hospital Blocks. The Ministry further highlighted the role of the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) in reducing regional imbalances in tertiary healthcare through the establishment of 22 new AIIMS, of which 18 are functional, and the upgradation of 75 Government Medical Colleges, with 71 projects already completed.

2.3.8 The National Health Mission (NHM) has also significantly expanded the network of public healthcare facilities across the country. As per Health Dynamics of India 2022-23, the number of PHCs increased from 25,308 to 31,882 and CHCs from 5,396 to 6,359 since 2014-15. Population norms for establishing health facilities have been relaxed in tribal, hilly and difficult areas, and more than 1.80 lakh Ayushman Arogya Mandirs have been operationalised to provide comprehensive primary healthcare closer to communities. The Ministry further informed that nearly 5.23 lakh health personnel have been deployed in underserved regions. Recognising the healthcare needs of rapidly urbanising areas, the National Urban Health Mission (NUHM) focuses on providing equitable healthcare services to urban populations, particularly slum dwellers and other vulnerable groups. As of September 2025, there were 7,998 Urban Sub-Health Centres, 5,401 Urban Primary Health Centres, 1,373 Polyclinics and 240 Urban Community Health Centres operational across the country. Emergency transport and outreach services also play an important role in improving accessibility, particularly in remote regions. National Ambulance Services, operational in 34 States and Union Territories through toll-free numbers 108 and 102, provide free emergency and patient transport through Basic Life Support and Advanced Life Support ambulances. In addition, 1,573 Mobile Medical Units have been deployed in remote and tribal areas, including under the PM-JANMAN initiative, thereby reducing travel time, out-of-pocket expenditure and delays in accessing healthcare.

2.3.9 The Committee is of the view that the Government should first and foremost define the criteria of functional arm of Ayushman Bharat i.e Arogya Mandir. The Government needs to come out with technical specification in terms of infrastructure,

HR, availability of supplies and the level of services etc. to ensure uniform understanding and implementation across State services. Need is to ensure implementation of all 12 service packages and strengthen under served services viz. Mental Health, Senior, palliative, dental and ophthtalmic care in all Arogya Mandirs. The Government should fill up critical vacancies, introduce incentives and career path, especially for CHOs and strengthen competency base training. There is further need to enhance community engagement by expanding localized IEC comapigns and strengthn participation of Panchaats, Jan Arogya Samiti (JAS), Mahila Arogya Samiti (MAS) and frontline workers to improve service uptake. The Committee further recommends the Government to ensure availability of reliable ABDM compliant IT infrasturctuve and use of Ayushman Bharat Health Account (ABHA) and Electonic Health Record (HER) for continuum of care and referrals. Moreover, there is need to Digitize Community-base Assessment Checklist (CBAC), integrate with ABHA and NCD portals, and build frontling worker capacity for effective screening and follow-up and integrate Ayush services.

DIGITAL HEALTHCARE INITIATIVE

2.3.10 Digital health initiatives have emerged as important instruments for overcoming geographical barriers in healthcare delivery. The stakeholders and the general public forwarded the pivotal observations on Digital Health Services that inter-alia include (i) To make healthcare more patient centric through Innovation and Technology; (ii) Streamlined Electronic Health Records (EHR); (iii) Ensure digital health adoption/integration in over 90% of healthcare facilities within 10 years; (iv) Leveraging AI and Subscription Models in ultrasound for eradicating Sex Determination Fear; (v) Promotion of Digital health services and training of people to use them; (vi) Providing trained and experienced NCD caregivers at primary health centres by promoting telemedicine, teleconsultation (Hub & Spoke Model) and digital prescriptions; (vii) Strengthened Ayushman Bharat by Leveraging AI; (viii) Encourage Innovation for low cost healthcare; (ix) Digital Query System for Doctors; (x) Use of teleconsultation in referral system; (xi) Addressing the Accessibility gap in telemedicine through hub & spoke model; (xii) Financial Surveillance via AI like tools; (xiii) Capacity building in Digital Health; (xiv) Implement AI-enabled National Digital Health Ecosystem with National Health Software and AI-enabled National Health Fund for accessibility, affordability and fostering ethical practices in healthcare; (xv) Improve adoption of ABHA digital health IDs, to support portability and reduce inefficiencies; (xvi) Multiple Individual Associated Specialties Artificial Intelligence, Aerospace, Avionics, Military, Automobile, Railway, Marine and Medical sciences; (xvii) Cashback-Enabled Digital Health services to be opted by Doctors; and (xviii) Promoting and expanding Digital health services and telemedicine, Capacity building in Digital Health and Develop the framework for telemedicine.

2.3.11 The Ministry of Health and Family Welfare, in its submission, stated that it has embraced digital health as a transformative tool to improve accessibility, quality, and equity in healthcare service delivery across India. Leveraging Information and Communication Technology (ICT), these initiatives aim to create a seamless, interoperable, and citizen-centric digital health ecosystem under the vision of Universal Health Coverage (UHC). As of November 2025, over 82.84 crore ABHA IDs had been created, 4.33 lakh health facilities and

7.27 lakh healthcare professionals had been registered, and nearly 77 crore health records had been linked under ABDM. More than 2.20 lakh health facilities are using ABDM-enabled software, while the Scan and Share service is operational in over 24,000 health facilities across 714 districts. States such as Uttar Pradesh, Rajasthan, Maharashtra, Madhya Pradesh, and Gujarat lead in ABHA adoption. To facilitate seamless adoption, NHA operates a 24×7×365 multilingual support service through Toll-Free Helpline 14477 or 1800-11-4477 for healthcare professionals and other ecosystem participants, ensuring timely, accurate, and language-appropriate support for both technical integration and operational queries.

2.3.12 The Ministry further stated that ABDM promotes innovation through open APIs and sandbox environments, enabling startups and technology partners to develop affordable digital health solutions. Capacity-building initiatives, multilingual support services, user-friendly interfaces, awareness activities, community outreach, and training programmes for doctors, nurses, frontline workers, and citizens have helped improve understanding of digital health services and informed consent for data sharing. ABDM's open network approach lowers entry costs for innovators, allowing them to build applications serving both urban and rural populations at scale. The Ministry also highlighted the progress of the U-WIN portal, which has registered 13.74 crore beneficiaries and recorded over 57.49 crore vaccine doses, and the eSanjeevani platform, which has delivered more than 425 million teleconsultations through 136,058 Ayushman Arogya Mandirs, 18,090+ hubs, and 771 online OPDs supported by over 2.28 lakh doctors, specialists, and health workers, making it one of the world's largest telemedicine services. Extensive training is being conducted for doctors, CHOs, and healthcare workers to strengthen teleconsultation services and enhance last-mile delivery.

Artificial Intelligence

2.3.13 With regard to Artificial Intelligence, the Ministry informed that several AI-based solutions are being developed for disease screening, surveillance, clinical decision support and digital prescriptions. The AI unit of MoHFW, operated by Wadhwani Institute of Artificial Intelligence, is working on image-based AI solutions in collaboration with Centers of Excellence in AI in Healthcare viz. AIIMS-Delhi, AIIMS-Rishikesh and PGIMER Chandigarh, as well as other government institutes such as Central Tuberculosis Division, NHSRC, NCDC and CDAC-Mohali to build AI solutions for early screening, follow-up, disease surveillance, clinical decision support and capacity building of healthcare staff. Clinical Decision Support System (CDSS) in e-Sanjeevani and Media Disease Surveillance Solution in IDSP have been deployed PAN India. Diabetic Retinopathy and Binary Classifier model of Chest X-Ray solution are deployed in AIIMS-Delhi ecosystem and ready for expansion. Dermatology solution and enhancement of Chest X-ray solution are currently being developed, and explorations are underway for Oral Cancer and Alcoholic Hepatitis Solution with PGIMER, Chandigarh. The revamping of the AarogyaSetu application from a contact tracing app to a comprehensive National Health App, integrated with ABDM, and collaboration with the Indian Institute of Technology Kanpur aim to develop advanced AI capabilities, including federated learning platforms, quality-preserving databases, open benchmarking platforms for comparing and validating AI models, and consent-based research frameworks under ABDM. With longitudinal health records accessible through ABDM, AI tools can process records and create meaningful insights, including ambient listening AI solutions that can generate prescriptions from doctor-patient conversations, thereby facilitating change management from manual to digital systems.

2.3.14 ABDM has standardized and streamlined EHR creation by enabling secure, consent-based sharing of interoperable health records across providers, with 2.25 lakh healthcare facilities (1.81 lakh government, ~45,000 private) using ABDM-enabled HMIS solutions, supported by over 140 private HMIS vendors and public systems such as NextGen. The Digital Health Incentive Scheme (DHIS) provides financial incentives to healthcare providers—both hospitals and individual doctors—for performing ABDM-linked digital transactions such as creating and updating digital health records, issuing e-prescriptions, linking records to ABHA IDs, and enabling consent-based data sharing, thereby encouraging wider adoption of digital health practices and improving the quality of electronic health records. Regarding the issues of Multiple Individual Associated Specialties Artificial Intelligence, Aerospace, Avionics, Military, Automobile, Railway, Marine and Medical sciences, the Ministry is required to consult the stakeholders to form its future course of action. The cashback-enabled digital health services suggestion aligns closely with the provisions of DHIS, which functions like a cashback mechanism, rewarding doctors for each verified digital transaction, thereby lowering the cost of adoption and making digital workflows more attractive.

2.3.15 The Committee observes that, notwithstanding the considerable expansion of healthcare infrastructure and digital health services, regional disparities in healthcare accessibility continue to persist across the country. The concentration of specialist services and advanced healthcare facilities in urban areas, coupled with shortages of healthcare personnel and infrastructure in rural and remote regions, continues to constrain equitable access to healthcare. The Committee strongly recommends for posting of post graduate specialists like surgeons, Gynaecologist, Paediatricians, Orthopedicion at CHC levels. The Committee is of the considered view that sustained investment in public healthcare infrastructure, geographically balanced distribution of health facilities and human resources, strengthening of referral and emergency transport systems, expansion of digital health services, incentivizing private sector participation in underserved regions, and targeted interventions for underserved regions are essential for ensuring equitable access to quality healthcare across the country.

2.3.16 The Committee is of the view that while the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), with its outlay of ₹64,180 Crores, has initiated crucial structural corrections, the profound urban-rural asymmetry in healthcare infrastructure requires expedited intervention. The operationalization of 1.80 lakh Ayushman Arogya Mandirs, alongside the targeted establishment of 3,382 Block Public Health Units (BPHUs), 730 District Integrated Public Health Labs (IPHLs), and 602 Critical Care Hospital Blocks (CCBs), provides a robust foundation. Furthermore, the Committee notes the significant expansion under the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), including the establishment of 22 new AIIMS and the upgrading of 75 Government Medical Colleges.The Committee believes that the corresponding surge in medical colleges and the exponential increase in undergraduate and postgraduate seats must be strategically harnessed to correct regional human resource deficits by improving health care access by posting trained past graduate doctors at CHC level. The Committee, therefore, recommends that the Government implement a geographically responsive deployment policy, linking the increased output

of medical professionals directly to mandatory service periods in deficit States, tribal regions, and aspirational districts. Furthermore, infrastructural gaps in the targeted 17,788 building-less Sub-Centres must be prioritized for immediate construction to ensure physical accessibility. The Committee recommends for enchanced facilities for these medical professionals in these areas.

2.3.17 The Committee is of the view that the Ayushman Bharat Digital Mission (ABDM) has fundamentally transformed the accessibility landscape, evidenced by the creation of over 82.84 crore ABHA IDs, the registration of 4.33 lakh health facilities on the Health Facility Registry (HFR), and the linking of 77 crore health records. The monumental success of eSanjeevani, which has delivered over 425 million consultations through a Hub-and-Spoke model across 1.36 lakh Ayushman Arogya Mandirs, proves that digital interventions can effectively bridge geographical divides. The rollout of the U-WIN portal for immunization and the transition of AarogyaSetu into a comprehensive National Health App further solidify this ecosystem.The Committee believes that maintaining the momentum of digital adoption requires continuous incentivization and advanced technological integration. The Committee, therefore, recommends that the Digital Health Incentive Scheme (DHIS) be significantly expanded to function as a robust "cashback" and financial reward mechanism for doctors and hospitals, thereby lowering adoption costs and encouraging the generation of Electronic Health Records (EHR). Additionally, the Committee recommends accelerating the deployment of Artificial Intelligence, leveraging the Clinical Decision Support System (CDSS) and partnerships with institutions like IIT Kanpur and the Wadhwani Institute, to enable early screening, smart diagnostics, and ambient listening tools for seamless prescription generation in both urban and remote settings.

2.3.18 The Committee is of the view that the concentration of advanced healthcare facilities in urban areas paradoxically leaves urban slum and vulnerable populations exposed to prohibitive out-of-pocket expenditures and corporate healthcare monopolies. The interventions under the National Urban Health Mission (NUHM) are critical to addressing such disparity. The operationalization of 7,998 Urban Sub-Health Centres (USHCs), 5,401 Urban Primary Health Centres (U-PHCs), 1,373 Polyclinics, and 240 Urban Community Health Centres (U-CHCs) demonstrates a vital commitment to community-embedded urban healthcare.The Committee believes that to truly ensure affordability for migratory and slum populations, the public urban health infrastructure must be aggressively scaled to outpace the reliance on private providers for primary and secondary care. The Committee, therefore, recommends the rapid scaling of 100-bedded U-CHCs in all metropolitan cities, coupled with specialized funding under the National Health Mission (NHM) to manage overcrowding in urban public hospitals. Simultaneous policy frameworks must be introduced to provide low-interest loans and tax incentives to private sector entities willing to establish tertiary care and diagnostic facilities exclusively in Tier-2 and Tier-3 cities, thereby redirecting private investment away from saturated metropolitan hubs to deficit regions.

2.3.19 The Committee expresses concern to find that regional disparities are acutely exposed during health emergencies, infectious disease outbreaks, and disasters. The establishment of Metropolitan Public Health Surveillance Units (MSUs) and the expansion of the Integrated Health Information Platform (IHIP) across all 36 States and

UTs, achieving over 70% reporting, are commendable milestones in real-time disease surveillance. The deployment of BHISHM (Bharat Health Initiative for Sahyog, Hita, and Maitri) cubes and the establishment of 15 Health Emergency Operation Centres (HEOCs) significantly bolster rapid response capabilities.The Committee believes that proactive biosecurity and epidemic preparedness must be a localized reality rather than a centralized luxury. The Committee, therefore, recommends the expedited completion and operationalization of the five Regional Centres for Disease Control and the National Centre for Disease Control (NCDC) upgrades, particularly the specialized divisions for Antimicrobial Resistance (AMR), One Health, and Climate Change. The Government must ensure that the surveillance networks established at Points of Entry (PoE) and regional laboratories are fully integrated with the ABDM infrastructure to provide immediate, predictive data modeling for localized health interventions.

2.3.20 The Committee is of the view that the burden of healthcare costs disproportionately impacts vulnerable demographic segments. The data explicitly highlights that poorer households, older adults, and individuals with lower education levels incur significantly higher Out-of-Pocket Expenditure (OOPE). Furthermore, women face pronounced barriers to access and suffer from lower insurance claim settlement rates, which fundamentally contradicts the vision of Universal Health Coverage. This inequity is compounded by stark regional variations in treatment costs—where hospitalization expenses in southern states like Tamil Nadu and Telangana (~₹50,000–₹55,000) are more than double those in Odisha (~₹22,000).The Committee believes that the digital health infrastructure must evolve beyond data interoperability to become a proactive instrument for financial protection and ethical healthcare delivery. The Committee, therefore, recommends the immediate implementation of an AI-enabled National Digital Health Ecosystem, supported by a dedicated AI-enabled National Health Fund. Such framework must institutionalize AI-driven financial surveillance tools to monitor billing anomalies, audit exorbitant out-of-pocket costs, standardize tertiary care pricing across the private sector, and ensure swift, equitable claim settlements for marginalized groups.

2.3.21 The Committee, further, recommends the Government to expand the assisted and offline modes of ABHA ID creation in low-connectivity regions, capitalizing on the momentum that women currently constitute 49.15% of ABHA holders. This must be coupled with targeted capacity-building programs, localized community outreach, and the expansion of multilingual support via the 14477 toll-free helpline to foster digital literacy. To further build trust and ensure patient-centric care, the Committee believes that adopting specific technological safeguards, such as leveraging AI and subscription models in ultrasound diagnostics to eradicate sex-determination fears, must be prioritized. These targeted interventions will ensure that technological advancements in healthcare directly safeguard the financial and social security of the most vulnerable citizens.

2.4 HUMAN RESOURCE AND INFRASTRUCTURE

Availability of Human Resources: Persistent Challenges

2.4.1 Availability of human resources remains one of the major challenges affecting accessibility and quality of healthcare services across the country. Several instances pointed

out persistent vacancies of doctors, nurses, technicians and specialists at Primary Health Centres (PHCs), Community Health Centres (CHCs) and even premier institutions such as AIIMS. The physical existence of a healthcare facility does not guarantee functional accessibility; it is the presence of skilled human resources and operational infrastructure that imbues it with life and purpose. Shortages of specialists, particularly surgeons, pediatricians, gynecologist's and anesthetists in rural and semi-urban areas, continue to adversely affect healthcare delivery. The doctor–population ratio in India stands at approximately 0.9 per 1,000, below the WHO norm of 1:1,000, while specialist shortages at CHCs exceed 79 per cent. The shortage of specialists at CHC level be addressed by offering enhanced benefits. Moreover, nearly 69,000 Indian doctors practice abroad, further exacerbating domestic shortages. The nursing workforce, though growing with 42.94 lakh nurses and 5,253 institutions producing nearly 3.87 lakh nurses annually, continues to face vacancies, especially in government hospitals. While estimates based solely on allopathic doctors indicate a doctor-population ratio of approximately 0.9 per 1,000 population, the Ministry has submitted that the ratio improves to nearly 1:811 when both allopathic and AYUSH practitioners are considered together. Nevertheless, significant inter-State disparities and mal-distribution of healthcare personnel continue to constrain equitable access to healthcare services, particularly in rural, tribal and aspirational districts. The Committee is of the opinion that concentration of doctors in urban areas has resulted in a deviant situation of unemployment amongst MBBS doctors whereas there is a shortage at both PHC/CHC level. These distributions of human resources needs to be addressed appropriately by making it attractive for doctors to work at CHC/PHC level.

2.4.2 The inputs and suggestions from the Stakeholders and the general public highlights the disproportionate doctor-population ratio, shortage of competent doctors, need for filling vacant posts, and ensuring adequate personnel to provide essential services. Suggestions included appointing biomedical engineers and physiotherapists in all public hospitals, strengthening district-level government medical colleges and hospitals, regularizing contract doctors, and providing better service conditions with fixed working hours for resident doctors.

2.4.3 To address these challenges, the Ministry informed the Committee that Community Health Officers (CHOs) have been introduced at Ayushman Arogya Mandirs to strengthen primary healthcare delivery and support telemedicine and non-communicable disease management. The Ministry has implemented a comprehensive suite of monetary and non-monetary incentives under the National Health Mission (NHM), including hard area allowances, negotiable salaries through the "You Quote, We Pay" scheme, and preferential PG admission for those serving in difficult areas. The District Residency Programme (DRP) mandatorily posts PG medical students in district hospitals, ensuring specialist presence at the secondary level. The total additional human resources supported under NHM now stands at over 5.23 lakh, including 1.18 lakh Community Health Officers at Ayushman Arogya Mandirs. The National Medical Commission (NMC) has significantly expanded medical education capacity, with medical colleges increasing from 387 to 818 and MBBS seats rising by 151 per cent since 2014. Additionally, 157 new nursing colleges have been sanctioned, and the Indian Nursing Council is updating curricula with digital and technological components to enable nurses to effectively use modern technology.

2.4.4 The Ministry further informed the Committee that postgraduate medical education has also witnessed substantial expansion, with PG seats increasing by over 163 per cent to 82,059 seats. In September 2025, the Union Cabinet approved the creation of an additional 5,000 PG seats and 5,023 MBBS seats, while increasing the per-seat cost ceiling to ₹1.5 crore to facilitate further expansion of medical education infrastructure. Measures have also been undertaken to address faculty shortages through re-engagement of retired faculty up to the age of 70 years, introduction of Visiting Faculty Schemes, recognition of DNB qualifications for faculty appointments, and constitution of Standing Selection Committees in premier institutions.

2.4.5 Stakeholders further emphasised the need for training and incentivizing healthcare workers to serve in rural and tribal areas, expediting recruitment processes, ensuring timely remuneration to ASHA and NHM workers, and introducing uniform pay scales for specialist doctors. Suggestions also included promoting allied healthcare professionals, paramedical services, allowing part-time opportunities for super-specialist doctors in government hospitals, and hiring consultants and specialists at sub-district and taluka rural hospitals.

2.4.6 The Committee notes that States have been advised to create separate recruitment boards for health to fast-track recruitment, and significant progress has been made in augmenting human resources under NHM. Further, the Union Budget 2025-26 has proposed adding 10,000 additional seats in medical colleges and hospitals, contributing to 75,000 seats over the next five years. Regarding nursing capacity development, the government has relaxed norms for opening nursing programmes, increased the age of superannuation for nursing faculty to 70 years, and expanded maximum sanctioned seats to 300 per institution. The Ministry also highlighted that the SASHAKT app and portal is being leveraged to plan, monitor and provide resources for health worker trainings, with over 1.54 lakh ASHAs, 67,911 CHOs, and 18,521 Medical Officers trained across expanded service packages.

2.4.7 The Ministry further stated that more than 57,755 Multipurpose Workers and 19,204 Staff Nurses have also been trained through the SASHAKT platform under the expanded service packages of Ayushman Arogya Mandirs. To strengthen the community health workforce, incentives for ASHAs were revised in March 2025, increasing the fixed monthly payment from ₹2,000 to ₹3,500 and the one-time recognition award after ten years of service from ₹20,000 to ₹50,000, in addition to team-based incentives and non-monetary support such as uniforms, identity cards, bicycles and mobile phones.

2.4.8 Stakeholders also suggested incorporating respiratory curriculum in all UG/PG courses, strengthening respiratory medical departments, and addressing mental health concerns including suicides among medical students through fixed duty hours and well-being programmes. The Ministry further highlighted the introduction of Competency-Based Medical Education, the mandatory Family Adoption Programme, mentor-mentee systems and AETCOM modules on ethics and communication skills in medical education curricula. The compulsory three-month District Residency Programme for postgraduate students has also been introduced to strengthen service delivery at district hospitals and provide greater exposure to community-based healthcare settings.The National Task Force constituted pursuant to the Hon'ble Supreme Court's order has formulated short-term, mid-term and long-term action plans on safety, working conditions, and well-being of medical professionals.

2.4.9 The Committee, having examined stakeholder submissions and the Ministry's progress on capacity building through the SASHAKT portal, strongly recommends that the Ministry of Health and Family Welfare formulate a comprehensive strategy to strengthen health human resources in rural and tribal regions by expediting recruitment processes, establishing uniform pay scales for specialist doctors, and ensuring the prompt, uninterrupted payment of remuneration to ASHA and NHM personnel. To immediately alleviate critical shortages in under-resourced areas, the Committee is of the view that the Ministry must institutionalize flexible hiring mechanisms, such as part-time engagements for super-specialists and consultant appointments at taluka and sub-district hospitals, while simultaneously expanding the role of allied health and paramedical professionals. Furthermore, the Committee recommends further scaling the SASHAKT digital ecosystem to continuously track, upgrade, and standardize training modules for all frontline and medical cadres across expanded healthcare service packages.

2.4.10 The Committee is of the view that despite commendable efforts to expand medical education capacity, evidenced by the 151% increase in MBBS seats, the 163% increase in PG seats, the establishment of 818 medical colleges, and the induction of over 5.23 lakh personnel under the National Health Mission, the severe shortfall of specialists at Community Health Centres fundamentally compromise equitable healthcare access. The physical infrastructure of Primary Health Centres and premier institutes alike is rendered ineffective without a stable, adequately distributed workforce. While the induction of nearly 25,000 AYUSH doctors and the formalization of 57 allied professions under the National Commission for Allied and Healthcare Professions (NCAHP) Act, 2021 are positive steps, they must be matched with aggressive retention strategies and safe working environments. The Committee, therefore, recommends that the Government immediately mandate all States to establish dedicated Health Recruitment Boards to drastically fast-track the filling up of vacant posts in strict accordance with IPHS 2022 norms. To counter rural attrition and correct inter-State disparities, it is imperative to regularize contract doctors, expand the "You Quote, We Pay" scheme, implement uniform pay scales for specialists. Furthermore, the mandatory District Residency Programme (DRP) must be rigorously monitored to guarantee a sustained specialist presence at the secondary level, particularly within aspirational and tribal districts.

2.4.11 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. Finally, the Committee appreciates the March 2025 increase in ASHA fixed incentives to ₹3,500 and recognition awards up to ₹50,000, but recommends that

systemic delays in remuneration to ASHA and NHM workers be eliminated through seamless and timely disbursement mechanisms. Public hospitals must also be mandated to appoint dedicated biomedical engineers and physiotherapists to bolster comprehensive care.

Infrastructure Development and Essential Services

2.4.12 The infrastructure deficit, while still significant, is being tackled through dedicated capital expenditure and targeted programmes. The Ministry informed the Committee that more than 1.8 lakh Ayushman Arogya Mandirs are presently operational across the country, collectively recording a cumulative footfall of over 484 crore and facilitating more than 41 crore teleconsultations. These centres have also undertaken large-scale screening for hypertension, diabetes and common cancers, thereby contributing significantly to early detection and prevention of non-communicable diseases.Under PM-ABHIM, with an outlay of over ₹64,000 crore, construction is underway for 17,788 building-less Sub-Centres, 3,382 Block Public Health Units, and 602 Critical Care Hospital Blocks. India currently has 1.3 hospital beds per 1,000 population (public and private combined), below the WHO norm of 3.5, with the public sector providing only 0.79 beds per 1,000. Significant regional disparities persist, with States like Kerala and Tamil Nadu performing better, while Bihar and Uttar Pradesh lag behind. Access to advanced diagnostics and equipment remains concentrated in urban centres and corporate hospitals, while public facilities in rural areas often lack essential equipment, leading to referrals and delays.

2.4.13 Stakeholder inputs emphasised that government hospitals are dilapidated, understaffed, and lacking basics, forcing the public to seek private or tertiary care for minor issues. Suggestions included strengthening PHCs with proper facilities as per local needs, achieving 3 beds per 1,000 population by offering incentives to the private sector such as tax holidays, soft loans, subsidised land, and reduced electricity costs. Other recommendations included investing in Health and Wellness Centres to reduce the burden on tertiary hospitals, establishing dedicated healthcare capex funds, modifying CSR guidelines to prioritise healthcare infrastructure in rural and Tier-2 towns, and facilitating use of pre-owned equipment in Tier-2 and Tier-3 cities. Additional suggestions included developing urban Public-Private Partnership clinics to cater to middle-income populations, adopting operational expenditure (OPEX)-based models for rapid deployment of healthcare infrastructure without substantial upfront capital expenditure, and establishing dedicated vascular and endovascular surgery departments along with increased investment in research and development to promote indigenous manufacturing of vascular hardware and medical devices.

2.4.14 The Ministry informed the Committee that as per Health Dynamics of India 2022-23, there has been an increase in Sub-Health Centres from 1,53,655 to 1,69,615; PHCs from 25,308 to 31,882; CHCs from 5,396 to 6,359; and Sub-District Hospitals from 1,022 to 1,340 compared to 2014-15. The 15th Finance Commission has recommended health grants of Rs. 70,051 crore to local governments for strengthening primary health infrastructure in rural and urban areas. Budgetary allocations for the Department of Health and Family Welfare have increased by 174%, rising from Rs. 35,063 crore in 2013-14 to Rs. 95,957.87 crore in 2025-26, with NHM allocation increasing by approximately 20% to Rs. 37,226.92 crore.The Committee was further informed that urban healthcare infrastructure under the National Urban Health Mission comprises Urban Primary Health Centres, Urban Community Health

Centres, Urban Sub-Health Centres and Polyclinics, established in accordance with prescribed population norms to improve healthcare accessibility in rapidly urbanising areas.

2.4.15 The Committee was also informed about the expansion of free drugs and free diagnostics initiatives under the National Health Mission. According to the Ministry, these initiatives have substantially increased availability of essential medicines and diagnostics at public healthcare facilities, with an expanded list of 172 drugs and 63 diagnostics at the PHC level. The Pradhan Mantri Bhartiya JanaushadhiPariyojana (PMBJP) has opened over 16,955 Jan AushadhiKendras, providing generic medicines at 50–80 per cent cheaper rates. To ensure 24×7 emergency care, the Government has operationalized dedicated trauma centres and critical care blocks, and recently launched a scheme providing cashless treatment of up to ₹1.5 lakh for road accident victims. The eSanjeevani national telemedicine service has delivered over 425 million consultations, connecting 136,058 Ayushman Arogya Mandirs (spokes) with 18,090+ hubs at secondary and tertiary facilities, effectively bridging the specialist gap in real-time.

2.4.16 Stakeholder suggestions included using vans with portable X-ray, ultrasound, and ECG to cover rural populations, strengthening the hub-and-spoke model of telehealth with the Department of Post providing logistic support, and promoting Public-Private Partnerships in diagnostic services. The Ministry informed that the Free Diagnostics Service Initiative is operational in all 36 States/UTs, with tele-radiology services in 12 States and CT scan services in 34 States, through in-house, PPP, and hybrid modes. Ambulatory services through PPP mode, especially for accident and trauma cases, are being expanded, with 1,573 Mobile Medical Units operational under NHM and an additional 694 MMUs under PM JANMAN for Particularly Vulnerable Tribal Groups. The Ministry further informed the Committee that the existing norm provides for one Mobile Medical Unit for every ten lakh population, subject to a maximum of five units per district, with each unit staffed by a Medical Officer, Nurse, Pharmacist, Laboratory Technician and Driver. These units play an important role in delivering healthcare services in remote, difficult and underserved regions.

2.4.17 Stakeholders also recommended developing Health Facility Access Index and ensuring easy accessibility to healthcare facilities, though the Ministry noted that the National Quality Assurance Standards already assess facilities for physical access features like ramps and disabled-friendly toilets. Regarding suggestions for division of Government Hospital wings into Free/Affordable/Premium categories, the Ministry clarified that treatment in Government hospitals is either free or highly subsidised, with separate counters for disabled, elderly, and pregnant women. Members, however, highlighted the gap between policy and ground-level implementation, stating that many sub-centres and rural facilities continue to face shortages of medicines, diagnostics and qualified healthcare personnel.

2.4.18 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 to restore rural public facilities, specifically prioritizing Primary Health Centres and Health and Wellness Centres based on local demographic needs and disease burdens. Furthermore, the Committee believes it is imperative to

accelerate the deployment of 15th and 16th Finance Commissions health grants for rehabilitating dilapidated sub-district infrastructure, ensure the immediate rollout of the proposed 200 Day Care Cancer Centres across district hospitals, and mandate that public medical institutions establish dedicated vascular and endovascular surgery departments to combat complex, emerging disease burdens. The Committee further recommends that the Government should implement in letter and spirit the budget announcements (2026-27) pertaining to the Health Sector, including Health and Family Welfare, Health Research and Ayush intended to ensure the accessibility and affordability of health care facilities.

2.4.19 The Committee believes that to supplement public expenditure and alleviate the severe overburdening of tertiary public hospitals, public capital must be synergized with private capabilities without heavy upfront capital demands. 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. Concurrently, the Committee is of the view that the Ministry must adopt Operational Expenditure (OPEX)-based Public-Private Partnership (PPP) models, facilitate the regulated deployment of high-quality pre-owned equipment in smaller cities, and establish urban PPP clinics tailored to middle-income populations. Furthermore, 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.

2.4.20 The Committee is of the view that access to advanced medical technology remains heavily concentrated in urban corporate centers, and immediate structural interventions must be taken to decentralize these essential services. The Committee, therefore, recommends deploying mobile diagnostic units equipped with portable X-ray, ultrasound with liver scan facility to assess fatty liverand other diseases like pancreatitis etc., ECG machinery portable ventilators for life saving directly to rural and remote populations, while simultaneously leveraging Public-Private Partnerships to scale high-quality diagnostic services across all public healthcare facilities. To ensure seamless operational execution and timely medical interventions, the Committee believes the Ministry should mandate the expansion of the hub-and-spoke telehealth model across all districts. Additionally, the 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.

2.4.21 Beyond immediate infrastructure and diagnostic coverage, the Committee believes that long-term healthcare resilience requires systemic policy innovation and rigorous accountability. The Committee, therefore, recommends increasing strategic investments in research and development to promote the indigenous manufacturing of medical devices and specialized hardware, thereby neutralizing import dependencies and significantly lowering overall patient treatment costs. Finally, to ensure transparent resource distribution and actively eliminate geographic inequities across the country, the Committee is of the view that the 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.

Accessibility for Vulnerable and Disadvantaged Groups

2.4.22 The issue of accessibility for vulnerable and disadvantaged groups received particular attention during the deliberations. Women, elderly persons, persons with disabilities, migrant populations and low-income households face multiple barriers in accessing timely and affordable healthcare. Low-income populations remain the hardest hit, which is why the expansion of PM-JAY is focused on the bottom 40 per cent of the population, ASHA workers, and gig workers. For women, who often face delayed health-seeking behaviour and high maternal care costs, the Janani Shishu Suraksha Karyakram (JSSK) guarantees free transport and care, while the LaQshya initiative ensures quality in labour rooms. The fact that women constitute 49 per cent of PM-JAY card users indicates progress in gender-sensitive financial protection. High maternal health expenditure, rising incidence of non-communicable diseases, inadequate geriatric care and difficulties in accessing specialized treatment were highlighted as areas requiring urgent intervention.

2.4.23 Stakeholder inputs emphasised the need for focus on SC/ST populations and migrant workers, with specific recommendations for strengthening tribal health through inclusive care. The Ministry informed the Committee that NHM envisages achievement of universal access to equitable, affordable and quality healthcare services for all populations including OBC, SC and ST, with separate budgets for SC/ST coverage. As per established norms, population norms for setting up health facilities in tribal and hilly areas have been relaxed, and 30,593 Ayushman Arogya Mandirs are operational in 178 districts with higher tribal populations.Under the relaxed norms applicable to tribal and hilly areas, one Sub-Health Centre is established for every 3,000 population instead of 5,000, one Primary Health Centre for every 20,000 population instead of 30,000, and one Community Health Centre for every 80,000 population instead of 1.20 lakh population, recognising the unique geographical and accessibility challenges in such regions.

2.4.24 The elderly now receive dedicated focus through the universal PM-JAY coverage for all citizens aged 70 years and above, with over 86 lakh cards issued to provide ₹5 lakh cover specifically for this group. The expansion of Ayushman Arogya Mandirs to deliver palliative and geriatric care at the community level is a critical step toward addressing their chronic, long-term needs. For persons with disabilities, inclusivity is being embedded into standards through the National Quality Assurance Standards (NQAS) and IPHS, which now assess facilities for physical access features like ramps and disabled-friendly toilets. The establishment of Physical Medicine and Rehabilitation (PMR) Centres in every district is envisioned to provide dedicated, accessible care, moving beyond a one-size-fits-all model to ensure dignity and specialized support for all. Members also emphasized the need for greater awareness regarding government health schemes and entitlements so that eligible beneficiaries are able to effectively avail healthcare services. Schemes such as Janani Suraksha Yojana have reduced childbirth-related expenditure, while the National Dialysis Programme has saved an estimated ₹8,000 crore in out-of-pocket expenditure. Screening for non-communicable diseases (diabetes, hypertension, cancers) has been decentralized to primary centres, improving early detection.

2.4.25 The PM JANMAN mission provisions mobile medical units for Particularly Vulnerable Tribal Groups (PVTGs), ensuring outreach to remote communities. Under the DhartiAabaJanjatiya Gram Utkarsh Abhiyan, with a total outlay of Rs. 79,156 crore covering 63,000 villages and benefitting more than 5 crore tribal people, MoHFW will support up to 1,000 Mobile Medical Units for villages where health facilities are beyond 5 km in hilly areas and 10 km in plain areas. The Sickle Cell Anaemia Elimination Mission aims to cover 7 crore people in tribal belts with screening, counselling and care. For migrant workers, the U-Win platform creates a portable digital vaccination record, solving the issue of missed doses for children of migrant families. Stakeholder recommendations included strengthening screening programmes in the community and establishing Centres of Excellence in the public sector.

2.4.26 The Committee is of the view that socially and geographically marginalized segments, specifically Scheduled Castes (SC), Scheduled Tribes (ST), Particularly Vulnerable Tribal Groups (PVTGs), and migrant laborers, encounter persistent structural barriers that severely compromise their right to timely healthcare. The Government's decision to relax population norms for setting up public health facilities in tribal and hilly areas (establishing a Sub-Health Centre for every 3,000 population, a PHC for every 20,000, and a CHC for every 80,000) and the deployment of 30,593 Ayushman Arogya Mandirs (AAMs) across 178 tribal-majority districts are highly progressive policy recalibrations. The Committee believes that the immense capital outlays under the ₹79,156 crore DhartiAabaJanjatiya Gram Utkarsh Abhiyan and the ₹24,104 crore PM JANMAN Mission serving PVTGs have the potential to fundamentally transform tribal health equity, but must be translated into immediate, resilient last-mile delivery mechanisms to counter high out-of-pocket expenditure and localized health crises. The Committee, therefore, recommends that the Ministry of Health and Family Welfare must expedite the deployment and rigorous tracking of the envisioned 1,694 Mobile Medical Units (MMUs) under these schemes to systematically cover villages situated beyond 5 km in hilly terrains and 10 km in plain regions.

2.4.27 The Committee recommends that the Government must establish dedicated public Centres of Excellence within high-burden tribal belts to anchor the screening, counselling, and therapeutic targets of the 7 crore population mandated under the Sickle Cell Anaemia Elimination Mission. Furthermore, to safeguard the health of floating labor populations, the Ministry must also cross-link the U-Win platform's portable digital vaccination record system with inter-State labor registries to guarantee that children of migrant families receive uninterrupted, contiguous immunization coverage regardless of relocation. Also, PM-JAY's expansion to 12 crore families, ASHA workers, and all senior citizens aged 70 and above must be backed by aggressive grassroots awareness campaigns.

2.4.28 The Committee recommends extending the coverage under the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to all children below five years of age and all senior citizens aged 60 years and above, irrespective of their socio-economic status or geographical location. The Committee considers this universalization a pivotal step toward advancing Universal Health Coverage (UHC) and mitigating the disproportionate financial burden associated with childhood and geriatric illnesses. To operationalize this effectively, the Committee further recommends that the Ministry ensure adequate financial provisioning, establish seamless enrolment mechanisms, and

build robust synergy with existing child and elderly health programs to guarantee equitable, timely, and affordable healthcare services to every eligible beneficiary.

Quality Assurance and Regulatory Oversight

2.4.29 The Committee also deliberated upon issues relating to quality assurance and regulatory oversight in healthcare delivery. Several concerns were raised regarding excessive diagnostic testing, increasing rates of Caesarean-section deliveries in private hospitals, lack of transparency in pricing of healthcare services, and insufficient monitoring of private healthcare providers. It was suggested that stronger regulatory frameworks may be required for ensuring transparency in treatment costs, standardization of rates for common procedures, and wider availability of generic medicines in private hospitals.

2.4.30 Stakeholders opined banning private practice by government doctors, ensuring rotation of specialists across the network of mission hospitals, and formulating a medical practitioner cadre with fair and transparent policies on eligibility-based selection and transfer in the States. Suggestions also included establishing a separate cadre of hospital administrators so that doctors can focus on patient care, and promoting the Family Practitioner (Allopathic) concept.

2.4.31 The Ministry informed the Committee that the National Medical Commission has introduced the Family Adoption Programme in the MBBS curriculum, with medical colleges adopting villages and students adopting families to provide equitable healthcare access to rural populations. The National Board of Examination has DNB (Family Medicine) programmes providing a career pathway into community-based health services. Regarding fee structures, NMC has framed guidelines for determination of fees for 50% of seats in private medical institutions and deemed universities. The Ministry also noted that the National Commission for Allied and Healthcare Professions (NCAHP) Act, 2021 was enacted to formalise roles and education standards for 57 allied and healthcare professions, with the Commission constituted on January 8, 2024.

2.4.32 The Ministry further informed the Committee that enrolment portals under the National Commission for Allied and Healthcare Professions were launched in October 2024 to facilitate registration and regulation of allied health professionals. It was also submitted that fees for fifty per cent of seats in private medical institutions and deemed universities are regulated under NMC guidelines to improve affordability of medical education.The National Medical Register (NMR) portal, launched in August 2024, processes applications for issuance of Unique NMR IDs to registered medical practitioners. The Ministry further clarified that working hours for doctors in central government hospitals do not normally exceed 48 hours per week, though duty timings are guided by exigencies and patient load. Regarding suggestions for allowing private practitioners to use government infrastructure, the Ministry noted that human resource is inducted on a contract basis depending upon requirement.

2.4.33 Overall, the Committee observed that while substantial efforts have been undertaken by the Government to improve affordability and accessibility through insurance coverage, free drugs and diagnostics, digital health initiatives, and strengthening of primary healthcare infrastructure, significant challenges continue to persist. Regional disparities, shortage of healthcare personnel, high out-of-pocket expenditure, inadequate regulation of private healthcare costs, and uneven implementation of healthcare schemes continue to affect equitable healthcare access. The generalized deficits in affordability and accessibility are

refracted through the prism of social and economic vulnerability, and policy is increasingly adopting a targeted, inclusive lens.

2.4.34 The Committee noted stakeholder suggestions emphasising a multi-tiered, inclusive and context-sensitive approach in healthcare, bridging the gap between public and private sectors by strengthening public health infrastructure and expanding health insurance coverage, and regularising healthcare systems through Public-Private Partnerships. Stakeholder's views included identifying more locations for setting up new AIIMS and Government Medical Colleges, strengthening specialist and super-specialist care by forming clusters of 5-6 medical colleges, developing all medical colleges at par with AIIMS Delhi, and guaranteeing availability of essential drugs, diagnostics, and fully functional infrastructure at all public facilities.

2.4.35 The Ministry informed the Committee that 22 new AIIMS have been approved under PMSSY, with 18 functional, and 75 Government Medical Colleges have been approved for upgradation, with 71 completed. The Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), launched in October 2021, is a dedicated capital expenditure scheme designed to strengthen India's public health infrastructure. The Committee also noted that AB-PMJAY, presently the world's largest government-funded health assurance scheme, covers nearly 12 crore families with health insurance coverage of ₹5 lakh per family per year and has recently been expanded to include families of ASHA and Anganwadi workers as well as all senior citizens aged 70 years and above. Further, the Union Budget 2025-26 has announced the establishment of 200 additional Day Care Cancer Centres during the year, with the objective of extending such facilities to all district hospitals within the next three years.

2.4.36 The Committee is of the view that while the scaling of 1.8 lakh Ayushman Arogya Mandirs (AAMs) and the delivery of over 425 million consultations via the eSanjeevani platform through 18,000 hubs have significantly transformed primary healthcare and contributed to reducing Out-of-Pocket Expenditure (OOPE) from 64.2% to 43.4%, a persistent and troubling gap remains between policy formulation and ground-level execution. Reports of recurrent shortages of mandated essential medicines (172 drugs) and diagnostic capabilities (63 tests) at sub-centres and rural primary health facilities continue to force vulnerable populations to seek expensive private care, thereby diluting the impact of the National Health Mission's free initiatives. The Committee believes that structural institutionalization and supply-chain resilience are paramount. The Committee, therefore, recommends that the Government immediately strengthen the hub-and-spoke tele-health network by integrating the extensive logistics network of the Department of Post to ensure the uninterrupted, real-time supply of medicines and diagnostic reagents to remote spokes. The Ministry must expand the fleet of Mobile Medical Units (MMUs) beyond the current ceiling of five units per district in high-demand areas, equipping them with portable X-ray, ultrasound, and ECG machines for comprehensive rural coverage. Furthermore, the Committee recommends the development and implementation of a standardized Health Facility Access Index to continuously audit and map physical, operational, and structural barriers at public facilities, thereby ensuring absolute accountability, compliance with National Quality Assurance Standards (NQAS), and zero stock-outs of mandated essential medicines and diagnostic reagents at the grassroots level.

2.4.37 The Committee is of the considered view that socio-economic vulnerabilities uniquely distort health outcomes for low-income households, women, the elderly, and persons with disabilities. Although women constitute 49 per cent of Pradhan Mantri Jan Arogya Yojana (PM-JAY) card users, and targeted schemes like the Janani Shishu Suraksha Karyakram (JSSK) and LaQshya have significantly compressed maternal healthcare delivery liabilities, delayed health-seeking behaviors and rising out-of-pocket spending on chronic non-communicable diseases (NCDs) remain critical concerns. The Committee believes that the expansion of universal PM-JAY coverage to all citizens aged 70 years and above, marked by the issuance of over 86 lakh cards providing a ₹5 lakh cover, demands structured physical and clinical institutionalization to avoid becoming a mere financial mechanism. The Committee, therefore, recommends that the Government scale up decentralized palliative and geriatric care infrastructure across all operational AAMs to manage the long-term chronic needs of the aging demographic. The Ministry must mandate the time-bound establishment of a Physical Medicine and Rehabilitation (PMR) Centre in every district of the country to ensure specialized, dignified care for persons with disabilities. To bridge the gap between policy intent and ground-level execution, the Committee further recommends that compliance with the NQAS and Indian Public Health Standards (IPHS) regarding physical access features, such as ramps and disabled-friendly toilets, be subjected to mandatory annual independent audits. Finally, the Government must launch a hyper-localized, multi-lingual Information-Education-Communication (IEC) campaign to raise community awareness regarding decentralized entitlements, including the National Dialysis Programme and free community-level NCD screenings.

2.4.38 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 within private hospitals continue to drive high out-of-pocket expenditure and severely exploit economically vulnerable patients. While the Ministry's implementation of the National Medical Commission (NMC) guidelines to regulate fees for 50% of seats in private medical institutions and deemed universities is a commendable step toward affordable medical education, the actual costs of clinical treatments and procedures in the private sector remain inadequately monitored. The Committee believes that absolute transparency and stringent accountability must be enforced to protect patients from commercialized exploitation. 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. The Ministry must introduce mandatory compliance audits for private clinical establishments to monitor deviations from standard medical practices, such as unwarranted surgical interventions, and strictly audit private hospitals offering DNB and residency training to prevent exorbitant fee extraction. Concurrently, the government must enforce the mandatory availability and prescription of generic medicines in private hospitals.

2.4.39 The Committee believes that the current institutional framework in the public sector unnecessarily burdens highly trained medical specialists with routine administrative and logistical operations, resulting in long patient wait-times and diminished quality of clinical care. The Committee believes that bridging the gap

between macroeconomic outlays and ground-level healthcare delivery requires a structural separation of clinical and administrative workflows. 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.

2.4.40 The Committee is of the view that to systematically dismantle regional imbalances in super-specialty treatment, the Ministry must implement a multi-tiered strategy that includes clustering groups of 5-6 medical colleges to share specialist resources and upgrading existing state medical institutions to function at par with AIIMS Delhi. Finally, the National Medical Register (NMR) portal, launched in August 2024, must be cross-leveraged alongside the enrolment portals of the NCAHP to maintain real-time, transparent oversight of the country's medical and allied health workforce credentials and transfers, ensuring that statutory standards are uniformly maintained across both the public and private sectors. The government must ensure the time-bound, rigorous execution of the Union Budget 2025-26 mandate to operationalize 200 additional Day Care Cancer Centres this year, maintaining strict oversight to guarantee that every single district hospital nationwide is equipped with fully functional oncology day-care facilities within the designated three-year horizon.

2.4.41 The Committee is of the view that the recent Cabinet approval adding over 10,000 new medical and PG seats (scaling to 75,000 over five years) is a right step toward correcting the doctor-population ratio. Innovations like the mandatory Family Adoption Programme, the District Residency Programme (DRP), and Competency-Based Medical Education reflect a forward-looking academic vision. The Committee believes that while primary care is expanding, super-specialty care remains geographically concentrated, necessitating further decentralization. The Committee, therefore, recommends that alongside the 22 approved AIIMS, the Government must identify geographic clusters to develop existing state medical colleges at par with premier institutes. Furthermore, academic curriculum must be urgently modernized. Undergraduate and postgraduate curricula should be immediately updated to include strengthened, mandatory modules on respiratory medicine, and dedicated departments for endovascular/vascular surgery must be established. Finally, the Committee recommends increased R&D funding aimed at indigenizing specialized medical devices and vascular hardware to reduce import dependencies. The Committee is, however, concerned to note that the rapid expansion of PG medical seats without adequate clinical exposure and proper training is severely diluting the quality of health care standards. The Committee recommends that the expansion of under graduate and post graduate seats should be done only after ensuring quality education, adequate training and clinical exposure.

2.4.42 The Committee is of the considered view that strengthening public healthcare infrastructure, improving financial protection mechanisms, ensuring availability of affordable medicines and diagnostics, enhancing regulatory oversight of private healthcare services, expanding human resource capacity, and ensuring targeted interventions for vulnerable groups are essential for achieving affordable, accessible and equitable healthcare for all citizens.

CHAPTER- III

VIEWS OF STAKEHOLDERS

3.0 Department of Health Research (DHR)

3.1 The Department of Health Research (DHR) informed the Committee that its mandate is to promote, coordinate and oversee health research to generate scientific evidence for policy-making and translate research into affordable, accessible and equitable healthcare. The Department strengthens research capacity through programmes such as Health Technology Assessment in India (HTAIn), Model Rural Health Research Units (MRHRUs), Multidisciplinary Research Units (MRUs), Viral Research and Diagnostic Laboratories (VRDLs), the Grant-in-Aid Scheme, and the Human Resource Development (HRD) Scheme. DHR also supports indigenous development of diagnostics, vaccines and medical devices, promotes translational research, and ensures robust ethical and regulatory standards.

3.1.1 The Indian Council of Medical Research (ICMR), the implementing arm of DHR, serves as India's apex biomedical research body through a network of 27 institutes and centres. It conducts and funds research on priority health issues, develops affordable indigenous diagnostics, vaccines and medical technologies, undertakes disease surveillance and registry maintenance, and supports tribal health research and bioethics. Together, DHR and ICMR provide the foundation for evidence-based health research and innovation, advancing affordable, accessible and high-quality healthcare across the country.

3.2 Development of Innovative and Cost-Effective Treatment Procedures and Technologies

3.2.1 The Department of Health Research (DHR) informed the Committee that it has promoted the development of several affordable and indigenous healthcare technologies for early diagnosis and treatment of major diseases, thereby improving affordability and accessibility of healthcare. These include CRISPR-Cas-based point-of-care (PoC) diagnostic kits for malaria and tuberculosis, as well as an AI-enabled handheld X-ray device for cost-effective TB detection. The PathDetect M.TB Rif. & INH molecular diagnostic tool enables rapid identification of resistance to Rifampicin and Isoniazid among TB and multidrug-resistant TB (MDR-TB) patients. Rapid PoC diagnostic technologies, such as the Mpox detection kit, isothermal PCR kits for Chikungunya, and scrub typhus detection kits, have significantly enhanced outbreak preparedness and response. Innovations such as i-Scope, an automated Pap smear-based cervical cancer diagnostic system, and Cerebo, a portable non-invasive brain injury detection device, facilitate timely diagnosis and intervention. In addition, Mobilab provides point-of-care testing for liver and kidney disorders by analysing biomarkers such as albumin and bilirubin. In paediatric care, affordable indigenous formulations, including isotretinoin for high-risk neuroblastoma and PREVALL, an oral suspension of 6-mercaptopurine for Acute Lymphoblastic Leukaemia (ALL), are available at a fraction of international costs, substantially improving access to life-saving treatments.

3.2.2 To strengthen indigenous medical technology innovation, ICMR launched MedTech Mitra (December 2024), which provides end-to-end mentoring, regulatory guidance, clinical

validation and commercialization support to innovators and MSMEs. Over 400 innovators have benefited from the platform. The platform addresses the "valley of death" in the innovation process, stages where many promising solutions otherwise fail due to lack of support. Patent Mitra (March 2025) complements this initiative by facilitating intellectual property protection and technology transfer, supporting 78 innovators, filing 24 patents, and enabling technology commercialization.

3.2.3 Under the ICMR–DHR Centres of Excellence (CoE) scheme, seven IITs have been established as hubs for medical technology innovation, resulting in the development of 43 indigenous medical technologies, 16 start-ups, 11 patents, and significant capacity building. Supporting initiatives such as the mPRAGATI Metal Additive Manufacturing Facility at IIT Delhi and 26 Centres for Advanced Research further promote the development and validation of affordable diagnostics and medical devices.

3.2.4 DHR has also institutionalized Health Technology Assessment in India (HTAIn) to generate evidence-based recommendations on the safety, effectiveness and cost-effectiveness of health technologies. HTAIn supports informed policy decisions, optimizes public expenditure, reduces out-of-pocket expenditure, and strengthens clinical and health policy guidelines. Additionally, DHR has proposed the establishment of the Medical Innovations Development Acceleration Council (MIDAC) to accelerate the development, validation and commercialization of indigenous devices, diagnostics, vaccines and therapeutics through public-private partnerships.

3.2.5 The Committee appreciates the highly promising outcomes of the MedTech Mitra platform, which has already mentored over 400 innovators, and the establishment of Centres of Excellence (CoEs) across seven IITs, yielding 43 indigenous medical technologies and 16 start-ups. The Committee believes that achieving self-reliance in medical technology is the most sustainable pathway to significantly lower the cost of critical treatments, such as the drastically reduced prices already achieved for paediatric formulations like isotretinoin and PREVALL. The Committee, therefore, recommends a substantial expansion of the CoE scheme to other premier engineering and medical institutes across the country to follow the suit with intention to lower the cost of treatment. The Committee also recommends that the Government should establish a dedicated procurement quota within national health programs for indigenously developed, validated technologies to guarantee market access for start-ups and MSMEs navigating the "valleys of death" with a hope to cross over.

3.2.6 The submission of DHR highlights the pivotal role of the Health Technology Assessment in India (HTAIn) in providing rigorous, evidence-based recommendations on the cost-effectiveness and safety of health interventions. Given the imperative to optimize government spending and reduce the out-of-pocket burden on citizens, the Committee is of the view that systematic evaluations must become the bedrock of all public healthcare expenditure. The Committee, therefore, recommends that HTAIn clearance be made a mandatory prerequisite for the inclusion of any new diagnostic tool, medical device, vaccine, or therapeutic procedure into the procurement lists of the National Health Mission and the Pradhan Mantri Jan Arogya Yojana (PMJAY). The

Committee, further, recommends the establishment of state-level HTA nodes to ensure that cost-effectiveness thresholds are tailored to regional health priorities and economic realities to expand the length and breadth of health schemes of the programmes to the last miles.

3.2.7 The proposed Medical Innovations Development Acceleration Council (MIDAC) represents a critical intervention for de-risking biomedical research in areas that lack lucrative commercial incentives but possess immense public health importance. Furthermore, the Model Rural Health Research Units (MRHRUs) and Tribal Health Research Network are essential for ensuring that innovations reach the most vulnerable populations especially rural, hilly and tribal region. The Committee believes that an equitable healthcare system cannot rely solely on market-driven research but must touch the poor population through welfare measures. The Committee, therefore, recommends the immediate operationalization and robust capitalization of MIDAC to foster public-private partnerships specifically targeting neglected tropical diseases and regional outbreaks. The Committee believes linking MRHRUs directly with the MedTech Mitra ecosystem, ensuring that new point-of-care diagnostics (such as the AI-enabled handheld X-ray devices and CRISPR-CAS kits) are field-tested and deployed directly in underserved rural and tribal corridors.

3.2.8 The introduction of the Patent Mitra initiative in March 2025 is a commendable step, having already facilitated 24 patent applications and the successful transfer of one technology to the industry. However, to translate laboratory success into widespread accessibility, the bridge between patenting and commercial-scale manufacturing must be strengthened and expanded. The Committee is of the view that a robust intellectual property framework is only effective if it culminates in the rapid commercialization and deployment of affordable health solutions for all & irrespective of gender. The Committee, therefore, recommends creating a fast-track technology transfer mechanism within Patent Mitra that actively matches patent-holders with public sector undertakings (PSUs) and established private manufacturers. The Committee also recommends providing targeted financial subsidies or tax incentives to private sector entities that successfully license and mass-produce technologies protected under the Patent Mitra and CoE frameworks and intended to ensure accessibility and affordability of healthcare facilities.

3.3 Effective Preventive Healthcare Strategies for Reducing Healthcare Costs

3.3.1 The Department of Health Research (DHR) informed the Committee that it is committed to developing innovative, affordable and cost-effective healthcare strategies to strengthen disease prevention, improve health outcomes and reduce the overall economic burden on India's healthcare system. In line with this mandate, DHR, through the Indian Council of Medical Research (ICMR), has supported several impactful initiatives, including large-scale community trials, nutritional interventions, novel vaccines, diagnostic technologies and disease surveillance tools. These efforts focus on early detection, timely intervention and prevention to reduce disease burden and treatment costs, thereby advancing the goal of Universal Health Coverage.

3.3.2 ICMR supported the RATIONS trial in four districts of Jharkhand to evaluate the impact of nutritional supplementation on preventing tuberculosis (TB) among household contacts of TB patients. The study demonstrated a reduction in TB incidence. ICMR also contributed to increasing TB preventive therapy coverage from 35 per cent to 98 per cent under the National Tuberculosis Elimination Programme (NTEP) through targeted interventions and the development of three indigenous TB diagnostic kits. In addition, handheld X-ray devices were validated for early TB detection and found to be portable and user-friendly, while the CyTB test for latent TB infection was validated and recommended for inclusion in the national TB programme owing to its improved performance over the conventional Mantoux test.

3.3.3 To address the growing burden of non-communicable diseases, ICMR recommended age-specific HbA1C cut-offs and evidence-based dietary strategies for the prevention and remission of Type 2 diabetes. It has also developed syndromic diagnostic algorithms covering acute respiratory syndrome, diarrhoea, fever and encephalitis to strengthen disease surveillance, facilitate early diagnosis and improve public health response. Further, based on its research findings, ICMR recommended preventive measures to reduce bile acid-induced fibrosis and inflammation.

3.3.4 The Health Technology Assessment in India (HTAIn) programme, an attached office of DHR, has made significant contributions towards preventive healthcare and cost savings through rigorous health technology assessments and cost-effectiveness analyses. HTAIn recommended the use of cost-effective rapid diagnostic tests for sickle cell disease, procured at ₹82–100 per test instead of ₹350, enabling the screening of nearly seven crore people and generating estimated government savings of around ₹1,750 crore while supporting the development of eight indigenous diagnostic kits.

3.3.5 In the area of injection safety, HTAIn recommended the procurement of safety-engineered syringes at less than ₹5.90 per unit, with projected annual savings of approximately ₹420 crore by preventing needle-stick injuries and associated treatment costs. For cervical cancer screening, it recommended visual inspection with acetic acid (VIA) once every five years for women aged 30–65 years, a strategy subsequently incorporated into the National Programme for Prevention and Control of Non-Communicable Diseases (NPCDCS), with estimated lifetime out-of-pocket savings of ₹5.2 crore for every one lakh women screened.

3.3.6 Through the Costing of Health Services in India (CHSI) initiative, HTAIn established cost estimates for 1,573 health benefit packages under Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and supported the revision of 857 packages, thereby improving reimbursement efficiency. It also recommended tele-screening for diabetic retinopathy using colour fundus photography, a strategy scaled up across 165 Family Health Centres in Kerala, resulting in estimated savings of nearly ₹8 crore by preventing advanced-stage complications.

3.3.7 HTAIn further recommended the use of the indigenous Sohum device for universal neonatal hearing screening. The device has been deployed across 58 districts in six States and

has also been exported to five countries. In Tamil Nadu, HTAIn recommended decentralised point-of-care screening and early treatment for Hepatitis B and C at Primary Health Centres, leading to the screening of over eight lakh pregnant women, identification of more than 2,000 positive cases and projected savings of approximately ₹260 crore through prevention of end-stage liver disease.

3.3.8 To strengthen cardiovascular care, HTAIn recommended portable ECG screening at Primary Health Centres. As a result, 371 ECG machines have been deployed across eight States, with estimated savings of ₹66.57 crore for every one lakh individuals screened. For latent TB infection, HTAIn recommended the CyTb test at a procurement cost below ₹204 per test. Procurement at ₹199 per test resulted in estimated savings of ₹52.6 crore while facilitating early diagnosis and treatment for nearly 50 lakh individuals.
HTAIn also recommended the indigenous Truenat platform over CBNAAT for tuberculosis diagnosis. More than 7,000 Truenat machines have since been deployed across public and private healthcare facilities, generating procurement savings of approximately ₹490 crore. During the COVID-19 pandemic, HTAIn identified high-throughput COBAS testing systems as not being cost-effective, leading to the cancellation of procurement of four machines and resulting in savings of around ₹10 crore. In the treatment of HER2-positive breast cancer, HTAIn recommended a six-month trastuzumab therapy regimen in place of the conventional one-year regimen as the more cost-effective option. The subsequent revision of treatment guidelines has resulted in estimated annual savings of approximately ₹416 crore under National Health Authority reimbursement packages.

3.3.9 The Committee takes note of preventive healthcare strategies of DHR for reducing healthcare cost. The DHR clearly demonstrated that preventive interventions, such as rapid diagnostic tests for Sickle Cell Disease, universal neonatal hearing screening (Sohum), and tele-screening for diabetic retinopathy, have saved the exchequer thousands of crores while preventing irreversible disease progression. The Committee is of the view that shifting the healthcare paradigm from curative treatments to proactive, early detection is the most effective strategy to manage India's disease burden. The Committee, therefore, recommends the immediate integration and nationwide rollout of ICMR-validated syndromic diagnostic algorithms and point-of-care screening tools across all Ayushman Arogya Mandirs and Primary Health Centres (PHCs). The Committee is of the view that dedicated budgetary allocations be made for state governments to deploy decentralized screening models, similar to the successful Hepatitis B & C screening in Tamil Nadu and ECG deployments in Gujarat, to intercept chronic diseases at their onset.

3.3.10 The rational interpretation of DHR data reveals that targeted cost-effectiveness analyses, such as the Costing of Health Services in India (CHSI) and the optimization of Breast Cancer therapy (Trastuzumab) from a 1-year to a 6-month regimen, have vastly improved reimbursement efficiency and saved hundreds of crores annually. The Committee believes that standardizing treatment regimens based on synthesized, indigenous evidence (through platforms like SARANSH) is essential to prevent over-medicalization and ensure the financial sustainability of public health insurance. 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.

3.4 Development of an Inclusive and Equitable Healthcare System through Health Research

3.4.1 The Department of Health Research (DHR) informed the Committee that the Multi-Disciplinary Research Units (MRUs) and Model Rural Health Research Units (MRHRUs) constitute an important component of the Department of Health Research's efforts to strengthen the country's health research ecosystem and enhance preparedness against diseases with epidemic potential. MRUs have been established in medical colleges to promote and strengthen the research environment by bridging critical infrastructural gaps, ensuring the geographical spread of health research infrastructure, and facilitating evidence-based development and application of diagnostic procedures, processes and treatment methods. Their overarching objective is to improve the health status of the population through high-quality medical research.

3.4.2 MRHRUs have been established to facilitate the transfer of health technologies to rural areas, thereby improving the quality of healthcare services for rural populations. These units serve as a vital interface between technology developers, including researchers from medical institutions, health system implementers at the Central and State levels, and rural communities. They also contribute to the equitable geographical distribution of health research infrastructure across the country. In addition, MRHRUs are actively involved in establishing clinical trial networks and implementing multicentric research projects. At present, the country has a network of 118 MRUs and 36 MRHRUs.

3.4.3 The research priorities under the MRHRU programme encompass a wide range of public health concerns, including cardiovascular diseases, diabetes, cancer, stroke, bacterial diseases, orthopaedic disorders, maternal and child health, elderly and palliative care, public health, tuberculosis, nutrition, and other communicable and non-communicable diseases such as viral infections, renal disorders and chronic obstructive pulmonary diseases (COPDs).

3.4.4 MRHRUs have also successfully piloted and scaled up several innovative healthcare technologies and public health interventions. These include the TN-Stroke Mobilization and Rapid Treatment (TAEI-SMART) App for the management of stroke patients at MRHRU Tirunelveli, Tamil Nadu; health technology assessment of a Portable Automated Auditory Brainstem Response (ABR) Neonatal Hearing Screening Device at MRHRU Tigiria, Odisha; the Demography Integrated Surveillance for Health Assessment (DISHA) programme for dengue and chikungunya surveillance at MRHRU Tigiria; and the establishment of a Disease Development and Environmental Surveillance System (DDESS) at the same centre. Other noteworthy initiatives include anaemia screening using an anaemia chart by MRHRU Raichur, Karnataka, and the establishment of diagnostic facilities for dengue, chikungunya and leptospirosis at MRHRU Dahanu, Maharashtra. These initiatives demonstrate the

significant role of MRHRUs in translating research into practical, community-based healthcare solutions, particularly in rural and underserved regions.

3.4.5 The Committee considers that the current network of 118 Multi-Disciplinary Research Units (MRUs) and 36 Model Rural Health Research Units (MRHRUs) is not sufficient for adequate development of an inclusive and equitable healthcare system. While successful pilot projects like the DISHA surveillance system and the TAEI-SMART stroke management app have proven effective, the Committee is of the view that a footprint of just 36 MRHRUs is geographically inadequate to represent the diverse epidemiological profile of rural India. The Committee believes that rural populations must be actively included in clinical trials to ensure that medical research is genuinely equitable. The Committee, therefore, recommends a time-bound expansion plan to establish at least one MRU in every government medical college and one MRHRU in every district across the country. The Committee also recommends that these units be explicitly mandated to operate integrated environmental and disease surveillance systems (like DDESS) to track emerging outbreaks at the grassroots level and to conduct large-scale, multi-centric clinical trials directly within rural communities.

3.5 Health Literacy for Informed Healthcare Decisions

3.5.1 DHR has undertaken several initiatives to improve health literacy by translating research into practical tools and evidence-based guidance. These include conducting workshops and training programmes for researchers and public health professionals, sensitizing States on Health Technology Assessment (HTA), supporting evidence-based guideline development through initiatives such as SARANSH, and promoting digital health literacy through training on health data platforms and digital tools such as DARPAN. These efforts aim to strengthen informed decision-making and facilitate the adoption of scientific innovations at the grassroots level.

3.5.2 The Committee observes that the DHR has initiated crucial steps to translate scientific research into accessible knowledge through state sensitization workshops and digital tools like the DARPAN dashboard. However, the Committee believes that scientific advancements and clinical evidence fail to achieve their full impact if the research remain confined to academic circles and are not systematically transferred to frontline health workers and the general public. The Committee, therefore, recommends the establishment of dedicated "Evidence Translation Cells" within State Health Departments to systematically convert ICMR research findings and HTAIn evaluations into vernacular, highly accessible guidelines for ASHA and Anganwadi workers. The Committee believes in scaling up regional digital literacy programs to ensure that district-level public health functionaries are fully trained to utilize evidence synthesis tools and data dashboards for real-time, programmatic decision-making.

3.6 Strategies for Disease Prevention through Screening, Diagnostics and Cost-Effective Treatment

3.6.1 DHR informed the Committee that it is promoting disease prevention through affordable diagnostics, large-scale screening programmes and indigenous, cost-effective treatments. ICMR has developed and validated point-of-care and AI-enabled diagnostic tools for diseases such as tuberculosis, malaria, cervical cancer, Mpox and other communicable and non-communicable diseases. It has also supported screening initiatives for latent TB, sickle cell disease, anaemia, and cervical and breast cancer, along with affordable therapies for childhood cancers and malnutrition, thereby reducing out-of-pocket expenditure.

3.7 Role of DHR in Prevention, Diagnosis and Treatment of Diseases

3.7.1 DHR informed the Committee that its research programmes address a wide spectrum of diseases in line with the WHO's International Classification of Diseases. Key focus areas include non-communicable diseases, maternal and child health, anaemia, malnutrition, women's health, and cancer through research, innovation, evidence-based treatment protocols, nutritional interventions, and screening programmes, thereby strengthening affordable and equitable healthcare. The Committee recommends DHR to undertake more such projects to enhance the prospects of affordable and accessible healthcare.

3.8 Use of AI, Drones and IT in Disease Surveillance and Healthcare Delivery

3.8.1 The Committee has been informed that the Indian Council of Medical Research (ICMR) has undertaken several initiatives to integrate Artificial Intelligence (AI) and digital technologies into healthcare and biomedical research to strengthen disease surveillance, diagnostics and clinical decision-making. ICMR established the ICMR- National Institute of Research in Digital Health and Data Science to advance research in digital health, AI and data science. It also developed the Ethical Guidelines for AI in Biomedical Research and Healthcare, providing a framework for the ethical development, deployment and adoption of AI-based solutions in healthcare.

3.8.2 ICMR has developed advanced AI-enabled diagnostic and predictive tools. An AI-driven tuberculosis X-ray screening system has demonstrated over 96 per cent sensitivity and specificity, while an AI-based predictive tool has been developed to assess assisted reproductive outcomes in men. AI-based early warning systems for COVID-19, dengue and malaria have also been initiated to strengthen disease surveillance and outbreak preparedness. To advance AI-enabled medical diagnostics, ICMR partnered with the Indian Institute of Science (IISc), Bengaluru, establishing the ICMR–IISc Centre for Medical Image Datasets (MIDAS). The Centre develops disease-specific reference datasets for medical image analysis, supports researchers, clinicians and start-ups, and has released imaging datasets for oral cancer and dural-based lesions.

3.8.3 ICMR has further supported investigator-initiated projects on AI/ML-based diagnostics, predictive models for early disease detection, disease burden estimation, predictive analytics for non-communicable diseases and smartphone-based non-invasive

diagnostics. These initiatives improve early diagnosis, clinical workflows, public health surveillance and evidence-based healthcare delivery. To promote responsible adoption of AI, ICMR also facilitates collaboration among researchers, clinicians, industry and policymakers.

3.8.4 The Committee has been given to understand that the i-DRONE (ICMR's Drone Response and Outreach in North-East) initiative has pioneered the use of drones to improve last-mile healthcare delivery in rural and remote areas. Initially launched for delivering COVID-19 vaccines to remote areas of Manipur and Nagaland, the initiative has since expanded to support the Universal Immunization Programme (UIP) and the transportation of essential medicines and medical supplies across diverse terrains, including islands, foothills and hilly regions. Drones have successfully delivered medical supplies in the Lahaul and Spiti districts of Himachal Pradesh at altitudes above 10,000 feet, even under sub-zero temperatures. In Yadadri Bhuvanagiri district, Telangana, drones have reduced turnaround time for tuberculosis sample testing and improved follow-up under the National Tuberculosis Elimination Programme (NTEP). The initiative has also expanded to transport critical biological materials. In Karnataka, drones transport intraoperative pathological samples, particularly onco-surgical biopsies, from peripheral hospitals to tertiary centres, enabling faster diagnosis and timely surgical decisions. In Delhi-NCR, drones have been used for the safe transport of blood bags and blood components, while in Sonipat and Jhajjar (Haryana) they have been piloted for transporting donor corneas to reduce ischemic time and improve transplant outcomes.

3.8.5 The Committee takes into account the successful pilots under the i-DRONE initiative, ranging from vaccine distribution in hilly terrains of Nagaland and Himachal Pradesh to ultra-critical intraoperative biopsy transport in Karnataka, blood delivery in Delhi-NCR, and corneal transport in Haryana, demonstrate that drone technology can overcome severe geographical and logistical barriers. The Committee, however, views that transitioning from isolated pilot projects to a operationalized, nation-wide medical drone delivery system is paramount for achieving universal health accessibility. The Committee believes that reducing turnaround times for pathological testing and ischemic windows for organ transplants directly translates into lives saved. The Committee, therefore, recommends that the Department of Health Research collaborate with the Ministry of Civil Aviation to establish designated "Green Medical Air Corridors" connecting peripheral health centers to district and tertiary care hospitals across all hilly, island, and hard-to-reach regions. The Committee is of the view that the formal integration of drone-based logistics into the Universal Immunization Program (UIP), the National TB Elimination Program (NTEP), and the National Organ and Tissue Transplant Organization (NOTTO) to ensure the uninterrupted, rapid transport of vaccines, diagnostic samples, blood products, and tissue grafts.

3.8.6 The Committee is assured that the creation of the ICMR-IISc Centre for Medical Image Datasets (MIDAS) and the release of ethical guidelines for AI in healthcare mark significant steps forward. The Committee believes that AI-powered point-of-care tools can democratize specialized diagnostic expertise in resource-constrained rural public health facilities. The Committee, however, observes that a lack of standardized, indigenous reference data often stifles private and academic medtech innovation in

India. The Committee, therefore, recommends expanding the MIDAS initiative beyond oral cancer and dural lesions to include thematic reference datasets for high-burden conditions such as diabetic retinopathy, maternal-fetal anomalies, and chest radiographs. The Committee, further, recommends that AI-enabled be progressively procured and deployed at all Ayushman Arogya Mandirs to empower mid-level health providers with immediate, high-accuracy diagnostic capabilities.

3.8.7 The Committee notes that ICMR has initiated AI-based predictive analytics for disease burden estimation and early warning systems for outbreaks such as Dengue, Malaria, and COVID-19 through the newly established ICMR-National Institute of Research in Digital Health and Data Sciences. The Committee is of the view that proactive, data-driven epidemic forecasting is far more cost-effective than reactive outbreak management, which severely strains healthcare infrastructure and public finances. The Committee, therefore, recommends establishing real-time linkages between ICMR's AI early-warning predictive models and state public health management cadres to enable automated alerts for vector-borne and infectious disease surges. The Committee believes that dedicated funding for investigator-initiated AI/ML projects focusing on non-communicable disease (NCD) risk projection, enabling targeted lifestyle and clinical interventions long before acute hospitalization is required.

3.8.8 The Committee appreciates the critical breakthroughs in cost reduction, such as providing pediatric formulations like PREVALL for childhood leukemia at one-tenth of international costs, alongside diagnostic solutions for occupational diseases like silicosis. The Committee believes that no family should face catastrophic health expenditure or impoverishment due to specialized childhood cancers or occupational hazards that afflict vulnerable labor populations. The Committee is of the view that public sector production and procurement must be leveraged to drive market prices down across all rare and high-cost conditions. The Committee, therefore, recommends that formulations like PREVALL and pediatric isotretinoin be included in the National Essential Medicines List (NEML) and guaranteed through centralized public procurement schemes to ensure zero-cost availability across all government pediatric oncology centers. The Committee also recommends launching targeted, mandatory screening drives using DHR-validated low-cost diagnostics for occupational diseases like silicosis in high-risk industrial, mining, and construction corridors across India.

3.9 Optimal Use of Resources to Strengthen Health Services for Underserved Populations

3.9.1 The Department of Health Research (DHR) and the ICMR have launched several strategic initiatives to improve healthcare access, strengthen research capacity and optimize resource utilization, particularly in rural, tribal and geographically challenging regions. To strengthen health research infrastructure, DHR-ICMR has established Multidisciplinary Research Units (MRUs) and Model Rural Health Research Units (MRHRUs), supported by regional hubs and mentorship programmes to build research capacity and train healthcare professionals, especially in rural and underserved medical colleges.

3.9.2 ICMR institutes, including ICMR–National Institute of Traditional Medicine (NITM), ICMR–National Institute of Malaria Research (NIMR) and ICMR–Vector Control Research Centre (VCRC), have piloted culturally appropriate traditional medicine-based interventions and eco-friendly disease control measures, such as bio-larvicides, in tribal and rural communities. To promote indigenous medical technologies, DHR-ICMR has established Centres of Excellence (CoEs) at seven Indian Institutes of Technology (IITs). These centres develop affordable, need-based healthcare technologies under the 'Make in India' initiative and facilitate collaboration between IITs and ICMR for clinical validation and large-scale deployment, particularly in rural areas. DHR also provides translational research grants to convert research into affordable products and interventions for underserved populations.

3.9.3 The Committee is pleased to observe that the National Health Research Priorities (NHRP) focus on antimicrobial resistance (AMR), One Health, tuberculosis, vector-borne diseases, cancer and non-communicable diseases, with emphasis on high-burden and underserved regions. In this regard, the Committee recommends that under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), DHR-ICMR must continue for strengthening pandemic preparedness by upgrading Virus Research and Diagnostic Laboratories (VRDLs) to improve early pathogen detection, outbreak investigations and disease control.

3.9.4 The Committee has been informed that five Viral Disease Diagnostic Laboratories at Kota, Rishikesh, Raipur, Rajkot and Bibinagar are being upgraded to Biosafety Level-3 (BSL-3) standards, expanding diagnostic capability for high-risk pathogens at the State level. ICMR has also deployed two mobile BSL-3 laboratories to provide rapid on-site diagnostics during outbreaks, particularly in remote and inaccessible areas. To strengthen regional surveillance, ICMR is establishing four Regional National Institutes of Virology at Jammu, Jabalpur, Dibrugarh and Bengaluru, complementing the existing national network for responding to future epidemics and pandemics. DHR-ICMR is also establishing the National Institute of One Health (NIOH) at Nagpur to coordinate and integrate One Health activities nationwide. The Institute will undertake interdisciplinary research across human, animal, plant and environmental health, strengthening surveillance, early detection and response to emerging infectious diseases through a comprehensive One Health approach.

3.9.5 The Committee takes note of significant establishment of five BSL-3 facilities (in Kota, Rishikesh, Raipur, Rajkot, and Bibinagar), the deployment of mobile BSL-3 units, and the setting up of the National Institute of One Health (NIOH) at Nagpur alongside four regional National Institutes of Virology (NIVs). The Committee views that decentralized regional biosecurity infrastructure is essential to detect pathogen clusters early and prevent localized outbreaks from escalating into national crises. The Committee believes that cross-sectoral threats at the human-animal-environmental interface require a unified governance structure. The Committee, therefore, recommends the time-bound operationalization and full staffing of the four regional NIV hubs (Jammu, Jabalpur, Dibrugarh, and Bengaluru) and the National Institute of One Health (NIOH) at Nagpur. The Committee, visualizes that expanding the deployment of Mobile BSL-3 diagnostic units to cover every geographically isolated, eco-sensitive, and international border zone would definitely ensure rapid on-site

outbreak investigation and ensure immediate necessary medical interventions for needy patients.

3.10 Research & Development Projects Enhancing Healthcare Affordability and Accessibility

3.10.1 The Committee applaudes that the R&D initiatives of DHR have significantly improved healthcare affordability and accessibility through the development of indigenous diagnostics, medical technologies and affordable treatments. Key innovations include AI-enabled TB screening devices, CRISPR-based diagnostic kits, rapid tests for infectious diseases, automated cervical cancer screening, brain injury assessment tools, and low-cost paediatric cancer therapies. DHR has also strengthened national programmes such as the India Hypertension Control Initiative (IHMI) and Anaemia Mukt Bharat, while Health Technology Assessment in India (HTAIn) has supported evidence-based adoption of cost-effective interventions under Ayushman Bharat and other public health programmes.

3.11 Barriers to Health Innovation and Strategies to Overcome

3.11.1 DHR informed the Committee that several challenges continue to impede the development and adoption of affordable healthcare technologies in India. A major constraint is the high cost of innovation and regulatory compliance, as developing diagnostics, therapeutics and medical devices requires substantial investment and multiple approvals, discouraging smaller innovators. To address this, the Department of Health Research (DHR) and the Indian Council of Medical Research (ICMR) provide targeted funding through the First-in-the-World Challenge and regulatory support through MedTech Mitra and Patent Mitra, reducing financial and procedural barriers.

3.11.2 Another challenge is limited access to research and validation infrastructure, including accredited laboratories and Good Manufacturing Practice (GMP) facilities. To bridge this gap, ICMR launched the I-RISE Portal in November 2024, enabling innovators to access advanced research infrastructure across its institutes. The portal has facilitated over 1,700 bookings, accelerating affordable health technology development. In addition, the proposed Medical Innovation and Development Accelerator Centre (MIDAC), a Section 8 company under DHR, will establish a nationwide network of validation centres and biobanks. The fragmented research-to-market pathway often delays commercialization of innovations. DHR addresses this through Centres of Excellence (CoEs) that promote translational research and by integrating Health Technology Assessment in India (HTAIn) to assess cost-effectiveness and support policy adoption. The uneven distribution of innovation, concentrated largely in urban areas, limits access in rural regions. DHR promotes equitable dissemination through Model Rural Health Research Units (MRHRUs), Multidisciplinary Research Units (MRUs) and the National Health Research Priorities (NHRP). Limited private sector participation in public health R&D, owing to low commercial incentives, is being addressed through MedTech Mitra, Patent Mitra, and collaborations with the Atal Innovation Mission and industry partners.

3.11.3 The Committee commends that DHR has adopted an integrated strategy comprising risk mitigation support through the First-in-the-World Challenge and MedTech Mitra; Health Technology Assessment (HTA) for large-scale adoption of cost-effective interventions; Centres of Excellence at IITs and other academic institutions to accelerate affordable MedTech innovation; implementation of the National Health Research Priorities (NHRP) focusing on tuberculosis, antimicrobial resistance (AMR), cancer and non-communicable diseases; and promotion of the One Health approach to strengthen collaborative research across human, animal and environmental health sectors.

3.11.4 The Committee highlights that the I-RISE portal, launched by ICMR in November 2024, has facilitated over 1,700 bookings for high-end research infrastructure, directly lowering compliance and validation hurdles for early-stage innovators. Furthermore, DHR proposes establishing a national network of Biobanks and Validation Centres under MIDAC a section 8 Company. The Committee believes that capital-intensive biomedical instruments in public institutions must be treated as national assets rather than isolated institutional property. The Committee is of the view that lack of access to biological samples and standardized testing facilities remains a major barrier for Indian MSMEs. The Committee, therefore, recommends making it mandatory for all central health institutions, AIIMS, and state medical colleges receiving government grants to list their advanced research equipment on the I-RISE portal for shared access. The Committee, further, recommends the immediate rollout of the proposed national network of accredited Biobanks and Validation Centres under MIDAC to provide start-ups with seamless access to high-quality clinical samples and testing facilities.

3.11.5 The Committee emphasizes DHR's efforts to tackle NCDs through the scale-up of the India Hypertension Control Initiative (IHMI) and nutritional advocacy by ICMR-NIN regarding High in Fat, Sugar, and Salt (HFSS) food labelling. The Committee, however, is of the view that curb-side clinical treatment alone cannot halt the growing burden of metabolic disorders, hypertension, and cardiovascular diseases. The Committee believes that strong, preventive public policy interventions are necessary to foster healthier population-level choices and minimize long-term chronic healthcare costs. The Committee, therefore, recommends that the Government expedite mandatory, standardized front-of-pack HFSS food labelling regulations, incorporating the scientific thresholds established by the ICMR-National Institute of Nutrition (NIN). The Committee also recommends expanding the India Hypertension Control Initiative (IHMI) framework into a universal protocol across every primary healthcare center in the country, ensuring protocol-based management and unbroken supply chains for essential anti-hypertensive drugs.

3.11.6 The Committee understands that developing breakthrough biomedical technology involves high capital requirements, complex regulatory compliance, and significant market risk, often leading to limited private sector participation. Schemes like the "First in the World Challenge" and translational grant frameworks are designed to mitigate these financial "valleys of death." The Committee believes that

relying exclusively on imported cutting-edge technologies exposes national health security to supply chain vulnerabilities and prohibitive pricing. The Committee is of the view that state-backed risk-sharing mechanisms are necessary to build indigenous global technology leaders. The Committee, therefore, recommends the creation of a dedicated, high-value 'National Biomedical Breakthrough Innovation Fund' under DHR to expand programs like the 'First in the World Challenge' for high-risk, high-reward translational research. The Committee believes establishing tax-incentivized co-developmental frameworks and matching-grant schemes to encourage private medtech and pharmaceutical enterprises to co-fund public R&D projects from prototype to market launch.

3.12 Translating R&D into Safe, Affordable and Scalable Healthcare Solutions

3.12.1 DHR informed the Committee that it has established a comprehensive R&D funding ecosystem through intramural and extramural research grants to promote innovations aligned with national health priorities. These initiatives have enabled the development and deployment of indigenous diagnostics, AI-based TB screening tools, biomedical devices, and HTA-supported interventions, facilitating the translation of research into scalable public health solutions.

3.13 Ensuring Sustainability through Accessibility, Affordability and Quality

3.13.1 DHR stated that it promotes sustainable healthcare by supporting community-based research, evidence-based adoption of cost-effective technologies through HTAIn, decentralized research infrastructure, innovation platforms such as MedTech Mitra, and national programmes including PM-ABHIM and the National Health Research Priorities (NHRP). These initiatives strengthen healthcare access, quality, disease surveillance and pandemic preparedness.

3.14 R&D through Public-Private Partnership (PPP) Models

3.14.1 DHR informed the Committee that public-private partnerships play a vital role in accelerating health innovation through platforms such as MedTech Mitra, Patent Mitra, and ICMR Centres of Excellence at IITs and AIIMS. These initiatives facilitate regulatory support, technology transfer, clinical validation, indigenous manufacturing and commercialization by bringing together government agencies, academia and industry to develop affordable and accessible healthcare technologies.

3.15 Adapting Existing Medicines through R&D for Local Health Needs

3.15.1 DHR informed the Committee that it is optimizing existing medicines and treatment protocols to improve affordability and suitability for Indian healthcare needs. Key initiatives include HTA-based optimization of treatment regimens, such as reducing the duration of Trastuzumab therapy while maintaining clinical effectiveness, evaluation of cost-effective treatment and delivery models, and the First in the World Challenge, which provides stage-

wise funding to support the development of innovative, affordable and scalable healthcare solutions.

3.16 Addressing Inequities in Health Infrastructure and Service Access through Strategic R&D

3.16.1 DHR stated that it is addressing disparities in healthcare access through research on decentralized service delivery, community-based interventions, telemedicine, and State-specific Health Technology Assessment (HTA). These initiatives aim to provide evidence-based solutions for improving healthcare infrastructure and equitable access, particularly in underserved regions.

3.17 R&D to Advance Universal Health Coverage (UHC) and Community Healthcare

3.17.1 DHR informed the Committee that its R&D priorities support Universal Health Coverage (UHC) by focusing on high-burden diseases, community-based innovations, behavioural and social research, digital and assistive health technologies, and emergency preparedness for vulnerable populations. These initiatives seek to strengthen community healthcare, reduce health inequities, and ensure affordable and accessible healthcare for disadvantaged and marginalized groups.

3.18 Fair and Transparent Drug Pricing

3.18.1 DHR informed the Committee that, while NPPA regulates drug prices under the Drugs (Prices Control) Order, 2013, greater transparency and fairness can be achieved by integrating Health Technology Assessment (HTA) into pricing decisions. DHR is promoting value-based pricing, research on pricing models for innovative therapies, and capacity building in health economics, pricing transparency and regulatory frameworks to balance affordability with innovation.

3.19 Future Investment in Health R&D and Strategic Measures (2025–2029)

3.19.1 DHR informed the Committee that the DHR–ICMR Viksit Bharat Strategic Plan (2025–2029) aims to strengthen India's health research ecosystem through increased investment in indigenous and affordable health technologies, research on priority public health challenges, digital health and AI, evidence-based policymaking, pandemic preparedness, and global leadership in medical research. The strategy emphasizes innovation, expansion of digital infrastructure, strengthening surveillance systems, promoting physician-led research, and extending research coverage to high-burden districts to improve healthcare accessibility, affordability and quality.

3.20 Identifying Barriers to Health Innovation and Promoting Equitable Access

3.20.1 DHR informed the Committee that it is addressing barriers to health innovation through interdepartmental collaboration, strengthened research infrastructure, targeted R&D,

and international partnerships. Key initiatives include MedTech Mitra, the One Health Mission, ICMR Centres of Excellence, the Indian Clinical Trial and Education Network (INTENT), and research on affordable diagnostics, vaccines, AI-enabled healthcare, epidemic preparedness, and implementation science. These measures aim to translate scientific advances into affordable and accessible healthcare solutions.

3.21 R&D for Improving Access to Healthcare

3.21.1 DHR stated that its R&D programmes enhance healthcare access by improving affordability, availability, accessibility, and acceptability of services. Through indigenous technologies, Health Technology Assessment (HTAIn), research infrastructure, MRUs, MRHRUs, community-based projects, and State-specific research priorities, DHR promotes evidence-based, context-specific and scalable healthcare solutions, particularly for underserved populations.

3.22 Strengthening India's Global MedTech Ecosystem and Product Development

3.22.1 DHR informed the Committee that it is strengthening India's position in the global pharmaceutical and MedTech value chain by expanding clinical trial networks, supporting research across ICMR institutions, establishing Centres of Excellence and advanced manufacturing facilities, and promoting indigenous innovation through intellectual property and technology transfer policies. The proposed Medical Innovations Development Advancement Company (MIDAC) will further accelerate translational research, clinical validation, and commercialization of medical technologies through partnerships among government, academia and industry.

3.22.2 The Committee understands highlights the limitations of the current market-based drug pricing mechanism administered by the National Pharmaceutical Pricing Authority (NPPA) under DPCO 2013, particularly regarding innovative biologics, biosimilars, and high-cost therapies. The Committee is of the view that pricing based on average retailer margins fails to deliver fair, sustainable pricing for novel interventions. The Committee believes that pricing governance must strike a balance between the cost-based model and a value-based model to ensure both affordability and industry sustainability. The Committee, in this regard, recommends that Health Technology Assessment (HTAIn) outputs on clinical efficacy, social value, and cost-effectiveness be formally integrated into NPPA's price-fixation guidelines for all high-cost biologics, orphan drugs, and biosimilars. The Committee, further, recommends that DHR collaborate with the NPPA to establish legal and economic policy frameworks for Value-Based Pricing and Managed Entry Agreements (MEAs), while strengthening capacity to utilize TRIPS flexibilities for critical, life-saving therapies.

3.22.3 The DHR-ICMR Viksit Bharat Strategic Plan (2025–2029) sets ambitious targets to transition India into a high-value global innovation hub by advancing frontier research in synthetic organs, gene therapy platforms, and therapeutic vaccines. To support this, stage-wise funding mechanisms—such as the "First in the World Challenge" (offering ₹1 crore for PoC, ₹4 crore for prototype, and ₹10 crore for

rollout)—have been structured. The Committee believes that India's long-term health security depends on shifting from low-cost generic manufacturing to pioneering transformative, cutting-edge therapies. The Committee, therefore, recommends dedicated annual budgetary outlays under the 2025–2029 Strategic Plan specifically earmarked for high-risk, frontier biomedical research in gene therapy and synthetic biology. The Committee also recommends for establishing specialized 'Frontier Health Accelerators' across leading research institutions to facilitate the seamless transition of projects through DHR's three-tiered funding framework from concept to nationwide market deployment.

3.22.4 The Committee notes that in order to elevate the domestic MedTech sector within the global value chain, ICMR has operationalized a Phase-I First-in-Human trial network, the 79-centre INTENT network for Phase II/III trials, and the mPRAGATI Metal Additive Manufacturing facility at IIT Delhi. Furthermore, the Department of Expenditure has granted in-principle approval for establishing MIDAC. The Committee is of the view that a lack of affordable prototyping tools and delayed clinical validations remain the primary bottlenecks for domestic MedTech enterprises. The Committee, therefore, recommends replicating the mPRAGATI rapid-prototyping and additive manufacturing model across all major technical and medical hubs to give start-ups and MSMEs affordable access to advanced engineering tools. The Committee believes that establishing an expedited validation track within the 79-centre INTENT network under MIDAC would allow domestic manufacturers to conduct regulation-compliant preclinical and clinical evaluations within fixed, fast-tracked timelines.

3.22.5 The Committee understands stresses that Universal Health Coverage (UHC) requires balancing the five dimensions of access: Affordability, Availability, Accessibility, Accommodation, and Acceptability. DHR has initiated R&D into assistive tech for the differently-abled, voice-based applications for low-literacy users, and scientifically validated AYUSH formulations (such as Punarnavadi Mandura for anemia). The Committee believes that equity cannot be achieved without customizing health delivery to the socio-cultural, physical, and literacy constraints of marginalized populations. The Committee, therefore, recommends that DHR launch a targeted grant scheme for digital and assistive innovations, prioritizing voice-assisted diagnostic tools for low-literacy populations and AI-based triaging systems for primary health settings. The Committee is of the view to expand clinical trials under the AYUSH-ICMR Advanced Centres to evaluate, standardize, and scale cost-effective traditional formulations into mainstream national health programs to reduce out-of-pocket therapeutic expenditures.

3.23 Ministry of Ayush

3.23.1 The Ministry of Ayush, in its submission to the Committee, highlighted the measures being undertaken to improve the affordability and accessibility of healthcare, particularly by reducing out-of-pocket expenditure (OOPE). The Ministry informed that it is implementing the Centrally Sponsored Scheme of the National Ayush Mission (NAM) through the State and

Union Territory Governments for the promotion and development of Ayush systems of medicine across the country.

3.23.2 The primary objective of the National Ayush Mission is to provide cost-effective, equitable and accessible Ayush healthcare services by strengthening Ayush health infrastructure and improving service delivery. The Mission also seeks to establish a holistic wellness model through Ayushman Arogya Mandir–Ayush [AAM (Ayush)], with emphasis on preventive and promotive healthcare based on Ayush principles and practices, thereby reducing disease burden and out-of-pocket expenditure. Under the Mission, the Ministry provides grant-in-aid to States and Union Territories based on the proposals submitted through their State Annual Action Plans (SAAPs). Financial assistance is provided for activities prescribed under the NAM Guidelines, including strengthening healthcare infrastructure, supply of Ayush medicines, deployment of human resources and other measures aimed at improving access to affordable Ayush healthcare services.

3.23.3 The Ministry of Ayush informed the Committee that it has undertaken several initiatives to strengthen collaboration with private healthcare organizations and improve access to Ayush services. Through its Drug Policy Section (DPS), the Ministry has held consultations with the Insurance Regulatory and Development Authority of India (IRDAI), the General Insurance Council, public and private health insurers, and other stakeholders to address insurance-related issues in the Ayush sector. It also constituted a Core Group of Experts on Insurance Coverage for Ayush Systems on 4 October 2023 to facilitate wider insurance coverage. In response to the growing demand for Ayush treatment, IRDAI, through its guidelines dated 31 January 2024, advised insurers to provide cashless Ayush treatment with 100 per cent reimbursement up to the insured sum. The Ministry has also organized sensitization programmes for Ayush and insurance stakeholders across the country and is actively consulting the National Health Authority (NHA) for inclusion of Ayush treatment packages under Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY).

3.23.5 The Ministry further informed that the Central Government Health Scheme (CGHS) has expanded access to Ayush healthcare through empanelment of private institutions. At present, 54 private Ayush Day Care Centres are functioning in Delhi-NCR and 68 private Ayush IPD hospitals are empanelled under CGHS across the country. The empanelment of private Ayush Day Care Centres was introduced in 2020 on a pilot basis for Ayurveda and Yoga & Naturopathy in Delhi-NCR and was extended up to June 2025 for NABH-accredited centres. The proposal to expand empanelment to Ayurveda, Yoga & Naturopathy, Unani and Siddha across all CGHS cities is under consideration. The 68 empanelled private Ayush IPD hospitals, empanelled since before 2008, are authorized to provide both inpatient and day-care treatment, significantly improving access to holistic Ayush healthcare for CGHS beneficiaries.

3.23.6 The National Institute of Homoeopathy (NIH) informed the Committee that, in collaboration with Hindustan Copper Limited, it organized a free healthcare camp in Kolkata during 2024-25. It also participated in the Gangasagar Mela from 10-16 January 2025, where 2,021 patients received Homoeopathic treatment, thereby extending affordable healthcare services to the public.

3.23.7 The Ministry of Ayush informed the Committee that no statutory price control mechanism currently exists for Ayush drugs. However, Indian Medicines Pharmaceutical Corporation Limited (IMPCL), the central PSU under Ministry of Ayush, use to prepare the Costing data product wise as well as segment wise on the basis of full absorption costing methodology based on cost audit and annual accounts of the company and this data is submitted with Office of Chief Adviser Cost, Dept. of Expenditure, Ministry of Finance, through Ministry of Ayush, for vetting the price of Ayurvedic and Unani Medicines. The vetted prices are implemented and valid till next vetting.

3.23.8 The Committee notes the proactive consultations held by the Ministry of Ayush with the Insurance Regulatory and Development Authority of India (IRDAI) and the subsequent advisory mandating 100 per cent reimbursement for cashless Ayush treatments. However, the Committee is of the view that true affordability for the most vulnerable sections of society can only be achieved if holistic healthcare is firmly integrated into robust public welfare schemes. The Committee believes that the ongoing consultations with the National Health Authority (NHA) must be concluded without further delay. The Committee, therefore, recommends that the Government immediately formalize the inclusion of comprehensive Ayush treatment packages under the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Furthermore, a strict monitoring mechanism must be established to ensure that private insurers comply seamlessly with the IRDAI directives, thereby minimizing administrative bottlenecks and reducing out-of-pocket expenditure (OOPE) for the public.

3.23.9 The Committee acknowledges the ongoing efforts to expand access to Ayush healthcare through the empanelment of private institutions under the Central Government Health Scheme (CGHS). However, the Committee is of the view that restricting the empanelment of Ayush Day Care Centres to the Delhi-NCR region on a pilot basis creates geographic disparities in healthcare access for beneficiaries. The Committee, therefore, recommends that the Ministry swiftly approve and implement the proposal currently under consideration to expand the empanelment of private Ayurveda, Yoga & Naturopathy, Unani, and Siddha Day Care Centres, as well as IPD hospitals, across all CGHS-covered cities nationwide. This expansion must be closely tied to National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation to guarantee high standards of service delivery and equitable access to holistic healthcare across the country.

3.23.10 The Committee observes with concern the Ministry's submission that no statutory price control mechanism currently exists for Ayush drugs in the open market. While acknowledging the price-vetting methodology applied to the central public sector undertaking (IMPCL), the Committee believes that leaving private sector Ayush pharmaceuticals unregulated exposes patients to arbitrary pricing, directly contravening the National Ayush Mission's objective of cost-effective healthcare. The Committee, therefore, recommends that the Ministry of Ayush, in coordination with the Ministry of Finance and relevant pharmaceutical pricing authorities, formulate and

implement a comprehensive statutory price control framework. This mechanism should cap the maximum retail prices of essential and widely prescribed Ayush medicines, ensuring they remain affordable for the general populace while curbing overall out-of-pocket expenditure.

3.23.11 The Committee acknowledges the pivotal role of the National Ayush Mission (NAM) in establishing a holistic wellness model via Ayushman Arogya Mandir-Ayush [AAM (Ayush)] to promote preventive healthcare and reduce the overall disease burden. However, the Committee is of the view that the dependency on State Annual Action Plans (SAAPs) for grant-in-aid can often lead to procedural delays, hampering the timely deployment of human resources and the strengthening of critical healthcare infrastructure. The Committee believes that robust preventive and promotive healthcare at the grassroots level is the most effective strategy to sustainably lower out-of-pocket expenditure. The Committee, therefore, recommends that the Ministry establish a strict, time-bound framework for the evaluation and approval of SAAPs. Furthermore, a dedicated monitoring mechanism must be instituted to ensure prompt fund disbursement and execution by the State and Union Territory Governments, thereby accelerating the nationwide delivery of cost-effective and equitable Ayush services.

3.23.12 The Committee notes with appreciation the outreach initiatives undertaken by the National Institute of Homoeopathy (NIH), notably the free healthcare camps organized in collaboration with Hindustan Copper Limited and the medical relief provided to over 2,000 patients during the Gangasagar Mela. The Committee is of the view that such public-private collaborations and targeted interventions during mass gatherings are highly effective in extending affordable Ayush healthcare directly to the masses. The Committee believes that this proactive outreach model should not remain an isolated effort but must be systematically replicated across all disciplines. The Committee, therefore, recommends that the Ministry formulate a structured policy mandating all National Institutes and autonomous bodies under its purview to actively partner with Central Public Sector Enterprises (CPSEs) and private stakeholders. By systematically leveraging Corporate Social Responsibility (CSR) funds, these institutes can permanently scale up the deployment of free healthcare camps and mobile clinics in remote and underserved regions, significantly enhancing grassroots accessibility.

3.23.13 The Ministry of Ayush informed the Committee that, although public health is primarily a State subject, it supports States and Union Territories in improving access to affordable Ayush healthcare through the National Ayush Mission (NAM). Financial assistance is provided for operationalization of Ayushman Arogya Mandirs (Ayush), co-location of Ayush services at Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs), upgradation of Government Ayush hospitals, dispensaries and teaching institutions, establishment of new Ayush dispensaries and colleges, supply of essential medicines, implementation of Ayush public health programmes, infrastructure development of undergraduate and postgraduate institutions, and Information, Education and Communication (IEC)/Behaviour Change Communication (BCC) activities.

The Central Council for Research in Unani Medicine (CCRUM) informed the Committee that it provides treatment through 21 clinical institutes and units offering General OPD, Reproductive and Child Health OPD, Geriatric OPD and Non-Communicable Disease clinics. Healthcare services are also delivered through Arogyas, Health Melas, health camps, exhibitions, Mobile Research Programmes, School Health Programmes, Scheduled Caste Sub-Plan (SCSP) and Tribal Sub-Plan (TSP) Mobile Healthcare Programmes. In addition, CCRUM operates extension and relocation centres at Dr. Ram Manohar Lohia Hospital, Dr. Deen Dayal Upadhyay Hospital, All India Institute of Ayurveda, AYUSH Wellness Centre, Safdarjung Hospital (New Delhi), JJ Hospital (Mumbai) and Kannur (Kerala) to expand access to Unani treatment.

3.23.14 The Ministry of Ayush informed the Committee that the Central Council for Research in Siddha (CCRS) delivers healthcare through nine peripheral research institutes and units located in Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Puducherry, Delhi and Goa, besides co-located Siddha OPDs at the National Institute of Epidemiology (ICMR), CLRI Chennai, Pondicherry Central University, AYUSH Wellness Clinic at Rashtrapati Bhavan Estate and the All India Institute of Ayurveda. Specialized services are provided through Non-Communicable Disease, Geriatric, Reproductive and Child Health, Varmam, Thokkanam Bone Setting and Yogam OPDs, complemented by regular health awareness programmes. To improve accessibility of Siddha medicine, CCRS has implemented the Swasthya Rakshan Programme through six peripheral institutes by organizing regular medical camps, undertaken Information, Education and Communication (IEC) activities through Arogya Fairs, Ayush Expos, Global Summits and Ayurveda Parvs, provides free consultations and medicines, offers eSanjeevani tele-consultation services with patient registration, audio-video consultation, e-prescriptions and SMS/email notifications, and promotes Siddha medicine through print, electronic and social media platforms.

3.23.15 The Ministry of Ayush stated that the National Institute of Sowa-Rigpa (NISR) operates regular male and female outpatient departments (OPDs) and a 10-bedded teaching hospital providing inpatient services.

3.23.16 The Committee was informed by the Ministry that the North Eastern Institute of Ayurveda and Homoeopathy (NEIAH), Shillong, provides Ayurveda and Homoeopathy OPD and IPD services, operates a peripheral rural OPD at Smit Village in Meghalaya, supplies Ayush medicines free of cost (subject to availability), conducts regular yoga sessions, health awareness programmes, medical camps and Poshan-related activities, and has adopted five villages for healthcare outreach. The Institute is implementing a public health research project on Ayurvedic interventions for Iron Deficiency Anaemia among tribal women in Meghalaya and is collaborating with the Central Council for Research in Homoeopathy (CCRH) on adolescent menstrual health. NEIAH has also integrated physiotherapy, dentistry, laboratory and radiology services with Ayush treatment and actively participated in the Desh Ka Prakriti Parikshan Campaign, registering over 10,000 beneficiaries. Internal digital platforms such as e-Office, AYUSH NEXT, A-HMIS, LIMBS, Sanjeevani and Desh Ka Prakriti Parikshan are also being utilized to improve service delivery.

3.23.17 The Ministry of Ayush highlighted that the National Institute of Homoeopathy (NIH) provides highly affordable healthcare through OPD services with a registration fee of ₹5, including medicines, and nominal investigation charges. The Institute offers specialized clinics, comprehensive diagnostic facilities and a 100-bedded hospital, with plans to expand to 250 beds. Treatment, medicines, food and inpatient care are provided free of cost for general and cabin beds, while air-conditioned cabins are available at ₹200 per day. The Institute also operates 10 Peripheral OPDs across different districts of West Bengal, extending Homoeopathic healthcare to patients from West Bengal and neighbouring States.
The Institute of Teaching and Research in Ayurveda (ITRA), Jamnagar, informed the Committee that it operates extension and satellite clinics at old-age homes, Air Force and Army establishments, INS Valsura, district jail and other community locations, thereby improving access to Ayurvedic healthcare services for diverse sections of the population.

3.23.18 The Ministry of Ayush, on a query on availability of Ayush-specific pharmacy centres in the country, through its Drug Policy Section (DPS), informed the Committee that during the Review Meeting of the Ministry of Ayush held on 27 February 2025 under the Chairmanship of the Hon'ble Prime Minister, it was decided that Pradhan Mantri Bhartiya Janaushadhi Kendras (Jan Aushadhi Kendras) may be leveraged to promote Ayush medicines through appropriate co-branding, for a wider visibility which can be expanded further, if required. The Ministry of Ayush is trying to explore further action in this regard.

3.23.19 The Committee notes the decision taken during the Review Meeting chaired by the Hon'ble Prime Minister on 27 February 2025 to leverage Pradhan Mantri Bhartiya Janaushadhi Kendras for the promotion of Ayush medicines through appropriate co-branding. However, the Committee is of the view that merely "exploring further action" is an inadequate response to an executive directive aimed at reducing out-of-pocket healthcare costs. The Committee believes that utilizing the established nationwide retail network of Jan Aushadhi Kendras will exponentially increase the accessibility and affordability of essential, quality-tested Ayush pharmaceuticals. The Committee, therefore, recommends that the Ministry of Ayush rapidly finalize and execute this co-branding initiative in a strict, time-bound manner, ensuring that high-quality, standardized Ayush medicines are made available across all Jan Aushadhi Kendras without further administrative delay.

3.23.20 The Committee appreciates the diverse outreach strategies adopted by the National Institutes and Research Councils, such as the co-location of Unani and Siddha OPDs in major allopathic hospitals by CCRUM and CCRS, the adoption of rural villages by NEIAH, and the establishment of satellite clinics by ITRA. Concurrently, the Committee notes that the broader mainstreaming of Ayush through co-location at Primary Health Centres (PHCs), Community Health Centres (CHCs), and District Hospitals (DHs) is currently contingent upon the manpower support and demand projected by States and Union Territories in their respective Programme Implementation Plans (PIPs) and State Annual Action Plans (SAAPs). The Committee is of the view that relying entirely on the proactive requests of individual States leads to severe regional disparities in healthcare accessibility, and that highly cost-effective

integrative models should not be restricted to specific autonomous institutes but must be universally adopted as standard operating procedure.

3.23.21 The Committee believes that out-of-pocket expenditure can be most effectively minimized when patients have simultaneous, unhindered access to both conventional and holistic Ayush treatments under a single roof, directly within their communities. The Committee, therefore, recommends that the Ministry of Ayush, in strict coordination with the Ministry of Health and Family Welfare, formulate a mandatory baseline policy requiring a minimum percentage of all newly sanctioned and existing PHCs, CHCs, and DHs to feature operational, co-located Ayush facilities. The Central Government should aggressively leverage the National Ayush Mission (NAM) to actively incentivize States to meet these integration targets rather than passively awaiting proposals. Furthermore, the Ministry must institutionalize the satellite clinic model across all its institutes to systematically cover underserved areas, tribal regions, and vulnerable populations nationwide.

3.23.22 The Committee takes positive note of the integration of digital health platforms, such as eSanjeevani, A-HMIS, and AYUSH NEXT- by institutions like CCRS and NEIAH to facilitate tele-consultations, e-prescriptions, and patient registration. The Committee is of the view that digital interventions are paramount in bridging the geographical divide, particularly for patients who face logistical and financial barriers to physical healthcare access. The Committee believes that expanding these tele-medicine services across all Ayush disciplines will drastically reduce the indirect costs of healthcare, such as travel expenses and wage loss. The Committee, therefore, recommends that the Ministry establish a centralized mandate to integrate eSanjeevani and comprehensive Hospital Management Information Systems (HMIS) across all Ayush dispensaries, peripheral institutes, and clinical units across the country to guarantee continuous remote access to affordable care.

3.23.23 The Committee commends the National Institute of Homoeopathy (NIH) for providing highly subsidized and comprehensive healthcare- including a nominal ₹5 registration fee that covers medicines, and notes its planned expansion from a 100-bedded to a 250-bedded facility. Conversely, the Committee observes that developing institutions like the National Institute of Sowa-Rigpa (NISR) operate with a significantly smaller 10-bedded teaching hospital. The Committee is of the view that robust inpatient infrastructure is critical for the holistic management of complex, chronic, and non-communicable diseases. The Committee believes that the highly affordable fee structure and expanding inpatient capacity modeled by NIH must serve as the benchmark across the Ayush sector to ensure structural parity. The Committee, therefore, recommends that the Ministry urgently allocate targeted funding to upgrade the bed capacity and diagnostic infrastructure of smaller institutes like NISR. Simultaneously, the Ministry must ensure that a universally subsidized tariff structure, covering registration, diagnostics, and essential medicines, is implemented across all National Institutes to genuinely benefit economically disadvantaged populations.

3.23.24 The Ministry of Ayush informed the Committee that capacity building and continuing professional development of Ayush professionals and nursing personnel is being undertaken through the Capacity Building and Continuing Medical Education (CME) component of the Ayurgyan Scheme, implemented since 2021–22. The Scheme aims to bridge knowledge gaps through need-based professional training. So far, ₹16.76 crore has been released for organizing training and CME programmes, benefiting more than 5,000 Ayush personnel. The All India Institute of Ayurveda (AIIA) informed the Committee that it conducts regular capacity-building programmes for Ayurvedic professionals and nursing cadres. Under the Ayurveda Nursing Skill Upgradation Programme, 10 batches have been completed and 110 nurses trained. Induction training has also been provided to 52 staff nurses and 27 ward attendants.

3.23.25 AIIA has been designated by the Ministry of Ayush, through the Rashtriya Ayurveda Vidyapeeth (RAV), to conduct Continuing Medical Education programmes for Ayurvedic professionals. Training has been imparted in Rasa Shastra and Bhaishajya Kalpana, Kaumarbhritya, Kriya Sharir, Dravyaguna, Panchakarma, Swasthavritta, Kayachikitsa, Rog Nidan Evam Vikriti Vigyan, Shalya Tantra, Shalakya Tantra, Stri Rog Evam Prasuti Tantra, Samhita Siddhant, and Ayurgyan programmes conducted during 2024 at AIIA, New Delhi and AIIA Goa Hospital. In all, 1,080 Ayurvedic professionals from national institutes, research institutes and colleges have been trained.

3.23.26 The Ministry of Ayush informed the Committee that the North Eastern Institute of Ayurveda and Homoeopathy (NEIAH), Shillong besides offering BAMS, BHMS and postgraduate programmes, it has been conducting a one-year Panchakarma Technician Certificate Course with an annual intake of 20 students since the 2018–19 academic session, thereby strengthening the skilled Ayush workforce.

3.23.27 The Ministry of Ayush informed the Committee that, under the National Ayush Mission (NAM), States and Union Territories are supported in implementing structured Ayush Public Health Programmes in rural, tribal and other vulnerable areas. These programmes utilize the preventive, promotive, curative and rehabilitative strengths of Ayush systems, either independently or alongside conventional healthcare. The key initiatives include the National Programme for Prevention and Management of Osteoarthritis and other Musculoskeletal Disorders, focusing on awareness, screening and Ayush interventions; integration of Ayush with the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS); SUPRAJA for Ayush-based maternal and neonatal care through Ayush teaching hospitals; VAYO MITRA for geriatric healthcare; and AYURVIDYA, which promotes healthy lifestyles among school children through Ayush.

3.23.28 To improve access in underserved regions, the Mission also supports Ayush Mobile Medical Units for remote and tribal areas, KARUNYA for Ayush-based palliative care services, and the National Programme on AYUSH for Morbidity Management and Disability Prevention (MMDP) of Lymphatic Filariasis, which provides Ayush interventions for managing lymphoedema and preventing disability.

3.23.29 The Ministry of Ayush informed the Committee that, under the National Ayush Mission (NAM), financial assistance is provided to States and Union Territories for implementing structured Ayush Public Health Programmes across the country, including rural, tribal and other vulnerable areas. These programmes utilize the preventive, promotive, curative and rehabilitative potential of Ayush systems as standalone interventions or in convergence with conventional healthcare.

3.23.30 The programmes include the National Programme for Prevention and Management of Osteoarthritis and other Musculoskeletal Disorders, focusing on awareness, screening and Ayush interventions; integration of Ayush with the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS); SUPRAJA for strengthening Ayush-based maternal and neonatal healthcare through Ayush teaching hospitals; VAYO MITRA for promoting healthy and productive ageing through geriatric healthcare services; AYURVIDYA for promoting healthy lifestyles among school children through Ayush; Ayush Mobile Medical Units to provide healthcare services in remote, underserved and tribal areas; KARUNYA for Ayush-based palliative care services to improve the quality of life of patients; and the National Programme on AYUSH for Morbidity Management and Disability Prevention (MMDP) of Lymphatic Filariasis, which provides Ayush interventions for the management of lymphoedema and prevention of disability.

3.23.31 The Ministry of Ayush informed the Committee that mainstreaming Ayush is a core strategy of the National Health Mission (NHM) to ensure accessible, affordable and quality healthcare. Under NHM, Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) doctors and paramedics are supported through co-location at District Hospitals (DHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs), with priority accorded to remote PHCs and CHCs.

3.23.32 The Ministry stated that the expansion of co-located Ayush facilities depends on the manpower support available under NHM and the demand projected by States and Union Territories for establishing Ayush units in public health facilities. Under the National Ayush Mission (NAM), financial assistance is also provided for infrastructure development and supply of medicines for co-located Ayush units based on proposals received through the State Annual Action Plans (SAAPs). To accelerate the mainstreaming of Ayush, the Ministry has requested States and Union Territories to adequately project their requirements for co-location of Ayush units at PHCs, CHCs and DHs in their Programme Implementation Plans (PIPs) under NHM and State Annual Action Plans (SAAPs) under NAM, thereby strengthening the integration of Ayush services within the public healthcare system.

3.23.33 The Committee acknowledges the ongoing capacity-building efforts under the Ayurgyan Scheme and the specific training programmes conducted by the All India Institute of Ayurveda (AIIA) and the North Eastern Institute of Ayurveda and Homoeopathy (NEIAH). However, the Committee is of the view that the current scale of training—benefiting approximately 5,000 personnel and a limited number of nursing and technical staff—is vastly insufficient to meet the nationwide demand for accessible Ayush healthcare. The Committee believes that a critical shortage of trained allied professionals, such as Panchakarma technicians and Ayush-specialized nurses, directly

hampers the delivery of affordable, holistic care at the grassroots level. The Committee, therefore, recommends that the Ministry mandate all National Institutes and teaching hospitals under its purview to introduce formalized diploma and certificate courses for allied Ayush healthcare workers, emulating the NEIAH model. Furthermore, funding under the Ayurgyan Scheme must be substantially augmented to support a decentralized, nationwide training network.

3.23.34 The Committee appreciates the formulation of specialized Ayush Public Health Programmes under the National Ayush Mission (NAM), such as SUPRAJA, VAYO MITRA, KARUNYA, and the deployment of Ayush Mobile Medical Units, directed at underserved, tribal, and remote areas. The Committee is of the view that these preventive and promotive interventions are vital for managing non-communicable diseases and reducing the long-term disease burden among the most vulnerable demographic segments. The Committee believes that the uninterrupted delivery of these specific outreach programmes is essential for ensuring national health equity. The Committee, therefore, recommends that the Ministry establish a dedicated, ring-fenced budget allocation within NAM explicitly for these targeted public health programmes and mobile medical units. Strict monitoring must be enforced to ensure that funds intended for rural and tribal healthcare outreach are not diverted, thereby guaranteeing sustained accessibility to affordable Ayush care for marginalized populations.

3.23.35 The Ministry of Ayush informed the Committee that, to promote cost-effective and value-added Ayush services, the Drug Policy Section (DPS) has constituted a Committee to revise the "Guidelines for Insurance Coverage of Ayush Treatments and Settlement of Claims on the Basis of Benchmark Rates of Various Therapies/Interventions (2016)". The revision aims to expand the coverage of Ayush treatment procedures under insurance packages and update the benchmark rates for various therapies.

3.23.36 Regarding the strengthening of Ayush infrastructure, the Ministry stated that, as public health is a State subject, the responsibility primarily rests with the respective State/UT Governments. However, under the National Ayush Mission (NAM), financial assistance is provided to States/UTs for strengthening Ayush infrastructure and facilities, including in underserved areas, through activities such as Ayush Mobile Medical Units. States and UTs may avail such assistance by submitting proposals through their State Annual Action Plans (SAAPs) in accordance with NAM guidelines.

3.23.37 The Ministry of Ayush informed the Committee that the National Ayush Mission (NAM) is being implemented through the State/UT Governments to promote and strengthen Ayush systems of medicine by providing cost-effective, equitable and accessible healthcare. The Mission aims to improve Ayush healthcare services, establish Ayushman Arogya Mandir (Ayush) with emphasis on preventive and promotive healthcare, and reduce disease burden and out-of-pocket expenditure. Financial assistance is provided to States/UTs through State Annual Action Plans (SAAPs) for infrastructure development, supply of medicines, deployment of manpower and other approved activities. To enhance access to Ayush services, NAM supports operationalization of Ayushman Arogya Mandirs (Ayush),

co-location of Ayush facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs), upgradation of Government Ayush hospitals and dispensaries, establishment of new dispensaries where facilities are unavailable, supply of essential medicines, implementation of Ayush Public Health Programmes, establishment of new Ayush colleges in underserved States, strengthening of undergraduate and postgraduate institutions, and Behaviour Change Communication (BCC)/Information, Education and Communication (IEC) activities.

3.23.38 Regarding cost factors and mechanisms to improve affordability through research and innovation, the Drug Policy Section (DPS) stated that the pricing of Ayush medicines is influenced by fluctuations in the cost and availability of raw materials, geographical and seasonal variations, and the multi-ingredient nature of formulations, making standardization difficult. The Central Council for Research in Ayurvedic Sciences (CCRAS) further informed that individualized treatment, variability in raw material costs, limited pharmacoeconomic evidence and integration with conventional healthcare influence the cost of Ayurvedic care. To improve affordability, CCRAS is promoting personalized medicine through the Ayur Prakriti Web Portal, strengthening prevention-oriented healthcare, expanding Rasayana therapy for geriatric care, integrating Ayurvedic interventions in maternal and child healthcare, and developing integrative models combining Ayurveda with modern medicine. Operational studies completed at Safdarjung Hospital, Himachal Pradesh, Maharashtra, and under NPCDCS have demonstrated the feasibility of such integration. In collaboration with ICMR, Ayush–ICMR Advanced Centres for Integrative Health Research (AI-ACIHR) have been established at AIIMS Delhi, Jodhpur, Nagpur and Rishikesh to undertake research in gastrointestinal disorders, women and child health, geriatric care and cancer. CCRAS also emphasized improving Quality-Adjusted Life Years (QALYs) through preventive healthcare, lifestyle modification and holistic disease management to reduce long-term healthcare costs.

3.23.39 The Central Council for Research in Unani Medicine (CCRUM) informed the Committee that it is undertaking drug standardization research using modern analytical techniques such as High-Performance Liquid Chromatography (HPLC) to improve quality, reduce wastage and enhance efficiency. The Council also prioritizes the use of low-cost and easily available drugs and promotes preventive healthcare through Ilaj bil Ghiza (Diet Therapy) and Ilaj bit Tadbeer (Regimenal Therapy) to reduce dependence on expensive treatments.

3.23.40 The Central Council for Research in Siddha (CCRS) stated that the cost of Siddha healthcare is influenced by expenditure on raw materials, manufacturing, quality control, manpower, research and regulatory compliance. To reduce costs, CCRS is undertaking standardization of classical formulations, development of cost-effective formulations using modern technologies, and clinical, pre-clinical and medicinal plant research. It has established a Centralized Instrumentation Research Facility (CIRF), promotes public-private partnerships, Siddha entrepreneurship through MSMEs, digital consultation, pharmacovigilance, artificial intelligence applications and e-commerce platforms. The Council is also expanding GMP-certified pharmacies, decentralizing manufacturing and

promoting cultivation of medicinal plants through the Siddha Medicinal Plants Garden at Mettur Dam to ensure sustainable and economical supply of raw materials.

3.23.41 The Committee appreciates the constitution of a dedicated committee by the Drug Policy Section (DPS) to revise the "Guidelines for Insurance Coverage of Ayush Treatments and Settlement of Claims on the Basis of Benchmark Rates of Various Therapies/Interventions (2016)". The Committee is of the view that outdated benchmark rates and non-standardized therapy pricing lead to arbitrary claim settlements, forcing patients to pay out-of-pocket top-ups or face claim rejections by insurance providers. The Committee believes that transparent, actuarially sound, and updated tariff schedules are essential to ensure that private and public health insurance policies deliver genuine financial protection to policyholders seeking Ayush treatments. The Committee, therefore, recommends that the Ministry of Ayush expedite the finalization and rollout of the revised guidelines in a strict, time-bound manner. This revision must establish uniform, standardized benchmark rates across all recognized Ayush therapies and mandate their adoption by insurance underwriters to prevent out-of-pocket cost escalation during claim settlements.

3.23.42 The Committee observes from the submissions of the research councils (CCRAS, CCRUM, and CCRS) that the high cost of Ayush care is heavily driven by raw material price volatility, seasonal supply shortages, and complex formulation processes. While noting initiatives such as the Siddha Medicinal Plants Garden at Mettur Dam and the promotion of MSMEs, the Committee is of the view that an unorganized raw material supply chain severely inflates input costs, which are ultimately passed on to the consumer. The Committee believes that stabilizing raw material pricing through structured, local supply chains and decentralized processing is a critical prerequisite for lowering the retail price of finished Ayush medicines. The Committee, therefore, recommends that the Ministry formulate a national strategy to establish regional herbal cultivation clusters in coordination with State Forest and Agriculture Departments. Furthermore, the Ministry must scale up support for decentralized, Good Manufacturing Practice (GMP)-certified small and medium enterprise (MSME) pharmacy units, guaranteeing a steady supply of affordable, high-quality raw materials and finished formulations.

3.23.43 The Committee highlights the collaborative research initiatives undertaken by CCRAS, CCRUM, and CCRS, including drug standardization using modern analytical techniques like High-Performance Liquid Chromatography (HPLC), Centralized Instrumentation Research Facilities (CIRF), and the creation of Ayush–ICMR Advanced Centres for Integrative Health Research (AI-ACIHR) across various AIIMS facilities. The Committee is of the view that a lack of standardized quality controls and limited pharmacoeconomic data often result in prolonged treatment protocols and unnecessary resource expenditure. The Committee believes that establishing concrete clinical evidence and quantifying Quality-Adjusted Life Years (QALYs) will demonstrate the true cost-effectiveness of Ayush interventions and prevent wastage in healthcare delivery. The Committee, therefore, recommends that the Ministry mandate systematic pharmacoeconomic studies for all widely prescribed

classical and proprietary Ayush formulations. Additionally, the Ministry should expand the Ayush-ICMR AI-ACIHR network to all major tertiary medical colleges across the country to standardize treatment protocols, eliminate ineffective drug variations, and drive down long-term treatment costs through evidence-based integrative medicine.

3.23.44 The Ministry of Ayush informed the Committee that the affordability and accessibility of the Ayush healthcare system are constrained by limited awareness and understanding of Ayush among service providers. To address these challenges, the Drug Policy Section (DPS) is developing Standard Treatment Guidelines, standardized documentation for insurance claims, and undertaking stakeholder sensitization to improve insurance coverage and reimbursement for Ayush treatments.

3.23.45 The Ministry stated that the National Ayush Mission (NAM) is being implemented through the State/UT Governments to promote cost-effective, equitable and accessible Ayush healthcare by strengthening healthcare services, establishing Ayushman Arogya Mandir (Ayush) with a focus on preventive and promotive care, and reducing disease burden and out-of-pocket expenditure. Financial assistance is provided through State Annual Action Plans (SAAPs) for infrastructure, medicines, manpower and other approved activities. To expand affordable Ayush services, NAM supports Ayushman Arogya Mandirs (Ayush), co-location of Ayush units at PHCs, CHCs and DHs, upgradation of Ayush hospitals and dispensaries, establishment of new dispensaries in underserved areas, supply of essential medicines, implementation of Ayush Public Health Programmes, establishment of new Ayush colleges in underserved States, strengthening of undergraduate and postgraduate institutions, and Behaviour Change Communication (BCC)/Information, Education and Communication (IEC) activities.

3.23.46 Regarding Medical Value Travel (MVT), the Ayush Development Section (ADS) informed the Committee that the Ministry organized the Ayush Medical Value Travel Summit 2024 in Mumbai on 30 September 2024 to promote India as a global destination for traditional medicine and wellness. The Medical and Ayush Visa Portal, administered by the Ministry of Home Affairs, enables registered hospitals and wellness centres to issue visa invitation and extension letters for foreign patients. The Advantage Healthcare India Portal, launched by the Ministry of Health and Family Welfare on 17 August 2023 during the G-20 Health Ministers' Meeting, serves as a one-stop platform providing authentic information on India's medical and wellness services.

3.23.47 To promote the globalization of Ayush, the Ministry introduced a separate Ayush Visa on 27 July 2023 for foreign nationals seeking Ayush treatment. In collaboration with the Bureau of Indian Standards (BIS), it facilitated the establishment of the ISO Technical Committee (ISO/TC 249/SC 2) for Ayurveda and Yoga, while the SSD 16 Committee has published IS/ISO 21426:2018 on medical spa service requirements. Under its International Cooperation (IC) Scheme, the Ministry supports exports, international recognition, Ayush Academic Chairs, training programmes and global collaborations. So far, 24 Country-to-Country MoUs, 15 Ayush Chair MoUs, 51 Institute-to-Institute MoUs and 43 Ayush Information Cells have been established worldwide.

3.23.48 The Committee expresses concern over the constraints on affordability and accessibility arising from limited awareness and understanding of Ayush among healthcare service providers. While the Drug Policy Section (DPS) is currently developing Standard Treatment Guidelines (STGs) and standardized documentation for insurance claims, the Committee is of the view that the lack of institutionalized clinical protocols has historically led to skepticism among allopathic practitioners and private health insurers, resulting in arbitrary claim rejections or delayed treatments. The Committee believes that establishing evidence-based, universally recognized clinical benchmarks is essential to build provider trust, standardize care delivery, and ensure predictable reimbursement. The Committee, therefore, recommends that the Ministry of Ayush must accelerate the notification of comprehensive STGs across all recognized Ayush streams. Furthermore, the Ministry must make these guidelines mandatory for all empanelled public and private healthcare institutions and integrate them into cross-disciplinary CME modules to bridge the knowledge deficit among service providers and insurance underwriters.

3.23.49 The Committee takes positive note of the Ministry's initiatives to position India as a global destination for traditional medicine, including the introduction of a dedicated Ayush Visa, the launch of the Advantage Healthcare India Portal, and the establishment of international MoUs and Ayush Information Cells worldwide. The Committee is of the view that while Medical Value Travel (MVT) brings significant foreign exchange and international recognition, the economic benefits of this growing sector must be strategically harnessed to bolster domestic healthcare equity. The Committee believes that high-margin international wellness and medical tourism can serve as a vital financial engine to support underfunded public health infrastructure. The Committee, therefore, recommends that the Ministry, in coordination with the Ministry of Health and Family Welfare, formulate a framework that requires accredited private and public MVT-empaneled Ayush hospitals to contribute a designated percentage of their revenue from foreign patients into an 'Ayush Public Healthcare Equity Fund'. This fund should be exclusively utilized to subsidize complex Ayush treatments, diagnostics, and essential medicines for economically disadvantaged domestic patients.

3.23.50 The Committee observes the progress made in facilitating international and national quality benchmarks, such as the ISO Technical Committee (ISO/TC 249/SC 2) and the publication of IS/ISO 21426:2018 regarding medical spa service requirements. However, the Committee is of the view that without strict regulatory enforcement, the private wellness and Ayush sector remains susceptible to unstandardized service quality, varying safety protocols, and commercial exploitation. The Committee believes that adherence to accredited quality standards is directly linked to patient safety and fair pricing. The Committee, therefore, recommends that the Ministry of Ayush, in collaboration with the Bureau of Indian Standards (BIS) and the Quality Council of India (QCI), institute a mandatory accreditation framework based on ISO/BIS standards for all commercial Ayush wellness centres and clinical spas operating in the country. To ensure affordability and prevent predatory pricing in the

private sector, this accreditation must be strictly linked to public price disclosures and transparent tariff structures for all offered therapies.

Strengthening Ayush Services

3.23.51 The Committee invited views and suggestions from stakeholders/general public. The suggestions broadly emphasized strengthening AYUSH services through greater integration of AYUSH systems and local health traditions with Health and Wellness Centres and the mainstream healthcare system. Stakeholders recommended expanding population-based Ayurveda facilities across the country, co-locating Ayurveda hospitals and dispensaries with Government allopathic health facilities, and promoting multidisciplinary healthcare involving Ayurveda, Yoga, Naturopathy, Unani, Siddha, Homeopathy, and modern medicine. The representations also stressed the need to strengthen AYUSH services through adequate financial and human resources, enhanced outreach, scientific validation of traditional practices through dedicated research and academic partnerships, and development of appropriate training programmes to facilitate the integration of AYUSH into standard healthcare practices.

3.23.52 The Ministry informed that AYUSH services are being integrated with the public healthcare system through the co-location of AYUSH facilities at Primary Health Centres, Community Health Centres, and District Hospitals under the National Health Mission and the National Ayush Mission. Around 13,093 public health facilities are providing AYUSH services, with 12,319 Ayush Arogya Mandirs operational across the country, supported by over 24,600 AYUSH doctors, 3,700 pharmacists, and 2,300 allied Ayush professionals.

3.23.53 The Ministry further stated that the National Ayush Mission provides financial assistance for the establishment and upgradation of AYUSH hospitals, dispensaries, Health and Wellness Centres, educational institutions, and the supply of essential medicines, with the objective of expanding access to AYUSH services and promoting holistic healthcare. The Ministry also highlighted India's collaboration with the World Health Organization, including the WHO Global Traditional Medicine Centre, and various international partnerships to strengthen the global recognition of AYUSH systems.

2.23.54 The Ministry of AYUSH, through its research councils, is promoting evidence-based integration of AYUSH with modern medicine by undertaking collaborative research with institutions such as AIIMS, ICMR, IITs, NIMHANS, and other premier organisations. The Committee has been apprised that Standard Treatment Guidelines, scientific validation of AYUSH interventions, and structured training programmes are being developed to facilitate the safe and effective integration of AYUSH into mainstream healthcare and strengthen its role in public health service delivery.

3.23.55 The Committee is of the view that true holistic healthcare necessitates seamless patient access to both traditional and modern medical systems under a single roof to facilitate cross-referrals and integrated management. The Committee, therefore, recommends the strict enforcement of a policy mandating the compulsory co-location of

Ayurveda and other AYUSH dispensaries or hospitals alongside all government Allopathic centers, Primary Health Centres (PHCs), Community Health Centres (CHCs), and District Hospitals. The Committee believes that geographical equity in traditional healthcare delivery is paramount. The Committee, therefore, recommends the formulation and immediate execution of a definitive policy that ensures the establishment of population-based Ayurveda and AYUSH facilities uniformly across the country.

3.23.56 While acknowledging the collaborative efforts between AYUSH research councils (CCRAS, CCRUM, CCRH, CCRS) and premier institutes like AIIMS, ICMR, and IITs, the Committee observes that the evidence base research and development must be pro-actively expanded to ensure treatment of diseases under Ayush System. The Committee believes that rigorous empirical validation is crucial for the mainstream and global acceptance of traditional practices of treatment under Ayush System. The Committee, therefore, recommends the allocation of dedicated, ring-fenced funding to accelerate the scientific validation of AYUSH interventions through robust academic and industry partnerships. The Committee is of the view that multiple branches of healthcare (Allopathy, Ayurveda, Yoga, Homeopathy, etc.) must be integrated with a strict research mindset to understand the emerging trends of diseases due to climate change and global ecological disaster and disorder. The establishment of Ayush-ICMR Advanced Centres for Integrative Health Research (AI-ACIHR) must be scaled to all major tertiary care centers, prioritizing joint clinical trials for non-communicable diseases (NCDs), cancer care, and geriatric health.

3.23.57 The Committee acknowledges the progress made in establishing an AYUSH vertical within the Central Drugs Standard Control Organization (CDSCO) and the initiation of Standard Treatment Guidelines (STGs). The Committee, therefore, recommends the expedited finalization and nationwide enforcement of comprehensive STGs for all major disease classifications across all AYUSH disciplines to ensure safe, evidence-based, and standardized integrative care. The Committee believes that domestic and international trust hinges upon uncompromising quality control. The Committee, therefore, recommends the continuous and speedy promotion and enforcement of WHO-CoPP (Certificate of Pharmaceutical Product) and Quality Council of India (QCI) certifications for all AYUSH pharmaceutical products.

3.23.58 The Committee considers that the successful implementation of an integrative medical model relies entirely on a well-trained, multi-skilled, and unbiased healthcare workforce. The Committee, therefore, recommends the immediate development and deployment of competency-based, evidence-oriented training programs specifically designed to safely integrate AYUSH services into mainstream standard treatment workflows. The Committee believes that fostering mutual respect and practical synergy between allopathic and traditional practitioners is vital to reducing systemic bias. The Committee, therefore, recommends the immediate introduction of integrated curriculum modules, exchange fellowships, and cross-system Continuous Medical Education (CME) sessions across both Allopathic and AYUSH educational institutions so as to complement each other and capable of reducing rural-

urban gaps in accessibility of medical facilities at the grass root level, especially rural, hilly and tribal regions.

3.24 SWOT Analysis of the National Health Mission (NHM)

3.24.1 The Ministry of Ayush informed the Committee that the National Rural Health Mission (NRHM), launched in 2005, together with the National Urban Health Mission (NUHM), constitutes the National Health Mission (NHM). NHM aims to reduce maternal and child mortality; prevent and control communicable and non-communicable diseases; provide comprehensive primary healthcare; promote population stabilization, gender equality and healthy lifestyles; mainstream AYUSH; and ensure universal access to nutrition, sanitation, immunization and quality public healthcare. The Ministry presented the following SWOT analysis in the context of achieving the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC).

(i) Strengths: NHM provides a comprehensive framework integrating RMNCH+A, communicable and non-communicable diseases, nutrition and disease-specific programmes such as TB, Malaria, Cancer, NCDs and Leprosy. Community participation has been strengthened through ASHAs, VHSNCs, Jan Arogya Samitis and Rogi Kalyan Samitis. The Mission has improved health infrastructure, diagnostics, medicines and quality of care through NQAS, while allowing States flexibility through Programme Implementation Plans (PIPs). Under Ayushman Bharat, Sub-Health Centres and PHCs have been transformed into Ayushman Arogya Mandirs to provide Comprehensive Primary Healthcare. Data-driven monitoring through HMIS, Common Review Mission and ODK-based IPHS self-assessment supports evidence-based planning.

(ii) Weaknesses: Persistent shortages of doctors, specialists and paramedics, especially in rural areas, continue to affect service delivery. Multiple data systems create duplication, while communicable diseases such as TB, Malaria and vector-borne diseases remain difficult to eliminate in remote areas. Regional disparities in health outcomes, delays in fund release, limited absorptive capacity, financial constraints—particularly in smaller States, UTs and North-Eastern States—and disparities between contractual and permanent staff affect programme implementation.

(iii) Opportunities: NHM offers significant scope for expanding health infrastructure and improving service quality. The Ayushman Bharat Digital Mission enables greater use of telemedicine, electronic health records and digital health platforms. Better integration of Ayushman Arogya Mandirs, CHCs, District Hospitals and PM-JAY can strengthen continuity of care. IPHS 2022, NQAS, digital training of ASHAs and ANMs, convergence with Jal Jeevan Mission, POSHAN Abhiyaan, Samagra Shiksha, the One Health approach and enhanced government investment present further opportunities.

(iv) Threats: Dependence on Central Government funding, public health emergencies, pandemics and climate-related events may disrupt services and divert resources. The rising burden of non-communicable diseases, overlapping health programmes and

persistent regional and socio-economic disparities continue to challenge equitable healthcare delivery.

3.24.2 The Committee takes note of the comprehensive SWOT analysis submitted by the Ministry of Ayush regarding the National Health Mission (NHM). While acknowledging the Mission's significant achievements in expanding community participation, transforming primary health centers into Ayushman Arogya Mandirs, and establishing data-driven monitoring tools, the Committee observes severe structural weaknesses that continue to hamper healthcare delivery. Key among these are persistent shortages of doctors and specialists in rural areas, disparities between contractual and permanent healthcare staff, administrative delays in fund releases, limited absorptive capacity in smaller and North-Eastern States, and the duplication of digital data systems.

3.24.3 The Committee finds that NHM has substantially strengthened India's public health infrastructure and expanded access to essential health services over the past two decades. However, addressing remaining gaps in quality, equity, urban healthcare, human resources and system resilience through sustained investment, integrated planning and digital health will be essential for achieving the SDGs, Universal Health Coverage and equitable healthcare in the country.

3.24.4 The Committee considers that while the transformation of primary care infrastructure under Ayushman Bharat is commendable, the failure to address fundamental human resource deficits, financial bottlenecks, and data fragmentation severely undermines the Mission's capacity to deliver equitable healthcare and combat the rising non-communicable disease (NCD) burden. The Committee believes that achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) requires moving beyond incremental operational tweaks toward a synchronized strategy that integrates human resource parity, financial streamlining, and unified digital governance.

3.24.5 The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in close coordination with the Ministry of Ayush and State Governments, undertake a comprehensive overhaul of the NHM implementation framework through the following structured measures:

a) **Human Resource Rationalization and Staff Security: Formulate a uniform national policy to 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, and systematically scale up digital training modules for frontline health workers (ASHAs and ANMs).**

b) **Fiscal Streamlining and Absorptive Capacity: Institute a real-time, Direct Benefit Transfer (DBT)-linked fund disbursement tracking mechanism to eliminate administrative delays in releasing Central grants to States. Furthermore, the Ministry must provide specialized technical and administrative**

handholding to smaller, Union Territory, and North-Eastern States to enhance their fiscal absorptive capacity and ensure unhindered resource utilization.

c) **Data Convergence and Continuity of Care: Rationalize and merge overlapping data reporting software into a single, unified architecture integrated with the Ayushman Bharat Digital Mission (ABDM). This platform must establish seamless digital referral pathways linking Ayushman Arogya Mandirs with Community Health Centres, District Hospitals, and AB-PMJAY tertiary care networks to guarantee end-to-end, lifelong continuity of care for every citizen.**

3.25 AIIMS New Delhi

3.25.1 During its interaction with the Committee on 15th July, 2026, AIIMS New Delhi stated that although public investment in healthcare has increased over the past decade, further enhancement is essential to achieve Universal Health Coverage (UHC), reduce out-of-pocket expenditure, strengthen infrastructure and expand the healthcare workforce. Despite significant progress, affordability and accessibility remain major concerns. Key affordability challenges include high out-of-pocket expenditure, unaffordable private healthcare and indirect costs such as travel and accommodation incurred by patients seeking treatment in public hospitals. Accessibility is constrained by urban-rural disparities, overcrowding at tertiary institutions and geographical barriers in remote and underserved areas. The Institute also highlighted shortages and uneven distribution of healthcare professionals, limited availability of specialists at district and peripheral facilities, and the continued exposure of vulnerable populations to catastrophic health expenditure despite the financial protection provided under Ayushman Bharat PM-JAY.

3.25.2 The Institute observed that the public and private sectors perform complementary roles in healthcare delivery. While the public sector faces excessive patient load, long waiting times and infrastructure constraints, the private sector is characterized by high treatment costs, concentration of secondary and tertiary care facilities in urban areas, inadequate regulation and variation in pricing and quality standards. The Committee was informed that the Government has launched several initiatives to improve affordability and accessibility, including Ayushman Bharat PM-JAY, Ayushman Aarogya Mandirs, the Ayushman Bharat Digital Mission, Jan Aushadhi Kendras, AMRIT Pharmacies, the National Digital Health Ecosystem, and expansion of AIIMS and new medical colleges.

3.25.3 AIIMS suggested progressively increasing public health expenditure to 2.5–3 per cent of GDP, in line with the National Health Policy, to strengthen healthcare infrastructure, expand the health workforce, improve the availability of medicines and diagnostics, and reduce out-of-pocket expenditure. It emphasized strengthening Ayushman Aarogya Mandirs with adequate manpower, diagnostics, teleconsultation and medicines, while upgrading district hospitals into comprehensive secondary care centres with specialist, emergency and critical care services to reduce unnecessary referrals and improve access closer to patients' homes.

3.25.4 The Institute underscored the transformative potential of Artificial Intelligence (AI) and digital technologies in improving healthcare access and quality, particularly in rural and underserved regions. It highlighted AIIMS innovations such as UPPCHAR, an AI-enabled mobile application for supportive care of advanced cancer patients; MadhuNetrAI, an AI-

powered diabetic retinopathy screening platform; AI-assisted Chest X-ray Triage, which prioritizes chest X-rays and generates preliminary reports within 5–10 minutes under radiologist supervision; and the "Never Alone" Digital Mental Health Initiative, an AI-enabled WhatsApp platform providing mental health screening, self-help resources and access to expert consultation.

3.25.5 The Institute further recommended establishing a technology-enabled National Referral System linking primary, secondary and tertiary healthcare facilities through electronic referrals and standardized protocols; promoting public-private partnerships in diagnostics, telemedicine, emergency care, medical education and infrastructure; improving transparency and standardization in pricing of medical procedures, diagnostics and implants; and expanding digital health through telemedicine, e-prescriptions, AI-enabled clinical decision support, digital referrals and remote patient monitoring.

3.25.6 AIIMS also advocated transitioning to value-based healthcare, establishing a National Quality Framework through wider adoption of NABH and NQAS standards, strengthening human resources through expansion of medical and allied health education and equitable deployment of specialists, and developing integrated emergency and trauma care networks. It further recommended promoting rational use of medicines and diagnostics, expanding financial protection through strategic purchasing, and strengthening preventive and promotive healthcare through screening, vaccination, nutrition, lifestyle modification and early diagnosis of non-communicable diseases.

3.25.7 The Institute emphasized preparing for an ageing population by expanding geriatric, rehabilitation, palliative, long-term and home-based care services. It also recommended improving patient experience through patient navigation services, affordable accommodation, multilingual information platforms, digital grievance redressal and patient experience monitoring.

3.25.8 To promote quality improvement across the country, AIIMS proposed a National Apex Hospital Improvement Programme to replicate best practices from AIIMS and other Institutes of National Importance, including digital patient navigation, integrated appointment systems, queue management, public dashboards, grievance redressal and affordable care models. It further suggested improving administrative efficiency by reducing unnecessary investigations and procedures in the private sector and enhancing performance monitoring, resource allocation, equipment utilization, procurement and supply chain management in public hospitals through measurable key performance indicators. Finally, it stressed patient empowerment through health education, awareness of government financial assistance schemes and greater engagement of patient advocacy groups to facilitate information sharing and social support.

3.25.9 The Committee believes that technology-enabled healthcare solutions offer an unprecedented opportunity to bridge geographic divides, mitigate specialist shortages, and reduce patient congestion at apex tertiary care centers. The Committee is of the view that proven, cost-effective digital innovations developed by Institutes of National Importance (INIs) should not remain isolated successes but must be scaled nationally. The Committee, therefore, recommends the immediate establishment of a dedicated national programme to document, standardize, and replicate best administrative and clinical practices from AIIMS New Delhi across all state Government Medical Colleges

(GMCs) and district hospitals. This must include structured mentorship, digital patient navigation systems, public dashboards, dynamic queue management, and integrated appointment modules.

3.25.10 The Committee recommends scaling up validated AI platforms, specifically: (i) *MadhuNetrAI* for frontline screening and early detection of diabetic retinopathy in resource-constrained primary settings; (ii) *UPPCHAR* for AI-assisted health education, supportive care, and treatment adherence in advanced oncology; (iii) *AI-assisted Chest X-ray Triage* to prioritize high-volume diagnostic imaging within 5–10 minutes while preserving final validation by certified radiologists; and (iv) *"Never Alone"* digital mental health frameworks (WhatsApp-integrated) for round-the-clock screening and facilitated expert consultation. The Committee further recommends accelerating the full integration of e-prescriptions, clinical decision support systems (CDSS), and remote patient monitoring under the *Ayushman Bharat Digital Mission (ABDM)*.

3.25.11 The Committee believes that the current unorganized patient flow severely strains tertiary institutions like AIIMS, leading to extreme congestion, prolonged waiting times, and indirect financial hardship for rural families traveling long distances. Furthermore, both public and private sectors must be viewed as complementary components of the health ecosystem. The Committee, therefore, recommends the implementation of a mandatory, technology-enabled referral framework linking *Ayushman Aarogya Mandirs (AAM)*, district hospitals, and tertiary/private institutions. Standardized electronic referral protocols and real-time feedback loops must ensure that tertiary care facilities entertain primary and secondary-level conditions only through structured, verifiable referrals, thereby reducing overcrowding.

3.25.12 The Committee is of the view that private sector capacity, currently urban-centric and variably regulated, must be strategically leveraged to serve public health goals. The Committee recommends formulating robust PPP frameworks in high-capillary service areas, including advanced diagnostics, emergency ambulance networks, telemedicine, and medical education. To prevent commercial exploitation, all PPP initiatives must operate under strict price ceilings, defined Service Level Agreements (SLAs), and independent quality audits to ensure equitable access for vulnerable populations.

3.25.13 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. The Committee, therefore, recommends that the Ministry mandate standardized baseline pricing and mandatory public disclosure of tariffs for common medical procedures, diagnostic panels, and surgical implants. Private hospitals must strictly adhere to national *Standard Treatment Guidelines (STGs)* to eliminate unwarranted investigations, unnecessary hospitalizations, and polypharmacy. The Committee also recommends the statutory enforcement of *Essential Diagnostics Lists*

(EDL), Antimicrobial Stewardship Programmes, and mandatory generic drug prescribing across all public and empanelled private facilities. Jan Aushadhi Kendras and AMRIT Pharmacies must be co-located within all secondary and tertiary hospital premises with guaranteed stock availability.

3.25.14 The Committee is of the view that public hospitals must increase throughput by monitoring and publicly disclosing Key Performance Indicators (KPIs), such as Average Length of Stay (ALOS), Bed Occupancy Rates, Healthcare-Associated Infection Rates, and waiting times, alongside dynamic resource allocation and automated supply chain management. Enforcement of stringent audit mechanisms to curb over-investigation and excessive billing practices.

3.25.15 The Committee believes that India's changing demographic profile necessitates an immediate pivot toward elder care, alongside a fundamental shift from volume-based care to patient-centric, value-based healthcare where patients are active, informed participants in their care journey. The Committee, therefore, recommends integrating dedicated geriatric medicine, palliative care, rehabilitation, and home-based care networks into primary (*Ayushman Aarogya Mandirs*) and secondary (District Hospital) care tiers. Specialized workforce training in geriatric nursing and allied health care must be fast-tracked to manage the rising burden of non-communicable diseases (NCDs) and age-related ailments. The Committee also recommends institutionalizing multi-lingual patient navigation desks and establishing formal *Patient Advocacy Groups / Patient Representative Organizations*. These platforms must actively educate patients not only on disease management but also on available government financial assistance schemes (such as AB-PMJAY and illness assistance funds) to eliminate catastrophic out-of-pocket expenditure.

3.25.16 The Committee is of the view that health system financing should progressively transition toward value-based outcomes measured by standardized patient safety metrics and National Quality Assurance Standards (NQAS/NABH). Furthermore, robust, real-time digital grievance redressal mechanisms must be made mandatory across all empanelled institutions.

3.25.17 The Committee believes that physical infrastructure alone cannot deliver care without an adequately trained, equitably distributed, and motivated health workforce. The severe shortage and stark urban-rural maldistribution of specialists, nurses, and allied health professionals at district and peripheral facilities remain fundamental barriers to healthcare access. 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.

3.25.18 The Committee is of the view that postgraduate medical seats (MD/MS/DNB) and clinical training programs must be rapidly expanded at all district-

level hospitals. Furthermore, statutory recognition and continuous professional development for nurses, paramedics, and allied health professionals must be institutionalized to support task-shifting and multi-skilled healthcare delivery. The Committee recommends establishing a dynamic, transparent National Health Workforce Registry under ABDM to track real-time staffing levels and prevent chronic vacancy gaps in underserved regions.

3.25.19 The Committee believes that delay in emergency response and lack of real-time critical care coordination are major contributors to avoidable mortality and catastrophic out-of-pocket expenditure during medical crises. The Committee, therefore, recommends the creation of a unified, technology-enabled Emergency Care Network linking basic/advanced life support ambulances, district emergency departments, trauma centers, and tertiary hospitals through a single national access line and GIS-based tracking.

3.25.20 The Committee considers that public and empanelled private institutions must mandatorily publish live updates regarding ICU beds, ventilator availability, and emergency department occupancy on centralized public dashboards, preventing chaotic hospital-hopping by distress-ridden families. The Committee recommends the implementation of universal emergency triage guidelines and tele-ICU linkages, enabling district doctors to stabilize critically ill patients under expert consultation from apex institutions like AIIMS prior to or during transport.

3.25.21 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.

3.25.22 The Committee is of the view that public health procurement should shift toward "strategic purchasing," leveraging the market size of *Ayushman Bharat (AB-PMJAY)* to drive down cost tariffs, enforce strict clinical quality norms, and expand coverage to currently vulnerable populations exposed to catastrophic health spending. The Committee recommends expanding population-based screening, routine adult vaccination, lifestyle interventions, and early NCD diagnostics across all *Ayushman Aarogya Mandirs (AAM)*, thereby reducing the high long-term financial burden of advanced secondary and tertiary illness.

Views of the Select Hospitals

3.26 STAR DENTAL

3.26.1 Star Dental Centre Pvt. Ltd. (Clove Dental), in its submission to the Committee, stated that dental healthcare is not covered under either public or private health insurance schemes. It has no collaboration with public healthcare organizations for improving affordability of

dental care. On a query on transparency in billing, the institute stated that all their billings are done through patient management software in a transparent manner and the records are duly kept. Star Dental further informed that while it has expanded its presence to a few Tier-II cities, it does not currently operate clinics in rural areas. Treatment charges are standardized across all its clinics in the country and the standardized rates are integrated into its patient management software, ensuring automatic application of uniform charges. Star Dental emphasized that oral and dental healthcare has not yet been accorded adequate priority in national healthcare policies and minimal Government schemes cover dental treatments. Further, dental expenses are currently not covered under insurance schemes. The organization urged the government to promote dental healthcare similar to the mainstream healthcare and also cover dental health in government insurance scheme.

3.26.2 The Committee is of the view that oral and dental healthcare has not been accorded adequate priority within the national healthcare framework, resulting in a significant gap in both affordability and accessibility. Submissions received by the Committee indicate a stark absence of dental coverage in both public and private health insurance schemes, as well as a lack of collaborative initiatives between private dental organizations and public healthcare institutions. While organized private dental networks have successfully expanded into Tier-II cities and established transparent, software-integrated standardized billing practices, their complete absence in rural areas leaves a vast segment of the population underserved.

3.26.3 The Committee believes that optimal public health outcomes cannot be realized until dental care is formally recognized and promoted on par with mainstream medical care. The existence of standardized treatment rates and transparent patient record-keeping within the private sector demonstrates that dental healthcare costs can be systematically structured, regulated, and monitored for insurance integration. The Committee, therefore, recommends that the Government take immediate, concrete policy measures to mainstream dental healthcare and explicitly incorporate comprehensive dental treatments into government-sponsored health insurance schemes. Additionally, the Government must proactively facilitate public-private partnerships to incentivize private dental healthcare providers to expand their clinical and operational footprint into rural regions, thereby ensuring that equitable, transparent, and affordable dental care becomes accessible to all citizens across the country.

3.27 Jawaharlal Nehru Medical College

3.27.1 Jawaharlal Nehru Medical College, on a query regarding insurance and claim settlement, stated that for Private Insurance claims, the lead time is 25 to 30 days after submission of bills. Average time taken for bill settlement of Government Scheme Patients is 6 to 8 months. Most common reasons for bill rejection are insufficient Post-operative Investigations. On an average package rate are 30% higher than the Government insured patients. There are no separate ICU Packages for critical patients who require surgical interventions. This has been brought to the notice of Suvarna Arogya Suraksha Trust (SAST) - Karnataka. Bilateral diseases or bilateral surgical procedures under PMJAY is not permitted. The issue has been brought to the notice of SAST.

3.27.2 The Committee is of the view that the severe delays in claim settlements under government health schemes fundamentally undermine the accessibility of healthcare for vulnerable beneficiaries. While the acceptable turnaround time for claims processing under frameworks like Karnataka's Suvarna Arogya Suraksha Trust (SAST) is stipulated to be between 15 to 21 days, the actual average lead time of 6 to 8 months reported by institutions such as Jawaharlal Nehru Medical College is unacceptable. This systemic bottleneck, starkly contrasting the 25 to 30 days taken by private insurers, severely cripples the working capital of empanelled providers. When coupled with frequent bill rejections due to ambiguously defined "insufficient post-operative investigations," these delays actively discourage private sector participation and threaten the operational stability of participating medical colleges.

3.27.3 The Committee believes that the structural rigidity of the current reimbursement matrix actively penalizes critical care providers and restricts patient access. The prevailing disparity, wherein government package rates remain an average of 30% lower than private insurance equivalents, challenges the sustainability of quality care delivery. More critically, the absence of separate ICU packages for critical patients requiring surgical interventions, alongside the illogical prohibition of bilateral surgical procedures under PMJAY, forces suboptimal clinical pathways, creating unnecessary financial burdens and requiring repeated hospitalizations for patients. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in strict coordination with the National Health Authority (NHA) and respective State Health Agencies (SHAs), immediately execute the following systemic interventions:

a) **Enforcement of Settlement SLAs: Institute a rigid, technology-driven 30-day maximum turnaround time for all government scheme claim settlements, mandating the automatic payment of penal interest to healthcare providers for any delays beyond this operational window.**

b) **Rationalization of Benefit Packages: Undertake a comprehensive and immediate revision of the Health Benefit Packages (HBP) to introduce standalone, unbundled ICU packages for post-surgical critical care, while systematically aligning overarching package rates with the realistic operational costs of tertiary care.**

c) **Authorization of Bilateral Procedures: Allow the bilateral diseases treatment and simultaneous surgical procedures under PMJAY, permitting concurrent clinical interventions in a single operative setting to reduce patient trauma, mitigate risk, and lower the cumulative cost of care.**

d) **Standardization of Clinical Audits: Formulate and publish an exhaustive, standardized, and specialty-specific checklist of required post-operative investigations to eliminate arbitrary claim rejections by state schemes like SAST and streamline the adjudication process.**

3.28 Rajiv Gandhi Cancer Institute & Research Centre (RGCIRC)

3.28.1 RGCIRC, in its submission to the Committee, stated that it is a non-profit, standalone tertiary cancer care centre established in 1996 under the Indraprastha Cancer Society & Research Centre. Dedicated to providing affordable, ethical and high-quality oncology care, it has treated over 3.5 lakh patients and is recognized as one of Asia's premier cancer hospitals. The Institute spends around ₹70 crore annually, primarily through pharmacy discounts and the Patient Welfare Fund, to provide free or subsidized treatment, with financial assistance ranging from ₹50,000 to ₹10 lakh per patient based on need. Philanthropic care is further supported through CSR and NGO partnerships, including GAIL, BPCL, ONGC, Coal India and the Yuvraj Singh Foundation. RGCIRC also facilitates Patient Assistance Programmes (PAPs) offered by pharmaceutical companies, enabling eligible patients to receive medicines free of cost.

3.28.2 General Hurdles in Making Cancer Care Affordable and Suggested Measures

i. High Capital and Infrastructure Costs

- **Land acquisition:** Scarcity of institutional land in Tier-I and Tier-II cities significantly increases hospital establishment costs. A 500-bed hospital requiring about five acres of land may incur land costs of ₹50–250 crore in NCR. The Institute recommended allotment of land at concessional institutional rates for healthcare projects.
- **Construction:** Specialized infrastructure such as operation theatres, radiation bunkers, parking and sewage treatment plants substantially raise construction costs. Establishing a 500-bed hospital may require an investment of around ₹600 crore.
- **Medical equipment:** Advanced medical equipment is largely imported, attracting import duties, 18% GST, and higher costs due to exchange-rate fluctuations, making equipment nearly 35% costlier in India. Greater emphasis on 'Make in India' is recommended to reduce import dependence and costs.

ii. Taxation Policy: Healthcare services are largely GST-exempt, preventing hospitals from claiming input tax credit on medical equipment, consumables and related services. RGCIRC suggested 0% GST instead of exemption to enable input tax credit and reduce overall treatment costs.

iii. Shortage of Skilled Manpower: Demand for specialist doctors, nurses and technicians continues to outpace supply, while migration of trained professionals to the Middle East, the UK and Europe further aggravates workforce shortages and increases operational costs.

iv. Cost of Financing Hospitals: Establishing a 500-bed hospital typically requires an investment of around ₹1,000 crore with a gestation period of nearly four years. In the absence of concessional institutional finance or priority-sector lending, hospitals increasingly depend

on private equity, leading to pressure for higher returns and consequently higher treatment costs. RGCIRC recommended concessional financing for healthcare infrastructure.

v. Insurance and Government Health Schemes: Nearly **70–80%** of cancer treatment expenditure in India is met through out-of-pocket payments, with the average treatment cost around ₹7.5 lakh per patient. High insurance premiums, inadequate coverage, claim rejections and rising medical inflation further increase the financial burden. RGCIRC observed that reimbursement rates under schemes such as CGHS, ECHS, ESIC and Ayushman Bharat are based on marginal costing and do not adequately account for capital investment, inflation or reasonable surplus, making them financially unviable for specialized private hospitals. It recommended periodic revision of package rates considering these factors.

vi. Public-Private Partnership: RGCIRC noted that many public-private partnership models have been unsuccessful due to conflicting priorities between governments and private providers. It suggested a revenue-sharing model, wherein Government provides land while private entities manage hospital operations. Revenue generated could support public health insurance and facilitate expansion of healthcare infrastructure, creating incentives for continued investment and technology upgradation.

vii. Diagnostics and Supportive Treatment: Repeated diagnostic investigations such as PET-CT, MRI, laboratory and genetic tests significantly increase treatment costs. RGCIRC recommended introducing ceiling prices for these investigations, extending price regulation to identified cancer medicines and supportive therapies, including anti-emetics and anti-infectives, and ensuring effective implementation of trade margin rationalization. Common infrastructure for diagnostics, imaging and laboratory services among private hospitals was also suggested to reduce costs through shared resources.

Cancer Drug Affordability

3.28.3 RGCIRC highlighted that despite price regulation under the Drug Price Control Order (DPCO) and inclusion of 131 anti-cancer formulations in the National List of Essential Medicines (NLEM), retail margins for several commonly used cancer drugs remain significantly high, with margins of 50–60% reported for some molecules. Manufacturers also circumvent price caps by introducing alternate strengths or formulations not covered under existing regulations. The Institute recommended periodic price re-fixation, stricter regulation of retail margins, and a comprehensive approach to cost reduction covering supportive therapies, anti-infectives and antifungal medicines alongside cancer drugs. It further noted that Patient Assistance Programmes (PAPs) generally benefit only out-of-pocket patients and exclude those covered under insurance or Government health schemes. High import duties, GST on medicines and medical equipment, rising insurance premiums and inadequate insurance coverage further add to patients' financial burden.

Participation in Ayushman Bharat (PM-JAY)

3.28.4 While appreciating Ayushman Bharat (PM-JAY) as a significant Government initiative, RGCIRC stated that many specialized private hospitals remain outside the scheme

because package rates are often up to 70% lower than prevailing market costs and do not adequately cover the expenses of advanced cancer care. Additionally, lengthy documentation and claim settlement procedures discourage participation. The Institute suggested rationalization of package rates and simplification of administrative processes to encourage greater empanelment of private hospitals.

Collaboration with Public Health Institutions

3.28.5 RGCIRC collaborates with AIIMS, New Delhi, ICMR–National Institute of Cancer Prevention and Research (NICPR), Noida, CSIR–Central Drug Research Institute (CDRI), Lucknow, and Jamia Millia Islamia, New Delhi for joint research, training, development of cost-effective diagnostics and therapies, public awareness and cancer prevention initiatives. These collaborations promote early detection, strengthen preventive oncology, facilitate community outreach and clinical innovation, and contribute to reducing treatment costs through knowledge sharing and research.

Government–Private Collaboration and Areas for Joint Action

3.28.6 RGCIRC proposed a Government–private partnership model under which Government may provide land for hospital establishment while private entities undertake operations and management. Revenue generated through such partnerships could support public health insurance and improve healthcare access.

3.28.7 The Institute also suggested collaborative initiatives including: (i) reviving partnerships with Anganwadi and ASHA workers for community awareness, screening and referral; (ii) organising regular cancer screening camps at PHCs, CHCs, Government hospitals and dispensaries using RGCIRC's trained personnel, mobile units and diagnostic equipment; (iii) Government support for community mobilization and logistics, with RGCIRC providing clinical expertise, mobile mammography services and follow-up care; (iv) Capacity building of Government healthcare professionals on cancer prevention, early detection and screening protocols; (v) Joint campaigns to improve HPV vaccination coverage among girls aged 9–26 years; and (vi) Inclusion of cancer screening under preventive health packages of Ayushman Bharat.

3.28.8 The Committee is of the view that the capital-intensive nature of establishing specialized oncology facilities, requiring investments of around ₹1,000 crore for a 500-bed hospital with a four-year gestation period, creates severe entry barriers and drives up operational treatment costs. The extreme scarcity and high acquisition cost of institutional land in Tier-I and Tier-II cities (ranging from ₹50 crore to ₹250 crore for five acres in the NCR region), coupled with the absence of priority-sector lending, forces healthcare providers into high-cost commercial financing or private equity, ultimately escalating financial burdens on patients. Furthermore, while healthcare services are currently GST-exempt, this status prevents tertiary hospitals from claiming Input Tax Credit (ITC) on heavy capital outlays for specialized construction, consumables, and advanced medical equipment (which attract an 18% GST burden and high import

duties, making equipment nearly 35% costlier in India). The Committee, therefore, recommends that the Government undertake the following structural interventions:

a) **Priority Sector Financing and Concessional Land Allotment:** Grant priority-sector lending status to healthcare infrastructure, particularly standalone, non-profit, and tertiary oncology centers, to enable access to low-cost institutional finance. State Governments must be mandated to allocate institutional land at concessional rates for public-interest healthcare projects in urban and semi-urban hubs.

b) **Zero-Rating Healthcare under GST:** Reclassify healthcare services from 'GST Exempt' to 'Zero-Rated GST (0%)' framework, enabling hospitals to claim Input Tax Credit on medical equipment, consumables, and specialized infrastructure, thereby directly lowering overall operational costs.

c) **Customs Rationalization and Domestic Manufacturing:** Rationalize import duties on non-indigenously manufactured high-end radiation and diagnostic equipment, while simultaneously providing targeted incentives under the 'Make in India' initiative to build indigenous manufacturing capabilities for advanced medical technology.

3.28.9 The Committee expresses grave concern over the fact that nearly 70% to 80% of cancer treatment expenditure in India is met through out-of-pocket payments, with average treatment costs reaching ₹7.5 lakh per patient. The empanelment of premier specialized cancer hospitals under public health schemes like Ayushman Bharat (PM-JAY), CGHS, ECHS, and ESIC remains severely constrained because prevailing reimbursement package rates, often up to 70% lower than market costs, are fixed on marginal costing principles without accounting for capital investment, medical inflation, or operational sustainability. Moreover, despite price regulation under the Drug Price Control Order (DPCO), retail margins on anti-cancer drugs remain exorbitantly high (50–60%), with manufacturers frequently circumventing price caps by introducing alternate strengths or formulations. Crucially, Patient Assistance Programmes (PAPs) currently exclude beneficiaries covered under public health insurance, while unstandardized diagnostic pricing (PET-CT, MRI, genetic testing) further inflates costs. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in coordination with the National Health Authority (NHA) and the National Pharmaceutical Pricing Authority (NPPA), execute the following measures:

a) **Dynamic Package Rate Revision:** Conduct a comprehensive, inflation-indexed revision of empanelment package rates under PM-JAY and government health schemes. Reimbursement structures must factor in capital depreciation, specialty infrastructure, and modern oncology protocols to ensure financial viability and encourage widespread private sector empanelment.

b) **Enforcement of Trade Margin Rationalization (TMR) and DPCO Expansion:** Expand the National List of Essential Medicines (NLEM) and DPCO coverage to include all alternate strengths, formulations, supportive therapies (such as anti-emetics and anti-infectives), and antifungal medicines. Strict Trade Margin

Rationalization must be enforced across all anti-cancer molecules to eliminate artificial retail markups.

c) **Ceiling Prices for Diagnostics and Universal PAP Access: Establish national ceiling prices for high-volume diagnostic procedures, including PET-CT, MRI, and genetic profiling, while encouraging shared diagnostic infrastructure among healthcare facilities. Additionally, issue clear guidelines enabling patients covered under public health schemes to access manufacturer-funded Patient Assistance Programmes (PAPs) without disqualification.**

3.28.10 The Committee believes that mitigating the cancer burden requires a shift from isolated tertiary care to an integrated framework emphasizing Public-Private Partnerships (PPP), community screening, and early intervention. Past PPP models have often faltered due to misaligned incentives; however, a structured revenue-sharing model, where the Government provides land and primary support while specialized private or non-profit institutes manage operations, mobile diagnostics, and technical training, presents a highly sustainable path for expanding tertiary care into underserved regions. The Committee, therefore, recommends that the Government execute the following joint action directives:

a) **Standardized Revenue-Sharing PPP Framework: Formulate a national policy framework for Public-Private Partnerships in oncology, under which the Government provides land and basic infrastructure while private entities manage hospital operations. A portion of the generated revenue should be directed to subsidize public health insurance and finance ongoing infrastructure expansion.**

b) **Integration of Cancer Screening in PM-JAY: Formally include comprehensive cancer screening (oral, cervical, and breast) within the preventive health packages of Ayushman Bharat.**

c) **Grassroots Screening and Immunization Collaboration: Institutionalize collaborative drives between state health departments and specialized oncology institutes to utilize ASHA and Anganwadi networks for community outreach. Establish regular diagnostic camps at Primary Health Centres (PHCs) and Community Health Centres (CHCs) using mobile diagnostic units, launch joint capacity-building programs for public healthcare personnel, and execute a national campaign for HPV vaccination among girls aged 9-26 years.**

3.29 Responses received from States/UTs on Affordability and Accessibility of Healthcare Facilities

3.29.1 Punjab

(i) **Collaboration with Private Healthcare Organisations to Improve Affordability:** To reduce out-of-pocket expenditure (OOPE) and enhance access to quality diagnostic services, the Punjab Health System Corporation (PHSC) has entered into Concession

Agreements with M/s Krsnaa Diagnostics Ltd. and M/s Pathcare Labs Pvt. Ltd. under the Public-Private Partnership (PPP) mode.

(ii) Radio-Diagnostic Services: A Concession Agreement for radio-diagnostic services was signed with M/s Krsnaa Diagnostics Ltd. on 20 April 2021 for a period of 10 years at discounted CGHS rates. A total of 80 types of scans are being provided across six clusters. MRI centres have been established at District Hospitals in Amritsar, Bathinda, Jalandhar, Ludhiana, Patiala and Mohali, while CT scan centres are available at all 23 District Hospitals and three Sub-Divisional Hospitals.

(iii) Laboratory Diagnostic Services: A separate Concession Agreement was signed with M/s Krsnaa Diagnostics Ltd. in August 2021 for a period of 12 years. Under the agreement, 254 laboratory tests are being provided at a uniform discount of 47.340% on CGHS rates. A total of 30 laboratories and 125 collection centres, including 30 satellite centres, have been established, along with a State Reference Laboratory at S.A.S. Nagar.

3.29.2 In addition, PHSC entered into an agreement with M/s Pathcare Labs Pvt. Ltd. on 31 May 2023 to provide laboratory diagnostic services at Aam Aadmi Clinics (AACs). Initially, 38 tests were covered. The agreement has since been renewed for another year and eight additional tests have been included, taking the total to 46 tests.

3.29.3 Andhra Pradesh

Accessibility of Healthcare at Primary Level: The Government of Andhra Pradesh has established 10,032 Village Health Clinics (Ayushman Arogya Mandirs) at the village level to provide accessible healthcare facilities to the rural population. As per Indian Public Health Standards (IPHS) norms, there should be one Sub-Centre for every 5,000 population. In Andhra Pradesh, however, one Village Health Clinic caters to approximately 2,500–3,000 population. Each Village Health Clinic is staffed by one Mid-Level Health Provider (MLHP)/Community Health Officer (CHO) with a B.Sc. (Nursing) qualification, along with an ANM. The clinics are equipped to conduct 14 types of diagnostic tests and provide 105 categories of medicines free of cost to the public. Tele-consultation services are also provided through Village Health Clinics, with consultations from PHC doctors and specialists located at district hubs.

3.29.4 Goa

i. Pradhan Mantri National Dialysis Programme (PMNDP): The Pradhan Mantri National Dialysis Programme aims to provide affordable dialysis services. In Goa, dialysis services are being provided under the PPP mode in collaboration with Apex Kidney Care Pvt. Ltd. (AKC), which commenced operations in the State in December 2017. There are 16 dialysis centres functioning under the Directorate of Health Services. All medicines, including Inj. Erythropoietin required for dialysis patients, are provided free of cost.

ii. Changing Diabetes Barometer (CDB) Project :Through 15 Community Diabetes Centres (CDCs), the project provides free insulin, diabetes medicines and complication screening. Counselling on diet, lifestyle and treatment adherence is also provided to empower patients to effectively manage their condition.

iii. Affordable and Compassionate Palliative Care:Home visits form an integral part of the palliative care initiative. Dedicated teams equipped with home-care kits provide end-of-life care and regular support to patients. NGOs including Shanti Avedna, Dilasa and Sneha Mandir further strengthen the programme by extending compassionate services to the community.

iv. ST Elevation Myocardial Infarction (STEMI) – Goa Project: The STEMI Goa Project has been addressing the rising incidence of STEMI cases in the State since December 2018. Services under the project are provided free of cost to all patients. The project presently has 20 spokes and four hubs. The hub-and-spoke model enables patients to reach the nearest hub within the golden hour, where they are diagnosed through Tele-ECG and thrombolysed using newer thrombolytics such as Reteplase and Tenecteplase. After stabilisation and thrombolysis, patients are transferred to the apex tertiary institution, Goa Medical College & Hospital, through specialised cardiac/ALS-equipped ambulances.

v. Goa Stroke Programme :Eligible patients under the Goa Stroke Programme are administered Inj. Tenecteplase 20 mg, a clot-busting drug used for treating ischaemic strokes. Despite its high cost of approximately ₹30,000 per vial, the medicine is provided free of cost to eligible patients.

vi. Swasth Mahila Swasth Goa Project :The project provides technology intervention through iBreastExam devices, along with training and capacity-building support, for breast cancer screening in Goa. Launched on 26 October 2021, the project aimed to screen one lakh women for breast cancer over two years. The target was exceeded, with 1,69,348 women screened and 74 confirmed cases of breast cancer identified by June 2025. In view of its community-level impact, the project was extended for another two years, up to December 2025.

vii. Early Detection of Lung Cancer Project: The Directorate of Health Services, Goa launched the Lung Cancer Early Detection Project to improve survival through screening and early detection of lung diseases. The project uses AI-based interpretation of digital chest X-rays followed by chest CT scans, wherever required. The qXR technology is currently deployed at 17 health centres having digital X-ray and internet facilities, with the system operating on the cloud.

viii. Goa Mediclaim Scheme: The Goa Mediclaim Scheme, introduced in 1999, provides financial assistance to every permanent resident of Goa for availing super-speciality treatments that are not available in Government hospitals in the State.

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3.29.5 Manipur

i. Accessibility and Affordability of Healthcare : Healthcare accessibility and affordability continue to be key concerns in Manipur, particularly in remote and hilly areas. Although the State has taken several measures to improve healthcare infrastructure and implemented schemes such as "Go To Hill 2.0", CMHT and Ayushman Bharat, disparities continue to exist in access to quality healthcare between urban and rural populations and between the valley and hill areas. Healthcare access is particularly challenging in the hill districts because of difficult terrain. There is also a significant shortage of specialist doctors, especially in rural areas.

ii. Under PM-DevINE, an ongoing project titled "Providing Super Specialty and Assured Specialty Health Care in Remote and Hill Districts" is being implemented through infrastructure and equipment support in five District Hospitals—Chandel, Ukhrul, Tamenglong, Senapati and Jiribam. The project is expected to address some of the existing gaps in the near future. The State has further indicated that there remains a shortage of centres capable of providing super-speciality and speciality care according to prevailing demand and needs.

3.29.6 Municipal Corporation of Delhi (MCD)

i. Public-Private Spending on Healthcare Infrastructure and Services : MCD has stated that there is considerable scope for increasing public-private spending on healthcare infrastructure. The capital cost of medical equipment may, inter alia, be met through Corporate Social Responsibility (CSR) support.

ii. Subsidy/Financial Protection to Reduce Out-of-Pocket Expenditure: The cost of CT scans may be reduced through Government subsidy. MCD has also suggested that MRI facilities may be initiated on an outsourced basis.

iii. Collaboration with Private Healthcare Organisations : Hindu Rao Hospital provides CT scan facilities in collaboration with FOCUS Diagnostics at discounted rates. Dialysis centres are also being operated under the PPP mode in two hospitals in collaboration with NIPRO. MCD has further suggested exploring collaboration between smaller hospitals and specialised hospitals, including transfer of stabilised post-operative patients to smaller hospitals. This would help release beds in specialised hospitals for new patients.

iv. Need for Changes in Health Policy/Schemes: MCD has stated that healthcare is labour-intensive and, therefore, the manpower component of expenditure should be increased. Adequate funds should also be provided for upskilling and reskilling of the healthcare workforce. It has further suggested that health may be considered a Fundamental Right, on the analogy of the Fundamental Right to Education.

v. Telemedicine and Reduction of Personal Visits/Expenditure: The e-Sanjeevani telemedicine service was started in MCD at Hindu Rao Hospital on 6 June 2022. Its

response was very encouraging during the COVID period; however, the number of patients attending online e-Sanjeevani OPD subsequently declined. MCD considers e-Sanjeevani a useful initiative for reducing personal visits to healthcare facilities and, consequently, out-of-pocket expenditure. However, it has suggested that the facility needs to be widely publicised to increase public awareness and utilisation.

vi. Community Health Programmes: ASHA and ICDS workers act as a bridge between the community and health centres in MCD. Chest Clinics and TB Hospitals implement the National Tuberculosis Elimination Programme (NTEP) through a community-based approach. The Pulse Polio Programme and other immunisation programmes are implemented with active community support. Kanwar camps, screening camps and mobile dispensaries also help extend healthcare services to the community.

vii. Challenges : MCD has identified the following key challenges: Budgetary constraints; Shortage of manpower; Shortage of appropriately skilled healthcare professionals, particularly radiologists and anaesthesiologists; Delays in procurement of medicines and surgical items due to their non-availability on the GeM Portal and absence of Rate Contract Agreements (RCA); and Lack of adequate knowledge of procedures, rules and regulations.

viii. Strategies/Action to Address Challenges

ix. MCD has proposed the following measures: Recruitment of staff at all levels; Improvement of infrastructure, including wards, OPD, OT, library, auditorium and centralised air-conditioning facilities; Timely allocation of budget; and Administrative training of doctors and paramedical staff.

3.29.7 Puducherry

3.29.8 Collaboration with Private Healthcare Organisations :Puducherry has entered into various MoUs with private healthcare organisations and NGOs to improve access to specialised healthcare: An MoU has been signed with Frontier Lifeline Hospital for cardiac surgeries at Indira Gandhi Government General Hospital; An MoU has been signed with Cankids NGO to support paediatric cancer care; An MoU has been signed with Apollo Hospitals for newborn surgeries, including cardiac and hearing-defect surgeries; An MoU has been signed with Aravind Eye Hospital for newborn eye screening and diabetic retinopathy screening.

3.29.9 Free Healthcare Camps and Health Check-ups

1. Mega Health Melas are organised twice a year in rural and urban areas, involving various departments and providing information on Government schemes and screening services.

2. Ayushman Shivirs are conducted weekly at all Ayushman Arogya Mandirs in PHCs and once a month at all CHCs. Approximately 70–100 persons per week at each PHC and 300 persons per month at each CHC benefit from these camps.

3. Speciality NCD camps are conducted periodically at various PHCs. During the current year, seven such camps had been conducted, providing services relating to NCDs, dental care, cancer screening, eye care, ENT services and Ayushman Cards.

4. Mega Health Melas are also planned exclusively for beneficiaries of the Adi Dravidar Welfare Department.

5. Periodic X-ray camps for TB detection have been conducted from January to June 2025, with 855 targets achieved.

6. AB-PMJAY card enrolment camps are conducted every month in all PHCs and in coordination with other health programmes, including Viksit Bharat, Good Governance Week and Health Melas. Since the launch of the programme, 5,38,714 persons have been enrolled.

3.29.10 Measures to Contain Exorbitant Costs of Diagnosis and Treatment of Rare Diseases, Including Cancer

3.29.11 A proposal was submitted to the Ministry for opening a separate cancer care centre, however, the proposal was not accepted. A separate area has nevertheless been earmarked for the proposed activity. A request has also been made to Tata Cancer Care Trust to construct a similar facility based on the model implemented in Uttar Pradesh. The proposal is presently under process. Doctors from all District Hospitals are being trained at JIPMER to provide day-care chemotherapy. The UT has also proposed establishment of a State-of-the-Art De-addiction Centre.

3.30 Assam

3.30.1 Best Practices Adopted by the State : Assam has adopted several measures to improve the affordability, accessibility and coverage of healthcare under AB-PMJAY and AA-MMJAY: Proactive Screening: In-patients and emergency cases are screened for NFSA eligibility to prevent exclusion from coverage under AB-PMJAY and AA-MMJAY; Hospital Handholding: Dedicated Hospital Administrators support AB-PMJAY/AA-MMJAY beneficiaries in public hospitals; e-KYC Drives: The “Apke Dwar Ayushman” campaign has achieved e-KYC of approximately 1.74 crore NFSA individuals through door-to-door and camp-based verification; Intensive IEC Campaigns: Comprehensive 360-degree outreach is undertaken through social media, newspapers, television, hoardings, health melas and workshops; Increased Service Uptake: The daily average number of treatments under AB-PMJAY/AA-MMJAY has increased from 500 to 2,000; Anti-Fraud Mechanism: A robust mechanism comprising District Medical Officers, third-party auditors and the ISA conducts clinical, beneficiary and infrastructure audits; Self-Sustaining Public Hospitals: Public hospitals utilise scheme claims for infrastructure development, thereby reducing their dependence on State grants.

3.30.2 The State has identified the following challenges: e-KYC Saturation: Migration and absence of some NFSA members hinder complete coverage; Technical Glitches: Occasional server-related issues disrupt seamless treatment processes; Inadequate Central Premium: The

premium of ₹1,052 per family, which has remained unchanged since inception, is considered insufficient in view of rising treatment costs and increased utilisation under Health Benefit Package 2022.

3.30.3 Convergence of AB-PMJAY and AA-MMJAY: The convergence of AB-PMJAY and AA-MMJAY, along with implementation of AA-MMLSAY and Vay Vandana, and Aadhaar validation of more than 90% of the NFSA population, is steering Assam towards Universal Health Coverage (UHC). These integrated efforts are aimed at ensuring that healthcare becomes affordable and accessible to every eligible citizen of the State.

3.31 Kerala

3.31.1 Kerala's public health system is recognised for its emphasis on universal, affordable and high-quality healthcare, with a strong focus on equity and social justice. Decentralised planning and community participation have contributed to high life expectancy, low infant and maternal mortality, and near-universal immunisation.

i. Primary Care Transformation: More than 800 Primary Health Centres (PHCs) have been upgraded into Family Health Centres (FHCs). These centres have extended working hours, increased staffing and broader service offerings, thereby improving access, particularly for rural and marginalised communities.

ii. Public Health Infrastructure: Kerala operates 5,415 Community Health Centres and 380 Urban Public Health Centres, providing comprehensive coverage across urban and rural areas. Major hospitals have also introduced advanced facilities, including stroke units and robotic surgery for cancer, setting national benchmarks in specialised healthcare.

iii. Free and Subsidised Healthcare: During the last three and a half years, more than 2.5 million people have received free treatment valued at over ₹6,788 crore, reflecting the State's commitment to financial protection.

iv. Digital Health and Innovation: Kerala has made significant progress in digital health, with nearly half of its public health facilities adopting the eHealth system. Services include online OP ticket booking, digital payments and a mobile health application, thereby streamlining patient access and health-data management. The State is also investing in AI-driven healthcare solutions, including a ₹350 crore Emerging Technology Hub in Thiruvananthapuram. Public hospitals have introduced advanced diagnostic technologies such as digital pathology and AI-guided rehabilitation devices.

v. Elderly and Vulnerable Population Care: Kerala is the first State in India to establish a statutory Senior Citizens Commission, focusing on the welfare, protection and rehabilitation of elderly persons. Elderly-care initiatives include palliative care, free medicines, permanent caregivers and AI-based surveillance for bedridden patients. Programmes such as Vayoamrutham provide additional support to persons above 65

years of age. Local governments have also been mandated to allocate 5% of their plan funds for elderly care.

vi. Decentralised Governance and Community Engagement: Local self-governments play a central role in health planning, resource allocation and monitoring, ensuring that healthcare services are tailored to local needs and vulnerable groups are prioritised. Accredited Social Health Activists (ASHAs) and volunteers are integral to community outreach, health education and service delivery, particularly in rural and underserved areas.

vii. Kerala's health sector is characterised by universal access, digital innovation and strong public health infrastructure. At the same time, the State faces challenges arising from an ageing population, a high burden of non-communicable diseases (NCDs) and the contraction of small private healthcare providers. Its proactive policies, community engagement and emphasis on equity continue to position Kerala as a model of public health both in India and globally.

3.32 Institutionalizing Public-Private Partnerships (PPP) and CSR for Diagnostic and Specialized Services

3.32.1 The Committee notes that high Out-Of-Pocket Expenditure (OOPE) is largely driven by the exorbitant costs of diagnostic tests and specialized treatments. The Committee is of the view that the strategic Public-Private Partnership (PPP) models implemented by Punjab, providing high-end radio-diagnostic (MRI/CT) and laboratory services at steeply discounted Central Government Health Scheme (CGHS) rates, and Goa's collaboration for free dialysis services, are highly effective mechanisms for cost reduction. Furthermore, the Committee acknowledges the suggestion from the Municipal Corporation of Delhi (MCD) that the capital cost of expensive medical equipment can be supplemented by external funding. The Committee, therefore, recommends that the Union Government develop a standardized PPP framework to assist all States in outsourcing high-cost diagnostic and dialysis services at capped rates. Additionally, the Ministry should formulate guidelines to systematically channel Corporate Social Responsibility (CSR) funds toward procuring capital-intensive medical infrastructure for public hospitals.

3.32.2 Overcoming Geographical Barriers in Remote Regions and Scaling Telemedicine

3.32.3 The Committee recognizes the severe accessibility challenges in remote, rural, and hilly terrains, as highlighted by the State of Manipur, where infrastructural deficits and a distinct shortage of specialist doctors disproportionately affect vulnerable populations. Concurrently, while telemedicine platforms like e-Sanjeevani offer a viable solution, their utilization often diminishes without sustained public awareness, as observed by the MCD. The Committee believes that physical infrastructure development in challenging terrains must be aggressively supplemented by digital outreach. The Committee, therefore, recommends the creation of a dedicated infrastructure fund to establish specialized hubs in geographically challenging districts.

Furthermore, the Committee recommends that the Government launch intensive Information, Education, and Communication (IEC) campaigns to publicize telemedicine services, mandating the integration of district-level specialist hubs with primary rural clinics to minimize unnecessary out-of-pocket travel expenses for patients.

3.32.4 Densifying Primary Care Networks and Decentralizing Health Governance

3.32.5 The Committee observes that robust primary healthcare is the cornerstone of disease prevention and early management. The proactive approach of Andhra Pradesh, establishing Village Health Clinics for every 2,500–3,000 population, surpassing standard Indian Public Health Standards (IPHS) norms, and Kerala's transformation of Primary Health Centres into extended-hour Family Health Centres managed through decentralized local self-governments, constitute exemplary models of grassroots healthcare delivery. The Committee is of the view that increasing the density of primary care facilities drastically reduces the burden on tertiary hospitals. The Committee, therefore, recommends that financial incentives must be provided to States that successfully densify their primary care networks and empower local self-governments to allocate dedicated plan funds for grassroots health monitoring.

3.32.6 Assuring Financial Protection for Critical Care and High-Cost Life-Saving Interventions

3.32.7 The Committee notes with grave concern that life-threatening emergencies, such as strokes and myocardial infarctions (STEMI), often lead to catastrophic financial ruin for affected families. The Committee commends the State of Goa for its STEMI project and Stroke Programme, which utilize a hub-and-spoke model to ensure treatment within the "golden hour" and provide highly expensive clot-busting drugs (such as Tenecteplase) entirely free of cost. Similarly, Puducherry's strategy of signing MoUs with specialized private institutions for pediatric cardiac and cancer care effectively bridges public sector gaps. The Committee believes that no citizen should be denied life-saving critical care due to financial constraints. The Committee, therefore, recommends the establishment of a national corpus to subsidize high-cost, life-saving emergency drugs (such as newer thrombolytics) across all public district hospitals. Furthermore, the Government should encourage States to enter into strategic Memorandums of Understanding (MoUs) with specialized private and non-profit institutions to provide free or highly subsidized tertiary care for critical ailments like cancer and pediatric anomalies.

3.32.8 Streamlining Procurement Frameworks and Augmenting the Healthcare Workforce

3.32.9 The Committee acknowledges the severe administrative and logistical bottlenecks impeding healthcare delivery, particularly the shortage of appropriately skilled professionals (radiologists, anesthesiologists) and critical delays in procuring essential medicines and surgical items, as underscored by the MCD. The Committee is of the view that a lack of agile procurement systems and inadequate upskilling budgets

severely hamstring public healthcare infrastructure. The Committee, therefore, recommends that the Government immediately address the procurement delays on digital marketplaces by instituting mandatory, fast-tracked Rate Contract Agreements (RCAs) for life-saving medicines and surgical consumables. Additionally, the Committee recommends a targeted increase in budgetary allocations explicitly earmarked for the recruitment, upskilling, and reskilling of specialized medical and paramedical personnel.

3.32.10 Integrating Emerging Technologies and Artificial Intelligence for Proactive Screening

3.32.11 The Committee observes that leveraging technology is essential for achieving Universal Health Coverage (UHC). Initiatives such as Goa's AI-based interpretation of digital chest X-rays for early lung cancer detection, Kerala's deployment of digital pathology and robotic surgery, and Assam's proactive digital screening and national identity validation mechanisms to ensure scheme saturation, demonstrate the transformative potential of modern technology in public health. The Committee believes that artificial intelligence and centralized digital health records are critical for the early detection of non-communicable diseases (NCDs) and the prevention of scheme exclusion. The Committee, therefore, recommends that the Ministry launch a centralized initiative to deploy AI-driven diagnostic tools for cancer and NCD screening across all secondary and tertiary public health facilities. Concurrently, States should be technically supported to conduct proactive, door-to-door digital verification drives to ensure 100% saturation and inclusion of eligible beneficiaries under national health protection schemes.

3.32.12 Fostering Financial Autonomy of Public Hospitals through Scheme Claim Reinvestment

3.32.13 The Committee observes that public healthcare institutions often grapple with perennial budgetary constraints that impede the routine maintenance and upgradation of infrastructure. The Committee is of the view that the innovative strategy adopted by the State of Assam, whereby public hospitals retain and utilize the claims reimbursed under national health protection schemes (such as AB-PMJAY) for their own infrastructure development, is a highly pragmatic and replicable model. This mechanism effectively reduces institutional dependency on State grants and transforms public hospitals into self-sustaining entities capable of continuously upgrading their services. The Committee, therefore, recommends that the Ministry of Health and Family Welfare issue standard operating procedures to enable and encourage public hospitals across all States to reinvest a substantial portion of the funds generated through insurance claims directly into local hospital infrastructure, medical equipment procurement, and patient welfare initiatives.

3.32.14 Enacting Dedicated Frameworks for Geriatric Care and Ring-Fencing Local Funds

3.32.15 The Committee notes with appreciation the pioneering initiatives undertaken by the State of Kerala, notably the establishment of a statutory Senior Citizens Commission, the deployment of AI-based surveillance for bedridden patients, and the mandate for local governments to allocate 5% of their plan funds specifically for elderly care. Furthermore, the Committee acknowledges the suggestion made by the Municipal Corporation of Delhi (MCD) to consider elevating health to the status of a Fundamental Right. The Committee believes that as the demographic profile of the nation evolves, the healthcare system must proactively cater to the complex and specialized needs of an aging population. The Committee, therefore, recommends that the Union Government formulate a comprehensive national policy specifically targeting geriatric and palliative care. Furthermore, the Ministry must incentivize States to mandate their local self-governments to ring-fence a fixed percentage of their budgetary allocations exclusively for elderly care, home-based palliative support, and the provision of free medicines for senior citizens.

3.32.16 Optimizing Tertiary Bed Capacity through 'Step-Down' Care Protocols

3.32.17 The Committee acknowledges the severe strain on tertiary and super-specialty hospitals, where a significant number of acute-care beds remain occupied by patients who have stabilized but require prolonged, lower-intensity recovery care. The Committee is of the view that the strategy proposed by the MCD, to establish formalized collaborations wherein stabilized post-operative patients are seamlessly transferred from specialized hospitals to smaller, peripheral health centres, is vital for optimizing the availability of tertiary beds for new, critical patients. The Committee, therefore, recommends that the Government establish a formal 'Step-Down Care' referral framework. Such a framework should facilitate the smooth transition of stabilized patients from apex tertiary institutions back to secondary or district hospitals, backed by integrated electronic health records and a robust ambulance network. This will ensure that highly specialized healthcare infrastructure is utilized optimally and primarily for critical and complex interventions.

3.32.18 Upward Revision of Scheme Premiums and Institutionalization of Clinical Audits

3.32.19 The Committee observes that while flagship health insurance schemes have significantly widened coverage, practical and financial challenges persist that threaten their long-term efficacy. The Committee takes serious note of the concerns raised by the State of Assam regarding the inadequacy of the central premium of ₹1,052 per family under AB-PMJAY, which has remained stagnant despite rising treatment costs and expanded health benefit packages. Concurrently, the Committee appreciates Assam's robust anti-fraud mechanism, which utilizes District Medical Officers and third-party auditors for rigorous clinical and infrastructure audits. The Committee believes that financial viability and strict vigilance are twin pillars for the success of universal health

coverage. The Committee, therefore, recommends that the Union Government urgently undertake a comprehensive actuarial review to upwardly revise the central premium under national health protection schemes, aligning it with current medical inflation. Simultaneously, the Ministry must mandate all States to institute rigorous, multi-tier clinical and beneficiary audits to eliminate malpractices and ensure that scheme benefits exclusively reach the rightful beneficiaries.

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CHAPTER IV

POLICY AND REGULATORY FRAMEWORK

4.1 Government policies on healthcare affordability and accessibility

4.1.1 NITI Aayog in its submission before the Committee stated that ensuring equitable, affordable, and quality healthcare is a key objective of the Government. Over the last decade, several flagship initiatives have been implemented to strengthen healthcare infrastructure, expand access to comprehensive primary healthcare, secondary & tertiary care, improve financial protection, promote digital health, increase the availability of affordable medicines and diagnostics, and strengthen the health workforce. These interventions collectively aim to improve accessibility and affordability of healthcare services across the country.

4.1.2 The Committee was informed about the following measurestaken by the Government to improve affordability of healthcare:

(i) **Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY):** AB-PMJAY is the world's largest publicly funded health assurance scheme, providing cashless health cover of ₹5 lakh per family per year for secondary and tertiary care. The scheme has issued 44.27 crore Ayushman Cards, covered over 11 crore hospital admissions, authorized treatments worth ₹1.57 lakh crore, and empanelled 38,038 public and private hospitals, substantially reducing catastrophic health expenditure.

(ii) **Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP):** The PMBJP improves access to affordable medicines through over 19,200 Jan Aushadhi Kendras, offering quality generic medicines at 50–80% lower prices than branded medicines. The scheme has generated savings of over ₹45,000 crore for citizens by reducing out-of pocket expenditure on medicines.

(iii) **AMRIT (Affordable Medicines and Reliable Implants for Treatment) Pharmacy:** The AMRIT initiative provides medicines, implants and surgical consumables at discounts of up to 50% through a network of affordable pharmacies. It has supplied medicines worth over ₹17,000 crore, generated patient savings exceeding ₹8,400 crore, and served 72.96 million beneficiaries, thereby reducing treatment costs and improving access to affordable medicines.

(iv) **Pradhan Mantri National Dialysis Programme (PMNDP):** The PMNDP provides free dialysis services through District Hospitals under the National Health Mission to reduce the financial burden of End-Stage Renal Disease. Since its launch, the programme has treated 31.74 lakh patients, conducted over 4 crore haemodialysis sessions across 1,816 centres, and generated estimated patient savings of ₹10,102 crore.

4.1.3 The Committee envisages that comprehensive health assurance is instrumental to reduce OOPE and to make healthcare affordable to all. Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has fundamentally altered the healthcare financing landscape by covering over 11 crore hospital admissions and empanelling 38,038 public and private hospitals. The Committee believes that the substantial benefits realized through AB-PMJAY, which has authorized treatments worth ₹1.57 lakh crore, must be structurally insulated from medical inflation and unchecked technological cost

escalations. The Committee, therefore, recommends that the government institute a statutory mechanism to periodically revise package rates under all government insurance schemes, factoring in regional economic variations to ensure continued and active participation of private sector hospitals without compromising the quality of care. Furthermore, the Committee is of the view that unwarranted variations in private healthcare costs create unpredictable out-of-pocket burdens that undermine financial protection. The Committee, therefore, recommends mandating transparent, standardized treatment packages across all healthcare providers to ensure cost predictability, reduce catastrophic health expenditure, and safeguard patient trust.

4.1.4 The Committee observes that the middle-income demographic, often excluded from publicly funded schemes, requires robust, accessible safety nets to prevent sudden impoverishment due to medical emergencies. The Committee, therefore, recommends the accelerated expansion of standardized, low-cost health insurance products, akin to Aarogya Sanjeevani, featuring simplified policy terms and wider demographic coverage. Concurrently, the Committee believes that the strict enforcement of the recently introduced IRDAI regulatory reforms, specifically the removal of upper age limits for purchasing policies and the reduction of waiting periods for pre-existing diseases to three years, is critical to enhancing patient inclusion and customer satisfaction. The Committee, therefore, recommends for the optimal utilization of the National Health Exchange platform to ensure expeditious, transparent cashless claim settlements and strict adherence to these modernized insurance mandates across all providers.

4.1.5 The Committee acknowledges the savings of over ₹45,000 crore generated by the 19,200 Jan Aushadhi Kendras and ₹8,400 crore by AMRIT pharmacies. The Committee believes that affordable generics and implants are the cornerstone of equitable healthcare. The Committee, therefore, recommends establishing Jan Aushadhi Kendras in all remaining block-level public health facilities and encouraging private tertiary hospitals to host AMRIT pharmacies to extend discounted implants and surgical consumables to a wider patient base.

4.1.6 The Committee notes that the Pradhan Mantri National Dialysis Programme (PMNDP) has already generated ₹10,102 crore in patient savings.The Committee is of the view that end-stage renal disease remains a significant financial drain. The Committee, therefore, recommends exploring public-private partnerships to expand free or highly subsidized haemodialysis centers beyond District Hospitals to sub-district levels.

4.1.7 The Committee believes that to sustain and expand the massive decentralized infrastructure of 19,200 Jan Aushadhi Kendras and over 1,816 PMNDP dialysis centres, state governments must proportionally elevate their fiscal commitments alongside the central government. The Committee, therefore, recommends that the Union Government actively incentivize States to enhance their respective health allocations to a minimum of 8% of their aggregate state expenditure.

4.1.8 The Committee, furthermore, is of the view that holistic wellness must be integrated seamlessly into the nation's primary financial protection frameworks to offer citizens a comprehensive continuum of care. The Committee, therefore, recommends the formal inclusion of Ayush treatment packages within the ambit of AB-PMJAY to

provide beneficiaries with regulated, traditional therapeutic options while maintaining zero out-of-pocket expenditure.

4.1.9 The Committee was further informed about the following measures taken by the Government to improve accessibility of healthcare services:

(i) **Ayushman Arogya Mandirs (AAMs):** Under Ayushman Bharat, over 1.86 lakh Ayushman Arogya Mandirs (AAMs) have been operationalized to provide comprehensive primary healthcare closer to communities, including preventive, promotive, curative, rehabilitative and palliative care. The programme has recorded over 540 crore patient visits, conducted more than 60 crore cancer screenings, and screened over 41 crore people each for hypertension and diabetes, strengthening early detection and continuity of care.

(ii) **Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM):** Launched in 2021, PM-ABHIM aims to strengthen India's public health infrastructure and pandemic preparedness by supporting the establishment of 744 Integrated Public Health Laboratories, 631 Critical Care Hospital Blocks, 23,224 Rural AAMs, 13,736 Urban AAMs, and 3,389 Block Public Health Units, thereby improving healthcare delivery from the village to the district level.

(iii) **National Health Mission (NHM):** The National Health Mission has strengthened public health systems through improved infrastructure, expanded human resources, essential medicines, immunization and disease control programmes. These efforts have contributed to significant improvements in health outcomes, including a reduction in Maternal Mortality Ratio, Infant Mortality Rate, Under-5 Mortality Rate, and an increase in full immunization coverage.

(iv) **Pradhan Mantri Swasthya Suraksha Yojana (PMSSY):** The scheme aims to reduce regional disparities in tertiary healthcare and strengthen medical education. Under the scheme, the number of AIIMS institutions has increased to 23, with undergraduate courses commenced in 19 AIIMS, while 75 Government Medical College upgradation projects have been approved to improve access toquality tertiary healthcare and medical education across the country.

(v) **Ayushman Bharat Digital Mission (ABDM):** The Ayushman Bharat Digital Mission has established one of the world's largest digital health ecosystems with over 93 crore ABHA accounts and more than 104 crore health records, enabling seamless digital health services, improved continuity of care, and greater efficiency in healthcare delivery.

(vi) **eSanjeevani National Telemedicine Service:** Launched in 2019, eSanjeevani has significantly expanded access to specialist consultations in rural and underserved areas by providing over 45 crore teleconsultations through more than 2.34 lakh healthcare providers, reducing travel costs and improving timely access to healthcare.

(vii) **Tele-MANAS:** Tele-MANAS provides free telephonic mental health services, including counselling and psychiatric support, through 53 Tele-MANAS Cells across all States and Union Territories in 20 languages. Since its launch, the programme has handled over 41 lakh calls, improving access to mental healthcare.

(viii) **National Ayush Mission:** The National Ayush Mission has strengthened the Ayush healthcare system by supporting 12,500 Ayush Arogya Mandirs, 203 Integrated Ayush Hospitals, and the co-location of 13,093 Ayush facilities in public health facilities in convergence with NHM. In 2024 alone, Ayush Arogya Mandirs served 11.5 crore beneficiaries.

(ix) **Expansion of Medical Education and Healthcare Workforce:** Over the last decade, India has significantly expanded its medical education capacity to strengthen the healthcare workforce. The number of AIIMS institutions has increased to 23, while the number of medical colleges has grown from 387 to over 820. Undergraduate medical seats have increased from about 59,000 to over 1.28 lakh, and postgraduate seats from around 31,000 to over 86,000. The Government has also announced the establishment of 157 nursing colleges co-located with medical colleges and plans to add 75,000 additional UG and PG medical seats over the next five years, enhancing the availability of skilled healthcare professionals across the country.

4.1.10 The Committee appreciates that the operationalization of over 1.86 lakh Ayushman Arogya Mandirs (AAMs) and the proactive screening of over 41 crore citizens for non-communicable diseases constitute a monumental and necessary shift toward preventive and promotive healthcare at the grassroots level. Furthermore, the Committee believes that the targeted investments under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), with accelerated pace of implementation, to establish Integrated Public Health Laboratories and Critical Care Hospital Blocks are paramount for fortifying decentralized pandemic preparedness. The Committee, however, recommends strict administrative monitoring to ensure the timely completion of all pending infrastructural projects under PM-ABHIM. Since without skilled manpower, the infrastructure and equipments keep lying idle and instead become a burden over the exchequer, the Committee further recommends alongside a mandate to continuously upskill frontline healthcare workers at AAMs, thereby ensuring standardized, high-quality primary care delivery from the village to the district level.

4.1.11 The Committee takes into account that the exceptional penetration of digital health initiatives, evidenced by the creation of over 93 crore ABHA accounts, 104 crore digital health records, and the execution of 45 crore eSanjeevani teleconsultations, has fundamentally dismantled geographical barriers to specialized healthcare. The Committee believes that sustaining this trajectory of improved continuity of care requires comprehensive participation across the entire healthcare spectrum. 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, while simultaneously expanding regional Tele-MANAS and eSanjeevani hubs to guarantee that specialized psychiatric and medical consultations are uninterruptedly accessible in the most remote areas. The Committee further believes that the teleconsultation interface should by user-friendly and easy to use with smooth functioning. Also to harvest the optimal potential of digital initiatives, the Government should strengthen the internet network in rural and remote areas on a mission mode with proper digital training to ASHA workers and healthcare volunteers, along with basic digital literacy to population.

4.1.12 The Committee believes that the unprecedented expansion in medical education infrastructure over the last decade, marked by the growth of medical colleges to over 820 and a near-tripling of undergraduate and postgraduate medical seats, addresses a critical historical deficit in human resources. The Committee, however, is of the view that generating educational capacity must be matched with strategic deployment to effectively reduce regional disparities in tertiary care as envisioned by the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The Committee, therefore, recommends the urgent formulation of a targeted national deployment strategy that integrates robust rural service incentives, enhanced infrastructural support for newly established nursing colleges, and preferential professional development pathways to ensure the equitable distribution of skilled medical, nursing, and Ayush practitioners across underserved districts.

4.1.13 The Committee is of the view that the unprecedented quantitative expansion of medical infrastructure, evidenced by the growth of medical colleges from 387 to over 820, the increase of AIIMS institutions to 23, and the planned addition of 75,000 medical seats and 157 nursing colleges, must be strictly commensurate with the highest standards of clinical excellence. The Committee believes that merely augmenting physical infrastructure and seat capacity without stringent, continuous evaluation risks diluting the operational proficiency of the national healthcare framework. 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 to ensure uncompromised educational and healthcare delivery standards.

4.1.14 The Committee understands that while the empanelment of 38,038 public and private hospitals under AB-PMJAY represents a monumental stride in providing secondary and tertiary care, maintaining uniform quality across this vast network requires intense regulatory scrutiny. The Committee is of the view that periodic legislative and financial oversight is essential not only to prevent fund leakage but also to ensure that the private sector adheres strictly to evidence-based clinical guidelines rather than profit-driven diagnostic redundancies. 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.

4.1.15 The following recent initiatives taken by the Government to improve access to specialized healthcarewere underlined by the NITI Aayog in its submission before the Committee:

(i)The announcement in Union Budget 2025–26 to establish Day Care Cancer Centres (DCCCs) in every district to decentralize cancer treatment, facilitate timely chemotherapy and follow-up care, and reduce the burden on tertiary hospitals. Accordingly, 297 DCCCs have been approved for FY 2025–26.

(ii) In addition, the Government has proposed the establishment of Emergency and Trauma Care Centres in district hospitals by expanding capacity by 50%, to provide

affordable 24×7 emergency services and improve equitable access to trauma care across the country.

(iii) The Union Budget 2026-27 also proposed setting up a NIMHANS-2 in North India and also upgrading National Mental Health Institutes in Ranchi and Tezpur as Regional Apex Institutions to improve access to mental health services.

4.1.16 The Committee has come across the heavy reliance on tertiary hospitals for continuous treatments, trauma response, and mental healthcare compromises accessibility and affordability for rural and district-level populations. The Committee believes that the recent policy mandates to decentralize specialized care, specifically the approval of 297 Day Care Cancer Centres (DCCCs) for FY 2025–26 and the 50% capacity expansion of 24×7 Emergency and Trauma Care Centres in district hospitals, constitute a vital structural correction. Furthermore, expanding advanced psychiatric infrastructure through the proposed establishment of NIMHANS-2 in North India and the upgradation of the National Mental Health Institutes in Ranchi and Tezpur into Regional Apex Institutions addresses a critical geographic deficit in mental healthcare.The Committee, therefore, recommends that the Government institute a stringent, centrally monitored timeline for the operationalization of the approved DCCCs and trauma care expansions to guarantee a seamless continuum of care without administrative delays. Furthermore, the Committee recommends proactive inter-ministerial coordination to expedite land acquisition and foundational deployment for NIMHANS-2 and the regional apex institutions, ensuring these centers are systematically integrated with district-level community screening and digital counseling networks to maximize early intervention.

4.1.17 The Committee is of the view that the physical infrastructure for specialized care cannot function optimally without a proportionally scaled and highly skilled technical workforce. The Committee believes that the Union Budget announcement to create one lakh allied health professionals through a five-year national roadmap is critical to addressing systemic gaps in diagnostics, peri-operative care, and post-treatment rehabilitation. To effectively navigate demographic and epidemiological transitions, evolving disease patterns, and the broad vision of Viksit Bharat @2047, the scope of these disciplines must transcend the initial Ten Priority Areas.The Committee, therefore, recommends the immediate execution of the five-year national roadmap with an expanded curriculum framework that formally incorporates advanced disciplines, including Critical Care, Respiratory & Cardiac Care, Molecular Diagnostics, Nuclear Medicine, Health Informatics, Geriatric Care, Rehabilitation & Palliative Care, Nutrition Science, and Public Health Laboratory Sciences. The Committee further recommends establishing robust accreditation protocols to ensure these expanded disciplines align strictly with Indian Public Health Standards (IPHS), thereby directly enhancing the operational functionality and quality of both public and private healthcare facilities.

4.1.18 The Committee feels that while public healthcare infrastructure is expanding at an unprecedented rate, a significant proportion of the populace remains reliant on the private sector for advanced diagnostic and tertiary care. The Committee believes that true affordability cannot be achieved if private healthcare costs remain fragmented and

largely unregulated outside of the government insurance ecosystems. The Committee, therefore, 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) to prevent unethical practices, unwarranted diagnostic testing, and arbitrary pricing in private medical facilities, thereby shielding citizens from medical impoverishment.

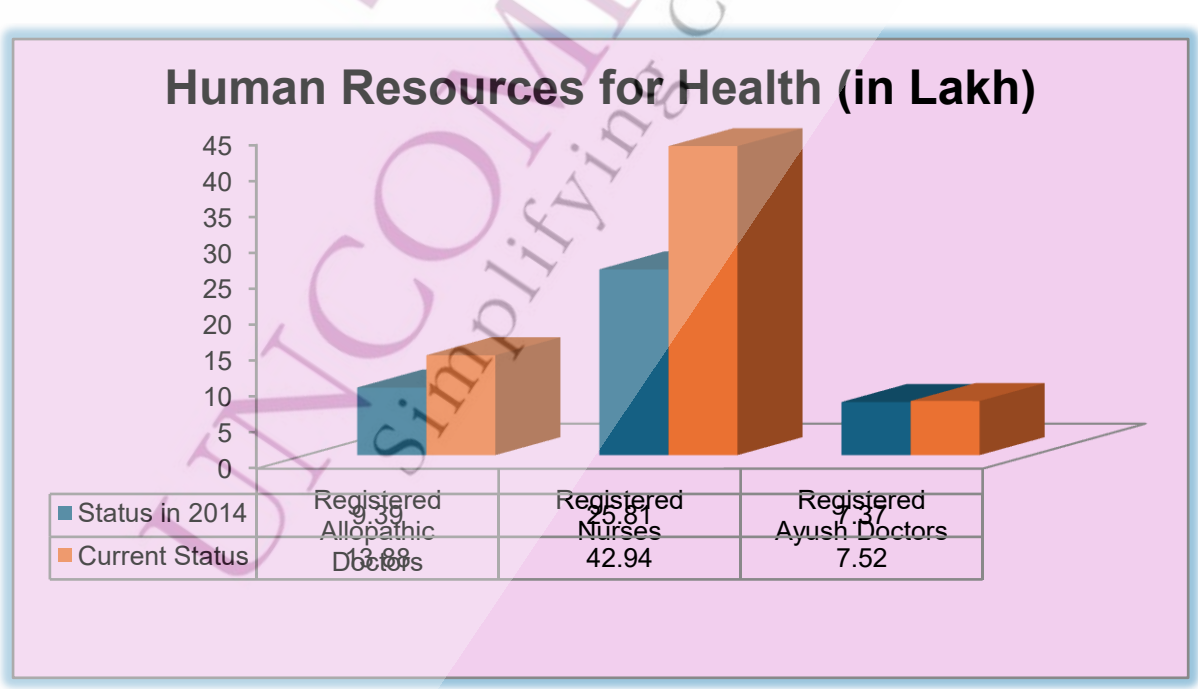
4.1.19 The Committee considers that the ambitious targets set by flagship initiatives, including the rollout of Day Care Cancer Centres, the PM-ABHIM infrastructure projects, and the addition of 75,000 medical seats, are heavily contingent upon sustained and optimally utilized capital outlays. The Committee believes that the mere allocation of central funds is insufficient if systemic administrative bottlenecks at the state level lead to the underutilization of budgetary estimates and subsequent delays in project execution. The Committee, therefore, recommends the institution of a dedicated, multi-tier financial oversight mechanism to rigorously audit quarterly fund utilization by State health departments. This mechanism must strictly link future tranches of central health grants to the verified, on-ground infrastructural progress of the preceding allocations.

4.1.20 The Committee was also informed of the impact and progress in health sector,on account of the afore-mentioned interventions, as follows:The combined impact of these initiatives has significantly improved financial protection in healthcare. According to the National Health Accounts, Out-of-Pocket Expenditure (OOPE) declined from 64.2% of Total Health Expenditure in 2013–14 to 43.4% in 2022–23. The NSSO 80th Round (2025–26) also indicates low out-of-pocket expenditure for treatment in public health facilities, reflecting the positive impact of expanded public healthcare services, health insurance, affordable medicines and free diagnostics.

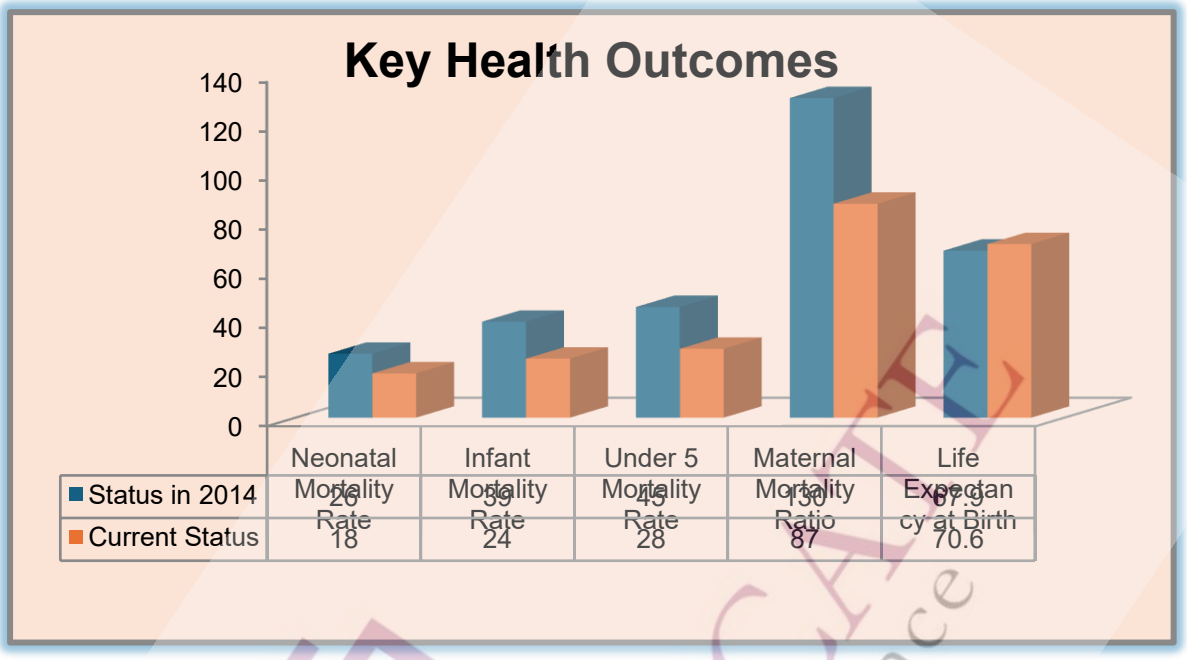
Medical Education		
	Status in 2014	Current Status
AIIMS Institutions	7 (2014)	23 (2026)
Medical Colleges	387 (2014)	818 (2025)
UG Medical Seats	51348 (2014)	128875 (2025)
PG Medical Seats	31185 (2014)	82059 (2025)
Ayush UG Colleges	500 (2013-14)	886 (2025)
Ayush National Institutes	9 (2014)	15 (2024)(12 main + 03 satellite institutes)

Health Financing		
	Status in 2014	Current Status
OOPE as % of Total Health Expenditure (THE)	62.60% (2014-15)	43.40% (2022-23)
Per capita Government Health Expenditure (GHE) (in rupees)	1108 (2014-15)	2786 (2022-23)
GHE of THE (% share)	29% (2014-15)	43.70% (2022-23)

Access to Essential Services (medicines, diagnostics & beds)		
	Status in 2014	Current Status
Jan Aushadhi Kendra	80 (2014)	19200 (2026)
Medicines at Jan Aushadhi Kendra	361 medicines (2014)	2110 medicines and 315 surgical items (2026)
Provision for number of Medicines at Sub-centre	57 (pre-Ayushman Bharat)	105
Provision for number of diagnostics tests at Sub-centre	7 (pre-Ayushman Bharat)	14
Provision for number of diagnostics tests at Primary Health Centre	19 (pre-Ayushman Bharat)	63
Total number of beds in Government Hospitals	628708 (2014)	840455 (2022)



UNCOMPLYCATE Simplifying compliance



4.1.21 The Committee notes with satisfaction that the Out-of-Pocket Expenditure (OOPE) has witnessed a precipitous decline to 43.40% of Total Health Expenditure (THE), heavily correlated with the Government Health Expenditure (GHE) increasing its share to 43.70%. The Committee is of the view that the ongoing expansion of essential diagnostics and the massive scale-up of Jan Aushadhi Kendras to 19,200 units have fundamentally transformed affordability for the common citizen. However, acknowledging the critical need for optimal fund utilization across health departments, the Committee believes that sustaining these positive outcomes, including the notable reductions in the Maternal Mortality Ratio and Infant Mortality Rate, requires insulating these financial gains from future inflationary pressures.The Committee, therefore, recommends the formulation of a statutory, multi-year financial outlay roadmap to systematically peg the per capita Government Health Expenditure (currently standing at ₹2,786) to medical inflation and evolving demographic health requirements. Furthermore, the Committee recommends the institution of stringent financial tracking and utilization audits for the expanded medicine procurement networks.

4.1.22 The Committee recognizes the unprecedented and aggressive augmentation of the nation's medical education framework, highlighted by the exponential growth of medical colleges from 387 to 818 and the near-tripling of both Undergraduate (128,875) and Postgraduate (82,059) medical seats. The Committee believes that this capacity building, alongside the operationalization of 23 AIIMS institutions, is indispensable for bridging historical deficits, as evidenced by the corresponding surge in registered allopathic doctors to 13.88 lakh and nurses to 42.94 lakh.However, the Committee is of the view that such exponential quantitative growth must be strictly matched with high operational proficiency, adequate faculty deployment, and uncompromising statutory compliance. The Committee, therefore, 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. Additionally, the Committee

recommends the creation of a specialized deployment policy to strategically integrate this augmented workforce into rural and underserved tier-3 districts, ensuring that the enhanced bed capacity of 8.40 lakh translates directly into accessible, high-quality patient care.

4.1.23 The Committee views that while flagship schemes like AB-PMJAY comprehensively protect the economically vulnerable bottom 50% of the population, a substantial segment, comprising approximately 30% of the demographic, often referred to as the "missing middle", remains devoid of structured financial health protection. The Committee believes that addressing this systemic gap is paramount for achieving true Universal Health Coverage.The Committee, therefore, recommends the urgent design and collaborative rollout of low-cost, comprehensive voluntary health insurance products specifically tailored for this demographic. Furthermore, the Committee recommends that the Government utilize robust digital exchange platforms to drive consumer awareness, enforce the regulatory standardization of these new insurance products, and facilitate operational efficiency across both public and private insurers.

4.1.24 The Committee takes note of the fact that the private sector manages a dominant share of hospitalized cases across the country, yet its geographic distribution remains disproportionately skewed towards metropolitan centers. The Committee is of the view that highly decentralized regulatory standards, where a vast majority of compliance mandates vary drastically by state, create significant administrative bottlenecks that deter private healthcare investment in Tier-2 and Tier-3 cities.The Committee, therefore, recommends a systemic overhaul of the existing regulatory framework to institute a "Single Window Clearance" mechanism for hospital registrations, blood bank licensing, and medical device manufacturing. The Committee believes that standardizing Clinical Establishment regulations nationally is crucial to improving the ease of doing business, thereby encouraging the expansion of affordable private care into underserved geographies.

4.2 Role of Regulatory Bodies

4.2.1 India's healthcare sector is governed by several key regulatory and apex bodies playing a critical role in ensuring healthcare affordability and accessibility.

4.2.2 **National Health Authority (NHA):**NHA is implementing two flagship initiatives Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and the Ayushman Bharat Digital Mission (ABDM). NHA drives healthcare equity through large-scale social insurance and infrastructure digitization.AB-PMJAY, the world's largest publicly funded health assurance scheme, provides financial protection by enabling cashless secondary and tertiary hospitalization for eligible beneficiaries, while ABDM strengthens healthcare accessibility by creating an interoperable digital health ecosystem that facilitates seamless service delivery, telemedicine, digital health records, and efficient exchange of health information. Together, these initiatives are transforming healthcare delivery by making quality healthcare more affordable, accessible, and equitable for all.

Key Statistics at a Glance (AB PM-JAY)

Parameter	Status (As on 30.06.2026)
Ayushman Cards created (AB PM-JAY)	44.23 crore
Hospital admissions authorised	12.59 crore
Estimated OOPE savings	1.91 lakh crore
ASHA/AWW/AWH cards created	44.04 lakh
Ayushman Vay Vandana cards created for senior citizen (aged 70 and above)	1.27 crore
Hospital Empanelled	37,413 Public-20,148 Private-17.265
Health Benefit Package (HBP)	HBP 2022: 1,961 procedures across 27 specialities (up from 1,393)
Gender parity in card creation/treatment	Women ~49% of Ayushman cards and cashless treatments

4.2.3 **Beneficiary Coverage:** AB-PMJAY, the world's largest publicly funded health assurance scheme, provides cashless health coverage of ₹5 lakh per family per year for secondary and tertiary hospitalization to over 12 crore vulnerable families (about 60 crore beneficiaries). Initially covering 10.74 crore families based on SECC 2011, the beneficiary base was revised to 12 crore families in 2023 to reflect population growth. Subsequently, coverage was extended to 37.14 lakh ASHAs, Anganwadi Workers and Helpers (March 2024) and all senior citizens aged 70 years and above, irrespective of socio-economic status (October 2024), benefiting around 6 crore senior citizens.

4.2.4 **Expanding Access through Public and Private Hospitals:** AB PM-JAY enables beneficiaries to avail cashless treatment through a nationwide network of empanelled public and private hospitals. The participation of private hospitals enhances geographical reach, reduces waiting time and improves access to specialized care, while public hospitals benefit from additional financial resources through claim reimbursements. Uniform empanelment standards, standardized Health Benefit Packages (HBPs), quality assurance protocols and transparent claims management ensure consistent service delivery.

4.2.5 **Comprehensive Health Benefit Packages:**The Health Benefit Packages have been periodically revised to improve coverage. Under HBP 2022, the number of treatment packages increased from 1,393 to 1,961 across 27 specialties, including advanced procedures such as bone marrow transplantation and cochlear implants. Bundled packages cover pre-hospitalization, hospitalization, implants, medicines and post-hospitalization follow-up, ensuring standardized cashless treatment.

4.2.6 **Technology-driven Governance:** The National Health Authority (NHA) has strengthened scheme integrity through AI/ML-based fraud detection, an Auto Adjudication Engine for faster claim processing, and a multi-channel grievance redressal system

comprising CGRMS, Ayushman App, WhatsApp chatbot, National Call Centre, Ayushman Mitras and State implementation mechanisms.

4.2.7 **National Portability and Convergence:** AB PM-JAY provides nationwide portability, allowing beneficiaries to access cashless treatment at any empanelled hospital across India. As on 30 June 2026, 27.75 lakh inter-state hospital admissions amounting to ₹6,635.36 crore had been authorized under the portability feature.

4.2.8 The scheme has also emerged as a common health assurance platform through convergence with other welfare programmes, extending cashless healthcare to Building and Construction Workers, sewer and septic tank workers, waste pickers, transgender persons under the SMILE Scheme, children covered under PM CARES, and eligible road accident victims.

4.2.9 **Key Achievements**

a) Generated estimated savings exceeding ₹1.25 lakh crore by reducing out-of-pocket expenditure on healthcare.

b) A Lancet Regional Health–Southeast Asia (2025) study reported that timely initiation of cancer treatment increased to 90% among PM-JAY beneficiaries, compared to 33% among non-beneficiaries.

c) High-value claims (above ₹1 lakh), though constituting only 1.9% of total claims, account for 17.4% of total claim value, reflecting improved access to advanced tertiary care.

d) Hospitalization rates under AB PM-JAY reached 31 per 1,000 population (2024-25) compared with 21 per 1,000 for the bottom 40% of the population in NSS 75th Round (2017-18), indicating improved healthcare utilization.

e) India's Out-of-Pocket Expenditure as a share of Total Health Expenditure declined from 62.6% (2014-15) to 43.4% (2022-23), supported by increased public health financing and schemes such as AB PM-JAY.

Ayushman Bharat Digital Mission (ABDM)

4.2.10 The current status of key indicators, as on 10th July 2026, is set out below:

ABHA	93.98 crore	**HPR**	9.87 lakh
Health Records Linked	105.27 crore	**ABDM Integrators**	511
HFR	5.34 lakh	**Scan & Register**	24.02 crore

4.2.11 Launched on 27 September 2021, the Ayushman Bharat Digital Mission (ABDM) is the digital pillar of Ayushman Bharat, implemented by the National Health Authority (NHA). It creates an interoperable digital health ecosystem using Digital Public Infrastructure (DPI), enabling seamless health records, service discovery, consent-based data sharing, appointment booking and claims processing, thereby improving affordability, accessibility and continuity of care.

4.2.12 **Core Digital Infrastructure:** ABDM comprises three registries—ABHA, Healthcare Professionals Registry (HPR) and Health Facility Registry (HFR)—and three digital gateways: Health Information Exchange & Consent Manager (HIE-CM), National Health Claims Exchange (NHCX) and Unified Health Interface (UHI), enabling interoperable health records, claims processing and digital health services.

4.2.13 **Citizen-Centric Digital Services:** The revamped Aarogya Setu 2.0 (June 2026) serves as the citizen-facing Personal Health Record (PHR) application, allowing users to access their ABHA-linked health records, Ayushman Card, treatment history, AI-powered health insights, and locate PM-JAY hospitals, Jan Aushadhi Kendras and blood banks. ABDM also enables multiple interoperable private PHR applications, similar to the UPI model.

4.2.14 **Digital Hospital Services:**

a) Scan & Register enables QR code-based hospital registration and has facilitated over 23 crore registrations across 23,000+ hospitals in 749 districts.

b) Scan &Pay enables seamless digital payments, reducing waiting time and improving patient experience.

4.2.15 **Unified Health Interface (UHI):** UHI allows citizens to discover and access services such as teleconsultation, ambulance booking, blood banks, Jan Aushadhi Kendras and PM-JAY hospitals through any ABDM-enabled application, reducing information asymmetry and improving healthcare access.

4.2.16 **National Health Claims Exchange (NHCX):** Developed by NHA in collaboration with IRDAI, NHCX standardizes digital health claims across public and private insurers while enabling citizens to track claim status, improving transparency and efficiency.

4.2.17 **Integration with Health Programmes:** As of July 2026, ABDM has been integrated with 19 national programmes, 37 State programmes and 42 government HMIS, including PM-JAY, National NCD Programme, RCH, POSHAN, UWIN and Viral Hepatitis Programme. This enables longitudinal digital health records and seamless continuity of care across healthcare providers.

4.2.18 **Provider-side Digitisation:** To promote digitisation of smaller healthcare facilities, NHA has introduced:

a) **e-Sushrut@Clinic**, a cloud-based HMIS for small clinics, PHCs and Ayushman Arogya Mandirs.

b) **Clinical Decision Support System (CDSS)**, developed with AIIMS, New Delhi, to support diagnosis and NCD management; currently deployed in **460+ facilities** with **3.5 lakh+ transactions**.

c) **Voice-to-Text (VTT)** solutions to simplify electronic health record documentation and reduce clinicians' administrative burden.

4.2.19 The Committee opines that the National Health Authority (NHA) has successfully driven healthcare equity through the world's largest public health assurance scheme, generating an estimated ₹1.91 lakh crore in out-of-pocket expenditure (OOPE) savings and authorizing 12.59 crore hospital admissions as of mid-

2026. To sustain this momentum and eliminate persistent geographic inequities, a more aggressive approach to hospital network expansion is required.The Committee believes that while the empanelment of 37,413 hospitals (including 17,265 private institutions) has vastly improved tertiary care utilization, significant access gaps remain in underserved and rural districts. The Committee, therefore, recommends that the NHA actively collaborate with state health authorities to prioritize the empanelment of private healthcare facilities in aspirational and remote districts. Furthermore, the Committee is of the view that underutilized healthcare infrastructure managed by various central ministries and Public Sector Undertakings (PSUs) represents an immediate opportunity to scale capacity. The Committee, therefore, also recommends that the NHA institute a fast-track compliance framework to seamlessly empanel all eligible PSU and federal ministry hospitals into the AB-PMJAY network.

4.2.20 The Committee further acknowledges the rapid rollout of 1.27 crore Ayushman Vay Vandana cards for senior citizens aged 70 and above, and believes that the NHA must proactively expand specialized health benefit packages (HBPs) to include comprehensive geriatric and palliative care protocols, thereby ensuring that the unique epidemiological needs of the elderly demographic above the age of 60 years are fully met without out-of-pocket vulnerabilities.

4.2.21 The Committee appreciates view that the establishment of the Ayushman Bharat Digital Mission (ABDM) has laid down a robust foundation for a modern digital public infrastructure, as demonstrated by the creation of 93.98 crore ABHA accounts and the linking of 105.27 crore health records by July 2026,however, the true potential of an interoperable health ecosystem can only be realized through universal adoption across both public and private sectors.The Committee believes that the low-cost digital tools developed by the NHA, such as *e-Sushrut@Clinic* and the AIIMS-validated Clinical Decision Support System (CDSS), are vital instruments to digitize smaller clinics and primary facilities without placing an administrative burden on clinicians. The Committee, therefore, recommends that the NHA mandate a phased, nationwide integration of all private diagnostic centers and hospitals into the National Health Claims Exchange (NHCX) and Unified Health Interface (UHI) gateways. The Committee is assured that such approval would further standardize digital health claims, accelerate cashless settlements, and reduce information asymmetry for patients booking consultations or locating generic medicines.

4.2.22 Furthermore, the Committee is of the considered view that the revamped Aarogya Setu 2.0 app must be utilized as the central, citizen-facing node for longitudinal health records. The Committee, therefore, recommends intensive localized awareness campaigns to ensure citizens actively utilize consent-based data sharing, thereby avoiding the repetitive costs and logistical challenges associated with lost physical diagnostic reports.

4.2.23 The Committee understands that primary healthcare units serve as the critical gatekeeper of the national healthcare framework, and their optimal performance directly mitigates the overcrowding of tertiary facilities. While the deployment of over 1.86 lakh Ayushman Arogya Mandirs (AAMs) has registered an impressive 540 crore patient visits, standardizing the quality of care across all regions remains an unfulfilled

mandate.The Committee believes that primary care must transcend basic consultations to deliver the full spectrum of the 12 Comprehensive Primary Health Care (CPHC) service packages, with a particular focus on underserved domains like mental health, eye care, and oral hygiene. The Committee, therefore, recommends that the government establish rigid, uniform criteria for an "IPHS-Compliant Functional AAM," explicitly binding central fund disbursements to the verified availability of human resources, essential drugs, and functional diagnostic tools.

4.2.24 To achieve a seamless continuum of care, the Committee envisages that localized screening data must be structurally linked to advanced treatment platforms. The Committee, therefore, recommends that the NHA completely digitize the Community-Based Assessment Checklist (CBAC) used by frontline workers, integrating it directly with ABHA IDs and the National Non-Communicable Diseases (NCD) portal to establish automated, digital referral pathways from village sub-centers directly to empanelled secondary and tertiary hospitals.

4.2.25 The Committee is of the view that specialized oncological, trauma, and psychiatric care must be aggressively decentralized to shield rural citizens from catastrophic travel and treatment costs. The budget mandates for FY 2025–26 and 2026–27, including the approval of 297 Day Care Cancer Centres (DCCCs), a 50% capacity expansion of Emergency Care in district hospitals, and the establishment of NIMHANS-2, represent vital policy interventions that require rapid execution.The Committee believes that specialized physical infrastructure cannot function in a vacuum without a parallel, highly specialized workforce. The Committee, therefore, recommends that the government implement the Union Budget announcement for the creation of one lakh allied health professionals through a strict, time-bound 5-year national roadmap.

4.2.26 The Committee is of the further view that to align with evolving disease patterns and the overarching vision of Viksit Bharat @2047, the training curriculum must expand beyond basic health roles. The Committee, in this regard, 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. This diversification will ensure that both newly constructed Critical Care Hospital Blocks under PM-ABHIM and private tertiary centers are permanently equipped with a world-class, IPHS-compliant workforce.

4.2.27 The Committee understands that the long-term financial sustainability and affordability of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) are intrinsically linked to robust regulatory oversight and the absolute prevention of resource leakage. The Committee notes that the National Health Authority (NHA) processes massive volumes of daily claims and has proactively deployed Artificial Intelligence (AI) and Machine Learning (ML) models, including an Auto-Adjudication Engine (AAE), to detect anomalous clinical scenarios, document forgery, and deepfake medical records.The Committee believes that minimizing fraud, waste, and misabuse is paramount to ensuring that finite public funds are strictly utilized for genuine beneficiaries rather than unscrupulous entities. The Committee,

therefore, recommends that the NHA aggressively scale up its AI-driven National Anti-Fraud Unit (NAFU) algorithms to proactively flag irregular treatment patterns, inflated billing, and manipulated radiological images across all empanelled public and private hospitals.

4.2.28 Furthermore, the Committee is conscious of the fact that technological deterrence must be matched with strict administrative action. The Committee, therefore, recommends instituting stringent, real-time punitive protocols, including immediate de-empanelment and heavy fiscal penalties, for clinical establishments engaged in fraudulent practices. Concurrently, the Committee recommends that these advanced auto-adjudication mechanisms be optimized to significantly reduce claim settlement turnaround times for compliant healthcare providers, thereby maintaining a high degree of trust and incentivizing wider private sector participation in the scheme.

National Pharmaceutical Pricing Authority (NPPA)

4.2.29 The National Pharmaceutical Pricing Authority (NPPA), established in 1997 under the Department of Pharmaceuticals, regulates the prices of essential medicines and selected medical devices under the Drugs (Prices Control) Order (DPCO), 2013, with the objective of ensuring both affordability and availability. The key functions of the authority are:

a) Fixes and revises ceiling prices of medicines listed in the National List of Essential Medicines (NLEM) and monitors compliance with DPCO, 2013.

b) Regulates prices of essential medical devices such as cardiac stents, knee implants and oxygen concentrators.

c) Ensures uninterrupted availability of essential medicines by regulating discontinuation of production and directing manufacturers to maintain or increase supplies during shortages or emergencies.

4.2.30 Balancing Affordability and Availability: To prevent shortages of essential medicines, NPPA has, in public interest, permitted one-time 50% increases in ceiling prices of selected scheduled formulations (2019, 2021, 2024 and 2026) where continued production became commercially unviable.

4.2.31 Transparent Pricing Mechanism: Ceiling prices are determined through a formula-based methodology using market data under DPCO, 2013. Draft price calculations are placed in the public domain for stakeholder comments before final notification. Manufacturers and retailers are also required to publicly display notified prices.

4.2.32 Digital Initiatives: NPPA has introduced the Pharma Sahi Daam App for consumers to verify notified medicine prices and the Integrated Pharmaceutical Database Management System (IPDMS 2.0) for real-time submission and monitoring of pharmaceutical pricing and production data.

4.2.33 Savings to consumers: The fixation of ceiling prices/MRP under various NLEMs under DPCO, 2013 and invoking of paragraph 19 from time to time has resulted in average annual total saving of more than ₹26,000 crore to the public due to implementation of DPCO, 2013. The break-up of the total annual savings through various measures taken by NPPA are as follows:

Particulars	Saving to consumer (in crore ₹)
Under NLEM, 2011	2,423
Under NLEM, 2015	2,643
Under NLEM, 2022 (till 09.07.2026)	3802
Coronary stents (calendar year 2025)	13,353
Anti-diabetic and cardiovascular drugs under paragraph 19	350
Orthopaedic knee implants	1,500
Anti-cancer drugs	984
Trade margin rationalisation of 6 medical devices during covid	1,000
Total	**26,055**

Note: The total savings calculated are in the nature of additional savings since prices of many scheduled drugs are historically under price control. Additionally, consumers are also benefited due to 10% cap on annual increase in MRP of non-scheduled drugs. Therefore, absolute savings on account of price regulation under DPCO, 2013 are likely to be much more than the above estimate.

4.2.34 Price control has resulted in savings of over ₹26,055 crore annually to citizens. It has been ensured that prices of both scheduled and non-scheduled drugs have remained in line with or less than the rate of general price rise in the wholesale price index, and prices of over 40% of scheduled drugs that figure in the National Lists of Essential Medicines since 2011 have reduced in absolute terms.

4.2.35 The Committee is of the view that the "trade margin rationalisation" (TMR) pilot projects executed by the National Pharmaceutical Pricing Authority (NPPA) have proven effective in enhancing healthcare affordability. Capping trade margins at 30% for 42 non-scheduled anti-cancer medicines and at 70% on the price to distributor (PTD) for critical medical devices (including oxygen concentrators, pulse oximeters, and glucometers) has yielded cumulative annual savings exceeding ₹1,984 crore for consumers. The Committee, however, believes that expanding this framework is vital to combat predatory markups, given that the collective average markup for common dosage forms currently stands at approximately 43%.The Committee, therefore, recommends that the Government should establish a permanent statutory framework for trade margin rationalisation under the Drugs (Prices Control) Order (DPCO), 2013, extending price caps to a broader spectrum of high-cost, non-scheduled chronic disease formulations. However, the Committee notes the legitimate operational concerns raised by micro, small, and medium enterprises (MSMEs) that heavily rely on traditional trading channels for market access. The Committee, therefore, recommends that the finalized TMR framework may incorporate a graded markup structure that shields low-cost MSME manufacturers from institutional displacement while consistently protecting the end consumer.

4.2.36 The Committee is of the view that the mandate of the NPPA extends beyond capping expenditure to ensuring the continuous, unhindered market availability of life-saving therapeutics. The Committee notes that the historic implementation of DPCO, 2013 has driven down Indian medicine costs to among the lowest globally, generating annual savings of ₹26,055 crore. The Committee, however, believes that extreme pricing pressures must not lead to commercial unviability, which inadvertently forces critical

formulations off the market and compels patients to resort to high-cost alternatives.The Committee notes that the NPPA has periodically exercised its emergency powers under Paragraph 19 of DPCO, 2013, most recently in June 2026 via S.O. 3004(E) & 3005(E), to grant one-time 50% upward revisions on essential ceiling prices to preserve supply lines. The Committee, in this regard, recommends that the Government formalize a fast-tracked, data-driven institutional mechanism within the NPPA to monitor raw material costs (such as Active Pharmaceutical Ingredients) allowing for the proactive, temporary invocation of Paragraph 19 before market scarcities manifest. Concurrently, the Committee recommends that the strict enforcement of guidelines governing the discontinuation of scheduled formulations be coupled with strategic production directives under Paragraph 3 to prevent artificial or structural drug shortages.

4.2.37 The Committee is of the view that the formulation-based, market-data average pricing approach under DPCO, 2013 ensures fairness and objectivity, yet its success ultimately relies on absolute implementation compliance at the retail level. While the NPPA has established a clear ceiling price for 935 formulations and fixed 3,845 retail prices for new drugs as of July 2026, information asymmetry remains an operational challenge for the average citizen.The Committee believes that digital public infrastructure is the most potent weapon to bridge this gap. The Committee, therefore, recommends that the Government must mandate the real-time synchronization of the Integrated Pharmaceutical Database Management System (IPDMS 2.0) with state drug control portals to enforce the 10% annual price-increase cap on non-scheduled drugs. Furthermore, the Committee recommends that the *Pharma Sahi Daam* mobile application be proactively promoted through nationwide public health networks. The Committee, moreover, views that strict compliance audits must be instituted to enforce the statutory mandate requiring retailers to conspicuously display official manufacturer price lists, ensuring that the financial benefits of NPPA price regulations are transparently and fully passed on to patients at the point of purchase.

4.2.38 The Committee is of the view that the definition of healthcare accessibility has evolved significantly, making advanced medical devices and complex combination formulations fundamental to modern tertiary treatment. The historical inclusion of coronary stents, knee implants, condoms, and intra-uterine devices within the National List of Essential Medicines (NLEM) has directly protected millions from catastrophic medical debt, with coronary stent price caps alone generating an unprecedented ₹13,353 crore in annual consumer savings.The Committee believes that as technology advances, the scope of the NLEM must dynamically expand to match emerging epidemiological realities. The Committee, therefore, recommends that the Standing National Committee on Medicines (SNCM) systematically evaluate and incorporate high-volume diagnostic and therapeutic medical devices, such as advanced pacemakers, ophthalmic lenses, and implantable pumps, into the scheduled list of the DPCO. Additionally, noting that the NPPA has successfully regulated 3,845 "new drugs" (including 1,380 anti-diabetic and 677 cardiovascular formulations) to control cost variations in altered dosages and combinations, the Committee, in this direction, recommends that the scrutiny of fixed-dose combinations (FDCs) be intensified to prevent manufacturers from bypassing ceiling price regulations through minor structural changes to scheduled drugs.

4.2.39 The Committee is of the considered view that while pro-active price regulation is paramount for patient protection, the regulatory framework must concurrently stimulate domestic pharmaceutical research and the development of advanced therapeutic delivery systems. The Committee notes that under Paragraph 32 of the Drugs (Prices Control) Order, 2013, the National Pharmaceutical Pricing Authority (NPPA) has successfully incentivized innovation by granting critical price control exemptions to 14 newly patented or indigenously researched products.The Committee believes that such strategic exemption serves as a vital catalyst for the Indian pharmaceutical sector to transition from generic manufacturing to pioneering advanced drug discovery. The Committee, therefore, recommends that the Government should establish a dedicated, fast-track evaluation cell within the NPPA and the Department of Pharmaceuticals to objectively assess and expedite these Paragraph 32 exemptions, explicitly prioritizing breakthrough treatments in oncology, rare diseases, and antimicrobial resistance.

4.2.40 The Committee, however, is of the view that this commercial incentive must not inadvertently foster prolonged monopolies that lock out vulnerable patient demographics. The Committee, therefore, recommends the enforcement of a strict, automated statutory transition protocol. This mechanism must ensure that immediately upon the expiration of the mandated five-year exemption window, these innovative formulations are seamlessly brought under standard DPCO retail price caps without administrative delay, thereby guaranteeing that the benefits of scientific advancement ultimately translate into affordable, mass-market access.

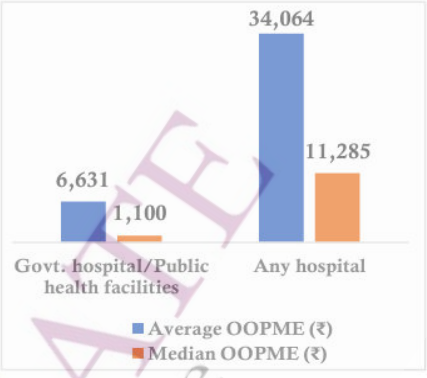
Insurance Regulatory and Development Authority of India (IRDAI):

4.2.41 The IRDAI regulates the insurance sector. It has introduced major consumer-centric reforms to enhance healthcare access and prevent financial distress. India's healthcare system is undergoing an epidemiological transition, with non-communicable diseases (NCDs) such as diabetes, hypertension and cardiovascular diseases becoming increasingly prevalent. These chronic conditions require lifelong treatment, resulting in sustained healthcare expenditure and increasing financial pressure on households and the health insurance ecosystem. This burden has been aggravated by medical inflation, estimated at 10–13% annually, significantly outpacing general inflation. Rising costs of hospitalization, diagnostics, medicines and other healthcare services have adversely affected the affordability of healthcare and health insurance.

4.2.42 The NSS 80th Round (2025) indicates notable progress in healthcare financing, with 46% of the population covered under at least one health insurance or health financing scheme, largely through Government-sponsored programmes. Public hospitals continue to provide significant financial protection, with low out-of-pocket expenditure (OOPE) for many hospitalization and outpatient episodes. However, private healthcare remains expensive, with households continue to incur substantial medical expenditure, when accessing private healthcare services. The average OOPE per hospitalization episode (excluding childbirth) was ₹34,064, with a median expenditure of ₹11,285. The average OOPE for outpatient care was ₹861 per treatment episode, while the average expenditure for childbirth across all hospitals was ₹14,775, substantially higher than the corresponding expenditure in public hospitals.

4.2.43 The Committee underscores that expanding insurance coverage alone is insufficient. Affordability also depends on containing healthcare costs, standardizing treatment protocols and pricing, improving transparency, and enhancing efficiency in healthcare delivery and claims management.

Medical institution	Out-pocket-medical expenditure	
	Average (₹)	Median (₹)
Govt. hospital/Public health facilities	6,631	1,100
Charitable/Trust/ NGO run hospital	39,530	10,000
Private hospital (incl. Govt. empanelled)	50,508	24,000
All	**34,064**	**11,285**



Note: 1. Government hospitals/Public health facilities include HSC/PHC/CHC, AAM, etc.
2. Private hospitals empanelled under Government health financing scheme/insurance viz. AB-PMJAY, CGHS/ECHS/other Central Government health schemes (e.g., Railways etc.), State Health Insurance Schemes, State Government-supported medical reimbursement (for employees), ESIS/ESIC etc., have been considered in the 'Private hospital' category.

4.2.44 Health insurance has become a critical pillar of financial protection, reducing catastrophic expenditure through risk pooling. During FY 2024–25, insurers settled 3.26 crore health insurance claims amounting to ₹94,248 crore, highlighting its growing role in financing healthcare. However, rising healthcare costs, medical inflation, non-standardized treatment protocols, wide variation in treatment charges, and differential billing practices—including room rent-linked pricing—have increased claim costs and insurance premiums while reducing price transparency. These issues contribute to disputes among policyholders, insurers and healthcare providers and undermine trust in the health insurance ecosystem.The sector also faces integrity risks, including provider-induced demand, fraud, inflated or fictitious claims, and ineligible beneficiaries, which increase healthcare costs, delay genuine claims and adversely affect the sustainability of insurance schemes. To address these challenges, the National Health Authority (NHA) has developed the National Health Claims Exchange (NHCX), a standardized digital platform for real-time exchange of claims information among insurers, TPAs and healthcare providers. While insurers and TPAs have been onboarded, wider participation of hospitals remains essential to realize its full benefits.

4.2.45 Further, IRDAI has constituted a Sub-Committee of the Insurance Advisory Committee to recommend policy and regulatory reforms aimed at making health insurance more affordable, accessible and customer-centric.Affordable healthcare requires a comprehensive ecosystem approach that simultaneously addresses healthcare delivery costs and the sustainability of health insurance. Greater standardization, transparency, digital integration and collaboration among healthcare providers, insurers, regulators and Government agencies will be critical to advancing affordable healthcare, sustainable health insurance and universal health coverage.

4.2.46 The Committee is of the view that while the National Sample Survey (NSS) 80th Round (2025) indicates notable progress with 46% of the population covered under at least one health insurance or financing scheme, expanding coverage alone cannot guarantee affordability if private sector healthcare costs remain uncontained. The

Committee notes with concern that households continue to face massive financial strain when accessing private healthcare, where the average out-of-pocket expenditure (OOPE) per hospitalization episode stands at ₹34,064, substantially higher than the protective, low-cost environment of public hospitals. This problem is severely compounded by an annual medical inflation rate of 10-13% that significantly outpaces general inflation, driven by a lack of standardized treatment protocols and exploitative differential billing practices, such as room rent-linked pricing for clinical procedures. The Committee believes that collaborative regulatory intervention between the Insurance Regulatory and Development Authority of India (IRDAI) and healthcare providers is imperative to stabilize the ecosystem. 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.

4.2.47 The Committee is of the view that the health insurance ecosystem has become an indispensable pillar of financial protection, as demonstrated by the settlement of 3.26 crore health insurance claims amounting to ₹94,248 crore during FY 2024–25. However, the Committee notes that the financial sustainability of this risk-pooling framework is heavily undermined by integrity risks, including provider-induced demand, fraudulent or fictitious billing, and ineligible beneficiaries, which systematically drive up claim costs and insurance premiums. The Committee believes that robust, unified digital infrastructure is the most effective mechanism to introduce absolute transparency and efficiency into claims management. 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). Concurrently, the Committee recommends that IRDAI expedite the full deployment of the Public Insurance Registry (PIR) as a foundational Digital Public Infrastructure to facilitate secure, consent-based information sharing, minimize late-stage claim settlement disputes, and eliminate systemic leakages.

4.2.48 The Committee is of the view that making health insurance accessible to an aging population undergoing an epidemiological transition requires the absolute removal of systemic entry barriers that have historically penalized vulnerable demographics, particularly senior citizens of 60 years of age and above individuals with chronic non-communicable diseases (NCDs). The Committee commends the landmark consumer-centric reforms introduced by IRDAI, including the removal of maximum entry age caps, the reduction of pre-existing disease (PED) waiting periods from four years down to three years, the reduction of the moratorium limit to five years, and the mandate for universal AYUSH coverage. The Committee believes that these progressive guidelines must be backed by strict regulatory penalties to prevent insurance companies from creating artificial compliance bottlenecks or hidden exclusions. The Committee, therefore, recommends that IRDAI institute a rigorous compliance audit framework to ensure absolute adherence to the mandated three-hour turnaround time for cashless

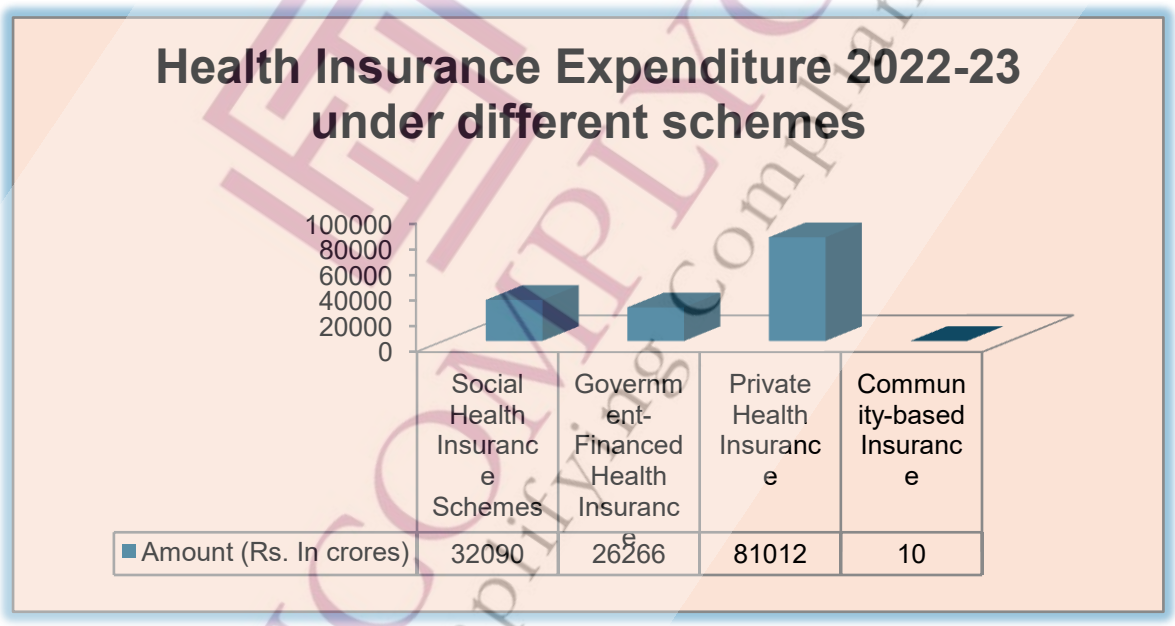
discharge approvals to eliminate hospital exit delays. Furthermore, the Committee recommends that the Sub-Committee of the Insurance Advisory Committee be directed to design affordable, micro-insurance model products specifically calibrated for late-entrants and low-income households to solidify universal health coverage.

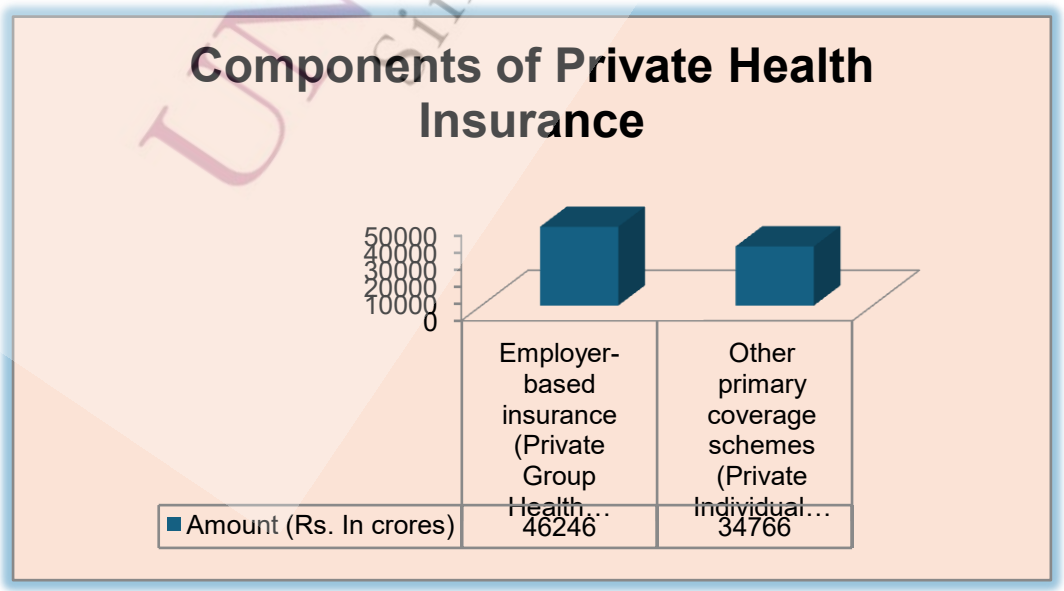
4.2.49 The Committee is of the view that the traditional health insurance model, which primarily covers secondary and tertiary hospitalization, is fundamentally misaligned with India's ongoing epidemiological transition. The Committee notes from the provided data that the rising prevalence of non-communicable diseases (NCDs), such as diabetes, hypertension, and cardiovascular diseases, necessitates continuous, lifelong medical management rather than episodic hospitalization. The Committee observes that the average out-of-pocket expenditure (OOPE) for outpatient care currently stands at ₹861 per treatment episode. The Committee believes that relying exclusively on hospitalization-centric insurance products leaves policyholders vulnerable to the compounding, long-term financial burden of routine chronic care.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. Furthermore, the Committee recommends that insurers design specialized products that explicitly subsidize the recurring costs of lifelong diagnostics, pharmacy bills, and specialist consultations for NCDs, thereby, securing financial protection across the entire continuum of care.

4.2.50 The Committee is of the view that the financial burden of childbirth within the private healthcare sector remains disproportionately high, directly undermining the broader objective of healthcare affordability. The Committee notes that the average expenditure for childbirth across all hospitals is ₹14,775, which is substantially higher than the corresponding out-of-pocket expenditure in public health facilities. The Committee believes that maternity care is a fundamental healthcare requirement and must not be a source of structural financial distress for households.The Committee, therefore, recommends that IRDAI introduce regulatory guidelines compelling insurers to offer standardized maternity benefits as a core, accessible component of base health insurance products, rather than categorizing them as heavily restricted or premium add-on riders. Concurrently, the Committee recommends that the multi-stakeholder Working Groups explicitly prioritize the standardization of maternity and childbirth treatment protocols across empanelled private hospitals, ensuring that institutional delivery costs are stringently regulated and transparently priced.Recognizing the need for coordinated reforms, IRDAI, in collaboration with CII, has constituted multi-stakeholder Working Groups to examine healthcare costs, treatment standardization, fraud mitigation, common empanelment, NHCX adoption, transparency and consumer protection. In parallel, IRDAI is developing the Public Insurance Registry (PIR) as a Digital Public Infrastructure to enable secure, consent-based sharing of insurance information, simplify policy servicing and improve transparency and efficiency. The Committee strongly recommends for transparency in claim settlements through a Public Insurance Registry so that inflated claims are reduced by corporate hospitals and there is a check on such malpractices.

Interpreting National Health Accounts Estimates for India 2022-23 on "Health Insurance Expenditures"

4.2.51 Health Insurance constitutes health-financing schemes financed by contributions/ premiums collected from individuals or Governments and pooled to actively purchase services from healthcare providers either by the Government (health department or government-governed Corporation/Trust/Society) and/or insurance company. The Committee observed from the National Health Accounts Estimates for India 2022-23 that expenditures of the following five types of health financing schemes are considered health insurance expenditures: (i) Social health Insurance (Central Government Health Scheme, Employees' State Insurance Scheme, and Ex- Servicemen Contributory Health Scheme); (ii) Government Financed Health Insurance Schemes (of both Union and State Governments); (iii) Employer-based insurance - other than enterprise schemes (Private Group Health Insurance); (iv) Other primary coverage schemes (Private Individual Health Insurance); and (v) Community-based health insurance.





UNCOMPLYCARE Simplifying Compliance

4.2.52 The Committee has thoroughly analyzed the data derived from the National Health Accounts Estimates regarding Health Insurance Expenditure (2022-23). The Committee is of the view that the overwhelming dominance of private health insurance expenditure, standing at ₹81,012 crores and substantially dwarfing both Social Health Insurance (₹32,090 crores) and Government-Financed Insurance, exposes a massive segment of the population to unregulated medical inflation and exorbitant out-of-pocket costs due to exclusionary policies. 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.

4.2.53 The Committee believes that the extraordinarily negligible expenditure of merely ₹10 crores in Community-Based Health Insurance represents a severe underutilization of grassroots financial risk protection, particularly for the vast informal sector that remains largely ineligible for employer-based private insurance or specific central schemes. The Committee, therefore, recommends that the government aggressively catalyze the expansion of community-level cooperative insurance models. The Committee is of the view that the Ministry of Health should introduce a formal "matching grant" framework to systematically inject public capital into these local community pools. This structural subsidization will empower rural and marginalized collectives to collectively pool risks and negotiate affordable, localized healthcare rates with regional medical facilities.

Central Drugs Standard Control Organisation (CDSCO)

4.2.54 The Central Drugs Standard Control Organisation (CDSCO), under the Directorate General of Health Services, Ministry of Health & Family Welfare, is India's National Regulatory Authority (NRA) for drugs, cosmetics and medical devices. It is responsible for regulating the safety, efficacy and quality of medical products under the Drugs and Cosmetics Act, 1940.CDSCO approves new drugs and clinical trials, prescribes drug standards, regulates the quality of imported drugs, coordinates with State Drug Control Authorities for uniform enforcement of drug regulations, and, together with State regulators, licenses critical products such as blood and blood products, vaccines, sera and IV fluids. Through a nationwide network of zonal offices, laboratories and port offices, CDSCO promotes transparency, quality assurance and patient safety.

4.2.55 The Medical Devices Rules (MDR), 2017, implemented under the Drugs and Cosmetics Act, 1940, have established a modern, risk-based regulatory framework for the import, manufacture, testing and distribution of medical devices. Aligned with global best practices, the framework strengthens quality, safety and performance while promoting innovation and ease of doing business.Key reforms include a fully digital licensing system, risk-based classification of devices, defined approval timelines, perpetual licenses with

periodic retention, and third-party audits for low-risk devices. The Committee was apprised that as of 1 July 2026, 3,480 Class A & B manufacturers, 1,100 Class C & D manufacturers, and 12,866 import licences had been approved, however, the Committee notes that there have been reports for long delays for Class A & B category medical devices resulting in low investments in the Medtech space.

Approval Status of Medical Device

Data on Medical Devices approved as on 01.07.2026:

- Manufacturing units of Class A & B devices licensed : **3480 nos.**
- Manufacturing units of Class C & D devices licensed : **1100**

No. of Medical Devices approved till date (Risk class wise)			
Class of MD	No. of devices	Class of IVD	No. of devices
Class A	16045	Class A	4050
Class B	33690	Class B	14230
Class C	11681	Class C	2420
Class D	2350	Class D	880

- Import license applications (Class A, B, C & D) approved: **12866 nos.**

No. of Medical Devices approved till date (Risk class wise)			
Class of MD	No. of devices	Class of IVD	No. of devices
Class A	630	Class A	3230
Class B	8495	Class B	21625
Class C	7725	Class C	7848
Class D	2920	Class D	735

4.2.56 The Government has strengthened the regulatory ecosystem through digital processing of applications, simplified compliance procedures, expansion of notified testing laboratories and regulatory personnel, and initiatives such as MedTech Mitra, which has supported 798 innovators with regulatory, technical and clinical guidance to promote indigenous medical device innovation.Additional policy measures, including simplified licensing for low-risk devices, enhanced testing infrastructure, and procurement of only licensed medical devices by hospitals and government agencies (effective 25 November 2025), have improved regulatory compliance and market confidence.Collectively, these reforms have promoted domestic manufacturing to a certain extent, increased competition, reduced regulatory burden and improved the availability of safe, quality-assured and affordable medical devices across both public and private healthcare sectors, while strengthening India's position as an emerging global MedTech hub.

4.2.57 The Committee is of the view that ensuring the availability of high-quality, safe, and effective medical devices across both public and private health institutions is paramount to building public trust and avoiding substandard clinical outcomes. The Committee notes that under the risk-based classification framework of the Medical Devices Rules (MDR), 2017, the Central Drugs Standard Control Organisation (CDSCO) has successfully licensed 3,480 manufacturing units for Class A & B devices, 1,100 manufacturing units for Class C & D devices, and approved 12,866 import license

applications as of July 1, 2026. Furthermore, to secure the supply chain, the Committee notes that CDSCO issued a circular on November 25, 2025, mandating that all procurement agencies, hospitals, and health institutions must require a valid CDSCO or State Licensing Authority (SLA) license for the procurement of medical devices. The Committee believes that structural accountability must be institutionalized through technology without human interface to ensure that uncertified or non-compliant equipment does not penetrate the healthcare delivery network.The Committee, therefore, recommends that the Ministry of Health and Family Welfare should impress upon the concerned State Government to stringently monitor the compliance of the November 25, 2025 Procurement Mandate across all public and private entities to verify that only legally licensed, globally compliant technologies reach patients. The Committee, furthermore, recommends the Government to encourage the State Governments to fully utilize the powers delegated under the MDR, 2017 to establish and notify additional Medical Device Testing Laboratories (MDTLs), expanding beyond the currently registered 84 MDTLs and 18 Notified Bodies. The Committee is of the firm view that expanding this public testing infrastructure and deploying the pool of 258 notified Medical Device Officers (MDOs) will drive robust domestic quality assurance, ultimately making safe medical technologies accessible to all socioeconomic strata. The Committee recommends for greater autonomy to State Licensing Authorities forlicensing of medical devices as per quality approved by notified laboratorieswhich are approved by the QCI.

4.2.58 The Committee is of the further view that the heavy financial dependency on high-cost, imported medical technologies significantly inflates out-of-pocket expenditures for patients across India. The Committee notes that the "MedTech Mitra" program, a collaborative ecosystem co-launched by NITI Aayog, ICMR, and CDSCO, has emerged as a vital mechanism for domestic indigenization, having received 856 applications, conducted 53 Technical Advisory Committee (TAC) meetings, and provided structured lifecycle handholding to 798 innovators. This end-to-end facilitation spans crucial operational areas, including regulatory strategy guidance for 611 innovators, test license facilitation for 74 innovators, and the establishment of 21 proofs of concept. The Committee believes that systematically addressing technical, clinical, manufacturing, and market-entry barriers via indigenous innovation is the most sustainable approach to introducing cost-effective alternatives into the market. The Committee, therefore, recommends that the Government to significantly scale up the budgetary and institutional capacity of the MedTech Mitra platform to accelerate the commercialization of domestic technologies. The Committee is of the considered view that CDSCO must streamline its processes to fast-track test license facilitation, funding support for pre-clinical/clinical trials, and final manufacturing licenses for innovators transitioning through designated platform. The Committee understands that by fostering a highly competitive domestic manufacturing ecosystem, the resulting market competition will naturally reduce medical device acquisition costs for both public and private hospital networks.

4.2.59 The Committee has been given to understand that protracted regulatory timelines, administrative redundancies, and high compliance burdens inadvertently inflate the final market cost of medical devices, thereby hurting healthcare accessibility.

The Committee takes into account that CDSCO has instituted progressive digital transformation measures under the MDR, 2017 policy measures, including the automated allocation of applications to reviewers, the auto-generation of regulatory certificates, and centralized online modules for compliance management. The Committee recommends the policy reforms aimed at reducing manufacturing license timelines, specifically cutting Class B approval timelines from 140 days to 115 days, and Class C & D timelines from 105 days to 90 days. The Committee believes that maximizing efficiency through digital framework is fundamental to improving the ease of doing business without diluting safety parameters.The Committee, therefore, recommends that the Government formally notify and implement the shortened manufacturing license timelines (115 days for Class B; 90 days for Class C & D) to eliminate operational delays. The Committee further recommends that CDSCO expand its centralized online portal to integrate automated post-approval changes (PACs) and finalize clear, distinct regulatory pathways for digital health and artificial intelligence-based medical software. The Committee is of the view that lowering these entry barriers will incentivize greater private sector investment in manufacturing, optimize supply chain timelines, and translate administrative savings into reduced treatment costs for patients. The Committee strongly believes that undertaken policy reforms and action plan would definitely promote indigenization and import substitution, thereby promoting accessibility and affordability of healthcare facilities. The Committee hopes that Medical Device Rules, 2017 would further strengthen India's healthcare sytem by ensuring safer high quality medical devices, of course, promoting greater affordability and wider access to healthcare services. The need of the hour is to provide quality care at an affordable cost to the cross-section of the society.

4.2.60 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 observes that CDSCO holds the definitive statutory mandate under the Drugs and Cosmetics Act, 1940 to prescribe drug standards and regulate the safety, efficacy, and quality of imported and domestically produced medical products. The Committee believes that the strategic deployment of regulatory fast-tracks for generic variants represents the most direct public health mechanism to democratize access to critical therapies. The Committee, therefore, recommends that CDSCO drastically speed up its clinical trial evaluation and licensing framework specifically tailored for generic medications. 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 Committee believes that coordinating closely with State Drug Control Authorities for uniform enforcement will ensure that these affordable, generic alternatives maintain impeccable therapeutic equivalence, protecting both patient pocketbooks and clinical safety standards.

4.2.61 The Committee visualizes that since India scales its domestic medical device ecosystem, there is urgent need for maintaining long-term regulatory agility and market trust that requires the continuous strengthening of administrative human capital and the decentralization of oversight mechanisms. The Committee notes that critical

institutional steps have already been taken, such as the delegation of Post-Approval Change (PAC) and Risk-classification decisions to Deputy Drugs Controllers (DDCs) to accelerate regulatory throughput. Furthermore, the regulatory framework has sought to build technical capacity through the recruitment of additional manpower, targeted training programs for inspectors, and active collaboration with international regulatory bodies to achieve alignment with global best practices. The Committee believes that ensuring uniform enforcement of the Medical Devices Rules (MDR), 2017 across all jurisdictions is vital for preventing regulatory fragmentation and maintaining high safety standards. The Committee, therefore, recommends the Ministry of Health and Family Welfare should establish a permanent, mandatory training and capacity-building framework for the expanded pool of 258 Medical Device Officers (MDOs) and State inspectors, focusing heavily on advanced risk-based classifications and Quality Management System (QMS) audit techniques in coordination with the 18 registered Notified Bodies. Concurrently, the Committee recommends that the Medical Device Technical Advisory Group (MDTAG) be mandated to hold fixed, quarterly statutory assemblies to drive continuous policy reforms, systematically evaluate international regulatory updates, and formalize global harmonization pathways. The Committee is of the view that these proactive governance measures are essential to eliminating localized regulatory delays, reducing compliance errors for domestic enterprises, and solidifying India's position as a highly credible, globally compliant manufacturing hub for affordable medical technologies.

4.2.62 The Committee is of the considered view that genuine indigenous manufacturing, rather than the mere assembly of imported components, is vital to securing healthcare self-reliance and reducing lifecycle costs. The Committee notes reports indicating the potential misuse of the 'Make in India' clause by entities that simply assemble imported components, particularly from China, to secure government contracts. The Committee believes that relying exclusively on current self-certification requirements and statutory documentation is insufficient for verifying the origin of high-value medical technologies. The Committee, therefore, recommends the implementation of a rigorous, mandatory verification mechanism for companies participating in Government procurement. This comprehensive framework must require a minimum of 40% local value addition, enforce component-level traceability, and mandate the submission of digital Bills of Materials (BoM). Furthermore, the Committee recommends that such mechanism include periodic third-party audits, strict country-of-origin disclosures for critical components, and independent verification of local content to ensure complete supply chain integrity and foster true domestic technology development.

4.2.63 The Committee is of the view that centralized, shared infrastructure models, which provide design, precision manufacturing, testing, validation, and clinical research facilities under one roof, significantly reduce capital investment requirements for individual companies and accelerate product development timelines. The Committee notes that the original 270-acre campus of the Visakhapatnam MedTech Park (AMTZ) is entirely allotted and fully utilized, necessitating immediate expansion to meet the growing demands of the industry and advance the strategic goal of contributing 25–30% of India's medical device market. The Committee, therefore, recommends the expedited acquisition and allocation of an additional 300–350 acres of contiguous land adjoining

the existing AMTZ campus to support facility expansions and accommodate new investments. The Government should also replicate the success of Visakhapatnam MedTech Park in other such parks in Odisha, Jharkhand, West Bengal, Bihar and Uttar Pradesh for medical devices and increase the number of MedTech Parks in different regions of the country viz. Odisha, Jharkhand, West Bengal, Bihar and Uttar Pradesh to promote local manufacturing and to provide world-class facilities to Medical Device industry in India by replicating AMTZ model. To further catalyze the growth and global competitiveness of the domestic medical device sector, the Committee recommends the formal introduction of an "Innovation Passport" mechanism designed to provide faster regulatory approvals and seamless access to global markets. Additionally, the Committee believes that the Government must deploy targeted financial and operational incentives, specifically including stamp duty and registration fee exemptions, capital and research subsidies, and duty exemptions on critical components.

4.2.64 The Committee, in nutshell, desires that the government must continue to strengthen the regulatory eco-system through simplified compliance procedures, expansion of notified testing laboratories and regulatory personnel, including institutions such as MedTech Mitra. The Committee believes that continuous policy measures including simplified licensing for low-risk devices enhanced testing infrastructure and procurement of only licensed devices by hospitals and Government agencies would further instill regulatory compliance and market confidence. The Committee is of the considered view that when implemented on ground level it would definitely promote domestic manufacturing increase competition reduced regulatory burden and improved availability of safe, quality assured and affordable medical devices across both public and private healthcare sectors, thereby ensuring India's position as an global MedTech hub and leader.

4.2.65 The Committee is of the view that the technical rigour and specialised expertise required for evaluating increasingly complex drug formulations and biologics cannot be sustained through the existing generalist administrative structure of the Central Drugs Standard Control Organisation (CDSCO). The Committee notes that persistent vacancies in the cadre of Drugs Controllers have continued to constrain the organisation's day-to-day regulatory throughput. The Committee believes that a dedicated technical workforce, distinct from general administrative staff, is essential to keep pace with global scientific and regulatory developments. The Committee, therefore, recommends that the Government expeditiously create a Specialist Core Cadre and a Scientific Review Cadre within CDSCO to institutionalise domain-specific technical evaluation capacity. 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.

4.2.66 The Committee has been given to understand that the sequential nature of laboratory testing and clinical trial processes has been a significant contributor to delays in bringing new drugs to market, thereby indirectly raising costs and restricting timely access to therapies. The Committee believes that regulatory speed can be substantially improved without compromising scientific scrutiny by re-engineering the

processes to run concurrently rather than in sequence. The Committee, therefore, recommends that CDSCO introduce parallel processing of laboratory testing and clinical trial evaluation, supported by a Single-Window Clearance System, to eliminate redundant procedural handoffs and reduce the cumulative time taken for testing and trial approvals. The Committee also recommends the Government to substantially expand the authorised testing ecosystem by empanelling additional public and private laboratories, covering both drugs and all categories of medical devices, that meet accreditation and competency benchmarks prescribed by Quality Council of India &CDSCO, besides existing CDSCO-affiliated laboratories must be upgraded in a phased manner under defined annual plans to keep testing infrastructure aligned with rising demand and evolving product complexity. The Committee strongly recommends for decentralization of A&B medical devices to State Level Authority (SLA) so that respective State Government can be empowered to create a positive regulatory mechanism and also to increase competition amongst various State Governments to attract Global companies to set up manufacturing base in their States helping the entire country in turn. As both Health and Industry are State subject, it would be appropriate for the State Government to regulate A&B medical devices to notified laboratories.

4.2.67 The Committee is of the view that regulatory approval alone is insufficient to guarantee drug quality unless it is matched by robust oversight of the distribution chain through which medicines reach patients. The Committee believes that gaps in traceability create vulnerabilities for the entry of substandard or spurious drugs into the supply chain. The Committee, therefore, recommends that the Government enforce end-to-end traceability of pharmaceutical products and mandate strict compliance with Good Distribution Practices (GDP) across manufacturers, distributors, and retailers. The Committee further recommends the creation of a unified Digital Drug Regulatory System (DDRS) that seamlessly connects Central and State drug regulators on a common technology platform, with an inbuilt Risk Management System to enable real-time monitoring, early identification of quality risks, and coordinated enforcement action. The Committee is of the view that these measures, taken together, will yield a strengthened, transparent, and technology-enabled drug regulatory framework marked by faster approvals, enhanced quality assurance, expanded testing capacity, and improved safety of drugs for the public.

Quality Council of India (QCI)

4.2.68 The Quality Council of India (QCI), established in 1996, promotes quality and standardization across sectors through its constituent accreditation boards, particularly the National Accreditation Board for Hospitals & Healthcare Providers (NABH) and the National Accreditation Board for Testing and Calibration Laboratories (NABL). Together, these institutions have accredited over 14,000 healthcare providers and 8,500 laboratories, significantly strengthening the quality, safety and reliability of healthcare services in the country.

4.2.69 NABH, India's national hospital accreditation body, is benchmarked against the globally recognized ISQua accreditation framework and evaluates hospitals against evidence-based standards covering patient care, clinical governance, infection control, infrastructure, quality management and patient safety. NABL accredits medical laboratories in accordance

with ISO 15189:2022 and is recognized under the Global Accreditation Cooperation (Global ACI) Mutual Recognition Arrangement, enabling acceptance of accredited laboratory results across 142 economies.

4.2.70 To enhance accessibility, QCI has introduced the Gunvatta Chakra initiative, providing awareness, capacity building, handholding, digital support and feedback mechanisms to enable hospitals and laboratories across the country to adopt internationally benchmarked quality standards. QCI has also ensured that accreditation remains affordable. NABH accreditation costs are 3–16 times lower than comparable international programmes such as JCI, while NABL accreditation costs are around eight times lower than comparable international laboratory accreditation programmes.

4.2.71 Building on these efforts, QCI announced a series of next-generation quality reforms in December 2025 to simplify accreditation, improve transparency and strengthen trust in the quality ecosystem. Key healthcare reforms include the introduction of the Q Mark, a QR code-based quality certification enabling citizens to verify accredited hospitals and laboratories; the Quality Setu platform for time-bound grievance redressal; a unified paperless accreditation portal; expansion of the NABH MITRA mentoring programme for hospitals, particularly in smaller towns; Gunvatta Pathshala for structured training of doctors, nurses and technicians in patient safety and accreditation; adoption of AI-assisted desktop surveillance to reduce compliance burden; and simplified accreditation norms, including relaxed eligibility criteria and a graded penalty framework to encourage wider participation. For laboratories, reforms include standardized accreditation scopes, accelerated approval of authorised signatories, simplified scope extensions and large-scale technical skilling initiatives.Collectively, these initiatives strengthen patient safety, promote standardization, simplify compliance, reduce accreditation costs and timelines, improve transparency and citizen confidence, and expand access to internationally benchmarked quality healthcare across both public and private sectors.

4.2.72 The Committee is of the view that while the quality ecosystem in India has grown significantly, hospital and laboratory accreditation remains largely voluntary and driven by market pull. To uniformly strengthen the safety, reliability, and quality of healthcare services, a standardized baseline must be established across both public and private sectors. However, this transition must not result in regulatory choking or administrative delays. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in coordination with QCI, formulate a phased roadmap to transition to mandatory entry-level quality certification. To prevent operational bottlenecks, such transition must be powered by QCI's newly announced Single, Paperless, Modular One-stop Accreditation Platform to replace legacy multi-portal systems, alongside the Quality Setu ticket-based system for time-bound grievance redressal. This transition should prioritize clinical establishments sequentially, so that benchmarks are progressively elevated to full NABH and NABL standards. To support this massive scaling, the Committee recommends expanding the national assessor pool by lowering entry barriers to bring in young experts, thereby, ensuring robust last-mile reach and drastically reducing turnaround times.

4.2.73 The Committee believes that the stark urban-rural divide in healthcare infrastructure can be effectively bridged by leveraging low-cost certification structures.

However, rigid compliance norms and capital strain have historically prevented smaller, semi-urban facilities from entering the formal quality ecosystem. The Committee, therefore, recommends that the government continuously expand the NABH "Entry-Level Certification" programs, specifically targeting smaller facilities in tier-2, tier-3, and rural areas by operationalizing QCI's relaxed accreditation norms that allow hospitals with even 20% occupancy to apply. To accelerate adoption without placing capital strain on smaller entities, the enforcement framework must shift from blanket bans to graded penalties coupled with guidance and course correction. Furthermore, direct and hands-on lifecycle support must be provided through NABH's MITRA programme, utilizing trained and officially empanelled mentors to actively guide small-town hospitals. This must be supplemented by the Gunvatta Pathshala initiative to provide role-based skilling for doctors, nurses, and technicians in patient safety, while utilizing AI-assisted desktop surveillance and desk-based monitoring for consistently performing hospitals to minimize the friction of physical inspections.

4.2.74 The Committee is of the view that institutionalizing efficiency and eliminating waste are critical parameters for optimizing public expenditure and making tertiary care accessible to the masses. The partnership between QCI and the National Health Authority (NHA) to fast-track empanelment for certified hospitals under Ayushman Bharat (PM-JAY) is an excellent mechanism, but it requires deeper structural optimization to transition from an inspection-heavy model to a trust-based ecosystem. The Committee, therefore, recommends that such digital health certification framework be deeply integrated into all central and state government insurance schemes, deliberately pivoting from rigorous inspection to a high-trust, low-friction environment characterized by reduced paperwork and shorter processing timelines. State governments should mandate that any private or public medical institution seeking public empanelment must possess a verified QCI quality certification. By utilizing technology-driven systems to accelerate processes, such integration would maximize the fiscal efficiency of public health budgetary allocations and fast-track cashless care delivery for vulnerable populations.

4.2.75 The Committee believes that diagnostic accuracy is the bedrock of affordable healthcare, as spurious or incorrect laboratory results lead to repetitive testing, misdiagnoses, and compounding medical costs. While scaling up legitimate laboratories, the state must simultaneously empower consumers and eliminate the administrative lag that keeps quality labs outside the accredited network. The Committee, therefore, recommends strict regulatory clampdowns on unaccredited, self-declared commercial testing labs. To rapidly expand the network of verified labs, QCI's NABL reforms must be fully deployed, including the introduction of a model scope for medical testing laboratories to ensure nationwide uniformity, a 48-hour self-declaration window for approving authorized signatories, and 48-hour scope extensions for similar testing methods to eliminate long waiting periods. Additional fees for product-based accreditation must be eliminated where test parameters are already covered. To ensure the technical sustainability of laboratory ecosystem, the government must support the technical skilling initiatives aimed at training 5,000 laboratory personnel in 2026. Furthermore, to protect citizens from fraudulent, substandard clinics, the government must systematically scale up the newly unveiled "Q Mark – Desh ka Haq" reform. This

QR-coded Mark of Quality must be prominently integrated into public health portals and physically mandated at the entrance of every clinical laboratory, ensuring full public disclosure, eliminating fake certificates, and allowing ordinary citizens to instantly verify a facility's authentic certification status.

National Medical Commission (NMC)

4.2.76 The National Medical Commission (NMC) was established under the National Medical Commission Act, 2019, replacing the erstwhile Medical Council of India with effect from 25 September 2020. As the apex statutory regulator of medical education and the medical profession, NMC is responsible for regulating undergraduate and postgraduate medical education, assessing and rating medical institutions, maintaining the National Medical Register, promoting professional ethics, and ensuring uniform standards of medical education through its four autonomous boards—Under-Graduate Medical Education Board (UGMEB), Post-Graduate Medical Education Board (PGMEB), Medical Assessment and Rating Board (MARB), and Ethics and Medical Registration Board (EMRB). Its overarching objective is to improve access to quality and affordable medical education while ensuring the availability of a competent, ethical and adequately distributed medical workforce to strengthen healthcare delivery across the country.

4.2.77 NMC has undertaken wide-ranging reforms to modernize medical education and strengthen regulatory governance. A competency-based medical education (CBME) curriculum has been implemented for both undergraduate and postgraduate programmes to produce globally competent, patient-centric and community-oriented medical professionals. The curriculum incorporates early clinical exposure, integrated teaching, skill-based learning, ethics and communication training, family adoption and community-based healthcare, thereby aligning medical education with the evolving healthcare needs of the country. Faculty development has also been strengthened through revised Teachers Eligibility Qualification (TEQ) Regulations, mandatory Basic Course in Biomedical Research, Medical Education Technology training, and continuous professional development programmes.

4.2.78 The Commission has leveraged technology to enhance transparency, accountability and efficiency in medical education. Digital governance initiatives include implementation of e-Office, online processing of permissions and recognitions, Aadhaar-enabled biometric attendance for faculty, Hospital Management Information Systems (HMIS), CCTV-based monitoring of medical colleges, virtual learning platforms, digital inspections, and public consultation on draft regulations. These reforms have significantly improved regulatory oversight, reduced procedural delays, and strengthened institutional compliance.

4.2.79 NMC has also focused on expanding India's medical education capacity to address the shortage of healthcare professionals. The Commission has facilitated the establishment of new medical colleges and expansion of undergraduate, postgraduate and super-specialty seats across the country. India has achieved the milestone of more than one lakh MBBS seats and has substantially expanded postgraduate training capacity, thereby improving the long-term availability of qualified doctors, particularly in underserved regions. To make medical education more affordable, NMC has issued guidelines requiring regulation of fees for 50 per cent of seats in private medical colleges and deemed universities, thereby expanding access to medical education for students from diverse socio-economic backgrounds.To improve quality assurance, NMC has introduced transparent assessment mechanisms, standardised

regulations, competency-based examinations, and strengthened institutional monitoring. It has also promoted ethical medical practice through professional conduct regulations, maintenance of the National Medical Register, and initiatives encouraging rational and generic prescribing practices. The Commission continues to refine medical education through periodic curriculum revision, stakeholder consultations and evidence-based regulatory reforms.Through these initiatives, the National Medical Commission has substantially strengthened the quality, transparency and accountability of medical education in India. By expanding medical education capacity, improving regulatory standards, leveraging digital governance, promoting competency-based learning and enhancing affordability of medical education, NMC is making a significant contribution towards increasing the availability of qualified medical professionals and improving the accessibility, quality and sustainability of healthcare services across both the public and private sectors.

4.2.80 The Committee believes that keeping medical education affordable is absolutely critical to preventing the commercialization of healthcare delivery. Under the current regulatory structure managed by the Medical Assessment and Rating Board (MARB), the evaluation of new institutions relies on strict compliance documentation, including an Essentiality Certificate from the respective State or Union Territory valid for three years, a Consent of Affiliation from a recognized university, and definitive proof of a corpus fund and financial solvency certified by a Chartered Accountant.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.The Committee further recommends that these mandatory baseline financial tracking mechanisms must be leveraged to audit institutional cost structures, ensuring that hidden capitation fees do not circumvent the mandate for socio-economic inclusivity in medical education training.

4.2.81 The Committee is of the view that expanding national training capacities must be paired with operational relaxations that allow quick scaling without compromising educational integrity. The transition from legacy MSR 1999 guidelines to the modern Minimum Standard Requirements (MSR) 2023 regulations represents a significant systemic reform. For instance, a 100-seat undergraduate institution now requires 420 beds and 85 faculty members compared to the historic requirement of 500 beds, while a 250-seat institution has seen its bed requirement optimized from 1,100 to 900 beds, balanced against an elevated mandatory bed occupancy rate of 80% to maintain rigorous clinical exposure. The aggregate capacity across the country now boasts approximately 80,000 postgraduate seats inclusive of AIIMS, Institutes of National Importance (INIs), and NBEMS tracks. 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.

4.2.82 The Committee further recommends that government medical institutions be permitted to initiate postgraduate courses concurrently with their undergraduate launch only after ensuring adequate cinical exposure, while private medical colleges should be cleared to introduce PG specialties from their third operational year using streamlined resource models requiring as few as two faculty members—specifically one

Professor and one Associate or Assistant Professor as per specialty subject to proven clinical exposue and real hands on training. Most significantly, the Committee strongly recommends NMC to ensure cheaper cost medical education and proficiency pursuit to enhance inclusivity and expanding opportunity for candidature of weaker section of society. The Committee also recommends tapping non-traditional public clinical resources, such as specialized Railways and Mines hospitals, to rapidly expand regional specialty training footprints in underserved zones viz. hilly and tribal regions. To ensure quality, the Committee recommends for an Exit examination for both graduate and post-graduate students.

4.2.83 The Committee believes that legacy five-year periodic recognition inspections created systemic vulnerabilities and structural inefficiencies in medical education monitoring. Under the Maintenance of Standards of Medical Education Regulations (MSMER) 2023 and the Graduate Medical Education Regulations (GMER), the NMC has executed a sweeping digital transformation toward a continuous monitoring model based on annual self-declarations submitted via a centralized portal. Routine seat renewals and institutional approvals are now managed through standardized virtual inspections to mitigate subjective biases and eliminate assessor exploitation, while physical assessments for new applicants require real-time final assessment reports to be jointly signed and instantly uploaded via an IT-enabled module.

4.2.84 The Committee, therefore, recommends the absolute consolidation of the centralized, Aadhaar-enabled biometric attendance system (AEBAS), which tracks over 4 lakh enrolled faculty, students, interns, and tutors across the nation. The Committee stands for ensuring universal compliance with the face-authentication upgrades introduced via the geo-fenced National Informatics Centre (NIC) mobile application to systematically eradicate "ghost faculty" and capture absolute employment logs. The Committee, in this regard, furtherfor recommends scaling the pilot Hospital Management Information System (HMIS) API integration module to bind all clinical material assessments directly to unique patient ABHA IDs. Such digital mapping, combined with live classroom and hospital area CCTV surveillance streamed through shared Network Video Recorder (NVR) links, will permanently prevent the manipulation of clinical workloads or the utilization of fake patients during institutional evaluations.

4.2.85 The Committee understands that the structural architecture of the NMC—specifically the functional coordination between the Under-Graduate Medical Education Board (UGMEB), the Post-Graduate Medical Education Board (PGMEB), and the Ethics and Medical Registration Board (EMRB)—must remain anchored to public health priorities. The Committee, in this connection, recommends that the UGMEB continuously refine the Competency-Based Medical Education (CBME) curriculum to emphasize primary and preventative clinical competencies. The Committee strongly believes that the strict enforcement of the Village and Family Adoption Programmes within undergraduate training will ensurethe future medical cohorts tuned with structurally and culturally oriented to address the unique healthcare accessibility barriers faced by rural communities.

4.2.86 The Committee is of the firms opinion that pharmaceutical expenditures represent the largest component of catastrophic out-of-pocket spending for patients in India. Shifting clinical practice from expensive branded medicines to unbranded generic equivalents is one of the most effective ways to lower healthcare costs for the public. The Committee, therefore, 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. The Committee strongly desires that the government must integrate the National Medical Register with public procurement data and establish automated grievance mechanisms through State Medical Councils to track, review, and audit prescribing patterns across both public and private hospital ecosystems.

National Testing Agency (NTA)

4.2.87 The National Testing Agency (NTA), established in 2018 under the Ministry of Education, is the national testing authority responsible for conducting high-stakes entrance examinations, including the National Eligibility-cum-Entrance Test (NEET-UG) for admission to undergraduate medical, dental, nursing, AYUSH and Homeopathy courses. Conducted in 13 languages across 5,400+ examination centres in India and abroad, NEET-UG provides a transparent, uniform and merit-based admission process, ensuring equal opportunities for candidates from rural, remote and economically weaker sections. By regulating the entry point into medical education, NTA plays a foundational role in developing a competent healthcare workforce, thereby contributing to the long-term accessibility, quality and equitable distribution of healthcare services.

4.2.88 Following concerns regarding the integrity of NEET-UG 2024, the Ministry of Education constituted a High-Level Committee of Experts (HLCE) under the chairmanship of Dr. K. Radhakrishnan, former Chairman, ISRO, to recommend reforms relating to examination processes, data security and the institutional functioning of NTA. Subsequently, the Hon'ble Supreme Court expanded the Committee's mandate to include examination security, technological enhancements, governance, stakeholder engagement and student support. After extensive consultations, the HLCE submitted its report in October 2024 containing 101 recommendations, comprising 60 short-term recommendations for implementation during the 2025–26 examination cycle, 35 long-term reforms, and 6 recommendations relating to monitoring and periodic review.

4.2.89 To oversee implementation, the Ministry constituted a High-Powered Steering Committee (HPSC), which has reported substantial progress in implementing Phase-I reforms. Major initiatives include restructuring of NTA, creation of additional technical posts, establishment of State and District Level Coordination Committees, improved test-centre allocation, strengthened Standard Operating Procedures, Aadhaar-based biometric authentication, multi-layer frisking, CCTV surveillance, mobile jammers, AI-enabled data analytics for detecting malpractice, enhanced grievance redressal mechanisms, and closer coordination with State Governments and law enforcement agencies.The reform roadmap further envisages a phased transition of NEET-UG from the Pen-and-Paper Test (PPT) to Computer-Based Testing (CBT), development of secure government-owned testing centres, introduction of the DIGI-EXAM system for secure candidate authentication, adoption of computer-assisted testing technologies, continuous capacity building of examination

personnel, and initiatives to reduce examination stress and promote social inclusiveness. Collectively, these reforms seek to make national entrance examinations more secure, transparent, technology-driven, accountable, tamper-proof and student-centric, while strengthening public confidence in medical admissions and supporting equitable access to quality medical education.

4.2.90 The Committee is of the view that the National Testing Agency (NTA) operates as a critical, upstream regulatory anchor in India's healthcare ecosystem. While it does not directly control medical tariffs or drug pricing, its entry-level oversight of human capital directly shapes the quality, equity, and long-term delivery costs of national healthcare. The administrative challenges observed in 2024 and May 2026 examination cycle highlight those vulnerabilities in paper-based logistics threaten the sanctity of merit-based selection. If compromised, the system risks tilting admissions back toward arbitrary commercialization, thereby inflating the downstream cost of medical professionals and hurting public trust. The Committee, therefore, recommends that the Ministry of Education and the Ministry of Health and Family Welfare jointly expedite the implementation of the High-Level Committee of Experts (HLCE) roadmap. The government must prioritize a phased, conditional transition of the National Eligibility-cum-Entrance Test (NEET-UG) from a Pen-and-Paper Test (PPT) to Computer-Based Testing (CBT) to completely eliminate vulnerable physical print-and-transport supply chains. The Committee further recommends that during the transitional phase, the NTA must institutionalize the proposed Computer-assisted Secure PPT (CPPT) model—utilizing encrypted, candidate-randomized papers printed locally within secure rooms—alongside robust, multi-layered biometric authentication and live AI-enabled CCTV analytics to guarantee a zero-error, tamper-proof testing environment.

4.2.91 The Committee believes that achieving true equity in healthcare delivery requires a socio-economically and geographically diverse medical workforce. Aspirants from rural, remote, and economically weaker backgrounds are statistically more inclined to serve underrepresented provincial regions later in their medical careers. By providing a single, standardized gateway into heavily subsidized government institutions, the NTA has successfully curbed exploitative "donation seats" and diminished the out-of-pocket financial burden of writing dozens of separate institutional exams. However, physical and economic barriers to testing centers still restrict lower-income candidates. The Committee, therefore, recommends that the NTA, in close coordination with State Governments, drastically scale up the creation of secure, government-owned testing centers by retrofitting Kendriya Vidyalayas, Navodaya Vidyalayas, and state universities. To eliminate the logistical and financial strain on rural candidates, the Committee recommends the deployment of specialized mobile testing units in underserved districts. This infrastructure expansion must be supported by a highly rationalized fee structure and priority-based center allocations for female, differently-abled, and economically vulnerable students to ensure no qualified candidate is excluded from the medical education pipeline due to geographic or financial distress.

4.2.92 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. Standardizing entry-level quality for these streams is vital to preventing misdiagnoses and subsequent medical complications that drive up

catastrophic out-of-pocket healthcare expenditures for vulnerable populations. The NTA's mandate to make NEET-UG the uniform entrance test for BAMS, BHMS, BUMS, and nursing courses is a major regulatory step toward uniformizing human capital quality across all medical disciplines.

4.2.93 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. Such collaboration should introduce hybrid Classical Test Theory and Item Response Theory (CTT-IRT) models to evaluate candidates on both fundamental aptitude and practical reasoning. 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, the government will level the playing field for candidates who rely solely on public school curricula, ensuring that primary healthcare across rural India is managed by highly competent, merit-selected professionals.

4.2.94 The Committee understands that the persistent vacancies and inequitable distribution of healthcare personnel, particularly in remote and underserved regions, fundamentally undermine the efficacy of primary healthcare delivery. The Committee believes that overcoming such systemic retention barriers requires states to abandon rigid, centralized human resource models in favor of innovative, localized, and incentive-driven workforce strategies. The Committee, therefore, recommends that state governments immediately transition to decentralized recruitment frameworks, empowering district and local authorities to hire personnel based on localized clinical needs. The successful digitalized, district-level recruitment of Community Health Officers (CHOs) executed in Karnataka must be adopted as a structural benchmark to streamline timelines and reduce rural vacancies. The Committee strongly appeals the Government for the implementation of robust, incentive-linked rural postings to attract and retain health professionals in difficult-to-reach areas. 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.

4.2.95 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 to deliver targeted public health services under defined supervisory guidelines.The Committee, therefore, recommends for the establishment of specialized, dedicated public health management cadres at the State level to systematically strengthen disease surveillance, emergency preparedness, health promotion, and evidence-based fiscal planning.The Committee,in this regard, recommends for fostering institutional partnerships between established medical colleges and grassroots primary healthcare facilities. Such collaborations are essential to

provide regular specialist mentoring, tele-mentoring, continuing medical education, and structural capacity building for all frontline healthcare workers.

4.2.96 The Committee visualizes that expanding the national pool of available medical doctors requires a decisive dismantling of legacy regulatory bottlenecks that artificially constrain the growth and operational efficiency of medical education. The Committee believes that transitioning from a restrictive compliance framework to a rationalized, resource-optimized model is imperative to accelerate the production of medical professionals and maximize the utility of existing clinical infrastructure.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, thereby removing a significant bureaucratic hurdle to institutional entry. The Committee further recommends for removing the administrative requirement for the annual renewal of the letter of permission from the Medical Assessment and Rating Board (MARB) thereby adoption of user regulatory mechanism. The Committee is of the view that regulatory oversight should instead be maintained through a robust mechanism of mandatory annual online disclosures.

4.2.97 The Committee recommends permitting the strategic sharing of institutional infrastructure across multiple colleges within the same university or across different universities, formalized through mutual agreements and Memorandums of Understanding (MoUs), to prevent the redundant duplication of capital assets.

4.2.98 The Committee is of the opinion that qualified visiting faculty be explicitly counted toward the fulfillment of minimum institutional faculty requirements, subject to their strict adherence to the stipulated thresholds for minimum class delivery.The Committee, therefore, recommends reducing the mandatory minimum duration requirement for hospital leases or formal MoU arrangements from 30 years to 25 years to significantly lower long-term real estate and capital barriers for new medical institutions.

UNCOMPLICATE
Simplifying Compliance

Chapter- V

Rationalization of Treatment Cost

5.1 The Committee has come across huge variation in the treatment of various diseases in the private sector hospitals *viz-a-viz* the public sector hospitals, particularly in secondary and tertiary care hospitals. The Committee, therefore, feels the urgent need to rationalize the treatment cost as a whole, of course, keeping in view the welfare motive of public sector as well as encouraging & incentivizing the private sector hospitals to play the complementary role with the public sector hospitals in ensuring the affordability and accessibility of healthcare facilities to the low and middle class population of the country.

5.1.1 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. Furthermore, the Committee believes that such a framework must rigorously uphold the welfare motive of the public sector while concurrently encouraging and incentivizing private sector hospitals to play a complementary, ethical role, thereby ensuring holistic affordability and accessibility of healthcare facilities to the low- and middle-class population. The constitutional provision of the welfare nature of the State and socialistic pattern of society cherished in the Directive Principle of State Policy under Part IV of the Constitution of India entrust the Government of the day to make the healthcare accessible and affordable for the people of the country in compliance with the direction of the Supreme Court of India under Article-21 of the Indian Constitution interpreting thereon inherent provision of Fundamental Right to Health. On the other hand, today's economy is the democratic and competitive driven liberal economy where market forces fixes/determines the rates. The need of the hour is to strike a balance between the constitutional provision and the prevailing market economy in order to ensure quality, cost-effectiveness, accessibility and affordability of healthcare. 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.

5.2 The Committee has come across to understand that there exist concerning variation in the treatment costs of various diseases between private sector hospitals and public sector hospitals, particularly concerning secondary and tertiary care. In the overall treatment costs/healthcare expenditure, the pharmaceutical and medical devices prices are the major components and play a critical role. The Government through various policy interventions since early 1960s has promoted the availability, affordability and accessibility of drugs. Price control on drugs was first introduced in the country in 1962 under the Defence of India Act, 1915, with the promulgation of the Drugs (Display of Prices) Order, 1962 and the Drugs (Control of Prices) Order, 1963. These orders led to freezing of the prices of drugs with effect from 1.4.1963. The National Pharmaceuticals Pricing Policy, 2012 (NPPP, 2012) was notified on 7.12.2012 for putting in place a regulatory framework for the pricing of drugs with the objectives of ensuring availability of required medicines at reasonable prices; providing

sufficient opportunity for innovation and competition; supporting industry growth; and meeting goals of employment and shared economic well-being for all.

5.2.1 The key principles of NPPP, 2012 are Essentiality of drugs; Regulation of prices of formulations; Market-based pricing. Essentiality of drugs criterion is to be met by considering the list of medicines specified in the National List of Essential Medicines (NLEM) declared and revised from time to time by the Department of Health and Family Welfare (DoHFW). Regulation of prices of formulations entails regulation of prices of formulations only. The price control of formulations only ensures more specific price control of the required medicine, prescribed by the doctor. Market-based pricing refers to pricing based on widely available information in the public domain as against individual manufacturer level production costing data. This is to facilitate establishment of a more transparent and fair pricing mechanism. NPPP, 2012 also recognises control over drug prices as only one element of an overall strategy for provision of affordable healthcare, with programmes of affordable healthcare to a majority of the population in the form of direct Government healthcare, insurance, a well spread- out, low-cost Jan-aushadhi pharmacy chain programme, etc. being other such elements.

5.3 Drugs (Prices Control) Order, 2013

5.3.1 The principles, approaches and methodologies as laid down in NPPP, 2012 are implemented through the Drugs (Prices Control) Order, 2013 ("DPCO, 2013"). The mechanism for price regulation as provided under DPCO, 2013, inter alia, includes the following:

(i) Fixation of ceiling prices: Under paragraph 4 of DPCO, 2013, the ceiling price of a scheduled medicine (i.e., a medicine included in Schedule-I to DPCO, 2013) is fixed based on the market data, by taking the simple average prices to retailers (PTR) of all the brands and generic version of such medicine that have market share of 1% or more of the total market turnover reckoned on the basis of moving annual turnover of that medicine. The ceiling price is arrived at by adding 16% margin on the said simple average. Goods and Services Tax (GST), wherever applicable, is added to the ceiling price to arrive at the Maximum Retail Price (MRP). No manufacturer shall sell a scheduled formulation above the ceiling price. Presently, ceiling prices of 935 formulations are in effect. The average price reduction due to refixation of prices is about 17%, resulting in total savings to consumers of around ₹3,802 crore.

(ii) Revision of ceiling prices based on Wholesale Price Index: Paragraph 16 of DPCO, 2013 provides that the Government shall revise the ceiling prices of scheduled formulations as per the annual Wholesale Price Index (WPI) for the preceding calendar year, on or before the 1st of April of every year. Although the annual permitted increase in the prices of scheduled drugs is based on the increase in WPI (all commodities), the WPI increase is the maximum increase permissible and may or may not be availed of by the manufacturer.

(iii) Retail price fixation for new drugs: As per paragraph 2(1)(u) of DPCO, 2013, the expression "new drug" means a formulation launched by an existing manufacturer of a drug

of specified dosages and strengths as listed in NLEM by combining such drug with another drug that may or may not be listed in NLEM, or a formulation launched by changing the strength or dosages or both of that drug. Under paragraph 5 of DPCO, 2013, the retail price of new drugs is also fixed based on market-based data, inter alia, by taking the simple average of the prices to retailer for all brands and generic version of such medicines that have a market share of 1% or more of the total market turnover reckoned on the basis of moving annual turnover of that medicine. The retail price is arrived at by adding 16% margin on the said simple average. GST, wherever applicable, is added to the retail price to arrive at the maximum retail price. As on 09.07.2026, 3,845 retail prices of new drugs stood fixed by NPPA under DPCO, 2013, including for anti-diabetic (1,380), cardio-vascular (677), anti-hypertensive (206), anti-cancer (61) and other (1,521) formulations.

(iv) Non-scheduled formulations: Non-scheduled formulations/drugs are those formulations/drugs that are not included in Schedule-I to DPCO, 2013. A manufacturer of a non-scheduled formulation may fix its maximum retail price, whether branded or generic. The manufacturers of non-scheduled formulations are not allowed to increase their maximum retail price by more than 10% over a period of preceding twelve months. Instances of overcharging are dealt with by NPPA under relevant provisions of DPCO, 2013.

(v) Fixation of ceiling price of a drug under certain circumstances: The Government may, under paragraph 19 of DPCO, 2013, in extraordinary circumstances, and if it considers necessary so to do in public interest, fix or revise the ceiling price or retail price of any drug.

(vi) Price control of medical devices: The Ministry of Health and Family Welfare, vide its notification dated 11.2.2020, notified all medical devices intended for use in human beings or animals as drugs under the Drugs and Cosmetics Act, 1940, with effect from 1.4.2020. Accordingly, NPPA, vide its notification dated 31.3.2020 notified that all medical devices shall be governed under the provisions of DPCO, 2013 with effect from 1.4.2020. Four medical devices namely, bare metal stents, drug-eluting stents, condoms and intra-uterine devices have been included in NLEM and consequently, in Schedule-I and their ceiling prices have been notified. In addition, under paragraph 19 of DPCO, 2013, NPPA has also capped the price of knee implants. Any instances of overcharging are dealt with under relevant provisions of DPCO, 2013.

(vii) Trade margin rationalisation: With a view to ensure affordability of anti-cancer drugs, NPPA imposed a cap on trade margin at the rate of 30% on 42 non-scheduled anti-cancer medicines under a "trade margin rationalisation" approach as a pilot, invoking paragraph 19 of DPCO, 2013 in public interest, in the year 2019. This led to a reduction in the price of 526 brands of medicines by an average of around 50 percent, resulting in annual savings of around Rs. 984 crore to the patients. Further, with the aim of regulating the prices of medical devices essential for diagnostic purposes, in general and specifically for covid management, NPPA capped the trade margin for oxygen concentrators at 70% on price to distributor (PTD) in June 2021, using the trade margin rationalisation approach. Similarly, in July 2021, the trade margin on pulse oximeter, glucometer, blood pressure monitor, nebuliser and digital thermometer was capped at 70% on PTD. Expected savings to the consumers due to such

reduction are around ₹1,000 crore per annum. These notifications were extended till 30.6.2023.

(viii) Incentivising research and innovation: For incentivising research and innovation, DPCO, 2013, in paragraph 32, provides for exemption of drugs from price control for certain period subject to fulfilment of certain conditions as specified in the DPCO, 2013. As on 09.07.2026, exemption under paragraph 32 have been granted to 14 products by NPPA.

5.3.2 As regards the issue of trade margin, the Committee has come across that the average mark up for common dosage forms of non-scheduled drugs, namely, tablets, capsules, sachet, gums and strips, is around 43% for distributors, stockists, wholesalers and retailers collectively. Such instances indicates that incidence of high trade margins is generally not the norm, however, the Committee desires that Government must look into the matter of high trade margin in the noticeable cases. In this regard, the Committee recommends that the Government should initiate consultation with stakeholders for making suitable policy and regulatory provision for trade margin rationalisation. During the consultation process, there is need to pay attention to the legitimate concerns raised, especially by low-cost micro, small and medium enterprises (MSME) manufacturers who rely mainly on the trading channel for market development to ensure that their low-cost drugs reach consumers.

5.3.3 The Committee is pleased to observe that the existing pricing and policy framework has resulted in the prices of both non- scheduled and scheduled drugs in India being generally the lowest across categories and across both manufacturing and non-manufacturing countries. However, the Committee believes that the aim behind formulating essential medicine list must ensure that these medicines are available in adequate amounts, in appropriate dosage with assured quality. This is so because essential medicines are those medicines that satisfy the priority health care needs of any population, based on efficacy, safety, quality and includes total cost of the treatment. The NLEM must be basically a list of medicines that are safe, efficacious and collectively address a majority of the public health concerns of India and are cost-effective.

5.4 National Pharmaceutical Pricing Authority (NPPA)

5.4.1 The National Pharmaceutical Pricing Authority (NPPA) was constituted on 29.8.1997 as an attached office of the DoP entrusted with the function inter alia, include fixation and revision of prices of scheduled formulations as per the provisions of DPCO, including monitoring and enforcement of prices. The mandate of NPPA is not only affordability of drugs, but also their availability. The steps taken by NPPA to ensure availability are as under:

(i) Any manufacturer of a scheduled formulation who intends to discontinue any scheduled formulation from the market has to seek permission from NPPA. There exists a set of guidelines that need to be complied with before discontinuation of the scheduled formulations. In certain cases, paragraph 3 of DPCO, 2013 is also invoked for issuing directions for continued manufacturing/ importing the drugs. Action can also be initiated under law for any violations.

(ii) As and when reports of shortages of particular drug(s) in any part of the country are received, the companies concerned are asked immediately to send stocks to the affected areas and to make drugs available.

(iii) During the covid pandemic in the country, NPPA played an active role in addressing the exigencies arising out of the pandemic and undertaking necessary measures to ensure continued availability of life-saving essential medicines and medical devices throughout the country.

5.4.2 The mandate of NPPA is to work towards ensuring the availability of drugs at affordable prices. While ensuring affordability, access cannot be jeopardised and the life-saving essential drugs must remain available to the general public at all times. Therefore, unviability of formulations should not lead to a situation where these drugs become unavailable in the market and the public is forced to switch to expensive alternatives. Keeping this in view, NPPA, in public interest, invoked paragraph 19 under DPCO, 2013 in the following instances:

(i) Allowed 50% increase on 21 formulations of 12 medicines on the then applicable ceiling price to ensure the availability of medicines {notified vide S.O. 4461(E) dated 13.12.2019};

(ii) Allowed 50% increase on 9 scheduled formulations of 3 drugs on the then applicable ceiling price {notified vide S.O. 2654(E) dated 1.7.2021}; and

(iii) 11 scheduled formulations of 8 drugs were given one-time increase of 50% of the present applicable ceiling price {notified vide S.O. 4498(E) dated 14.10.2024}.

(iv) 4 scheduled formulations of 3 drugs were given one-time increase of 50% of the present applicable ceiling price {notified vide S.O. 3004(E) & 3005(E) dated 11.06.2026}.

5.4.3 The fixation of ceiling prices/MRP under various NLEMs under DPCO, 2013 and invoking of paragraph 19 from time to time has resulted in average annual total saving of more than ₹26,000 crore to the public due to implementation of DPCO, 2013. The break-up of the total annual savings through various measures taken by NPPA

5.4.4 All price notifications for the formulations of which prices have been fixed by NPPA are available on the website of NPPA (www.nppaindia.nic.in). Thus, the entire procedure of price fixation is available in the public domain, which ensures transparency and accountability of the process. DPCO, 2013 mandates every manufacturer to issue a price list and supplement ary pricelist, if required, in specified Form to the dealers, State Drugs Controllers and the Government. Further, every retailer and dealer is mandated to display the price list and the supplementary price list, if any, as furnished by the manufacturer, on a conspicuous part of the premises where he carries on business leading to greater transparency with respect to pricing.

5.4.5 NPPA has introduced digital initiatives such as the Pharma Sahi Daam App, which is a mobile application that allows consumers to check the latest NPPA-notified prices of medicines. NPPA is also implementing the Integrated Pharmaceutical Database Management System 2.0, a centralised platform for pharmaceutical companies to submit production and pricing data, ensuring real-time regulatory oversight, thus ensuring ease of doing business.

5.4.6 The Committee is of the view that price control mechanisms on formulations alone are insufficient to guarantee universal healthcare accessibility across all demographics. As recognized by the foundational principles of the National Pharmaceuticals Pricing Policy (NPPP), 2012, regulatory control over drug prices represents only a single element within a much broader strategy required for affordable healthcare. The Committee believes that alternative infrastructure for delivering low-cost therapies must be aggressively expanded to shield the vulnerable populace from exorbitant out-of-pocket expenditures. The Committee, therefore, recommends that the Government should exponentially scale up the well-spread, low-cost Jan-Aushadhi pharmacy chain programme, prioritizing penetration into unserved rural and semi-urban districts. The Committee is of the view that the Government must also seamlessly integrate these pharmacy chains with direct Government healthcare and state insurance programmes, ensuring that affordable generic medicines serve as the frontline choice for public health delivery. The Committee recommends for a quality check mechanism to remove apprehensions regarding quality of medicines delivered through Jan Aushadi Kendras.

5.4.7 The Committee is of the view that the statutory provision under Paragraph 16 of the DPCO, 2013, which allows for the annual revision of ceiling prices for scheduled formulations based on the Wholesale Price Index (WPI), is a necessary mechanism to account for macroeconomic inflation. However, the Committee believes that since the WPI-based increase explicitly represents the maximum permissible hike and is not a mandatory increment, there is a risk of manufacturers routinely and uniformly availing the highest allowable price increase regardless of their actual, localized production costs. 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. The Committee is of the view that such heightened regulatory vigilance will prevent routine, arbitrary price inflations of scheduled medicines and ensure that the foundational objective of the DPCO, delivering required medicines at reasonable and fair prices, remains strictly uncompromised.

5.4.8 The Committee, in examination of rationalisation of treatment costs, further took into consideration the views of the certain hospital management to arrive at a conclusion for determination of treatment of disease at a rational cost.

5.5 Sankara Nethralaya

5.5.1 Sankara Nethralaya, in its submission before the Committee, stated that it has served as a model of affordable, ethical and high-quality eye care in the private not-for-profit sector

for over four decades. Guided by a patient-centric approach, the institution has consistently balanced clinical excellence with social responsibility by ensuring that nearly 40 per cent of its surgeries and outpatient services are provided either free of cost or at highly subsidized rates to economically disadvantaged patients. The institution emphasized that, with an enabling policy environment, public-private collaborations have the potential to significantly transform healthcare delivery and improve access to quality care.

5.5.2 The Committee appreciates that, as a not-for-profit institution, Sankara Nethralaya follows a transparent and standardized pricing policy for all treatments and services. The hospital does not adopt a variable tariff structure and ensures uniformity in treatment costs across patient categories. It has established well-defined package rates for common surgical procedures, covering surgeon's fees, consumables, investigations and post-operative care, thereby eliminating ambiguity and enabling patients to plan their medical expenses in advance. Unlike many private hospitals, the institution does not practice differential pricing based on demand, timing or urgency, ensuring fairness and equity in service delivery. Prior to surgery, patients are informed of the applicable package rates along with a detailed break-up of charges, while any exclusions, such as post-discharge medications, extended hospital stay or special investigations, are clearly communicated in advance. The Committee observes that consultation charges, day-care services and surgical package rates are displayed at the hospital reception and are made available to patients upon request, thereby promoting transparency and safeguarding patients' rights. The hospital management, in a written submission to the Committee, emphasized that the hospital does not levy exorbitant charges for diagnostic or treatment services and that all costs are standardized, transparent and aligned with its objective of making quality eye care accessible irrespective of a patient's financial status. The Committee understands that other centers for excellence like the Sankara Nethralaya in eye treatment be treated as a gold standard on the parameters of quality, affordability and public trust and the other hospitals in both the private and public sector should follow suit.

5.5.3 Sankara Nethralaya further stated that it is committed to providing ethical and affordable healthcare, including the management of rare and complex ophthalmic conditions. Although the institution is not a comprehensive oncology or rare disease treatment centre, it has adopted several measures to contain the cost of diagnosis and treatment of rare eye diseases. The Committee, keeping in view the practice and norms followed in Sankara Nethralaya recommends that other public and private hospitals should follow such best practices. It provides specialized treatment for rare ophthalmic conditions such as retinoblastoma, advanced vitreoretinal diseases, intraocular and extraocular tumours, advanced glaucoma and complex corneal disorders at reasonable and fixed rates, while extending free or subsidized treatment to deserving patients.

5.5.4 The Committee was also informed that the institution has established advanced in-house diagnostic facilities, including genetic testing for ocular disorders, thereby reducing dependence on external laboratories and minimizing costs for patients. High-cost diagnostic procedures and surgical interventions for rare eye diseases are further supported through cross-subsidy mechanisms and philanthropic contributions, ensuring that no patient is denied

treatment on account of financial constraints. While not being a comprehensive cancer treatment centre, Sankara Nethralaya stated that its operational philosophy ensures that patients requiring specialized care for rare eye conditions receive treatment that is affordable, compassionate and transparent.

5.5.5 The institution also placed before the Committee certain suggestions for improving healthcare delivery and strengthening public-private partnerships. It highlighted that although it supports the objectives of Government health assurance schemes such as Ayushman Bharat, delays and inconsistencies in reimbursement processes adversely affect the long-term financial sustainability of not-for-profit institutions. It, therefore, recommended that reimbursement mechanisms be streamlined and payments made in a timely manner to enable greater participation of private healthcare providers in serving economically weaker sections.

5.5.6 Sankara Nethralaya further expressed its willingness to collaborate with public healthcare institutions, provided such partnerships are based on mutual trust, clearly defined accountability and financial viability, enabling private institutions to contribute effectively without compromising the quality of care. The institution also highlighted the success of its Mobile Eye Surgical Unit (MESU) in extending specialized eye care services to rural and underserved populations and requested Government support for scaling up such initiatives through policy recognition, logistical assistance and integration with rural health programmes.

5.5.7 The Committee was further informed that compliance and reporting requirements for private healthcare institutions, particularly not-for-profit organizations, could be simplified through centralized digital platforms and the elimination of repetitive documentation, thereby reducing administrative burden while maintaining transparency. Sankara Nethralaya also emphasized the need for greater policy and financial support for preventive eye care initiatives, including school eye screening programmes, community outreach camps and the training of allied ophthalmic professionals, noting that investments in preventive care significantly reduce the long-term burden of visual impairment and healthcare expenditure.

5.5.8 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 believes that absolute transparency is the first step toward effective cost rationalizing. 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. Such mandatory packages must comprehensively include surgeon fees, diagnostic investigations, consumables, and standard post-operative care. The Committee believes that such measures would lead to self-regulating and rationalization of treatment cost by the hospital. The Committee further believes that by measure of legally eliminating hidden charges and differential pricing, would act as a de-facto capping of treatment cost and would also ensure that patients can precisely plan their medical expenses without fear of arbitrary billing inflation.

5.5.9 The Committee believes that the long-term sustainability of affordable healthcare delivery, particularly by private and not-for-profit hospitals, is heavily reliant on the efficiency of government health assurance schemes like Ayushman Bharat. The Committee is of the view that chronic administrative delays and inconsistencies in claim settlements actively discourages private institutions from dedicating beds to economically weaker sections. 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. The Committee firmly believes that the process of making Ayushman Bharat cards and process of settlement of claims by the hospitals needs to be simplified for better interest of needy patients as well as operational proficiency of the treating hospital. Furthermore, a provision for penal interest on delayed payments must be introduced to ensure mutual trust, accountability, and the uninterrupted participation of private providers in subsidized healthcare initiatives.

5.5.10 The Committee visualizes that genuine accessibility requires taking specialized, high-quality healthcare directly to rural and underserved populations, thereby eliminating the catastrophic indirect costs associated with travel, accommodation, and wage loss. The Committee believes that decentralized care models, such as Mobile Eye Surgical Units (MESU), have proven highly effective in bridging the urban-rural healthcare divide. The Committee, therefore, recommends that the government must provide targeted policy recognition, logistical assistance, and capital subsidies to both public and private institutions that deploy fully equipped mobile surgical and diagnostic units. These mobile units must be formally integrated into national rural health programs, ensuring that standardized treatment reaches the most marginalized demographics without compromising on clinical safety or quality.

5.5.11 The Committee considers that redundant and repetitive compliance requirements impose an unnecessary administrative and financial burden on healthcare providers, particularly not-for-profit organizations operating on cross-subsidy models. The Committee is of the opinion that reducing such operational friction is essential to lower the overarching cost of healthcare delivery. The Committee, therefore, recommends the urgent deployment of a centralized, single-window digital portal for all statutory compliance and reporting required from hospitals, effectively eliminating repetitive physical documentation. Additionally, the Committee believes that the most effective method to rationalize long-term healthcare costs is through early screening, diagnosis, detection and treatment, if required. 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 which significantly mitigate the future economic burden of advanced and complex diseases on both the state and the citizen. Moreover, awareness program amongst the school/college going children and community awareness as well needs to be emphasized in the policy action.

5.6 Views of the Private Healthcare Sector on the Cost of Treatment

5.6.1 In its submission before the Committee, Manipal Hospitals stated that while it remains committed to supporting Government healthcare initiatives, it urged policymakers to adopt a scientific, evidence-based, and practical approach while determining package rates and compensation under various Government-sponsored health schemes. The hospital emphasized that the process of costing medical procedures should involve consultations with private healthcare providers to ensure that reimbursement rates accurately reflect the actual cost of delivering quality healthcare. According to the hospital, pricing decisions should take into account infrastructure investments, operational and manpower costs, technology adoption, and the quality of treatment outcomes. It was further submitted that transparent and data-driven pricing mechanisms would not only ensure the financial sustainability of private sector participation in Government health schemes but also help maintain high standards of patient care for beneficiaries.

5.6.2 Manipal Hospitals further submitted that private healthcare providers continue to face several systemic and policy-related challenges that significantly increase the cost of healthcare delivery, many of which are beyond the control of hospitals. In this regard, it requested the Government to address the following issues:

(i) **High Capital Cost of Medical Equipment:** The hospital stated that quality healthcare requires sophisticated medical equipment, a large proportion of which is imported and attracts substantial customs duties and other levies. These additional costs increase capital expenditure and are ultimately reflected in the overall cost of treatment unless appropriate policy support is provided.

(ii) **Lack of Preferential Land Allotment:** It was submitted that, in most States, hospitals do not receive concessional or preferential allotment of land for establishing healthcare facilities. Consequently, the high cost of acquiring land significantly increases capital investment, thereby constraining the expansion of affordable healthcare infrastructure.

(iii) **Delayed Reimbursement under Government Health Schemes:** The hospital highlighted that although private hospitals actively support Government-sponsored health schemes, reimbursements are often delayed by several months and are frequently subject to deductions. Such delays and financial uncertainties adversely affect cash flows, making continued participation financially challenging and undermining the objectives of these schemes.

(iv) **Non-Availability of Input Tax Credit under GST:** The hospital pointed out that while healthcare services are exempt from Goods and Services Tax (GST), hospitals are not eligible to claim input tax credit on the GST paid for goods and services procured for healthcare delivery. As a result, the GST paid on inputs becomes an embedded cost, thereby increasing the overall cost of treatment.

5.6.3 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.

5.6.4 The Committee believes that the exorbitant capital required to procure sophisticated medical technology, a significant proportion of which must be imported, acts as a primary driver of high diagnostic and surgical costs. 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. To ensure this financial relief translates into affordable care, the Committee is of the view that tax exemptions on such equipment must be strictly contingent upon the importing healthcare facilities committing to standardized, capped pricing for the diagnostic tests and procedures utilizing that specific machinery.

5.6.5 The Committee understands that the prohibitive commercial cost of real estate acquisition severely restricts the expansion of affordable healthcare infrastructure, forcing private institutions to recover land investments through higher treatment tariffs. The Committee, therefore, recommends that the Ministry of Health and Family Welfare coordinate with State Governments to draft a unified national policy for the concessional or preferential allotment of land for the establishment of new healthcare facilities. The Committee believes that such preferential land grants to private investors in healthcare must be legally bound to entrust sense and responsibility of robust social obligations for providing treatment to the needy patient at the concessional/subsidized rates. Hospitals benefiting from subsidized land must be mandated to dedicate a fixed percentage of their beds capacity upto 20% of the total beds capacity of the hospital for outpatient services, especially to economically weaker sections at strictly capped and Government-approved rates.

5.6.6 The Committee has been given to understand that unilateral rate-setting for Government-sponsored health schemes generally skip the accounting for the practical realities of infrastructure investments, specialized manpower, and technology adoption required by the private sector. While empirical data collection is vital, the Committee believes that the interpretation of such data requires practical industry context. 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. By ensuring that compensation under health schemes accurately reflects the true cost of delivering quality care. The Committee firmly believes that the Government can ensure the financial sustainability of these programs and prevent private hospitals from compensating for scheme losses by inflating the treatment costs of general-category patients.

5.7 Jawaharlal Nehru Medical College (JNMC)

5.7.1 In its submission before the Committee, Jawaharlal Nehru Medical College (JNMC), Belagavi, informed that approximately 30,000 patients had been treated under the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) during the last three years. While expressing its continued commitment to the implementation of the Scheme, the institution highlighted several operational and financial challenges affecting the delivery of quality healthcare under the existing package rates.

5.7.2 Following treatment procedures/services performed in the institution during the last financial year
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SI. No	Treatment Procedure/Diagnostic service	No. of procedures performed	Base Package Cost	Package variation (Insured vs. Non insured)	Average waiting Average	Average Length of Stay (days)
1.	Angiography	3240	8700/-	5%	NIL	2
2.	Angioplasty (single stent)	1600	80000/-	5%	0	3
3.	CABG (Bypass Surgery)	720	230000/-	5%	1	10
4.	Chemotherapy (per cycle)	16200	80000/-	5%	NIL	0
5.	PET Scan	1400	22500/-	5%	NIL	0
6.	Breast Cancer surgery	310	95000/-	5%	NIL	4.5
7.	Cervical Cancer suregery	30	150000/-	5%	NIL	5
8.	Oral Cancer surgery	140	150000/-	5%	NIL	5
9.	Prostate Cancer surgery	50	200000/-	5%	NIL	5
10.	Bone Marrow transplant	3	1500000/	5%	--	12
11.	Cataract Surgery (per eye)	4500	6500/-	5%	NIL	1
12.	Hemodialysis (Per session)	35000	1200/-	5%	NIL	1
13.	Kidney Transplant	10	850000/-	5%		12
14.	Liver Transplant	4	2200000/	5%		30
15.	Laparoscopic appendectomy	1200	60000/-	5%		5
16.	Any other surgery/procedure frequently undertake in the hospital					

5.7.3 Standard daily room rent charged to patients, specifying resident doctor fees, basic nursing, meals

Room Category	Daily tariff	Inclusions (Nursing/Duty Doctor/Diet)
General Ward bed	2200/-	Including Nursing, Doctor, Diet, Bed Charges
Semi-private room	3500/-	Including Nursing, Doctor, Diet, Bed Charges
Private Room	5000/-	Including Nursing, Doctor, Diet, Bed Charges
ICU/CCU bed	10000/-	

Category	Key examples used in –house	Indicative price range billed to patient	Average margin over procurement cost (%)
Cardiac implants	e.g. DES Stent, Pacemakers, etc.	20000/- 60000/- As per NPA Guidelines	Nil
Orthopedic implants	e.g. knee/hip replacement etc.	50000/- as per NPPA guidelines	
Oncology consumables	e.g. targeted monoclonal antibodies, etc.	NA	
Dialysis consumables	e.g. Dialyzers, Blood tubing lines, etc.	700/-	10%

5.7.4 The hospital submitted that the current PMJAY package rates, particularly when compared with the Ayushman Bharat Arogya Karnataka (AB-ArK) Scheme, are inadequate for several high-cost specialties. It pointed out that the cost of orthopaedic implants is significantly high and that patients often require prolonged Intensive Care Unit (ICU) stay, which is not adequately covered under the existing package structure. The hospital, therefore, recommended that package durations should be clearly defined and any hospital stay beyond the prescribed period should be permitted through open billing. It further suggested that package rates should be scientifically rationalized and standardized, particularly for high-cost specialties such as Neurosurgery, Cardiovascular and Thoracic Surgery (CVTS), Orthopaedics, and ICU care, and that the AB-ArK package rates should be reviewed accordingly.

5.7.5 The institution also highlighted several functional limitations of the PMJAY IT Portal, which adversely affect patient management and claim processing. These include:

(i) the absence of visibility regarding annual utilization limits for high-cost diagnostic investigations such as MRI and CT scans at the family level, resulting in difficulties in treatment planning;

(ii) limited capacity for uploading supporting documents, particularly in cases involving prolonged ICU stay or extended hospitalization, leading to avoidable claim rejections;
(iii) the absence of a mechanism for tracking the status of queries or obtaining detailed reasons for claim rejections, thereby reducing transparency and delaying resolution of claims; and
(iv) inadequate opportunity for hospitals to present their grievances before the implementing authority. The hospital stated that it is required to respond to queries within 15 days, failing which the claims are permanently blocked without any further opportunity for review.

5.7.6 The hospital informed the Committee that to improve patient awareness and facilitate smoother implementation of the Scheme, it has established a dedicated team of Public Relations Officers (PROs) and counsellors to educate beneficiaries regarding eligibility criteria, utilization limits, documentation requirements, and claim status. According to the institution, this initiative has helped improve operational efficiency and reduce disputes with beneficiaries.

5.7.7 On the issue of promoting affordability through the Make in India initiative, the hospital observed that increased domestic manufacturing of orthopaedic implants and other medical devices has already contributed to reducing procedure costs. However, it emphasized the need for encouraging more Indian manufacturers to enter this sector by extending incentives such as the Production Linked Incentive (PLI) Scheme and other policy support, thereby reducing dependence on imported implants and medical equipment and making treatment more affordable.

5.7.8 The hospital further submitted that certain fiscal and regulatory reforms would significantly reduce healthcare costs. These include providing tax incentives to healthcare institutions, reducing licensing costs for hospitals, which are presently comparable to those applicable to industries, and ensuring that medicines, consumables, and medical devices are supplied to healthcare institutions at regulated prices.

5.7.9 Regarding procurement and pricing practices, JNMC informed the Committee that patients are not permitted to procure medicines, implants, or consumables from external sources. Billing is based on the procurement cost with a 20 per cent mark-up. The hospital further stated that an internal mechanism for cost regulation is in place and that procurement is undertaken through a centralized tender-based system, ensuring transparency and cost control.

5.7.10 As regards measures for reducing treatment costs under PMJAY, the hospital suggested the introduction of a real-time referral system for tertiary care institutions. It explained that direct referrals from lower-level facilities to tertiary hospitals, instead of routing patients through district hospitals, would reduce delays in approvals, shorten hospital stays, and lower overall treatment costs. The hospital also reiterated the need to promote indigenous manufacturing of implants and medical devices, rationalize package rates periodically based on actual treatment costs, improve transparency and functionality of the

PMJAY portal, and provide greater flexibility in reimbursement for prolonged ICU care and other high-cost treatments. These measures, according to the institution, would enhance both the affordability and accessibility of healthcare under the Ayushman Bharat–PMJAY Scheme.

5.7.11 The Committee is of the view that the rigid imposition of predefined package durations disproportionately penalizes healthcare institutions handling complex, acute cases. Treatments involving high-cost specialties, such as Neurosurgery, Cardiovascular and Thoracic Surgery (CVTS), Orthopaedics, and critical care, frequently necessitate prolonged Intensive Care Unit (ICU) stays that exceed standard package parameters. The Committee believes that forcing hospitals to absorb these outlier costs acts as a severe deterrent to the admission of critically ill scheme beneficiaries. The Committee, therefore, recommends the immediate unbundling of prolonged critical care from standard surgical packages. Clear clinical parameters must be defined to categorize "outlier events." 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.

5.7.12 The Committee believes that functional limitations and rigid procedural algorithms within the Ayushman Bharat–PMJAY IT portal and analogous state portals actively generate avoidable claim rejections and administrative delays, which ultimately drive up the operational cost of healthcare delivery. The Committee, therefore, recommends a comprehensive technological overhaul of all national and state health Insurance IT portals. The upgraded infrastructure must provide real-time visibility of annual utilization limits for high-cost diagnostic investigations (such as MRI and CT scans) at the family level to enable accurate treatment planning. Furthermore, the Committee recommends the immediate expansion of digital storage capacities on these portals to allow for the seamless uploading of voluminous medical records associated with prolonged ICU stays. A transparent, bidirectional tracking mechanism must also be instituted, compelling health authorities to provide detailed justifications for claim rejections and affording hospitals a fair appellate window beyond the current restrictive 15-day limit.

5.7.13 The Committee is of the view that the mandatory, hierarchical routing of critical patients through primary and district-level hospitals before such patients can access tertiary care introduces fatal delays, exacerbates the patient's clinical condition, and ultimately inflates the cost of treatment upon admission. The Committee, therefore, recommends the immediate deployment of a real-time, digital referral system that connects all tiers of healthcare facilities. Clear clinical triage protocols must be established to allow lower-level medical officers to bypass intermediary district hospitals and generate direct referrals to empanelled tertiary care institutions for complex, life-threatening conditions. The Committee believes that streamlining this pathway will significantly shorten overall hospital stays, minimize the need for redundant diagnostic testing across multiple facilities, and drastically lower the cumulative cost of care.

5.7.14 The Committee considers that achieving true affordability in specialized treatments, particularly in orthopaedics and cardiology, is impossible as long as the sector remains highly dependent on imported implants and medical devices. Furthermore, treating hospitals as commercial industries for the purpose of licensing and utility tariffs unnecessarily escalates their baseline operating costs. 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. Simultaneously, the Committee is of the view that state governments must be directed to comprehensively review and rationalize the institutional licensing costs imposed on healthcare facilities. 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.

5.7.15 The Committee is of the view that the existing disparity between the package rates offered under the Ayushman Bharat–PMJAY and various State-run health insurance schemes, such as the Ayushman Bharat Arogya Karnataka (AB-ArK), creates a fragmented healthcare financing ecosystem. The Committee notes the submissions of tertiary care providers highlighting that current PMJAY rates for several high-cost specialties are inadequate, which actively disincentivizes private sector participation and limits beneficiary access to complex procedures. 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' tasked with the scientific rationalization and periodic revision of standard package rates across all national and state health insurance schemes. This Board must ensure that package rates are dynamically indexed to actual regional procurement costs, inflation, and standardized clinical protocols, thereby harmonizing central and state tariffs while safeguarding equitable remuneration for healthcare providers.

5.7.16 The Committee is of the view that information asymmetry regarding scheme eligibility, utilization limits, and complex documentation requirements often leads to severe operational friction and avoidable disputes between beneficiaries and hospital administrations. The Committee believes that dedicated institutional facilitation, as demonstrated by the successful deployment of Public Relations Officers (PROs) and counselors at JNMC, can dramatically improve scheme uptake and protect vulnerable patients from exploitation. Furthermore, the Committee is of the view that a robust, accessible grievance redressal infrastructure is vital for public trust. The Committee, therefore, recommends that the Government mandate the establishment of dedicated 'Patient Navigation and Grievance Redressal Cells' across all tertiary care hospitals empanelled under national health schemes. These cells must be fully staffed with trained counselors and equipped with multi-modal communication platforms—including digital tracking, WhatsApp interfaces, and physical complaint boxes—to proactively educate

beneficiaries, assist with seamless documentation, and ensure the time-bound, transparent resolution of patient grievances.

5.8 RIMS hospital, Imphal

5.8.1 The Committee has been apprised of the information by RIMS hospital, Imphal on the variables like treatment procedures/services/cost factors, etc, as per the requisite format

Sl. No.	Treatment Procedure/Diagnostic Service	No. Of Procedures performed (2025–26)	Base Package cost	Package Variation (Insured vs. Non-insured)	Average waiting time (days)	Average Length of Stay (days)
1.	Angiography	464	Rs.10,000/-	Non-insured	1 day	2 days
2.	Angioplasty (single stent)	163	Rs.1.4 lakh	Non-insured	2 days	3 days
3.	CABG (Bypass Surgery)	2	Rs.1.5 to 2 lakhs	Health Scheme patients avail through the scheme (CMHT, PMJAY, CGHS) as per the cost of the package in the respective Health Scheme. For non-insured cost varies from Rs.1.5 to 2 lakhs	2 months (60 days)	7 days
4.	Chemotherapy (per cycle)	Avg. 3184 per year	Most of the patients avail the medicines through CMHT, PMJAY or CGHS scheme. For General patients cost varies from Rs.100/- to	Health Scheme patients avail medicine through the scheme (CMHT/PMJAY/CGHS) as per the cost of the package in the respective health scheme. For non-insured cost varies from Rs.100/- to Rs.15,000/- (However, this doesn't include immunotherapy)	Nil	3 – 5 days

				Rs.15,000/-			
5.	Breast Cancer Surgery		16	Rs.32,900/- for MRM and Rs.25,000/- for Simple Mastectomy deducted from card (CMHT/PMJAY)	Card insured and for non-insured, RIMS do not charge any amount. Patient buys consumables (Rs.20,000/- to Rs.25,000/-) approximately.	7 days (minimum)	4-8 days
6.	Cervical Cancer Surgery		3	Rs.40,000/- to Rs.50,000/-	Health Scheme patients avail through the scheme (CMHT, PMJAY) as per the cost of the package in the respective health Scheme. For non-insured cost varies from Rs.40,000/- to Rs.50,000/-	7	10
7.	Oral Cancer Surgery (ENT Deptt.)	(Ca. Tongue & Lymphoma Tonsil)	4	Rs.20,000/- to Rs.35,000/- (Approx.)	According to Health scheme (CMHT/PMJAY/CGHS) For non-insured, cost varies from Rs.20,000/- to Rs.40,000/-	1 week	2 weeks
8.	Prostate Cancer Surgery	Channel TURP	1	PMJAY – Rs.22,800/- CMHT – Rs.38,300/-	Rs.25,000/- to Rs.38,300/-	15 days	7-10 days
		Bilateral orchiectomy for Hormone Ablation	2	PMJAY – Rs.10,000/- CMHT –	Rs.6000/- to Rs.12,000/-	7 days	5-7 days

UNCOMPLY GATE Simplifying Compliance

				Rs.12,000/-			
		TRUS – guided Biopsy (12 core) Diagnostic	45	PMJAY – Rs.10,000/- CMHT – Rs.12,700/- (Done free of cost in the Department on OPD basis)	Rs.5,000/- to Rs.12,700/-	2 – 3 days	-
9.	Cataract Surgery (per eye)		900 per year	Free	Not Applicable	1 week	2 days
10.	Haemodialysis (per session)		8140	a)Rs.1200/- deducted from card (CMHT/PMJAY card) b) For non-card holder patient buy consumables	a) Insured – Rs.1200/- (CMHT/PMJAY) b) Non-Insured – RIMS does not charge any amount. Patients buy consumables (Approx Rs.1800/-)	5 months (150 days) for OPD basis Dialysis	For OPD dialysis patient discharge on the same day.
11.	Kidney Transplant			Rs. 6 lakhs (approx.)	a) Insured – Rs.3.5 lakhs + Rs.2.8 lakhs contribution from card-holderb) Non-Insured – Rs.6 lakhs	3 months (90Days)	10 days
12.	Liver Transplant		-	-	-	-	-
13.	Laparoscopic appendectomy		65	Rs.20,000/- deducted from card (CMHT/PMJAY)	Card insured and for non-insured RIMS do not charge any amount. Patients buy consumables (Rs.15000/– to Rs.20,000/-)	40 – 50 days	2- 3 days

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5.8.2 Pertaining to the information regarding the standard daily room rent charged to patients, the RIMS management furnish the details as under:_

Room Category			Daily tariff	Inclusion (Nursing/duty doctor/diet)
General ward bed			No Charges	Duty doctors, Nursing Services and diets are provided free of charges.
Semi-private room			-	
Private room	Premier		Rs.2000/-	
	New Special Ward		Rs.1000/-	
	Old Deluxe ward	with AC	Rs.1500/-	
		without AC	Rs.1000/-	
	Old Special ward	with AC	Rs.1500/-	
		without AC	Rs.700/-	
	Maternity private room		Rs.1000/-	
ICU/ICCU bed	with ventilator		Rs.500/-	
	without ventilator		Rs.300/-	

5.8.3 Pertaining to the Committee's query for a standard major surgical procedure performed at your institution, indicating the approximate, the average percentage contribution of each component toward the final invoice or 100% total bill weightage: Surgeon/professional fees, Anaesthesia and OT charges, Room rent, Nursing charges, consumables, implants/ stents/ medical devices, diagnostics/ investigations, pharmacy and administered drugs, the RIMS management informed that all standard major Surgical procedure performed at RIMS, Imphal, are free. However, in case some consumables are not available in the Institute's Store, then these are required to be purchased by the patient party.

5.8.4 As regards measures required to reduce treatment costs, rationalization/regulation of prices of drugs, implants, consumables and medical devices, standardization/transparency of package rates, and any policy/regulatory reforms considered necessary for the purpose, the RIMS management stipulated that at RIMS, Imphal, procurement of drugs, implants, consumables, and medical devices is carried out through the Government e-Marketplace (GeM), ensuring transparent and competitive pricing. The institution promotes the use of generic medicines and makes medicines available through AMRIT Pharmacy and Jan Aushadhi Centres, which significantly reduce treatment costs for patients.

5.8.5 RIMS management further informed that average waiting period for emergency procedures, Elective Surgeries is 4 to 6 hours; and a waiting period of 4 to 6 weeks for elective surgery. The Committee was further informed that 50% of patients treated at RIMS, Imphal, belong to the economically weaker Section. Since Healthcare services in RIMS, Imphal, are provided free of cost to patients and hence, there is no necessity for financial counselling. All possible help is extended to the patients in RIMS, Imphal. In addition, there is also a robust mechanism for patient grievance redressal, in the form of RIM Grievances Redressal Committee, headed by the Medical Superintendent. Besides, other mechanisms like complaint boxes and online complaint platform in RIMS Website as well as Whatapp Number for registering complaints are also displayed at various strategic locations.

5.8.6 As all treatments/medical procedures are done free of cost in RIMS, Imphal, there is no requirement for internal cost audit mechanism. However, all package for treatment in RIMS, Imphal, are either free or nominal or as per the available Government Schemes like PMJAY/CMHT/CGHS.

5.8.7 The Committee is of the view that establishing transparent institutional procurement mechanisms is foundational to reducing the baseline cost of medical treatments. Taking note of the highly successful integration of the Government e-Marketplace (GeM) alongside the deployment of AMRIT and Jan Aushadhi centres at public institutions like RIMS, the Committee believes that such models significantly curtail exorbitant out-of-pocket expenditures on pharmaceuticals and consumables. The Committee, therefore, recommends that the Government should mandate the establishment of AMRIT and Jan Aushadhi pharmacies within the premises of all AB-PMJAY empanelled hospitals, both in the public and private sectors. Furthermore, the Committee recommends that the Government formulate regulatory guidelines requiring private empanelled hospitals to adopt centralized, transparent tender-based procurement systems to strictly cap the internal mark-ups levied on life-saving consumables and medical devices at a mutually agreed-upon ceiling, such as the 20 percent margin observed in proactive institutions.

5.8.8 The Committee understands that the foundational objective of entirely free public healthcare is severely undermined when patients are compelled to procure surgical consumables and diagnostics from private vendors out-of-pocket due to institutional stockouts. The Committee observes with concern that even in public institutions offering ostensibly free major surgical procedures, patients frequently bear substantial financial burdens for critical items, such as oncology consumables or specialized dialysis tubing. The Committee believes that comprehensive healthcare accessibility dictates that no patient seeking treatment in a government tertiary facility should face catastrophic secondary costs for essential surgical supplies. The Committee, therefore, recommends that the Government augment the budgetary allocations specifically earmarked for the continuous, uninterrupted stocking of high-value consumables and surgical implants in public hospitals. The Committee further recommends the implementation of an automated 'Zero-Stockout Policy' supported by digital inventory management systems that trigger expedited government procurement long before critical supply thresholds are breached.

5.9 Standardization of Treatment Costs

5.9.1 In its submission before the Committee, the Rajiv Gandhi Cancer Institute & Research Centre (RGCIRC) informed that it has adopted a number of measures to ensure transparency, predictability, and affordability in the cost of cancer treatment. The Institute stated that it follows a transparent pricing policy by providing patients with upfront estimates of treatment costs, enabling them to make informed decisions and plan their finances accordingly.

5.9.2 The Institute further submitted that, in keeping with its mission of providing comprehensive cancer care from prevention to palliation, it offers affordable treatment

packages that bundle various clinical services, thereby improving cost efficiency and reducing the financial burden on patients. It also endeavours to maintain an appropriate balance between the adoption of advanced medical technologies and the need to keep treatment affordable.

5.9.3 RGCIRC further informed the Committee that it extends financial assistance to economically weaker patients through various institutional support mechanisms and collaborations with charitable organizations and philanthropic agencies. According to the Institute, these initiatives are aimed at making cancer treatment more cost-predictable, accessible, and financially manageable for patients.

5.9.4 Containing the Cost of Rare Disease and Cancer Care

5.9.5 With regard to measures adopted for containing the cost of treatment for rare diseases and cancer, the Institute submitted that it follows evidence-based treatment protocols and prepares individualized treatment plans tailored to the specific clinical needs of each patient. It also provides emotional and psychosocial support services, which contribute to improving treatment adherence and optimizing healthcare outcomes.

5.9.6 The Institute further informed the Committee that it has incorporated advanced treatment modalities, including immunotherapy and targeted therapies, wherever clinically indicated, to improve treatment outcomes. Recognizing the high cost associated with such therapies, RGCIRC stated that it actively mobilizes support through philanthropic contributions, Corporate Social Responsibility (CSR) initiatives, and charitable funding to assist patients requiring expensive treatments, thereby reducing their financial burden while ensuring access to quality cancer care.

5.9.7 The Committee is of the considered view that while the public display of standard package rates is necessary, the management of complex, multi-stage diseases like cancer requires highly individualized treatment plans, making total cost anticipation difficult for the average citizen. The Committee believes that patients must be insulated from financial unpredictability and mid-treatment billing shocks. The Committee, therefore, recommends that the government institute a statutory mandate requiring all tertiary care hospitals to provide a comprehensive, legally binding upfront cost estimate to the patient prior to the initiation of any complex or prolonged medical intervention. Furthermore, hospitals must be mandated to deploy dedicated 'Financial Navigators', specialized counselors who guide patients and their families through these estimates, available philanthropic support, and health assurance limits, thereby enabling fully informed financial planning.

5.9.8 The Committee is of the considered opinion that some private hospitals levy or charge large amounts for hospital stays especially in metropolitan cities. Having analysed the break up of the hospital billing structure the Committee believes that rationalizing of room charges needs to be done on an emergent basis.The Committee understands that hospital room charges are not uniform and vary across geographic regions and even among hospitals within the same area due to differences in

infrastructure, service levels and operating costs. 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. The Committee recommends for making this benchmark mandatory for all private hospitals in large metropolitan cities. The resident doctor cost, Nursing cost, disposable costs of consumables, meal charges, laundry charges can be added to the basic room tariff so that the entire cost is rationalized.

5.9.9 The Committee firmly believes that the current ecosystem often limits financial capping to acute interventions or surgical procedures, leaving patients highly vulnerable to unregulated out-of-pocket expenses during extended follow-ups, rehabilitation, or end-of-life care. The Committee is of the view that true affordability must encompass the entire lifecycle of disease management. The Committee, therefore, recommends the formulation and regulatory enforcement of 'Continuum of Care' packages. These advanced packages must comprehensively bundle preventive screening, diagnostic, curative, and palliative services under a single, capped financial umbrella, ensuring that economically disadvantaged patients are not forced to abandon care during the critical palliative or supportive phases.

5.9.10 The Committee is of the view that novel, highly efficacious treatment modalities, such as immunotherapy, genomic therapies, and targeted therapies, remain prohibitively expensive. Integrating these directly into standard capped packages currently risks overwhelming the financial sustainability of health assurance schemes. The Committee believes that the fragmented mobilization of Corporate Social Responsibility (CSR) and philanthropic funds by individual hospitals, while commendable, is insufficient for achieving national scale. 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. These pooled resources must be strictly earmarked to subsidize or entirely fund advanced, high-cost therapeutics for eligible patients, thereby bypassing standard commercial pricing barriers without burdening the hospital's operational budget.

5.9.11 The Committee knows that the intense psychological and emotional toll of catastrophic illnesses frequently leads to severe depression, loss of livelihood, and ultimately, treatment abandonment. Such abandonment not only jeopardizes patient survival but also results in a massive wastage of medical resources and financial investments already expended. The Committee is of the view that mental health and psychosocial support are not auxiliary luxuries, but clinical necessities that directly improve treatment adherence and optimize outcomes. The Committee, therefore, recommends that structured psychological counseling, emotional support services, and patient support groups be formally integrated as mandatory, zero-cost components within all approved treatment protocols and capped financial packages for severe, chronic, and terminal diseases across both the public and private sectors.

5.10 Proposed National Medical Device Component Financing Framework (NMDCFF): A Strategy for Strengthening Domestic Manufacturing and Reducing Import Dependency

5.10.1 India's medical device sector is projected to grow from approximately USD 13 billion in 2025–26 to USD 25 billion by 2030–31, driven by increasing healthcare demand, technological advancement, and supportive government policies. The Government of India has laid a strong foundation for sectoral growth through initiatives such as the Production Linked Incentive (PLI) Scheme for Medical Devices (₹3,420 crore), the Scheme for Promotion of Medical Device Parks (₹400 crore), the National Medical Devices Policy, 2023, Startup India, and financing support through institutions such as SIDBI.

5.10.2 Despite these initiatives, the sector remains structurally dependent on imports, with 70–80% of the market value attributable to imported components and sub-assemblies. While domestic manufacturing has expanded, value addition remains concentrated at the assembly stage, with limited indigenous production of critical inputs such as medical-grade electronics, sensors, semiconductors, precision-engineered components, specialty polymers, optical systems, and implant-grade biomaterials. This dependence increases production costs, exposes manufacturers to foreign exchange fluctuations and global supply chain disruptions, and constrains India's competitiveness in high-value medical device manufacturing. The COVID-19 pandemic further underscored the strategic importance of developing resilient domestic manufacturing capabilities for critical components. Accordingly, the next phase of India's medical device strategy should focus on strengthening indigenous manufacturing of critical components through targeted financial and policy interventions.

5.10.3 Medical device component manufacturing is characterised by high capital intensity, advanced technological requirements, long development cycles, and stringent regulatory compliance. Establishing manufacturing capabilities requires substantial investments in cleanroom infrastructure, precision engineering, semiconductor-enabled manufacturing, advanced tooling, testing and calibration laboratories, material characterization facilities, and internationally compliant quality management systems. Conventional financing mechanisms are often inadequate for such investments because of long gestation periods, technology risks, high certification costs, and delayed commercial returns. Consequently, there is a need for a dedicated financing framework that reduces investment risk, mobilises long-term capital, and accelerates commercialization of indigenous component manufacturing.

5.10.4 It is proposed that the Government establish a National Medical Device Component Financing Framework (NMDCFF) under the National Medical Devices Policy, 2023, to support investments across the entire medical device component value chain, from technology development and pilot manufacturing to commercial production and global market expansion. The framework should adopt a lifecycle-based financing approach and comprise six complementary pillars.

Pillar	Strategic Focus	Illustrative Policy Instruments
Capital Investment Support	Establish advanced manufacturing infrastructure	Long-term concessional loans, capital subsidies, interest subvention, Viability Gap Funding
Risk-Sharing	Reduce investment risk	Credit guarantee schemes, blended

Mechanisms	and improve access to finance	finance, first-loss guarantees
Technology Development & Commercialization	Accelerate indigenous innovation and technology transfer	R&D grants, prototype funding, pilot manufacturing support, regulatory certification assistance
Fiscal Incentives	Improve commercial viability of domestic manufacturing	Investment-linked incentives, accelerated depreciation, customs duty rationalization, incentives linked to domestic value addition
Market Development & Demand Assurance	Create predictable domestic demand	Preferential public procurement, domestic value addition criteria, long-term procurement commitments
Export Promotion	Enhance global competitiveness	Export credit, international certification support, market access assistance

5.10.5 Institutional Architecture

5.10.6 Implementation of the NMDCFF should adopt a coordinated, multi-agency approach involving key ministries, financial institutions, research organizations, and procurement agencies.

Function	Lead Agency	Supporting Institutions
Policy Coordination	Department of Pharmaceuticals	MoHFW, DPIIT, NITI Aayog, AMTZ
Financing	SIDBI, NABFID	IFCI, Public Sector Banks
Research & Innovation	DBT, DST, MeitY	BIRAC, ICMR, KIHT, AMTZ
Manufacturing Ecosystem	Department of Pharmaceuticals	Medical Device Parks, State Governments, AMTZ
Public Procurement	MoHFW	GeM, PM-JAY, CGHS, ESIC
Export Promotion	Ministry of Commerce & Industry	ECGC, EXIM Bank

5.11 Medical devices be brought under price control

5.11.1 On being asked about whether additional medical devices can be brought under price control, the Managing Director and Founder CEO of Andhra Pradesh MedTech Zone (AMTZ) stated that Medical devices constitute a substantial proportion of healthcare expenditure, particularly in high-cost procedures, chronic disease management, and life-saving interventions. While price regulation has been successfully implemented for selected devices such as coronary stents and knee implants, numerous other medical devices continue to exhibit considerable price variation, high out-of-pocket expenditure, and inconsistent pricing across healthcare providers.

5.11.2 Given the diversity of medical devices and their varying levels of clinical importance and market dynamics, regulating all devices using a single approach may neither be feasible nor desirable. Therefore, there is a need for a structured, evidence-informed framework that enables regulatory authorities to prioritize devices based on objective criteria rather than ad hoc decision-making. Below mentioned prioritization framework provides a transparent methodology to identify medical devices that are most likely to benefit from regulatory intervention based on public health need, patient affordability, market characteristics, and available evidence.

5.11.3 The prioritization framework adopts a multi-criteria evidence-based approach to evaluate medical devices for potential price regulation. Rather than relying on a single parameter, each medical device is assessed across multiple dimensions that collectively reflect its public health significance, economic impact, and regulatory relevance. Each criterion represents one component of the overall assessment. Collectively, these components provide a comprehensive understanding of the need for regulatory intervention and support transparent, evidence-informed decision-making.

S.No	**Device**	**Disease Burden (India)**	**Annual Procedures (Approx.)**	**Avg. Patient Cost (₹)**	**OOP Share**	**MDPRS Score***	**Proposed Action**	**HTA Priority**	**Primary Evidence**
1	Coronary Stents	CVD causes **28% of all deaths**	700,000 PCI/year	₹1.5–3.5 lakh	50–70%	94	Ceiling Price	**Very High**	**GBD 2021 (IHME); National Interventional Council (NIC) Registry; NPPA Ceiling Price Order (2017); National Health Accounts (NHA)**

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									India
2	Knee Implants	OA affects **22–28% adults >40 yrs**	220,000/ year	₹2.5–5 lakh	60–80%	90	Ceiling Price	**Very High**	**GBD Musculoskeletal Disorders; Indian Orthopaedic Association; NPPA Knee Implant Price Order (2017)**
3	Hip Implants	Hip fractures increasing with ageing	90,000/year	₹2.5–6 lakh	60–80%	87	Ceiling Price	**High**	**GBD; Indian Orthopaedic Association; published arthroplasty studies**
4	Intraocular Lenses	Cataract causes **66% of blindness**	7 million surgeries/ year	₹15,000–80,000	40–70%	86	Trade Margin Cap	**Very High**	**National Programme for Control of Blindness & Visual Impairment (NPCBVI); National Blindn**

UNCOMPLYCATE Simplifying Compliance

									ess Survey ; AIOS reports
5	Pacemakers	Arrhythmias	50,000 implants/ year	₹2–5 lakh	60–80%	84	Ceiling Price	**High**	**Indian Heart Rhythm Society ; Heart Rhythm Society publications**
6	Implantable Cardioverter Defibrillator	Heart failure	8,000 implants/ year	₹5–12 lakh	70–90%	80	Ceiling Price	**High**	**Indian Heart Rhythm Society ; ESC Guidelines; published Indian studies**
7	Cardiac Resynchronization Therapy Devices	Advanced heart failure	6,000/year	₹6–15 lakh	70–90%	79	Ceiling Price	**High**	**Indian Heart Rhythm Society ; ESC Heart Failure Guidelines**
8	Dialyzers & Consumables	CKD prevalence **11–15%**	>35 million dialysis sessions/ year	₹2,000 – 5,000/session	60–80%	89	Ceiling Price	**Very High**	**Indian Society of Nephrology; PM National Dialysi**

UNCOMPLYCATE Simplifying Compliance

									s Programme; GBD CKD
9	Orthopaedic Trauma Implants	RTIs: >150,000 deaths/ year	>1 million surgeries/ year	₹50,000–3 lakh	50–80%	83	Trade Margin Cap	**High**	**Ministry of Road Transport & Highways (MoRTH); WHO Global Status Report on Road Safety**
101	Spinal Implants	Degenerative spine disorders	120,000/ year	₹3–8 lakh	70–90%	82	Ceiling Price	**High**	**Association of Spine Surgeons of India; published Indian spine surgery studies**
111	Heart Valves	Rheumatic & degenerative valvular disease	15,000/year	₹3–8 lakh	70–90%	82	Ceiling Price	**High**	**Indian College of Cardiology; ESC Guidelines; GBD Rheumatic**

UNCOMPLYCATE Simplifying Compliance

									Heart Disease
12	Cochlear Implants	Severe hearing loss	2,500/year	₹6–12 lakh	80–90%	78	Ceiling Price	**High**	**MoHFW ADIP Scheme; WHO World Report on Hearing**
131	Continuous Glucose Monitoring	Diabetes (>100 million adults)	300,000 users	₹40,000–1.2 lakh/year	80–90%	73	Trade Margin Cap	**Moderate**	**ICMR–INDIAB Study; International Diabetes Federation (IDF)**
14	Insulin Pumps	Type 1 Diabetes	20,000 users	₹2–5 lakh/year	80–90%	71	Reference Pricing	**Moderate**	**ICMR; RSSDI Clinical Practice Recommendations**
15	Surgical Mesh	Hernia	500,000 repairs/year	₹30,000–1 lakh	40–70%	68	Trade Margin Cap	**Moderate**	**Association of Surgeons of India; published hernia registry**

UNCOMPLYCATE Simplifying Compliance

									studies
16	Blood Bags	Blood transfusion services	15–18 million/year	Included in package	Low	58	Procurement Monitoring	**Moderate**	**National Blood Transfusion Council (NBTC); MoHFW Annual Reports**

***Medical Device Price Regulation Score (MDPRS)** (100-point scale)-

Criterion	**Maximum Score**
Disease Burden	20
Annual Procedure Volume	15
Out-of-Pocket Burden	20
Market Size	10
Import Dependency	10
Evidence of Excessive Price Variation / Trade Margin	15
Availability of Alternatives	5
HTA / Clinical Evidence	5
Total	**100**

Priority I = Score ≥80
Priority II = Score 60–79
Priority III = Score 40–59

5.11.4 The Medical Device Price Regulation Score (MDPRS) is an evidence-based decision-support framework developed to facilitate the systematic prioritization of medical devices for price regulation. The framework integrates multiple dimensions that influence the need for regulatory intervention, including public health impact, patient financial burden, market characteristics, and available evidence.

5.11.5 Each medical device is assessed across eight predefined criteria, with each criterion assigned a maximum score based on its relative importance in determining the need for price regulation. Higher weights have been assigned to criteria such as disease burden and out-of-pocket (OOP) expenditure, recognizing their direct influence on public health outcomes and financial risk protection. Similarly, annual procedure volume, market size, import dependency, and evidence of excessive price variation or trade margins are incorporated to capture market dynamics and the potential impact of regulatory action. Additional

consideration is given to the availability of therapeutic alternatives and the strength of Health Technology Assessment (HTA) and clinical evidence, ensuring that regulatory decisions remain evidence-informed and clinically appropriate.

5.11.6 The cumulative score ranges from 0 to 100, with higher scores indicating a greater need for regulatory intervention. The MDPRS is intended to support not replace policy decisions. It provides a transparent, reproducible, and objective framework for identifying medical devices that may warrant different levels of price regulation. Final regulatory decisions should also consider broader policy objectives, including domestic manufacturing capacity, innovation, supply chain resilience, stakeholder consultation, and overall health system priorities.

5.11.7 The Committee is of the view that the structural reliance on imports for 70 to 80 percent of medical device components, such as medical-grade electronics, sensors, semiconductors, and precision-engineered parts, severely constrains India's global competitiveness and structurally inflates the baseline cost of healthcare. The Committee believes that conventional financing mechanisms remain fundamentally inadequate to support the high capital intensity, long gestation periods, and technology risks inherent in medical device component manufacturing. The Committee, therefore, recommends that the Government immediately operationalize the proposed National Medical Device Component Financing Framework (NMDCFF) under the National Medical Devices Policy, 2023. This framework must deploy a lifecycle-based financing approach, utilizing targeted instruments such as long-term concessional loans, credit guarantee schemes, and R&D grants, to transition the domestic industry from mere assembly operations to high-value, indigenous manufacturing of critical inputs.

5.11.8 The Committee dwells upon the view that while capital and technological support are vital for capacity building, creating a predictable and assured domestic market is equally essential to ensure the commercial viability of indigenous medical device component manufacturers. The Committee believes that without guaranteed demand, domestic manufacturers will struggle to achieve economies of scale against established global supply chains. The Committee, therefore, recommends that the Government should pro-actively implement the 'Market Development & Demand Assurance' pillar of the NMDCFF by instituting strict preferential public procurement policies. Procurement platforms and agencies under the Ministry of Health and Family Welfare, prominently including GeM, PMJAY, CGHS, and ESIC, must be mandated to enforce stringent domestic value-addition criteria and offer long-term procurement commitments to domestic manufacturers, thereby structurally incentivizing self-reliance.

5.11.9 The Committee opines that the successful execution of the NMDCFF necessitates seamless synergy across multiple administrative, scientific, and financial domains, rather than allowing ministries to function in isolated bureaucratic silos. The Committee believes that addressing complex challenges, ranging from pilot manufacturing and technology transfer to global market expansion, requires a unified and dynamic institutional architecture. The Committee, therefore, recommends the

formal establishment of a coordinated, multi-agency apex mechanism spearheaded by the Department of Pharmaceuticals. This body must systematically integrate financial institutions like SIDBI and NABFID for risk-sharing, scientific bodies like DBT, DST, and ICMR for research and innovation, and the Ministry of Commerce & Industry for export promotion, ensuring a holistic, end-to-end ecosystem that permanently secures India's medical device supply chain.

5.11.10 The Committee is of the view that the historical reliance on ad-hoc or purely reactive decision-making for rationalising medical device prices is inadequate for a complex, modern healthcare system. The Committee, therefore, recommends the formal institutionalization of a multi-criteria, evidence-based prioritization framework, structured similarly to the 100-point Medical Device Price Regulation Score (MDPRS). The government must establish a statutory mandate to evaluate all unregulated medical devices across critical dimensions, prominently including disease burden, annual procedure volume, and out-of-pocket burden. The Committee believes that deploying this transparent, reproducible methodology will enable regulatory authorities to systematically identify and prioritize devices that urgently warrant intervention, thereby shielding regulatory actions from industry opacity and arbitrary policymaking.

5.11.11 The Committee believes that medical devices categorized under the highest public health urgency, specifically those scoring more than 80 on the MDPRS framework, represent the most significant financial risk to vulnerable patient populations. The Committee, therefore, recommends immediate and absolute statutory price capping for all medical devices classified as 'Priority I'. This categorization must trigger automatic regulatory intervention to fix the maximum retail price, similar to the successful interventions previously applied to coronary stents and knee implants. The Committee is of the view that targeting high-volume, high-disease-burden devices will instantly alleviate the most severe instances of catastrophic health expenditure borne by the low and middle-income demographic.

5.11.12 The Committee is of the view that excessive and unregulated trade margins, often occurring between the manufacturer or importer and the final point of care, are primary drivers of the massive price variations observed across different healthcare providers. The Committee, therefore, recommends that for devices falling into the 'Priority II' bracket (MDPRS 60–79), or those demonstrating high import dependency, the government must impose strict trade margin rationalization. Rather than a flat price cap, the regulatory authority must cap the maximum permissible percentage markup from the first point of sale (price to distributor) to the maximum retail price (MRP). The Committee believes this targeted approach will eradicate exploitative profiteering in the supply chain while maintaining market viability for a diverse range of specialized clinical tools.

5.11.13 The Committee believes that while cost rationalization is a primary objective, price regulation must not inadvertently stifle medical innovation, restrict the availability of cutting-edge therapies, or compromise clinical outcomes. The Committee, therefore, recommends that the regulatory framework structurally integrate Health

Technology Assessments (HTA) and robust clinical evidence before finalizing the degree of price regulation for any specific device. A dedicated expert committee must evaluate the clinical superiority and availability of therapeutic alternatives for devices under review. The Committee believes that ensuring regulatory decisions, if, remain rigorously evidence-informed, would balance the dual imperatives of accessibility & affordability of treatment at rationalized cost on the one hand and the maintenance of world-class clinical standards within both the public and private healthcare sectors, on the other hand.

5.11.14 The Committee opines that the success of a medical device park can take place only when it has got its own World Class testing laborarities which are notified and certified for quality benchmark by the Quality Council of India. These laboratories need to be empowered to check all kinds of medical devices ranging from Category A, B, C and D. The Committee strongly recommends that the licensing mechanism also needs to be decentralized to various State Governments for even category A & B Medical Devices. This will inculcate a healthy competition within States to attract medical device manufactures from all across the Globe creating huge employment and saving on precious foreign exchange besides making the country Atam Nirbhar in the field of Medical Devices in the shortest possible timeframe.

5.11.15 The Committee further recommends that Government should chalk-out Inter-Governmental Action Plan by selecting consumable end products under National Health Mission (NHM) and thereby transforming demand into an engine growth to invite global investment. The Committee feels that there is need to target the products under National Health Mission (NHM) and in tandum with the Ministry concerned should manufacture the product in the country itself to make the product and medical devices affordable that would be beneficial to the needy patients.

5.11.16 The Committee realizes India has huge growth potential in manufacturing of medical devices. Well-coordinated inter-ministerial and inter-governmental (central and state) strategies aimed at offering manufacturers competitive advantage in manufacturing in India will result in importers finding it more profitable to manufacture in India than to import it. The Committee believes that logistical support in shared manufacturing facilities like Medtech parks would significantly reduce capital expenditure of manufacturers and thus giving a boost to manufacturing in India. The Mediparks should have NABL (National Accreditation Board for Testing and Calibration Laboratories) approved medical device testing laboratories to reduce time required in manufacturing a product.

5.11.17 The Committee further recommends that some of the Mediparks should focus on manufacturing medical device components and thus make the country self reliant on spare parts with provision for extending necessary services. This can further strengthen into India emerging as hotspot for medical devices spare parts and hub for medical devices repairing and service centres for other countries. Thus Medical Devices industry would have added advantage of huge employment generation capacity.

5.11.18 The Committee is of the considered view that in order to encourage indigenous manufacturing, the Government should provide incentives or encourage preferential purchase for domestically manufactured products in Government procurement. In this regard, the Department should ensure that in all public procurement, the preference must be given to Indian manufactured medical devices having domestic content of at least 50%.

Grievances Rederesal Mechanism

5.11.19 The Committee was apprised of incidents wherein NABH has on frivolous ground denied accreditation on the basis of false complaints resulting in harassment of small medical establishments. The Committee, therefore, feels the need for a suitable Grievance Redressal Mechanism to be institutionalized by Quality Control of India for all accreditation bodies like NABH/NABL so that they did not become another tool for corruption, high handedness and blatant harassment thus thereby increasing the cost of healthcare.

5.11.20 In nutshell, the Committee desires that Government should make provision for sufficient number of Testing Labs to evaluate the quality of the product; ensuring availability of raw-material components by promoting indigenous production at reasonable cost; formulating and impementing component-based financing schemes for encouraging indigenous production of medical devices under PPP model to promote components start-ups in the country. The Committee desires that the Government should encourage through various incentives to the Start-ups for manufacturing medical devices like Implantable Cardioverter Defibrillators (ICDs), heart valve, cardiac cath labs, pacemakers and PET scan at the reasonable cost. The Committee underscores the pivotal role of regulatory bodies in reducing the gap between the landing cost and MRP because some of these implants are not covered under the Ayushman Bharat Scheme, thereby enhancing OOPE for the patients. The Committee also recommends for Single Window System to promote MeDTech park like AMTZ in Vishakhapatnam in other parts of the country.

5.11.21 The Committee expresses serious concern over the huge difference between the landing costs of the medical devices or drugs and the MRP, despite the fact India is considered to be the pharmacy of the world. The Committee strongly believes that such gap needs to be reduced to the extent that the quality medical devices and the drugs are made available at the affordable cost to the needy patients. For example, the landing cost of Tenecteplase, a life-saving medicine for heart attack given in golden hour, is Rs. 18,000 but MRP is Rs. 50,000 and the billing cost is at MRP. The Committee appreciates the decision of the Government for capping the price of the cardiac stent to Rs. 25,000 to Rs. 30,000 in 2017 which earlier used to be around Rs. 1,90,000. The Committee, therefore, recommends that the gap should not be more than 20% between landing price and MRP for medical devices and drugs for ensuring quality drugs and medical devices at the affordable cost. The Committee also recommends for rationalizing the cost of peripheral stents and drug-eluting ballons. Since medical devics are used directly in patient care, the Committee, therefore, recommends that

manufacturers must operateunder strict Quality Management Systems such as ISO 13485 and FDA 21 CFR Part 820. The Committee further recommends that while rationalizing the price of high end medical consumables, the Government must ensure stringent quality control and uninterrupted market availability. Of course, the Government should design dynamic rationalizing mechanism for specialized consumables that balances aggressive consumer affordability with necessary manufacturing margin and prevent artificial market shortages and black marketing.

5.11.22 The Committee has been given to understand that the cost of clear aligners ranges between Rs. 1.5 to 5 lakhs, therefore, the regulatory body should consider the standardization of cost of clear aligners and dental materials. The Committee is of the view that, along side affordability, availability of the drug is also critical, and pharma companies should not neglect availability of any medicine on account of less profit margin linked with that drug. The Committee comes to know that lithium is a very important drug to control bipolar disorder and its availability at the affordable cost should be ensured throughout the year.

5.11.23 The Committee also recommends the Government to establish a a dedicated medical devices subsidy fund to complement existing manufacturing support schemes. The fund should partially offset the research, development and scaling cost of advanced medical equipment, enabling public hospitals to procure domestically produced devices at lower cast while systematically reduing dependence on import alternatives.

5.12 Tata Memorial Centre

5.12.1 The Committee observed that Tata Memorial Centre (TMC) has set up a benchmark in providing affordable cancer care. The Tata Memorial Centre (TMC), an autonomous grant-in-aid institution under the Department of Atomic Energy, Government of India, informed the Committee that it has adopted a comprehensive, patient-centric approach to enhance the affordability and accessibility of cancer care, particularly for economically weaker sections. The Centre follows a cross-subsidy model whereby revenue generated from paying patients is utilized to subsidize treatment for economically disadvantaged patients. At present, nearly 80–85 per cent of patients receive treatment at subsidized rates. In addition, TMC mobilizes financial assistance through philanthropic trusts, corporate Corporate Social Responsibility (CSR) initiatives, non-governmental organizations (NGOs), and individual donors to further reduce patients' out-of-pocket expenditure.

5.12.2 The Committee was informed that TMC actively facilitates access to Government health assurance schemes, including Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) and schemes for the Central Armed Police Forces (CAPF). A dedicated claims management cell has been established to facilitate cashless treatment and ensure timely settlement of claims. The Centre has also entered into credit arrangements with Indian Railways and several Public Sector Undertakings (PSUs) to provide cashless treatment to their beneficiaries.

5.12.3 TMC further informed the Committee that it works in close collaboration with public healthcare institutions to provide comprehensive cancer care encompassing preventive, curative and palliative services. The Centre also supports diagnostic and treatment services under extended care arrangements and facilitates access to non-oncology super-specialty services whenever required. As part of its preventive healthcare strategy, TMC regularly conducts COVID-19 vaccination drives, cancer screening camps for oral, breast and cervical cancers, and public awareness programmes in both urban and rural areas. To improve accessibility and reduce travel costs for patients, the Centre has expanded its telemedicine services for follow-up consultations, second opinions and counselling through the Navya platform, although it observed that many patients continue to prefer in-person consultations owing to the complexity of cancer treatment.

5.12.4 The Centre stated that it promotes the use of generic medicines wherever clinically appropriate and follows a centralized procurement system for medicines, consumables and medical equipment through transparent tendering and price negotiations. This enables the Centre to procure quality medicines and medical supplies at prices substantially lower than prevailing market rates. TMC also adheres to standardized, evidence-based treatment protocols and undertakes rigorous clinical and economic evaluation of new drugs and technologies before their adoption to ensure cost-effectiveness without compromising quality of care.

5.12.5 The Committee was informed that transparency in billing is ensured through an integrated Hospital Information System linked to the Schedule of Charges, which automatically generates bills based on the patient's registration category. To bridge the urban-rural gap in cancer care, TMC has significantly expanded its network through the establishment of Homi Bhabha Cancer Hospitals and associated centres in States such as Uttar Pradesh, Bihar, Punjab, Andhra Pradesh, Odisha and Assam, thereby improving access to advanced cancer care in Tier-II and Tier-III cities.

5.12.6 TMC further informed that it has established a robust grievance redressal mechanism and follows a multidisciplinary Disease Management Group approach to ensure evidence-based treatment planning while avoiding unnecessary investigations and interventions. High-cost treatment proposals are examined by a dedicated committee to ensure judicious utilization of resources without compromising patient care. With regard to free and subsidized treatment, approximately 75–80 per cent of hospital beds are earmarked for general category patients who receive treatment at highly subsidized rates. Patients who are unable to afford even these subsidized charges are provided financial assistance through the hospital's poor patient funds and support from charitable trusts and NGOs, while ensuring that all patients receive the same standard of medical care irrespective of their financial status.

5.12.7 The Centre also emphasized its commitment to capacity building through regular maintenance and upgradation of healthcare infrastructure, periodic training of medical and non-medical personnel, structured induction programmes for newly recruited staff, and postgraduate academic programmes in oncology. It informed the Committee that treatment costs are periodically reviewed and standardized through revisions to the Schedule of Charges, taking into account procurement costs, operational expenditure and inflation. The

Schedule of Charges is publicly available on the Centre's official website, ensuring transparency and accountability. Differential pricing and cross-subsidy mechanisms are employed to maintain affordability while sustaining high-quality healthcare services.

5.12.8 Regarding measures to contain the high cost of cancer treatment, TMC informed the Committee that it has developed advanced in-house diagnostic facilities, adopted standardized evidence-based treatment protocols, implemented differential pricing based on patients' paying capacity, centralized procurement of medicines and consumables, and established partnerships with charitable organizations to support treatment, accommodation and nutritional requirements of patients. The Centre also assists eligible patients in availing benefits under Government health insurance schemes and invests substantially in community awareness and early cancer screening programmes, recognizing that early detection not only improves clinical outcomes but also significantly reduces the overall cost of treatment.

5.12.9 The Committee believes that the stark disparity in healthcare costs between public and private institutions severely compromises patient welfare. Without a unified framework, out-of-pocket expenditure remains unsustainably high for low- and middle-income demographics. The Committee, therefore, recommends the urgent formulation of a standardized, evidence-based treatment protocol mandate across all secondary and tertiary care hospitals. The Ministry of Health and Family Welfare must establish a national statutory body to determine and implement a rigid cap on essential procedures and diagnostics. To ensure compliance, the government must mandate all healthcare facilities to publish a unified, transparent 'Schedule of Charges' on their respective platforms, mirroring the TMC model, to prevent arbitrary pricing and unwarranted clinical investigations.

5.12.10 The Committee is of the view that private sector hospitals must be incentivized and structurally guided to play a complementary role to public welfare initiatives. The current purely commercial approach of many private entities restricts affordability & accessibility for economically disadvantaged patients. The Committee, therefore, recommends the introduction of a cross-subsidy model across major private and trust-run hospitals. The cross subsidy model has been successfully implemented across many South Asian Countries. 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. The government should offer tax incentives or capital subsidies to private hospitals that successfully demonstrate the earmarking of at least 20 percent of their bed capacity for highly subsidized or free treatment.

5.12.11 The Committee believes that the unregulated pricing of pharmaceuticals, medical consumables, and equipment significantly inflates the overall cost of treatment. The Committee, therefore, recommends the establishment of a centralized digital procurement grid for all critical care medicines and high-end medical equipment. Private and public hospitals must be directed to utilize transparent tendering mechanisms to negotiate prices substantially lower than prevailing market rates. 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.

5.12.12 The Committee is of the view that complex billing procedures and the deliberate obfuscation of health insurance benefits actively deter patients from seeking timely secondary or tertiary care. The Committee, therefore, recommends that all secondary and tertiary healthcare facilities install a fully integrated Hospital Information System linked directly to their approved Schedule of Charges to automatically generate non-manipulable bills. Every private hospital above a specified bed capacity must be mandated to establish a dedicated claims management cell to facilitate cashless treatment under government schemes such as Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Strict penal provisions should be introduced for hospitals that deny admission to patients eligible under these central or state-sponsored health assurance initiatives.

5.13 Case Study: TMC Model of Cancer Treatment at affordable cost

5.13.1 The Committee appreciates the initiatives taken by the Tata Memorial Hospital to fulfill the objective of providing high quality care which is accessible and affordable. The Committee was apprised that the Tata Memorial Hospital established the National Cancer Grid (NCG) in 2012 with support from Department of Atomic Energy. The NCG has been working with the mandate of ensuring uniform standards of cancer care across the country accessible to all patients with cancer, irrespective of their geographical location or socioeconomic status. At present the NCG is a large network of more than 375 cancer centres, research organizations and patient groups working in the field of cancer care. Between the member organizations of the NCG, the network treats over 800,000 new patients with cancer annually, which is over 60% of all India's cancer burden. Incorporating all stakeholders of cancer care in India, it is a strong, unified and powerful voice in the fight against cancer.

5.13.2 The Committee has also been apprised by the Tata Memorial Centre (TMC) management that the development of resource stratified guidelines for management of cancer to ensure uniformity and high-quality care. The NCG partnered with National Health Authority to link these guidelines with reimbursement under the AB PM-JAY for cancer health benefit packages. This is one of the strong quality assurance measures for the affordable healthcare and considerably reduces the inequities between urban and rural systems. Tata Memorial Hospital in partnership with National Health Authority has expanded the Health Benefit Packages for cancer to cover almost cancer subtypes. The increased number of packages along with standardization of package rates have considerably helped in reducing the out of pocket expenditure for most cancers including those which present in advanced stages. Tata Memorial Hospital further worked with NHA to conduct sensitization workshops with state health authority and clinicians to enhance adoption of HBP across different states. The NCG has further developed packages for palliative care to curb the catastrophic health expenditures in patients who have advanced stage of cancer. These packages have been adopted by the NHA.

5.13.3 TMH and NCG have been working with HTAin and have created a health economics cell which evaluates the cost effectiveness of cancer interventions to provide guidance for their inclusion in treatment guidelines and the health benefit packages thus promoting value-based care.

5.13.4 Pooled procurement for high value and high cost medicines: Tata Memorial Centre (TMC) piloted pooled procurement to improve negotiability of high-value oncology and supportive care medicines. A total of 40 drugs were included in this pilot. The pooled demand for the drugs from 23 centres was equivalent to 15.6 billion Indian rupees (197 million United States dollars (US$)) based on maximum retail prices. The process included technical and financial evaluation followed by contracts between individual centres and the selected vendors. Savings of 13.2 billion Indian Rupees (US$ 166.7million) were made compared to the maximum retail prices. The savings ranged from 23% to 99% (median: 82%) and were more with generics than innovator and newly patented medicines. This process has made it possible to improve access to effective but expensive medicines by making them affordable for majority of patients and reducing the stockout at smaller centres in geographically remote areas.

5.13.5 The key to appropriate and timely cancer treatment is accurate pathological diagnosis which often is a challenge in smaller cities. The NCG started External Quality Assurance Schemes (EQAS) in surgical pathology H&E, immunohistochemistry and molecular pathology to strengthen the cancer diagnostics across the country. This service is available for all the member centres without any cost. To assist the smaller cancer centers who may not have access to all the required expertise in managing complex cancer cases in-house, the NCG started Virtual Tumor Boards. It is a web-based multidisciplinary clinic to discuss in detail the diagnosis and treatment plan for cases submitted by the oncologists across country. This enables decisions making for individual patients and but also provide an excellent resource of case-based learning.

5.13.6 Tata Memorial Hospital provides highly subsidized cancer care to 60% of patients registered with the centre. There are exclusive beds for these patients (60% of all bed strength) in the hospital. This includes all services including diagnosis, surgery, radiation, chemotherapy and supportive care. Over and above this subsidy, financial support is garnered through philanthropy and CSR to ensure there are no delays in care or treatment abandonment and no OOPE and CHE. Tata Memorial Hospital has a system of smart card and the details of all the billing and available funds are accessible to patients. In addition, a SMS is sent to patients whenever there is any bill is generated. This allows them to keep a track of all the expenses as well as generates the transparency. In addition, all the medical records, investigations, discharge summary, OT notes, radiation details can be accessed by the patients securely from anywhere through the webEMR. They can share these reports with any other provider.

5.13.7 The outpatient, inpatient and all other areas display the information on who to contact for grievances. The feedback forms are available in each area which patients and their caregiver complete after they avail a service. The feedback is communicated to the respective departments through the medical superintendent office and appropriate steps are taken after

doing the root cause analysis and processes are revised to prevent any future incidents. The patients are informed about the steps taken. The NCG has build oncology specific EMRs with six vendors to ensure seamless care as the patients move from one centre to another along the care continuum. These EMRs provide patients the ownership to their records. This provides a freedom to patients to continue treatment closer to their homes and improves the adherence to treatment and reduces the indirect cost for travel and accommodation while seeking cancer treatment.

5.13.8 To decentralize the care, Tata Memorial Hospital has started the teleconsultation facility which is utilized by close to 3000 patients annually. More than 70% of these teleconsultations are from north and northeastern states. Based on this NCG has started two National Teleconsultation pilots focusing on the common cancers and northeastern region. This will further reduce the need for travel to large tertiary care cancer centres. The NCG has established- EQuIP – the "Enable Quality Improve Patient care" is an initiative that trains teams across member organizations on Quality Improvement with the aim to ensure high quality care and decentralization of care.

5.13.9 NCG is actively involved in training and capacity building to improve the care closer to patients' home. Training support for oncologists, nurses and allied health professionals has been provided through fellowships, travelling schools (experts travelling to remote areas, northeast region) to provide on-site training and Massive open online courses. Till date more than 1500 professionals have been trained. Training in Cancer Research Methods – International Collaboration on Research methods Development in Oncology – CReDO workshop (has trained over 500 early career researchers, biostatisticians and patient representatives from 30 countries over the past 10 years).

5.13.10 Virtual Research Boards – expert online learning sessions in clinical research, providing continued mentoring to researchers from global experts in cancer research. NCG Clinical Trials Unit and Contract Research Organization – helps clinician researchers with various aspects of designing, developing and conducting research studies including study design, biostatistics, contracts, insurance, monitoring. NCG funded multicentric collaborative research – has funded several large potentially practice changing studies involving over 45000 patients recruited

5.13.11 Tata Memorial conducts regular cancer awareness programs (lifestyle changes, prevention of other noncommunicable disease, tobacco cessation, early signs of cancer) both for general population as well as targeted groups like school children, police, other professional groups through role play, and workshops.

5.13.12 In India, the health insurance coverage still remains below 20% with relatively poor rural coverage. This requires a concerted effort from all stakeholders including the ministry of health. The OOPE has reduced with AB-PMJAY but still continues to affect a significant proportion of patients where the care is largely outpatient based and for the diagnostic tests. We are working on addressing this from the NCG.

5.13.13 The Committee believes that the establishment of unified, national disease-specific networks is pivotal in minimizing geographical and socioeconomic healthcare inequities. The Committee, therefore, recommends that the government replicate the National Cancer Grid (NCG) model to establish similar national grids for other high-burden non-communicable diseases, such as cardiovascular diseases and diabetes. The Committee is of the view that resource-stratified treatment guidelines developed by these expert grids must be explicitly linked with the reimbursement structures of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). Such integration will mandate the adoption of comprehensive Health Benefit Packages (HBP) across both public and private sectors, ensuring uniform, value-based care while curbing the economic burden on patients presenting with advanced disease stages.

5.13.14 The Committee is of the view that the fragmented procurement of pharmaceuticals significantly inflates the operational costs of healthcare delivery, which is invariably passed on to the patient. The Committee believes that the monumental savings, achieving a median cost reduction of 82%, demonstrated by the pooled procurement pilot for high-value oncology medicines must serve as a foundational blueprint for national policy. The Committee, therefore, recommends the immediate institutionalization of a centralized, pooled procurement mechanism for all high-cost, life-saving, and supportive care medicines across all public healthcare institutions and empanelled private hospitals. This aggregated demand framework will maximize negotiating leverage against pharmaceutical vendors, thereby drastically reducing maximum retail prices and eliminating vital drug stockouts in geographically remote centers. The Committee, in turn, recommends that savings out of pooled procurement must be passed on to patients, to reduce out of pocket expenditure and utilized as source of cross-subsidy.

5.13.15 The Committee believes that the indirect costs of healthcare, including travel, boarding, and loss of livelihood for patients seeking tertiary care in metropolitan centers, severely exacerbate catastrophic health expenditures. The Committee, therefore, recommends the aggressive expansion and decentralization of specialized healthcare through the mandatory implementation of Virtual Disease Boards and comprehensive teleconsultation facilities in all district-level hospitals. The Committee is of the view that digitally linking smaller, remote medical centers with apex tertiary institutions will facilitate expert multidisciplinary treatment planning and External Quality Assurance Schemes (EQAS) for diagnostics. This will ensure that complex clinical decisions are made accurately without necessitating the physical displacement of the patient.

5.13.16 The Committee is of the view that seamless continuity of care and absolute financial transparency are fundamental right of the patient and critical components of an affordable healthcare ecosystem. The Supreme Court interprets Right to Health as a fundamental right under Article 21 of Indian Constitution i.e. Right to Life and in Part IV under Directive Principles of State Policy, thereby, Key constitutional pillars include Article 21, Article 47, outlining the duty of the State to improve public health, raise nutritional levels, and enhance the standard of living and

Article 39(e), that directs the State to protect the health and strength of workers of Indian Constitution. The Committee, therefore, strongly believes that it is the constitutional responsibility of the Government to keep the citizens of the Country healthy by providing adequate healthcare facilities at the affordable cost. The Committee desires that the private sector hospital should voluntarily play the pivotal role of complementing the efforts of the public sector hospital in that direction.

5.13.17 Moreover, the Committee believes that restricting a patient's access to their own medical records hinders their ability to seek localized care or second opinions, thereby locking them into potentially unaffordable care continuums. The Committee, therefore, recommends the accelerated, nationwide adoption of interoperable, specialty-specific Electronic Medical Records (EMRs) that grant patients secure, remote ownership of their clinical data via web portals. Furthermore, it must be made mandatory for all secondary and tertiary care hospitals to deploy real-time digital billing infrastructure. Systems utilizing smart cards and automated SMS alerts must be implemented to keep patients continuously apprised of generated bills and available fund balances, thereby eradicating opaque billing practices.

5.13.18 The Committee endorses the suggestions of the TMC to map the clinical guidelines for NCG and ensure that each of the steps in the pathway are covered by a health benefit package. The Committee views that the rate setting (with provision of predefined adjustments for patient condition, location of the hospital and type of the hospital) should be based on the actual costing data which can be collected through a national cost accounting system in a standard format with either all centres or atleast a representative set of hospitals. This process will ensure transparency and fair compensation of providers thus increasing the uptake. This will also help in identifying major cost drivers, cost inefficiencies, budget impact assessment for including of a technology and allow for monitoring of quality of care.

5.13.19 The Committee is of the view that arbitrary or static rate setting for health benefit packages compromises provider participation and obscures the true operational expenditure of medical care. While standardizing benefit packages is critical, ensuring those packages reflect reality is paramount. The Committee, therefore, recommends the immediate deployment of a standardized National Cost Accounting System. The government must mandate this framework to collect empirical, real-world costing data from either all empanelled centers or a rigorously selected, representative cross-section of hospitals nationwide. The Committee believes that clinical guidelines must be meticulously mapped across every step of the patient pathway to ensure that health benefit packages are explicitly tied to actual, data-backed costs rather than estimates.

5.13.20 Furthermore, 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. The Committee believes that instituting this level of structural transparency will guarantee fair and adequate compensation to healthcare providers, thereby significantly increasing their voluntary

uptake of national health schemes. Concurrently, it will empower policymakers to accurately identify systemic cost inefficiencies, isolate primary cost drivers, and conduct precise budget impact assessments prior to the integration of new medical technologies.

5.13.21 The HBP development and deployment can be further improvised using a well-documented and standard process. A structured monitoring and evaluation plan can be integrated to ensure that the benefits are reaching to the poor and vulnerable beneficiaries. This will require strengthening of digital systems (EMR and billing systems) with standard procedure coding, requirement of key performance indicators from each site and data sharing in a secure manner. The quality of drugs need special attention as there has been a considerable concern regarding the same at various national and international fora. A relook at approval and quality control process is highly desirable. The price control has helped a vast majority but at the same time it has become difficult for the industry to manufacture at that cost. The Committee, therefore, believes that it will be very helpful to have mutual dialogue to look at best possible prices so that quality is not compromised. This can be leveraged further to negotiate medicine prices at national level so that even novel yet very effective drugs can be included in national formulary. The national list of essential medicines can then drive procurement in the whole country.

5.13.22 The Committee is of the view that the development and deployment of Health Benefit Packages (HBPs) must transition from ad-hoc rollouts to a highly structured, well-documented standard operating procedure. While the packages exist, ensuring they reach the most vulnerable demographics requires rigorous oversight. The Committee believes that a robust monitoring and evaluation framework must be integrated into the national health infrastructure to continuously audit scheme efficacy and equity. The Committee, therefore, recommends the mandatory implementation of unified clinical procedure coding across all digital health and billing platforms. To ensure accountability without compromising patient privacy, the government must mandate all empanelled healthcare facilities to securely share predefined Key Performance Indicators (KPIs) with a central monitoring agency, thereby tracking the actual ground-level impact of these schemes.

5.13.23 The Committee expresses serious concern regarding recent national and international reports questioning the quality standards of certain pharmaceuticals. Furthermore, the Committee is of the view that while aggressive price controls have undeniably expanded access for the masses, pushing manufacturing costs below viable thresholds risks systemic compromises in drug quality and industry sustainability. The Committee believes that an immediate and comprehensive review of the national drug approval and quality control regulatory framework is highly desirable to restore absolute confidence in medical supplies. The Committee, therefore, recommends the institutionalization of a formal, mutual dialogue mechanism between the Ministry of Health and the pharmaceutical industry. This forum must aim to establish rational price ceilings that balance mass affordability with uncompromising quality assurance and manufacturing viability. The Committee recommends leveraging this collaborative platform to negotiate national-level pricing for novel, highly effective therapeutics. Bringing advanced medications into the National List of Essential Medicines (NLEM) at

negotiated rates will strategically drive high-quality procurement across the entire country.

5.14 Hub and Spoke Model of Cancer Care

5.14.1 The Committee appreciates the Hub and Spoke model of Cancer Care of TMC. The Hub and Spoke model stands for a network of hospitals on two levels. SCI/TCCCs are envisaged for cancer treatment as Hub and Spoke for providing cancer care, giving support to district hospitals and medical colleges. SCI will serve as the nodal and apex Institution to mentor other Government Institutes (including TCCC and RCC). Similarly, the TCCC should mentor cancer related activities including at the district level and below in their respective footprint area (the areas from where patients are accessing the TCCC). SCI would be hub and TCCCs as spokes, and facilities being created under NHM – District NCD clinics, CHC NCD clinics, Day Care Centres – as sub-spokes. Creating a network of these facilities is required for continuum of care, for which steps are being taken.

5.14.2 The Committee recapitulates its observation as made in its 139th Report on Cancer Care Plan & Management: Prevention, Diagnosis, Research & Affordability of Cancer Treatment. The Hub and Spoke Model is an efficient distribution model of providing comprehensive cancer care by creation of hubs and spokes in all the States of the country. The Committee notes that TMC has worked in close contact with the State Governments to create hubs and spokes in States. The Committee believes that such collaborations will enable in further strengthening the cancer care infrastructure along with knowledge, skill and resource sharing. The Committee appreciates the work done by TMC and DAE and advocates the need for establishing government funded hub and spoke model of cancer care across States. The Committee further believes that ensuring adequate human resource in Cancer centers under the hub and spoke model is also crucial for complete operationalization of the Centers. The Committee reiterates its recommendation that the Ministry of Health and Family Welfare must work in close collaboration with the Department of Atomic Energy to decide a timeline for implementing the hub and spoke model in each State. The Committee urges upon the Government to ensure that the existing SCI/TCCCs are upgraded to hubs and spokes depending on their existing infrastructure and capabilities.

CHAPTER VI

FUTURE OUTLOOK OF HEALTHCARE

6.1 HEALTHCARE ACHIEVEMENTS SO FAR

6.1.1 The NITI Aayog, in its presentation before the Committee, presented a detailed submission regarding the ongoing efforts and initiatives of the Government of India to ensure affordable, accessible, and high-quality healthcare. The Committee observes that through various policy interventions, structural reforms, and strategic recommendations, the nation's public healthcare framework has undergone substantial expansion over the past decade. The NITI Aayog in its detailed presentation apprised the Committee of the paramount aspects of achievement so far in the field of affordability and accessibility of healthcare in India.

6.1.2 The Committee was informed that public health delivery is primarily restructured around four main pillars under the Ayushman Bharat initiative. These comprise the Ayushman Arogya Mandirs (AAMs) to cater to primary healthcare by converting Sub-Health Centres and Primary Health Centres; the Pradhan Mantri Jan Arogya Yojana (PM-JAY) to provide health insurance coverage for secondary and tertiary care; the PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) focused on augmenting physical healthcare infrastructure and disease surveillance; and the Ayushman Bharat Digital Mission (ABDM) to facilitate digital integration and health record connectivity nationwide.

6.1.3 The Committee was apprised of the significant progress in primary healthcare delivery, where over 1.86 lakh Ayushman Arogya Mandirs have been made operational, catering to more than 540 crore patient visits. These facilities have conducted over 60 crore cancer screenings and screened more than 41 crore individuals for hypertension and diabetes. To enhance care at the grassroots level, the essential healthcare package at AAMs has been expanded from 9 to 12 service packages, incorporating critical services such as mental health counseling and telemedicine.

6.1.4 Furthermore, essential drug and diagnostic availability at primary units has seen marked improvement. The availability of essential medicines at the Sub-Centre level has increased from 57 to 105, while diagnostic tests have risen from 7 to 14. At Primary Health Centres, diagnostic test availability has expanded significantly from 19 to 63. To ensure uninterrupted basic care, the deployment of human resources has been prioritized through the stationing of Community Health Officers at Sub-Centres and dedicated medical officers at Primary Health Centres.

6.1.5 The Committee was apprised of substantial structural expansions aimed at addressing regional disparities in tertiary care and strengthening medical education. During the period from 2014 as on date, the number of AIIMS institutes expanded from 7 to 23, with undergraduate courses already commencing in 19 of them. Medical colleges nationwide increased from 387 to over 820, supported by a rise in undergraduate medical seats from approximately 51,000 to over 1,28,000, and postgraduate seats from roughly 31,000 to more than 82,000. Human resource capacity has expanded accordingly, with registered allopathic doctors rising from 9.39 lakh to 13.88 lakh, registered nurses increasing from 25.81 lakh to nearly 43 lakh, and total government hospital beds growing from over 6 lakh to more than 8,40,000. Accounting for both allopathic and AYUSH practitioners, the national doctor-to-population ratio has reached 1:811.

6.1.6 To further reinforce tertiary access, approval has been granted for 75 Government Medical College upgradation projects under the Pradhan Mantri Swasthya Suraksha Yojana, alongside the ongoing establishment of 157 new nursing colleges co-located with medical colleges. Under PM-ABHIM, critical infrastructure has been approved or operationalized, including 744 Integrated Public Health Laboratories, 631 Critical Care Hospital Blocks, 3,400 Block Public Health Units, and over 36,000 rural and urban AAMs. Specialized care has also received focused attention through the approval of 297 District Day Care Centres for localized cancer treatment, expanded 24x7 emergency and trauma services, and the proposed establishment of NIMHANS II to enhance national mental healthcare capacity.

6.1.7 The Committee came to know about the commendable progress regarding the mitigation of catastrophic out-of-pocket healthcare expenditure through targeted insurance and medicine supply schemes. Under PM-JAY, health coverage of ₹5 lakh per family per year is provided to over 12 crore vulnerable families, including 37 lakh families of ASHA and Anganwadi workers as well as over 6 crore senior citizens aged 70 and above. To date, over 44.27 crore Ayushman Cards have been issued across 38,000 empanelled public and private hospitals, facilitating over 11 crore hospital admissions valued at ₹1.57 lakh crore.

6.1.8 Complementing insurance coverage, the Pradhan Mantri Bhartiya Janaushadhi Pariyojana has expanded from 80 outlets in 2014 to over 19,200 Jan Aushadhi Kendras, offering a slate of 2,110 affordable medicines and generating estimated savings exceeding ₹45,000 crore for citizens. Similarly, the AMRIT scheme has served over 72.96 million beneficiaries by offering heavily discounted medicines, implants, and surgical consumables. Furthermore, the Pradhan Mantri National Dialysis Programme has conducted over 4 crore hemodialysis sessions across 1,816 centres, saving patients an estimated ₹10,000 crore in direct expenses.

6.1.9 The Committee learnt the effective deployment of digital solutions to streamline national healthcare delivery. Under the Ayushman Bharat Digital Mission, a comprehensive digital ecosystem has been established, resulting in the creation of over 93 crore Ayushman Bharat Health Accounts and the linking of more than 104 crore health records. The national telemedicine platform, eSanjeevani, has facilitated over 45 crore teleconsultations through 2.34 lakh healthcare providers, expanding specialized consultations into rural and underserved regions. To address mental health digitally, the Tele-MANAS framework operates 53 cells, 23 mentoring institutes, and 5 regional coordinating centres, having delivered over 41 lakh consultations in 20 languages across all States and Union Territories.

6.1.10 The Committee acknowledges the systematic integration of traditional systems of medicine through the National AYUSH Mission. This framework has established over 12,500 AYUSH Arogya Mandirs, which served approximately 11.5 crore beneficiaries in 2024 alone, and 203 Integrated AYUSH Hospitals, while co-locating nearly 13,000 AYUSH facilities within existing public health infrastructure under the National Health Mission. Institutional capacity has grown through the expansion of AYUSH undergraduate colleges from 500 to 886, National Institutes from 9 to 15, and a registered AYUSH practitioner base of 7.53 lakh.

6.1.11 The Committee takes note of the positive trajectory in key macro health outcomes and financial metrics resulting from these sustained interventions. Driven by these initiatives, out-of-pocket expenditure declined significantly from 62.6% in 2014 to 43.4% in 2022–23,

marking a reduction of nearly 20 percentage points. Over the same period, per capita Government health expenditure increased from ₹1,108 to ₹2,786, while Government health expenditure as a share of total health expenditure rose from 29% to over 43%. Concurrently, key national health indicators demonstrated substantial improvement: Neonatal Mortality Rate decreased from 26 to 18, Infant Mortality Rate dropped from 39 to 24, Under-5 Mortality Rate declined from 45 to 28, Maternal Mortality Ratio fell from 130 to 87 per 100,000 live births, and overall Life Expectancy at Birth expanded from 67.9 to 70.6 years.

6.2 Challenges and way forward

6.2.1 The Committee examined the affordability and accessibility of healthcare across India's public and private sectors, drawing on submissions from stakeholders and experts. It identified several key challenges facing the Indian healthcare system in delivering affordable, accessible, and better health outcomes. The Committee also deliberated on the solutions proposed to address these challenges and makes recommendations on ways to overcome them and improve healthcare outcomes.

Cross-subsidy Model to Mitigate rising cost of private healthcare

6.2.2 The Committee was apprised of the rising cost of private healthcare and the submissions before the Committee attributed much of the rising cost of private treatment to escalating infrastructure cost. Further world-class technology is concentrated in cosmopolitan cities and requires enormous capital outlay to install and maintain. Compounding this, super-specialist doctors command high compensation, adding further to hospital overheads. Because most private investment is profit-driven, patient care and outcomes are often treated as a secondary concern rather than the primary objective. With only around 14 percent of the population holding private insurance, the majority of patients are exposed to significant out-of-pocket spending. This is worsened by overbilling practices, where professional fees are inflated through the addition of procedural costs, and by the ever-present risk of complications, which can push a family into deep financial crisis and erode trust in the healthcare system even when the original treatment was appropriate.

6.2.3 The Committee, to address the issue of overbilling, recommends strengthening ethical oversight through hospital-level ethics committees, which review professional fees and hold doctors accountable, with real consequences such as reprimand for non-compliance. The Committee also calls for a dedicated regulatory body to oversee public-private partnerships and verify that services genuinely reach the needy rather than remaining a formality. The Committee suggests cross-subsidy models, in which higher-paying private patients effectively help fund treatment for poorer patients, and encourages large industries to channel CSR funding directly toward covering treatment costs for indigent patients through formal partnerships with hospitals.

6.2.4 The Committee observes that although the government has reserved a percentage of beds in private hospitals for free treatment of BPL cardholders and beneficiaries of schemes like Ayushman Bharat and PMJAY, many private hospitals simply opt out of these obligations, leaving the mandate poorly enforced in practice. A related problem is that the BPL eligibility criteria themselves are outdated and have not been revised in some time, which excludes many people who are genuinely poor, including a broader "upper-middle income poverty" group that faces very similar

financial strain but has no formal recognition or protection. There is currently no strong regulatory body dedicated to ensuring that private hospitals meet these public-service obligations.

6.2.5 The Committee recommends raising the mandatory bed-reservation quota for BPL, EWS, and PMJAY patients in private hospitals from the current ten percent to twenty percent, with strict and uniform enforcement across all private hospitals nationwide. Alongside this, the BPL eligibility criteria should be revised to reflect current economic realities and extended to cover the broader population living just above the poverty line who face comparable hardship. The Committee also suggests that hospitals should have an internal formal financial safety net for families facing unexpected cost escalation due to complications. The cost should be cross-subsidized towards the needy patients.

Ensuring Healthcare Accessibility to Rural Population

6.2.6 The Committee finds that access remains a major issue for India's rural population, who often must travel long distances to reach a hospital, since high-quality treatment facilities are largely concentrated in cities and are absent from small towns and district centres. This problem is worsened by inefficiencies in Primary and Community Health Centres, where doctors do not always serve their full contracted duration or follow service guidelines. Most rural and daily-wage patients also cannot afford to lose a day of work to seek treatment, yet OPD timings rarely accommodate this reality. The difficulty is magnified further in hilly, desert, and forest terrain, where simply reaching the nearest hospital is a challenge in itself. The Committee has been informed that the incidental cost of accessing care, including travel, food, and lost wages, comes to roughly five hundred rupees per visit, a sum many rural poor households simply cannot absorb.

6.2.7 The Committee calls for, to improved access in rural areas, investment in cheap and reliable transport so patients can reach the nearest hospital without sacrificing a day's income, building on the improvements already seen in emergency ambulance coverage for maternal and child health. The Committee also recommends stricter enforcement of PHC and CHC staffing requirements, ensuring doctors complete their full contracted duration and follow service guidelines, supported by biometric attendance tracking. To reinforce accountability, the Committee suggests surprise visits by senior bureaucrats and local elected representatives such as MLAs and MPs to verify that facilities are functioning as intended, which would also help rebuild public trust in local governance. Extending OPD hours into the evening is particularly valuable, allowing daily-wage earners and migrant workers to seek treatment without losing income, a model the Committee has seen apprised of that it works well through NGO-run OPDs that run from six in the evening past midnight, offering free consultation and medicines. Finally, hilly, desert, and forest regions should be prioritized for targeted infrastructure investment given how disproportionately access challenges affect them.

6.2.8 The Committee was apprised of that liver transplantation costs anywhere between twenty-five and fifty lakh rupees across Indian hospitals, putting it out of reach for all but high-earning professionals and business owners. Organ donation rates are also markedly uneven across the country, with the South donating more than the North,

and the West performing somewhat better than the North. The Committee further notes that some private centres charge very large sums for organ transplantation, which runs counter to the spirit of organ donation as a public service rather than a profit opportunity for hospitals. The Committee recommends for detailed study of the rural health care model being provided under AB-PMJAY.

6.2.9 The Committee finds the Maharashtra's approach as a model worth replicating nationally, in which senior private-sector surgeons are attached to municipal hospitals and oversee government-employed medical teams during complex operations, effectively extending high-end surgical expertise to public-sector patients. More broadly, the Committee suggests that public-private partnership should be treated as the long-term backbone of healthcare infrastructure development, rather than allowing the two systems to continue developing in isolation from one another.

6.2.10 The Committee, on the cost of transplantation specifically, recommends rationalizing the price of liver transplants performed in government-sector hospitals at four to five lakh rupees, a benchmark already achieved at IKDRC in Ahmedabad and Stanley Medical College in Chennai, as brought to the knowledge of the Committee, which would bring the procedure within reach of India's working middle class. The Committee also would highlight the example of Pravara Institute of Medical Sciences, Loni, Ahmednagar, Maharashtra wherein affordable and accesable health care in rural setting is being provided to a significant population on a very large scale including a affordable organ transplant program. The same model can be extended to provide accessible and affordable healthcare in rural parts of the country. The Committee also recommends for scaling of AIIMS-standard organ transplant programs to more States. To address the low organ donation rates in North India, the Committee suggests adapting successful state frameworks, noting that Tamil Nadu's donation laws have already been shared with a NITI Aayog panel member for possible national replication. The Committee stresses that organ donation should remain strictly public-service oriented, with regulatory safeguards to prevent private hospitals from treating it as a profit centre.

6.2.11 The Committee observes that the rising medical education costs are pushing many families toward education loans that take years to repay, and this financial burden shapes how newly qualified doctors approach their careers once they begin practising. At the same time, while new medical colleges are being established across many districts, staffing them with qualified faculty remains genuinely a challenge. Compounding this, the requirement that graduating doctors serve some time in rural, hilly, or tribal areas is sometimes circumvented by paying a fine, which undermines the very purpose the policy was meant to serve.

6.2.12 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, without allowing a fine-based opt-out, so that the underlying intent of the policy is actually met. Beyond this, the Committee visualize real potential in the Indian medical diaspora and proposes that a

streamlined registration pathway, building on the state medical council registrations which many NRI doctors already retain, would allow doctors of Indian origin nearing or post retirement to serve in district medical colleges. This would bring world-class exposure and language-matched care to patients closer to home, while broadening the learning opportunities available to local doctors and students.

6.2.13 The Committee was apprised that age-related and lifestyle conditions, including diabetes, hypertension, high cholesterol, and obesity, are increasingly common and, left unaddressed, driving major complications along with significant financial strain on the whole family. The Committee was informed that even in the developed countries like the United Kingdom, despite treatment being free at the point of delivery, the system there is described as being in a difficult state, with long waitlists and patient mistrust. The Committee observes that funding alone does not guarantee accessible or trusted care.

6.2.14 The Committee places strong emphasis on prevention, public health education on salt, sugar, and lifestyle-driven disease that has the potential to change patient behavior measurably. The Committee advocates promoting Yoga as a low-cost preventive practice, building on the platform created by International Yoga Day, positioned as a complement to clinical care rather than a replacement for it. More broadly, the Committee encourages replicating low-barrier community OPD models, offering free consultation and medicines during evening hours and delivered with an emphasis on dignity and self-worth, as a scalable way to reach street vendors, rickshaw pullers, and other daily-wage populations who are otherwise underserved.

6.2.15 The Committee acknowledges that structural deficits must be rectified to support equitable healthcare delivery. The Committee recommends bridging existing gaps in Sub-Health Centres (SHCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs) in strict accordance with IPHS 2022 norms. The Committee also recommends developing a phased roadmap to upgrade Ayush facilities in alignment with Ayush IPHS 2024 norms.

6.2.16 The Committee believes that strengthening procurement and supply chain management systems is critical to ensuring the uninterrupted availability of essential medicines and diagnostics across all healthcare levels. The Committee is of the view that Public-Private Partnerships should be promoted to expand diagnostic capacities, improve biomedical waste management, and enhance access to specialized services where the public sector is constrained.

6.2.17 The Committee believes that addressing child and adolescent health is foundational to long-term human capital gains. The Committee recommends significantly improving the screening quality and coverage of disease conditions by strengthening RBSK (Rashtriya Bal Swasthya Karyakram) teams. The Committee also recommends incorporating specific provisions for positive mental health and addressing mental ailments within the school ecosystem. The Committee is of the view that schools must promote yoga, meditation, physical activity, and comprehensive health and nutrition education through both curricular and extracurricular avenues, alongside ensuring the mandatory provision of first aid.

6.2.18 The Committee notes that NQAS lacks statutory backing and NQAS certification is "voluntary and does not derive from a separate statutory enactment," even though

100% coverage of public facilities is the stated goal. The Committee recommends considering a phased move toward statutory or executive-order backing for NQAS, at minimum, making certification a binding precondition for PMJAY empanelment and NHM fund disbursement, rather than relying solely on incentive-linkage through NHA. The Committee further observes that human resource capacity forms a critical pillar of the quality governance framework and recommends deployment of more than 2350 National and over 10,500 State Trained Assessors across the diverse geographical settings facilitating harmonized implementation of standards and promoting peer learning and exchange of best practices.

6.2.19 The Committee notes that there is fragmented multi-agency architecture with NQAS sits under MoHFW while NABH/NABL sit under QCI, which reports to DPIIT, a different ministry altogether. The Committee acknowledges this creates "potential for duplication of assessments, documentation requirements and administrative effort" for facilities pursuing multiple accreditations. The Committee recommends establishing a formal inter-ministerial coordination mechanism (MoHFW–DPIIT/QCI) to build a standards crosswalk or equivalence mapping between NQAS, NABH and NABL, so facilities aren't re-assessed against near-identical criteria. A shared digital evidence repository (leveraging the existing SaQsham platform) could let assessment documentation be reused across systems.

6.2.20 The Committee observes that teaching/research/high-volume service delivery not reflected in standards. The current frameworks may not fully reflect the broader responsibilities and operational realities of Government Medical Colleges and public sector hospitals, including teaching, research, national health programmes, and high-volume service delivery. The Committee recommends developing a supplementary NQAS module specifically for teaching/tertiary hospitals that captures academic and research functions, and coordinate this with National Medical Commission (NMC) recognition criteria so medical colleges aren't juggling contradictory or duplicative accreditation demands.

6.2.21 The Committee finds that there is no data on disproportionate burden for small/rural/remote facilities. No consolidated national assessment has been carried out regarding differential burden, sustainability, or benefits across categories of healthcare institutions, despite acknowledging that small, rural, remote and underserved facilities likely face proportionately higher costs than large corporate hospitals. The Committee recommends commissioning of a study on structured national assessment comparing compliance cost, time-to-certification, and assessor availability across facility size/location/ownership. The findings should be used to design tiered timelines, additional mentoring support, or higher NHM incentive weighting for ADP/ABP and underserved facilities, rather than treating all facilities under one compliance bar.

6.2.22 The Committee is of the view that, with NQAS running 2,350 + national and 10,500 + state assessors, rapid scale-up raises a natural question of scoring consistency even though there are standardised toolkits and objective scoring. The Committee recommends institutionalizing periodic inter-assessor calibration exercises and refresher cycles alongside the existing fortnightly learning series, and publish inter-rater reliability metrics as part of SaQsham's data analytics.

6.2.23 The Committee believes that SaQsham's analytics capability should be used to publish a public, facility-level dashboard tracking certification status, time taken, and geographic/tier-wise disparities, turning the "digital ecosystem" already built into an accountability tool, not just a workflow system.

Investment in Preventive Healthcare

6.2.24 The Committee observes that healthcare spending is predominantly directed toward treating advanced diseases rather than preventing illness, driving higher long-term costs. Tertiary care institutions face severe overcrowding by patients whose conditions could be effectively managed at primary or secondary facilities, which limits access for those requiring advanced specialist interventions. A significant proportion of patients bypass primary care to seek specialist consultation for manageable conditions. The Committee, therefore, recommends increasing investment in preventive healthcare, health promotion, and screening programmes to alleviate the burden on higher-tier hospitals. The Committee believes that tertiary care institutions must operate as true referral centres, evaluating non-emergency patients strictly upon referral while maintaining immediate access for emergencies. 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.

Structured District Residency Clinical Posting

6.2.25 The Committee observes that Community Health Centres (CHCs) and Sub-District Hospitals remain underutilized as teaching facilities, restricting students' exposure to district-level healthcare. Current faculty norms and training capacities are likely insufficient to address the rising demand for super-specialists in chronic care, oncology, and critical care. Discrepancies between government and private medical colleges regarding bed and faculty requirements inflate the cost of postgraduate programmes without enhancing educational quality. There are localized shortages of specialist faculty alongside underutilized expertise in other institutions. The Committee recommends that all medical colleges affiliate with designated CHCs and Sub-District Hospitals to facilitate structured district residency and clinical postings for students and interns.

6.2.26 The Committee believes that super-specialty (DM/MCh) training should be expanded by reintroducing appropriate flexibility in faculty norms. The Committee, therefore, recommends that DM/MCh faculty and their clinical beds be recognized as eligible teaching resources for undergraduate and postgraduate education to optimize resources and increase specialist manpower. 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.

Clinical Audit to Promote Cost-effective Care

6.2.27 The Committee notes that corporate hospital charges lack transparency and vary widely for procedures and investigations. Out-of-pocket expenditure is heavily driven by

the costs of medicines, implants, and diagnostics. Current healthcare financing mechanisms primarily reward service volume rather than clinical outcomes. Variations in clinical practice lead to unnecessary investigations and escalated costs. The Committee, therefore, recommends introducing standardized cost-accounting and transparent pricing to ensure charges align with audited costs and reasonable operating margins. The Committee believes centralized procurement must be strengthened, generic prescribing encouraged, and the prices of essential medicines and implants strictly regulated. The Committee is of the view that hospital reimbursement and incentives must be tied to quality indicators, patient safety, and efficiency rather than procedure volume. The Committee recommends implementing evidence-based national treatment protocols alongside regular clinical audits to promote cost-effective care.

Digital Health Records

6.2.28 The Committee is of the view that fragmented health records and duplicated diagnostic investigations reduce systemic efficiency and increase costs. Advanced diagnostic and therapeutic equipment is highly expensive and often underutilized, yet inaccessible in many districts. Substantial private sector healthcare infrastructure remains underutilized for achieving national public health objectives. Numerous procedures requiring hospital admission could be safely executed as day-care surgeries. The Committee recommends establishing interoperable electronic health records, telemedicine services, and AI-supported clinical decision systems. The Committee believes that validated AI-assisted screening programmes must be scaled up to facilitate the early diagnosis of common diseases. The Committee, therefore, recommends the creation of regional shared-resource networks, allowing government and accredited private hospitals to schedule access to high-cost equipment such as PET-CT, MRI, and molecular diagnostics. The Committee is of the view that a structured framework must be established to require or incentivize accredited private hospitals to contribute to national health programmes, including disease surveillance and immunization. The Committee recommends expanding day-care surgery services through the deployment of standardized clinical protocols and appropriate reimbursement mechanisms.

6.2.29 The Committee is of the view that the current commercial market for Electronic Medical Records (EMR) and Hospital Information Systems (HIS) restricts access to vital digital infrastructure due to prohibitively expensive licensing walls. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, alongside MeitY, commission a dedicated fund to subsidize top-tier software enterprises in building an enterprise-grade, open-source digital healthcare platform. The Committee believes this platform must natively bridge the gap between all stakeholders and incorporate direct IoT integration with bedside equipment. Once finalized, the software must be released globally under an open-source license, entirely free of cost, to democratize access to modern digital workflows. The Committee, therefore, strongly recommends for an open source extremely affordable AI solution to interpret X-rays, specially portable X-rays so that interpretation can be done at the Community Health Centers (CHCs) or Primary Health Care Centers (PHCCs) level. The Committee strongly recommends, therefore, rationalizing/capping the cost of AI used to interprete such x-rays at CHCs and PHCCs.

Strategic Action Plan of Health Savings Account (HSA)

6.2.30 The Committee observes that over 85% of the Indian workforce operates within the informal sector, entirely lacking institutional social security or structured healthcare coverage. While the government spends approximately 1.5% of its GDP on public healthcare, however the Committee has expressed that public financing alone cannot fully absorb the catastrophic out-of-pocket health expenditures (OOPE) faced by millions of families. Formalizing these employment relationships under standard corporate health covers is an administrative bottleneck in the short term. The Committee, therefore, recommends that the Government must deploy the economic tool of Health Savings Accounts (HSAs), modeled after successful global precedent and frameworks and Singapore pioneered HSAs approach via the Medisave system in 1984, followed by China (covering over 300 million workers) and the United States with over $50 billion managed in consumer HSAs.

6.2.31 The Committee, in this regard, finds that the Reserve Bank of India (RBI) has cleared the regulatory pathway for zero-balance HSAs (analogous to the Jan Dhan architecture), with the Bank of Baroda launching India's first dedicated HSA product on December 18, 2025. The Committee, therefore, recommends that Government to undertake Strategic action plan by mandating account creation, encouraging volunteery contribution and disintermediation of insurance. The Central Government should mandate that all temporary, gig, and informal sector workers be signed up for a zero-balance HSA. The administrative responsibility of on-boarding should rest on the immediate employer or contracting platform. To bypass employer resistance against mandatory payroll taxes for temporary labor, contributions should initially be voluntary. Employers should be systemically nudged to contribute a modest 100 to 200 per month per worker. Funds accumulated within these HSAs must be legally ring-fenced, usable only for health-related expenses and direct premiums for micro-health insurance policies. By linking insurers directly to HSA holders, the Government must intend to eliminate intermediaries and brokers who traditionally skim 30% to 40% off premium distributions, drastically lowering insurance costs for the poor.

Transit to Global Medical Device Manufacturing Hub

6.2.32 Indian healthcare delivery is deeply reliant on imported medical technology. Many government tertiary center or private hospital, and the critical diagnostic and life-support infrastructure is almost exclusively manufactured by foreign conglomerates that creates a severe national security liability and ties the cost of domestic clinical procedures to foreign exchange volatility (USD/EUR). According to the Association of Indian Medical Device Industry (AiMeD), India currently imports nearly 70-80% of its medical devices, exposing the system to external supply shocks and high capital expenditure requirements. The Committee, therefore, views that the Government must transit from an import-dependent market to a global manufacturing hub for medical devices. There is an urgent need to replicate the phased manufacturing and technology-transfer models successfully utilized by the domestic automotive sector and China's industrial frameworks.

6.2.33 The government should grant a complete 0-5 year corporate tax exemption to global medical equipment manufacturers that establish full-scale manufacturing

facilities within India with the rider of mandating component localization. The policy must explicitly disincentivize simple "screwdriver assembly" plants. Tax concessions must be systematically tied to progressive localization schedules, requiring components, sensors, and software architecture to be developed natively. The Committee understands that Collaborating with global giants will train cadre of Indian biomedical engineers and technicians and over time, these individuals will drive native enterprise, replicating the trajectory where domestic automotive firms evolved to successfully compete with global market leaders.

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

6.2.34 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.

6.2.35 The Committee observes that Cardiovascular disease (CVD) remains India's leading cause of premature mortality. Super-specialists holding a DM in Cardiology require up to 14 years of rigorous training and rarely settle outside Tier-1 cities. The Committee has come across that eighteen years ago, the Indira Gandhi National Open University (IGNOU) launched the Diploma in Community Cardiology, a two-year structural program for MBBS doctors executed in partnership with India's premier cardiac institutes. It successfully trained over 2,500 non-interventional cardiologists who managed early heart attack interventions and conducted pediatric cardiac screenings across rural and semi-urban communities. Although, the NMC recently recognized the validity of those initial 2,500 practitioners, the training pipeline remains frozen due to legacy pushback from the erstwhile Medical Council of India (MCI). The Committee, therefore, desires the NMC for considering to re-institutionalize the Diploma in Community Cardiology to position non- interventional cardiac care specialists directly at the sub-district level.

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

6.2.36 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. The Lancet Commission on Global Surgery states that low- and middle- income countries face an immense surgical deficit. India performs roughly 25 million surgeries annually against an estimated true demand of 70 million, driven significantly by a lack of localized diagnostic access. India has fewer than 12,000 registered radiologists. A

significant portion focus primarily on reporting teleradiology CT and MRI scans remotely, as a standard physical ultrasound requires roughly 20 minutes of localized, direct physical engagement, reducing throughput. The Committee recommends for preventing screening on a mission mode to diagnose early liver diseases , in view of the fact that the country is facing an epidemic of fatty liver disease. Liver scanning fibroscan machines can be installed at CHC level wherein the medical professional can be trained to interpret the findings.

6.2.37 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. To eliminate the risk of illegal fetal sex determination, the Indian government, via the Indian Council of Medical Research (ICMR), should collaborate with medical imaging manufacturers to mandate a dual-firmware market split i.e. technological safeguard. 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.

6.2.38 The Committee believes that public resource allocation must pivot toward early detection to systematically mitigate premature mortality from cardiovascular diseases and oncological malignancies. The Committee, therefore, recommends provisioning an affordable annual diagnostic package for every citizen over the age of 40. This bundle must include standardized haematological profiles, an Electrocardiogram (ECG), a basic Echocardiogram, and Low-Dose Computed Tomography (LDCT) scans of the chest and abdomen to facilitate curative, low-cost interventions.

Nursing Capacity Building

6.2.39 The Committee is of the view that the clinical proficiency deficit among entry-level nurses stems from standalone institutions lacking clinical exposure. The Committee, therefore, recommends that the Indian Nursing Council and State licensing boards legally bind nursing education to active clinical environments. The Committee believes no entity should be granted a license to operate a nursing college unless they own and operate a functional, baseline 100-bed general hospital. The Committee, therefore, recommends implementing a bedside learning framework. This will simultaneously improve immediate hospital nursing capacity and allow institutions to reduce tuition fees, making education more accessible while producing highly skilled graduates. The Committee recommends for creation of a ecosystem wherein Nursing Graduates can migrate for providing manpower for resource deficit countries.

6.2.40 To address the chronic shortfall of primary care physicians in rural and semi-urban areas, the Committee is of the view that India must adopt an advanced practice nursing framework. The Committee, therefore, recommends the introduction of a certified Nurse Practitioner (NP) framework. Experienced nurses undergoing this certification must be granted limited independent prescription rights for a strictly defined formulary of 47 essential primary care medications. Stationing these certified NPs at the Health and Wellness Centre (HWC) level will instantly bridge the primary care deficit.

GST Waiver a Health Insurance Premium

6.2.41 The Committee believes that the current fiscal logic—which taxes group health insurance at 18% while exempting individual retail policies—creates an unintended penalty for vulnerable workforces, such as gig workers and informal collectives. The Committee, therefore, recommends a full GST waiver on low-cost group health insurance premiums up to a specific designated cap per life covered. This adjustment will actively encourage platforms and cooperatives to secure essential safety nets for millions of low-income workers.

6.3 Strengthening Healthcare Delivery through Integrated Medical Education and Rationalisation of Regulatory Norms

6.3.1 The Committee is of the view that affordable healthcare is intrinsically linked to the availability of an adequate, competent and well-trained healthcare workforce. It believes that optimal utilisation of existing teaching infrastructure, clinical resources and specialist expertise is essential for strengthening medical education and improving healthcare delivery. The regulatory framework governing medical education should, therefore, facilitate integration, efficient utilisation of resources and uniform standards while maintaining the quality of medical education.

6.3.2 The Committee notes that varying statutory requirements for Government and Private Medical Colleges do not further the objective of maintaining uniform standards in medical education. Regulatory norms relating to faculty strength, bed strength, infrastructure and academic resources should be guided by educational requirements and patient care needs rather than the ownership of the institution. The Committee, therefore, recommends harmonisation of statutory standards applicable to Government and Private Medical Colleges.

6.3.3 The Committee further notes that changing disease patterns, increasing disease complexity and advances in medical science require greater integration between Specialty and Super-specialty services. The Committee recommends greater integration of Specialty and Super-specialty Departments in undergraduate and postgraduate medical education through appropriate academic and clinical exposure, wherever feasible. Such integration would optimise the utilisation of existing academic and clinical resources and strengthen multidisciplinary clinical training.

6.3.4 The Committee further recommends that faculty and beds in relevant Super-specialty Departments may be considered towards the teacher-student ratio and bed strength requirements of the corresponding broad specialty, in accordance with the norms prescribed by the National Medical Commission. This would facilitate better utilisation of existing infrastructure and specialist expertise while strengthening medical education and promoting the expansion of Super-specialty education and healthcare services.

6.3.5 The Committee is of the view that the requirement for separate faculty and bed strength for each Super-specialty programme may constrain the expansion of Super-specialty education and services. Rationalisation of these regulatory norms through recognition of shared academic and clinical resources would encourage greater

UNCORRECTED Simplifying Compliance

utilisation of existing infrastructure, expand training capacity, improve access to specialised healthcare services and strengthen the specialist healthcare workforce.

6.3.6 The Committee believes that these measures would promote efficient utilisation of available resources, strengthen medical education, facilitate expansion of specialised healthcare services and improve access to quality healthcare. This would contribute towards achieving the objective of affordable, equitable and quality healthcare.

6.3.7 The Committee, therefore, 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, facilitating optimal utilisation of institutional resources, encouraging expansion of Super-specialty education and strengthening the healthcare delivery system without compromising the quality of medical education.

6.4 CGHS facilities for Senior Citizens

6.4.1 The Committee is of the considered opinion that CGHS beneficiaries form a significant component of health beneficiaries seeking affordable and accessible health care in their post retirement phase. Logistical and administrative difficulties make it difficult for them to access referral from CGHS wellness centers for their treatment requirements. The Committee notes that beneficiaries above the age of 70 years can directly approach empanelled hospitals without going through the referral process for all consultations as well as procedures. Seeking treatment under the existing system in itself is time consuming with long queues and at times arbitrary and the beneficiaries can access the health care without referral only in case of emergencies. The Committee recommends that the 70 year age bar be reduced to 60 years so that all retired beneficiaries can approach empanelled hospital for their health care requirements without going through a time consuming cumbersome process for all purposes. This would reduce unnecessary paper work besides providing ease of living for retired personnel.

6.5 Climate change and Health

6.5.1 The Committee has been apprised by UNEP that climate change is now a first-order public health emergency for India, not a future risk. Air pollution and extreme heat — the two most climate-sensitive exposures — already account for well over a million preventable deaths a year between them, and both are worsening faster than the country's adaptation systems can keep pace. India has built credible institutional foundations for a response, including the National Programme on Climate Change and Human Health (NPCCHH) and city/state Heat Action Plans, but these remain underfunded, unevenly implemented and disconnected from the international climate finance architecture.

6.5.2 The Committee understands that India ranks among the countries most exposed on nearly every indicator the Lancet Countdown tracks having one of the largest absolute air pollution mortality burdens of any country, alongside China; it is warming in a way that is measurably increasing heatwave frequency and duration; and it is losing tree cover (about 2.33 million hectares between 2001 and 2023) that would otherwise buffer both heat and air pollution exposure. The Global Burden of Disease (GBD) 2019 study — carried out for India in partnership with UNEP at the invitation of the

Ministry of Environment, Forest and Climate Change — found that air pollution accounted for 17.8% of all deaths in the country that year, split between ambient particulate matter and household air pollution.

6.5.3 UNEP further submitted that Heatwave frequency and severity are set to keep rising through mid-century even under moderate emissions pathways, and climate-sensitive infectious diseases such as dengue are projected to expand geographically into currently low-risk states and shift seasonally, lengthening transmission windows in most parts of the country. Consequently, affordability and access are also affected. Out-of-pocket costs for treating heat illness, respiratory disease and vector-borne infection fall disproportionately on lower-income and informal-sector households who lack heat-safe workplaces or health insurance, and rural or hilly districts often face longer travel times to facilities equipped for climate-sensitive emergencies. Health financing planning has not yet systematically absorbed these climate-attributable costs, which the Lancet Countdown work suggests already run into tens of billions of dollars a year for India when premature mortality and lost productivity are counted.

Vector-borne and water-borne disease

6.5.4 Dengue cases reported to the National Centre for Vector-Borne Disease Control rose from about 28,000 in 2010 to roughly 289,000 in 2023, a roughly ten-fold increase and modelling studies project further increases in transmission-suitable months as temperatures and monsoon patterns shift, with new transmission risk emerging in areas such as the upper Himalayas, parts of the Thar Desert, and north-eastern states that previously saw little dengue activity. Similar climate sensitivity applies to malaria, chikungunya, and water-borne diseases linked to flooding and water stress, though the strength of projected effects varies by region and emissions pathway.

Non-communicable disease and mental health

6.5.5 Heat and air pollution both aggravate cardiovascular, respiratory and renal disease, and a growing evidence base links extreme heat and humidity to worsening mental health outcomes and, in some studies, increased interpersonal violence. Vulnerable groups — outdoor labourers, slum residents, the elderly, pregnant women, and people with pre-existing NCDs — carry a disproportionate share of this burden, which compounds existing health equity gaps.

Policy and institutional

6.5.6 The Committee is of the view that the Government should undertake concrete to broaden targeted health strategies and outreach to the full range of climate-vulnerable groups, including children, pregnant women and urban poor populations, alongside the elderly and outdoor workers already prioritised and explicitly address climate-linked nutrition and food-security risks (undernutrition and micronutrient deficiencies arising from disrupted agricultural productivity) and the psychological distress associated with heat, disasters and displacement. Moreover, the Committee observes that the Government should formulate minimum-standard Heat Action Plans for all districts

(not only cities) with defined triggers, cooling-centre and hospital-surge protocols, and independent evaluation, building on the Ahmedabad model. There is also a need to rormalise occupational heat-safety norms (work-rest cycles, shaded rest areas, hydration access) for outdoor and informal-sector workers, who bear a disproportionate share of heat-related morbidity. Besides that the Government must expand green healthcare guidelines into a comprehensive resilience framework: the existing guidelines focus more on climate change mitigation (reducing the health sector's own carbon footprint) than on adaptation, and should be broadened to also cover facility-level heat and flood preparedness, continuity of care during climate shocks, and workforce protection.

6.5.7 The Committee feels there is urgent need to establish a dedicated Climate and Health Cell or nodal coordination mechanism within the Ministry of Health and Family Welfare, potentially anchored by a MoHFW-led working group, to provide leadership and technical guidance and to embed climate-risk considerations across NHM, NCDC, IDSP, NCD and mental-health and nutrition programmes rather than treating climate and health as a parallel workstream. The Committee desires that elevate NPCCHH from a programme to a mission with ring-fenced, multi-year budget lines, mirroring the National Health Mission model, so heat and air-pollution health response is not dependent on annual reallocation.

Technological and Surveillance

6.5.8 The Committed desires that the Government should expand integrated climate-health early-warning systems that combine IMD heat/air-quality forecasts with real-time hospital admission surveillance for heat illness, respiratory disease and dengue, on a common state-level dashboard. There is further need to invest in climate-resilient health infrastructure — backup power and cooling for cold-chain and ICU capacity, flood-proofing of primary health centres — prioritised for the most heat- and flood-exposed districts. Moreover, the Government should incorporate climate-and-health modules into pre-service and in-service training and capacity building for the health workforce, addressing the current gap in frontline worker preparedness on climate-related health risks.

Financial and international cooperation

6.5.9 The Committee of the considered view that the Government should strengthen international cooperation and programme accountability: India may consider formal participation or strengthened engagement, as appropriate, with WHO's Alliance for Transformative Action on Climate and Health (ATACH) to access technical cooperation, financing expertise, indicators and global good practice. The Government may also develop a national health-sector climate finance pipeline — vulnerability and adaptation assessments plus a Health National Adaptation Plan — to make India's health system eligible for GCF, GEF and Adaptation Fund resources through the WHO/ATACH channel. The Government should also extend the UNEP–Ministry of Environment, Forest and Climate Change technical partnership model used for the 2019 air pollution burden study to heat-mortality attribution, health-system carbon-footprint assessment, and state-level vulnerability mapping.

Monitoring accountability and research

6.5.10 The Committee considers that the Government should develop a programme monitoring framework to track the various initiatives under NPCCHH and related climate-

health programmes against defined indicators and milestones. There is also need to strengthen operationalisation of climate-health action plans developed at subnational levels, so that state and district plans move from documents to funded, monitored implementation. Most significantly, strengthen the research agenda on climate change and human health, with particular attention to its impact on health outcomes beyond heat and air pollution — including nutrition, mental health and non-communicable disease — in partnership with ICMR and academic and research institutions, translating evidence into policy and practice.

Assuring Quality Healthcare at Grass-root Level

6.6.1 The Committee invited views and suggestions from stakeholders/general public. The suggestions broadly emphasized strengthening quality assurance in healthcare through patient-centric policies, improved implementation of the Indian Public Health Standards (IPHS), National Quality Assurance Standards (NQAS), and Kayakalp initiatives, and ensuring adequate basic infrastructure in healthcare facilities. Stakeholders also recommended regular review meetings by the Directorate General of Health Services (DGHS) with State officials, periodic visits to health facilities, and the constitution of District-level Medical Committees for monitoring and resolving operational issues. Further, suggestions included expanding NABH and NABL accreditation, publishing performance ratings of healthcare institutions to promote accountability, enforcing Standard Treatment Guidelines (STGs) and uniform treatment protocols based on WHO and international best practices, strengthening sanitation and biomedical waste management, and conducting annual quality audits of both public and private healthcare facilities.

6.6.2 The Ministry informed that the National Health Policy, 2017 places patient-centric and quality healthcare at the core of the health system, supported through the Indian Public Health Standards (IPHS) and the National Quality Assurance Standards (NQAS). It stated that quality assurance initiatives, including NQAS, Kayakalp, LaQshya, and IPHS, are being implemented across public health facilities to ensure safe, patient-centric, and quality healthcare services. Around 45,577 public health facilities have been certified under NQAS, while participation under the Kayakalp programme has expanded significantly to over 1.34 lakh health facilities.

6.6.3 The Ministry further stated that IPHS has been implemented across all levels of public healthcare facilities and is supported by an online self-assessment toolkit and dashboard for monitoring compliance. As on 7 November 2025, 99.8 per cent of public health facilities had completed self-assessment under IPHS, with 61 per cent scoring above 50 per cent. It also informed that quality oversight is ensured through the National Council for Clinical Establishments, State Councils, and District Regulatory Authorities under the Clinical Establishments Act, 2010, which monitor compliance with prescribed standards through regular inspections and audits.

6.6.4 The Committee is of the view that uniform clinical practices are vital for equitable and safe patient care across all healthcare institutions. The Committee, therefore, recommends the strict enforcement of mandatory Standard Treatment

Guidelines (STGs) across both public and private sectors. Treatment protocols and diagnostic criteria must be standardized and aligned with universally accepted evidence-based benchmarks, such as those prescribed by the World Health Organization (WHO) or the National Health Service (UK).

6.6.5 The Committee is of the view that while recognizing the role of the National Council for Clinical Establishment (NCCE), grassroots monitoring and active oversight require immediate fortification. The Committee believes that localized administration is critical for timely interventions. The Committee, therefore, recommends the formalization of dedicated District-level Medical Committees to conduct periodic reviews, resolve local grievances, and coordinate directly with the Director General of Health Services (DGHS) and state officials. Strict annual audits of all healthcare services must be institutionalized. District Regulatory Authorities (DRAs) must be fully empowered to inspect, audit, and penalize non-compliance. 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.

6.6.6 The Committee feels that although self-assessments *via* the IPHS dashboard and the widespread adoption of the Kayakalp initiative demonstrate progress, continuous infrastructural enhancement remains paramount. The Committee believes that preventive health is intrinsically linked to facility hygiene. Strict maintenance protocols for sanitation, specifically concerning wastewater management and environmental controls, must be rigidly enforced to prevent disease transmission emerging due to climate change and ecological disorders. Continuous capital and operational investments must be directed toward addressing basic infrastructure gaps to ensure 100% compliance with NQAS and IPHS benchmarks.

6.6.7 The Committee recommends the progressive expansion of NABH and NABL accreditations across the broader healthcare ecosystem. The Committee is of the view that transparency drives institutional excellence. Therefore, public performance ratings for healthcare facilities must be published periodically to ensure direct accountability to the public. Building upon the National Health Policy 2017, all governmental policies must be continuously revisited refined and reformed to prioritize the patient experience. Healthcare delivery must remain demonstrably gender-sensitive, inherently safe, and strictly confidential at all points of care.

Institutionalizing Community Level Healthcare Facilities and Monitoring System

6.7.1 The Committee invited views and suggestions from stakeholders/general public. The suggestions broadly emphasized promoting health-seeking behaviour and strengthening public trust in Government health services. Stakeholders also recommended greater involvement of local Panchayats, Village Health, Sanitation and Nutrition Committees (VHSNCs), and local communities in undertaking need-based assessments for planning and expanding healthcare facilities. Further, the representations stressed institutionalising community-based monitoring, conducting regular social audits of health programmes, and

promoting healthcare as a shared responsibility of individuals, families, communities, and the State.

6.7.2 The Ministry stated that community participation is integral to strengthening the healthcare system and improving access, accountability, and health outcomes. It highlighted the Accredited Social Health Activist (ASHA) programme under the National Health Mission as a key initiative for promoting community engagement, health awareness, and utilization of public health services, with around 10.33 lakh ASHAs deployed across rural and urban areas.

6.7.3 The Ministry further informed that Village Health, Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samitis (MAS), Jan Arogya Samitis (JAS), and Rogi Kalyan Samitis (RKS) have been established to promote community participation in health planning, monitoring, and service delivery. As of March 2025, over 5.65 lakh VHSNCs and 35,870 RKS are functioning across the country, while 72.26 lakh Village Health, Sanitation and Nutrition Days had been conducted to strengthen community-level healthcare.

6.7.4 The Committee is of the view that centralized planning sometimes fails to capture the nuanced realities of diverse demographic clusters. Facilities must be expanded based on empirical, grassroots data rather than uniform assumptions. The Committee, therefore, recommends that local panchayats, working in tandem with VHSNCs in rural areas and MAS in urban slums, be mandated to conduct comprehensive need-based analyses before any new healthcare facility is approved or existing infrastructure is expanded. The Committee believes that untied funds managed by these local bodies must be strictly appropriated and monitored to ensure that expenditures are directed toward locally identified priorities, bridging the gap between healthcare providers and the community.

6.7.5 While recognizing the establishment of 35,870 Rogi Kalyan Samitis (RKS) and over 5.65 lakh VHSNCs, the Committee notes that mere constitution does not guarantee effective oversight. The Committee believes that transparent accountability is the cornerstone of public trust. The Committee, therefore, recommends the formal institutionalization of Community-Based Monitoring systems across all public health facilities. Regular and mandatory Social Audits of all health programs must be conducted through RKS and JAS. The findings of these audits must be integrated into the performance reviews of the respective health facilities.

6.7.6 The Committee acknowledges the monumental role of the 10.33 lakh ASHAs as the foundation of primary healthcare and public health mobilization. However, operational guidelines issued in the years 2013 and 2014 require modernization and revision. The Committee, therefore, recommends that the Ministry immediately revise and update the ASHA operational guidelines for both rural and urban contexts to reflect current epidemiological realities and emerging public health challenges due to climate change and global ecological and environmental disorder. ASHAs must be systematically capacitated through continuous training programs and capacity building to better educate and mobilize marginalized communities, focusing sharply on the social

determinants of health and improving the utilization metrics of Ayushman Arogya Mandirs.

6.7.7 The Committee is of the strongly view that sustainable health outcomes cannot be achieved by state machinery alone thereby requiring a paradigm shift in societal behavior. The Committee believes that public health must be universally recognized as a 'Personal, Familial, Community, and State Joint Responsibility.' The Committee, therefore, recommends the deployment of state-level, culturally calibrated Awareness Campaigns designed specifically to encourage proactive health-seeking behavior and reinforce absolute trust in government health services.

Transforming Emergency Healthcare

6.8.1 The Committee invited views and suggestions from stakeholders/general public. The suggestions broadly emphasized strengthening emergency healthcare services through the development of integrated ground and air ambulance systems, strengthening casualty and emergency departments, and establishing dedicated emergency medicine departments with trained physicians in all district hospitals, medical colleges, and tertiary care centres. Stakeholders also recommended ensuring free emergency care at the point of service in both public and private hospitals, supported by timely reimbursement under Government health schemes and standardized ambulance-to-hospital referral protocols.

6.8.2 The representations further highlighted the need to establish district-level oxygen concentrator banks through public health infrastructure, include long-term oxygen therapy (LTOT) under health insurance schemes, and ensure regular follow-up and reassessment of patients receiving LTOT to improve clinical outcomes and patient safety. Suggestions were also made for introducing dedicated emergency helpline services and enhancing the recognition and capacity of emergency medicine within the public healthcare system.

6.8.3 The Ministry informed that India has significantly strengthened its emergency healthcare system through the expansion of ambulance networks, trauma centres, critical care blocks, mobile medical units, and digital health interventions. The Ministry coordinates nationwide emergency medical response through the National Ambulance Services (Dial 108/102), supported under the National Health Mission, with Basic Life Support (BLS), Advanced Life Support (ALS), bike and boat ambulances deployed as per population norms and local requirements. As of March 2025, over 22,000 ambulances and 1,573 Mobile Medical Units are operational across the country.

6.8.4 The Ministry further stated that emergency preparedness is supported through dedicated trauma and emergency facilities in major hospitals, rapid deployment of medical teams during disasters, and strengthening of critical care infrastructure under the PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). The Ministry also highlighted the implementation of the Cashless Treatment of Road Accident Victims Scheme, 2025, providing treatment cover of up to ₹1.5 lakh for seven days at designated hospitals nationwide.

6.8.5 The Committee is of the view that rapid, optimized medical transport is the bedrock of effective emergency intervention and disaster management. The Committee, therefore, recommends the immediate creation and deployment of highly optimized ground and air ambulance systems, ensuring equitable distribution across difficult terrains, rural settings, and high-density urban regions. To eliminate transit-to-treatment delays, the Committee recommends the strict formulation and enforcement of standardized ambulance-to-hospital handover protocols. The Committee believes that immediate public access to emergency transport must be drastically simplified. The Committee, therefore, recommends the widespread promotion and continuous provision of a unified, highly responsive centralized and operational helpline number.

6.8.6 The Committee believes that casualty and emergency medical services must be expertly staffed and financially sound at the time of crisis. 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. Furthermore, greater institutional recognition must be afforded to these crucial departments. The Committee is of the view that financial constraints must never delay life-saving interventions. The Committee, therefore, recommends that emergency care be provided entirely free of cost at the point of care in both public and private hospitals. Such mandate must be supported by automated, prompt reimbursement mechanisms executed through government schemes.

6.8.7 Recognizing the absolute necessity of sustained respiratory support, both during emergencies and post-discharge, the Committee is of the view that targeted infrastructural and policy enhancements are required. The Committee, therefore, recommends that the Government immediately establish district-level oxygen concentrator banks embedded within the existing public health infrastructure. The Committee believes that chronic respiratory care must be financially protected. The Committee, therefore, recommends bringing Long-Term Oxygen Therapy (LTOT) comprehensively under existing insurance schemes. Furthermore, mandatory follow-up and reassessment protocols for LTOT patients must be instituted to guarantee patient safety, clinical efficacy, and systemic cost-effectiveness.

6.8.8 The Committee acknowledges the vital safety nets established by the Cashless Treatment of Road Accident Victims Scheme, 2025, and the ongoing infrastructure projects under the PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). The Committee is of the view that robust hospital preparedness is non-negotiable. The Committee, therefore, recommends that the construction and operationalization of the approved 50-100 bedded Critical Care Blocks (CCBs) be expedited to guarantee readiness for pandemics, mass casualty events, and natural disasters.

Need of Strong Accreditation Ecosystem

6.9.1 The Committee understands that NABH brings the principles from ISQua, which is a globally competitive accreditation body, and works with hospitals, clinics and Ayush facilities in implementing quality management system. The Committee takes note

that QCI undertakes *Gunvattha Yatra* and conduct *Gunvattha Mitra* and inculcates capacity-building and skill development through gunvattha pathshala. Moreover, QCI promotes ease of doing business through *Gunvattha Manthan* and encouraged hospitals to adopt an attitude towards maintaining health quality at an affordable cost. The Committee desires that QCI should promote hospitals to acquire ISO 15189 in tier I, II and III cities which is the golden standard and globally recognized for diagnostic labs. The Committee believes that the *Gunvattha Chakra* activities and *Gunvattha Yatras* would definitely promote QCI to ensure global quality standard at affordable costs.

Quality of Generic Medicine and Control over Spurious Medicine

6.10.1 The Committee has come across about the quality and efficacy of generic medicine, therefore, CDSCO needs to take concrete steps to ensure the quality and efficacy of generic medicine which are made available at Jan Ausdhi Kendra. Moreover, the Committee wishes to point out that sometimes there is concern over the availability of spurious and fake drugs in the market having detrimental impact on the health of the common man, therefore, the 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 to the branded medicine available at the market at the comparatively at the higher rate. Need is to win the public trust. The Committee strongly recommends for complet ban on spurious medicine.

Reverse Brain Drain

6.11.1 The Committee has come across that a large number of Indian doctors who have migrated abroad and constitute our diaspora possess the latest skills and are ready to come back to nurture our manpower besides providing advanced health care. The number of such doctors who have although retired but are skilled senior doctors and living abroad, however, are willing to serve the nation provided those doctors are allowed to come and work in different parts of the country. The Committee, therefore, desires that such doctors may be given opportunity to register on the portal formed for the purpose and express their willingness in writing to serve the nation during the certain months of the year in different parts of the country, preferably in their home state, the benefits of their professional experience and expertise can be suitably utilized to ward off severe diseases in under served area/region of the country. Besides that the resident doctors in different hospitals will get additional benefits of gaining their experience in general public interest. Therefore, the Committee recommends the Government to undertake necessary steps in this direction.

Health Expenditure and GDP Allocation

6.12.1 The Committee notes with deep concern the low budget allocation for the health sector, comprising the Department of Health & Family Welfare, the Department of Health Research, and the Ministry of Ayush, which has hovered between 0.28% and 0.33% of GDP over the past five years. Although GHE has increased from 1.35% of GDP in 2017–18 to 1.43% in 2022–23, the Committee is of the view that this financial

trajectory is severely inadequate and falls significantly short of the National Health Policy (NHP) 2017 goal of raising Government Health Expenditure to 2.5% of GDP by 2025. Because the 2025-26 financial year has concluded without achieving this milestone, 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.

Healthcare Pricing and Regulatory Integration

6.13.1 The Committee notes with serious concern that CAG in its Report of 2023 states *inter-alia* that the National Health Authority (NHA) formulated tertiary procedure rates by simply replicating existing central schemes and state averages rather than conducting localized, scientific clinical cost assessments. As highlighted by performance audits on the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY), systemic gaps in hospital empanelment remain a challenge, exacerbated by pricing procedures far below actual operational costs, which has driven premier private hospitals to refuse empanelment. Furthermore, the Committee believes that IRDAI's failure to enforce a strict policy against dual pricing, whereby private hospitals arbitrarily inflate charges for insured patients, and its inability to mandate the integrated National Health Claims Exchange (NHCX) IT interface by the June 2026 deadline represent severe regulatory lapses. The Committee, therefore, recommends the following immediate interventions:

a) **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.**
b) **Mandatory NHCX Integration: IRDAI must issue stringent regulatory directives mandating the immediate technical integration of the NHCX interface with corporate hospital billing desks, imposing penalties for further delays beyond the June 2026 target.**
c) **Elimination of Dual Pricing: IRDAI must formulate and enforce a robust, standardized policy framework that explicitly prohibits the unethical practice of dual pricing, ensuring equitable and transparent billing practices for all patients regardless of their insurance status.**

Rural Healthcare Deployment and PM-JAY Expansion

6.14.1 The Committee observes with grave concern the critical 70-80% shortfall of specialist physicians in rural Community Health Centres (CHCs). The Committee is of the view that despite a 133% increase in postgraduate medical seats over the last

decade, the absence of effective deployment strategies has completely failed to bridge this rural healthcare disparity. The Committee is of the view that India does not face an absolute shortage of medical professionals; rather, the core crisis lies in deeply skewed distribution, with practitioners heavily concentrated in urban centers while rural areas remain severely underserved. To capitalize on this augmented educational capacity and establish a self-sustaining pipeline of medical professionals in underserved areas, the Committee believes that while augmenting postgraduate seats has expanded educational capacity, bridging this rural healthcare disparity requires robust retention and incentive frameworks rather than mere seat expansion. 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.

6.14.2 The Committee believes that stringent retention and deployment policies are urgently required. Furthermore, recognizing that Out-of-Pocket Expenditure (OOPE) is primarily driven by outpatient (OPD) care and medicines, the current PM-JAY framework, which exclusively covers inpatient hospitalization, remains fundamentally inadequate. The Committee, therefore, recommends that the Ministry expanding PM-JAY to comprehensively cover OPD treatments and essential medical supplies.

6.14.3 The Committee is of the view that the current Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) coverage limit of Rs. 5 lakhs per family is fundamentally inadequate, particularly given the recent inclusion of six crore senior citizens over the age of 70 who present high rates of comorbidities. Furthermore, the Committee believes that the omission of 600 high-end, complex medical procedures from the current framework actively misleads beneficiaries and inflicts unsustainable out-of-pocket expenditures on vulnerable families. The Committee, therefore, recommends an urgent collaborative intervention by the Department of Health and Family Welfare, the Department of Finance, and NITI Aayog to mandate the immediate coding of these 600 excluded procedures and enhance the annual AB-PMJAY financial package to Rs. 10 lakhs per family.

Cashless Health Schemes, Inclusive Insurance, and Hospital Empanelment

6.15.1 The Committee is of the view that the systemic and prolonged delays in clearing financial dues under major cashless health schemes, such as PM-JAY, are actively driving private hospitals to suspend services, thereby exacerbating the severe shortage of empanelled facilities and leaving patients stranded during medical emergencies.

Furthermore, the Committee believes that the widespread exclusion of Persons with Disabilities, characterized by an alarming 53% arbitrary rejection rate that leaves approximately 16 crore vulnerable citizens without coverage, and the blatant failure of insurance providers to comply with the mental health parity mandated by Section 21(4) of the Mental Healthcare Act, 2017, represent a profound regulatory failure in delivering equitable healthcare. 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, which is essential for rapidly expanding the network of empanelled hospitals. Concurrently, the Committee strongly urges the regulatory authorities to issue stringent directives penalizing insurance companies that arbitrarily deny coverage to Persons with Disabilities or fail to provide comprehensive, equal-basis coverage for mental health conditions and outpatient (OPD) treatments.

Upgrading Public Health Infrastructure and Expanding AIIMS

6.16.1 The Committee is of the view that the technology-driven best practices successfully demonstrated by AIIMS, such as AI-based diagnostics, digital grievance redressal, patient navigation, and advanced hospital management, must be rapidly standardized across the public healthcare system. The Committee believes that launching a 'National Hospital Programme' will effectively replicate these successful models across all Government medical colleges and major district hospitals, significantly elevating the quality and efficiency of patient care nationwide. Furthermore, the Committee notes with concern the glaring regional disparities in tertiary healthcare access. Despite the sanctioning of 23 AIIMS across the country, critical regions remain unrepresented, notably Mumbai, the nation's economic capital, and the State of Karnataka, particularly the high-need Aspirational District of Raichur in the Karnataka region. The Committee, therefore, recommends that the Government expedite the approvals and establishment of new AIIMS facilities in these geographically and demographically critical areas, while simultaneously executing the National Hospital Programme to ensure equitable, technology-enabled healthcare delivery across all states.

Emergency Neonatal and Paediatric Referrals

6.17.1 The Committee is of the view that the severe deficiency of specialized neonatal and paediatric care facilities within district hospitals poses a grave risk to public health, particularly for newborns and infants. The Committee believes that the current administrative protocol, which mandates acquiring a formal consent letter from a district hospital before a critical patient can be transferred to an empanelled facility, is deeply flawed and life-threatening. Such bureaucratic hurdles cause inexcusable delays during the critical 'golden hour' of medical emergencies, inflicting profound and unnecessary suffering on vulnerable patients and their families. The Committee, therefore, recommends the immediate abolition of the prior-consent requirement for all emergency neonatal and paediatric referrals to ensure seamless and rapid medical

intervention, alongside a targeted infrastructural drive to establish self-sufficient paediatric care units directly within all district hospitals.

Senior Citizen Insurance, Emergency Care, and Tertiary Infrastructure Expansion

6.18.1 The Committee is of the view that current healthcare delivery and insurance frameworks inadequately protect senior citizens and critically delay emergency medical interventions due to procedural financial barriers. The Committee believes that achieving equitable healthcare access requires both decentralized medical infrastructure and seamless, automated financial mechanisms. The Committee, therefore, recommends a multi-pronged intervention: first, the Insurance Regulatory and Development Authority of India (IRDAI) must mandate affordable insurance policies for citizens over 60 and deploy a dispute-free digital claim verification system; second, NITI Aayog and the Ministry of Health and Family Welfare must jointly establish autonomous tertiary healthcare centers in Tier-II and Tier-III cities, sustained by a cross-subsidization model where private ward revenues fund care for economically weaker sections; and third, a specific operational carve-out under PM-JAY must be instituted to guarantee immediate financial clearing for life-threatening emergencies, strictly enforcing a 'treatment first, payment later' protocol.

6.18.2 The Committee is of the view that expanding advanced tertiary healthcare beyond metropolitan areas to Tier-II and Tier-III cities is critical for equitable medical access. The Committee believes this can be effectively achieved by incentivizing private sector participation through targeted tax holidays, coupled with a mandatory obligation for these private facilities to provide cashless treatment to all Ayushman Bharat beneficiaries and uninsured patients at standardized CGHS rates. The Committee, therefore, recommends that the Ministry formulate a strategic public-private partnership framework to establish subsidized tertiary care centers in smaller cities, ensuring that commercial incentives are directly aligned with universal healthcare affordability and public welfare.

6.18.3 The Government should take steps to expand access to affordable bone marrow transplantation (BMT), which is presently largely available in private hospitals at a high cost of approximately ₹25–30 lakh per patient. All AIIMS should be equipped with dedicated BMT units, and, considering the large number of medical colleges in the country, one nodal BMT centre may be established for every five medical colleges to ensure wider geographical access. The facilities may be integrated with the existing framework of the National Organ and Tissue Transplant Organisation (NOTTO) and strengthened for the treatment of children suffering from Sickle Cell Disease and Thalassemia. Further, the Government may consider expanding empanelment of BMT centres under relevant public health schemes to reduce the financial burden on patients and ensure equitable access to this life-saving treatment.

Market Regulation

6.19.1 The Committee is of the view that efficiently managed, high-quality public healthcare institutions play a critical role not only in delivering accessible patient care but also in acting as definitive market regulators that organically drive down exorbitant private sector medical costs. The Committee believes that the current centralized model of healthcare delivery must be decentralized to reduce patient travel burdens, and that government facilities must urgently adopt a "corporate culture" characterized by operational efficiency, accountability, and robust public relations frameworks. 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, minimize travel time to capital cities, and actively regulate regional healthcare pricing through superior public service delivery.

Regulating Foreign Direct Investment in Private Healthcare

6.20.1 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. While acknowledging that foreign capital is highly beneficial and should be actively encouraged in the manufacturing sector, specifically for medical devices, consumables, and specialized medicines for rare diseases, its unrestricted application in direct hospital operations is proving detrimental to affordable patient care. 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. Concurrently, the Government must introduce a targeted regulatory framework that explicitly redirects and incentivizes such foreign investments toward the domestic manufacturing of medical technologies and pharmaceuticals.

Decongesting AIIMS Delhi

6.21.1 The Committee observes with deep concern the delays in operationalizing the memorandum of understanding signed in March 2024 between AIIMS New Delhi and the Central Armed Police Forces (CAPF) for the establishment of a specialized 970-bed facility at Maidan Garhi. The Committee recommends that the Ministry of Health and Family Welfare (MoHFW) expedite administrative clearances to ensure this state-of-the-art facility becomes fully operational without further delay. Furthermore, to alleviate the massive patient congestion and severe strain on the main AIIMS New Delhi campus, the Committee strongly supports utilizing available land resources in the

National Capital Region. Specifically, the Committee recommends that MoHFW, in coordination with the Ministry of Housing and Urban Affairs (MoHUA) and the Delhi Development Authority (DDA), immediately evaluate and submit a formal proposal to reserve a portion of the 400-acre vacant NTPC land near Badarpur Border, Sarita Vihar, for the establishment of a major new AIIMS branch. Given its direct connectivity to major highways, this strategic location will significantly improve healthcare access for the populations of South Delhi, Faridabad, Noida, and the wider NCR.

6.21.2 The Committee is of the view that the existing infrastructure at AIIMS, New Delhi, is severely overburdened by a combination of a massive local population, an alarming rise in lifestyle diseases among younger demographics, and a relentless influx of patients from neighboring States. While acknowledging the relief provided by southern satellite institutions, the Committee believes that the northern periphery of the National Capital Region, including North Delhi, parts of northern Haryana, and western Uttar Pradesh, continues to suffer from a critical deficit in accessible tertiary healthcare, which perpetuates severe patient congestion and extreme stress on medical professionals at the main campus. The Committee, therefore, reiterates its recommendation in 172nd Report that the Government urgently evaluate and execute the establishment of an additional, independently administered AIIMS facility or a fully equipped satellite center in the northern outskirts of Delhi, to strategically decentralize the tertiary healthcare burden and ensure equitable, timely medical access for the broader region.

Strengthening Human Resources in Medical Colleges and District Hospitals

6.22.1 The Government should undertake a comprehensive review of the availability and deployment of healthcare professionals, particularly non-clinical faculty in medical colleges and anaesthetists in district hospitals. Despite the substantial expansion of medical colleges, many institutions continue to face acute shortages of non-clinical teaching faculty, adversely affecting the quality of medical education. Similarly, several district hospitals serving populations of over 10 lakh reportedly have only one anaesthetist, making it difficult to ensure uninterrupted surgical services, particularly during leave or absence. The Government should, therefore, assess manpower requirements and ensure adequate, rational and equitable deployment of doctors and specialists through NHM and other appropriate mechanisms. At the same time, given the reported availability of doctors in certain States, efforts should focus on better distribution, appropriate remuneration and employment opportunities, rather than merely increasing the overall number of doctors.

Strengthening Awareness and Outreach of Government Health Schemes

6.23.1 The Government should undertake a comprehensive and sustained awareness campaign to ensure that rural and underserved populations are adequately informed about various Government health schemes, programmes and available healthcare services. Despite the launch of numerous initiatives, lack of awareness often prevents eligible beneficiaries from accessing their entitled benefits. Radio, television, local media

and other appropriate communication channels, including community-level outreach, may be effectively utilised to disseminate information in local languages. The Government should also establish mechanisms to assess whether the intended beneficiaries are actually availing the benefits of these schemes, so that gaps in awareness, access and implementation can be identified and addressed.

National Patient Navigation System

6.24.1 The Committee further recommends that the Government should establish Patient Navigation and Facilitation Desk in every Distrct Hopital and Medical College to assist patients with referral, disgnostics, AB-PMJAY benefits, medicine availability and grienvances redressal. There is further need to improve healthcare accessibility, especially for the elderly, women and economically weaker sections.

National Healthcare Affordability Dashboard

6.25.1 The Committee understands that there is need to create a district-wise digital dashboard on healthcare affordability and accessibility to track treatment costs, waiting times, specialist vacancies, diagnostics, medicine availability and redressal of patient grievances and to promote transparency, accountability and evidence-based policy interventions.

Outcome-Based Haspital Accreditation

6.26.1 The Committee feels that there is to complement infrastructure-based accreditation with outcome-based quality indicators. The need of the hour is to assess hospitals on patient safety, treatment outcomes, infection rates, waiting time, patient satisfaction and grievance resolution, besides, encourage quality improvement based on health outcomes rather then infrastructure alone.

UNCOMPLYSAFE
Simplifying compliance

RECOMMENDATION/OBSERVATIONS –AT A GLANCE

1. The Committee is of the view that while the current 51% allocation to primary healthcare establishes a vital preventive foundation, the disproportionately low spending on secondary (28%) and tertiary (11%) care drives citizens toward expensive private facilities, resulting in catastrophic out-of-pocket expenditure (OOPE). 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 to provide dependable, round-the-clock emergency, obstetric, and pediatric care, thereby reducing the referral burden on overstretched apex institutions. The Committee recommends for strengthening of the CHC infrastructure and facilities so that post-graduate doctors can work there in suitable conditions. Facilities like proper accommodation and salary incentives be extended to enable such doctors to work at CHC level. The Committee understands that there is overcrowding of patients but lack of facilities in public sector resulting into influx to private sector hospitals where exorbitant bill on the health expenditure is the real concern, therefore, there is lot of scope for improvement in public health sector by giving due impetus to preventive and community based healthcare.

(Para 1.3.4)

2. The Committee observes that government expenditure on governance and supervision currently stands at 8%, double the combined expenditure (both government and private) of 4%. While an extensive administrative apparatus is necessary, the Committee believes that such high overhead costs signal systemic inefficiencies and operational duplication. The Committee, therefore, recommends an immediate administrative rationalization program utilizing digital health infrastructure, such as the Ayushman Bharat Digital Mission. By automating routine oversight and streamlining scheme delivery, the government can safely redirect these administrative funds directly into the procurement of medical equipment, diagnostics, and specialist human resources and all vacancy position at CHC level be filled up on utmost priority basis.

(Para 1.3.5)

3. The Committee is of the view that, given the significant role of the private sector in delivering specialized treatments, a balanced regulatory framework is imperative to protect patients from financial vulnerability. 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. The Committee believes that implementing digital referral systems, outcome-based monitoring, and robust public-private partnership (PPP) frameworks will bridge the equity gap in advanced curative care, improving transparency and accessibility while strictly regulating costs for rationalising out-of-pocket expenditure.

(Para 1.3.6)

4. The Committee observes that while the private sector accommodates over 60% of inpatient and 70% of outpatient care, it remains highly heterogeneous, with a vast network of small clinics, nursing homes, and diagnostic centres operating without regulations. The Committee is of the view that the unbridled growth of clinics, nursing homes and diagnostic centres and uneven implementation of the Clinical Establishments (Registration and Regulation) Act, 2010, across states creates glaring disparities in both the quality and cost of care in private sector, leaving patients vulnerable to arbitrary pricing and substandard practices. 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. Further, the NABH system be made user friendly and transparat for the small health establishment as NABH compliance in itself adds to the total cost for these health care providers in small towns.

(Para 1.3.11)

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.

(Para 1.3.12)

6. The Committee is of the view that the current private healthcare landscape is disproportionately concentrated in urban tertiary markets, leaving a significant void in tier-2, tier-3, and rural areas despite a growing demand for specialized care in rural, semi-urban, hilly and tribal areas. The Committee believes that market forces alone will not bridge this geographical divide, and that advanced technologies, such as robotic surgery, AI-diagnostics, and telemedicine, currently remain confined to metropolitan corporate chains. The Committee notes with concern that smaller hospitals in these

regions severely lack access to modern infrastructure, advanced medical equipment, and emerging technologies. 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. By heavily incentivizing Public-Private Partnerships (PPPs) in non-urban areas, the government can ensure that the infrastructure, technological advancements, and high quality of care characteristic of the corporate private sector are made accessible and affordable to the broader rural and peri-urban population.

(Para 1.3.13)

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.

(Para 1.3.14)

Comparative Analysis: Strengths and Weaknesses of Public and Private Healthcare Sectors

8. The latest National Statistical Office survey (80th round of the National Sample Survey January-December 2025) highlights India's deepening healthcare affordability crisis. The Committee notes with deep concern that treatment in private hospitals is often five to ten times costlier than in government facilities, with childbirth and serious illnesses like cancer, heart disease, and kidney failure reflecting the sharpest divides. The average cost of inpatient treatment for an illness in India is about Rs 37,858, while out-of-pocket expenditure is about Rs 34,064. The average cost of hospitalization is Rs. 6,631 in government hospitals compared to Rs. 50,508 in private hospitals. The gap widens further for serious illnesses such as cancer, heart disease and kidney failure.

(Para 1.4.6)

9. The Committee would like to highlight that, as per the 80th round of the National Sample Survey January-December 2025 conducted by National Statistics Office on Household Social Consumption: Health, state-wise data shows that 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. In areas such as Ladakh, spending is recorded at only about Rs 8,000. However, lower spending does not necessarily mean better conditions. It may also point to limited access to healthcare, lower use of services, or people being restricted to cheaper options. The state-wise data also shows that where government health services are stronger, public spending on treatment remains lower. But where the private sector has expanded, spending rises rapidly.For example, in southern Indian states, the role of private hospitals is greater and spending is also higher. In contrast, in the north-eastern states, there is greater reliance on government services, resulting in relatively lower expenditure.

(Para 1.4.8)

10. The Committee is of the view that while the public healthcare system remains the crucial backbone for rural and low-income populations, with severe infrastructure deficiencies, workforce shortages, and extreme overcrowding that, in fact, erodes public trust and driving patients toward unaffordable private care. The Committee, however, notes with concern that excessive patient loads in government hospitals directly compromise consultation times and service efficiency. The Committee, nevertheless,believes that improving the perceived and actual quality of public healthcare is the most sustainable method to reduce the national burden of out-of-pocket expenditure (OOPE). The Committee, therefore, recommends for an accelerated capacity-building initiative focused on expanding bed capacity and recruiting specialized medical personnel in public facilities, particularly in high-demand metropolitan centers. Furthermore, the Ministry must strictly enforce Indian Public Health Standards (IPHS) to ensure that the availability of essential medicines, diagnostics, and modern amenities in government hospitals matches the responsiveness and patient satisfaction levels currently available exclusively to the private sector.

(Para 1.4.17)

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 believes that the rampant commercialization of private healthcare, characterized by grievances of excessive billing, unnecessary diagnostics, and soaring costs for routine procedures like childbirth (average out-of-pocket medical expenditure of Rs. 37,630 in private as compared to Rs. 2,299 in public), is directly pushing vulnerable households into catastrophic debt and distress causing asset sales. 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. Additionally, the government must mandate absolute price transparency prior to admission and establish a unified, fast-track grievance redressal ombudsman specifically designed to audit excessive billing and resolve insurance claim disputes in the private sector.

(Para 1.4.18)

12. The Committee is of the firm view that geographical inequities severely distort healthcare accessibility, with private tertiary care concentrated in urban centers and southern states, driving hospitalization costs above Rs. 50,000, while regions like the Northeast suffer from limited access to advanced care altogether. Although OOPE has declined to 43.4% (as per NHA Estimates 2022-23), 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, thereby shielding marginalized communities, the elderly, and women from the catastrophic financial impoverishment caused by private healthcare expenses.

(Para 1.4.19)

Role of Major Government Schemes in Healthcare Delivery and Financial Protection

13. The Committee is of the view that while the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) provides critical financial protection to over 500 million vulnerable citizens, its success heavily depends on the availability of robust medical infrastructure. Currently, a significant portion of PMJAY funds is absorbed by the private sector due to enduring deficiencies in public tertiary care. The Committee believes that to build long-term systemic resilience and reduce dependency on private facilities, the public sector's absorptive capacity must be drastically improved to enable public sector hospitals as tertiary care providers. The Committee, therefore, recommends the aggressive, fast-tracked execution of the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). The government must urgently prioritize the establishment of critical care hospital blocks and integrated public health laboratories at the district level. 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.

(Para 1.5.12)

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 rational government price caps under schemes like Ayushman Bharat and CGHS, continuously squeeze profit margins and threaten financial sustainability. The Committee believes that forcing an unviable financial model upon hospitals ultimately compromises patient care. The Committee, therefore, recommends that while the Ministry must aggressively mandate the uniform adoption of the Clinical Establishments Act and enforce a tiered quality-assurance framework, it must simultaneously 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.

(Para 1.5.13)

15. The Committee observes that digital initiatives, particularly the Ayushman Bharat Digital Mission (ABDM) and teleconsultation platforms like eSanjeevani and SeHAT, are transformative in bridging the geographical healthcare divide. However, the Committee is of the view that voluntary or fragmented adoption of these digital tools limits their potential to reduce diagnostic duplications and streamline patient referrals. The Committee believes that a seamless digital continuum is necessary to lower the financial and travel burdens on rural populations seeking specialist care. The Committee, therefore, recommends making ABDM compliance mandatory for all public healthcare facilities and private hospitals empanelled under PMJAY. Furthermore, the capacity of Ayushman Bharat Health and Wellness Centres (AB-HWCs) must be systematically augmented with uninterrupted high-speed digital connectivity to ensure that every rural citizen has seamless, reliable access to doctor-to-patient teleconsultations, effectively reducing the referral burden on higher-level urban hospitals.

(Para 1.5.14)

16. The Committee notes with deep concern that despite free treatment entitlements, outpatient expenditures and the cost of medicines continue to drive significant out-of-pocket expenditure (OOPE) for households. The Committee is, therefore, of the considered view that while schemes like the Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP) have successfully provided affordable generic medicines, their physical footprint remains inadequate compared to the overall population's need. The Committee believes that mitigating such specific limitation is the most direct way to protect the patients of economically weaker sections from financial distress. 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 to ensure accessibility and availability of medicines at affordable costs. Concurrently, the Ministry must implement rigorous, technology-enabled audits through the National Health Mission (NHM) to ensure zero out-of-pocket expenditure for pregnant women and neonates under JSSK, explicitly

penalizing medical centres that fail to provide complete free entitlements for drugs, diagnostics, and transport.

(Para 1.5.15)

Definition and Indicators of Affordability and Accessibility

17. The Committee is of the view that affordability and accessibility are intrinsically interlinked.Affordable healthcare holds limited value if facilities remain unavailable or inaccessible, just as accessible infrastructure fails equitability tests if it imposes catastrophic financial burdens on households.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). Immediate financial allocations must be directed toward eliminating Out-of-Pocket Expenditure (OOPE) by guaranteeing the uninterrupted supply of free essential medicines, diagnostic services, and emergency transport across all operational Ayushman Arogya Mandirs.

(Para 2.1.6)

18. The Committee believes that the mere physical availability of healthcare centers does not equate to genuine accessibility if such facilities suffer from inadequate staffing, a deficit of specialists, or substandard equipment.The Committee, therefore, recommends the Ministry of Health and Family Welfare to embark upon the web-based Indian Public Health Standards (IPHS) Dashboard *i.e.,*from a passive self-assessment mechanism into an active, real-time remediation tool. Statutory, time-bound interventions must be mandated to rectify any identified infrastructure and human resource gaps, specifically optimizing doctor-population ratios and hospital bed density, ensuring absolute compliance with both the IPHS and National Quality Assurance Standards (NQAS).

(Para 2.1.7)

19. The Committee is of the view that digital health innovations, particularly telemedicine platforms and the Ayushman Bharat Digital Mission (ABDM), act as crucial equalizers for populations facing severe geographical barriers/gaps.The Committee, therefore, recommends the rapid acceleration of digital health interoperability across the public and private sectors. This expansion must be aggressively supported by upgraded broadband connectivity and digital infrastructure at all rural healthcare facilities to maximize the functional reach of platforms like eSanjeevani. This will ensure seamless continuity of care and immediate access to specialized consultations, effectively bypassing the traditional barrier of physical travel time.

(Para 2.1.8)

OUT-OF-POCKET EXPENDITURE AND FINANCIAL PROTECTION

20. The Committee is of the view that despite the recent reduction in Out-of-Pocket Expenditure (OOPE) over the past decade, the current Government Health Expenditure (GHE) of 1.43 per cent of GDP remains inadequate to ensure universal financial protection. The Committee believes that persisting below the 2.5 per cent of GDP target envisaged in the National Health Policy, 2017, severely hinders the mitigation of catastrophic health expenditures and medical impoverishment. 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 to progressively reduce the populace's disproportionate reliance on costly private healthcare financing.

(Para 2.2.9)

21. The Committee believes that the heavy reliance on the private sector, which currently delivers nearly 60 per cent of hospitalisations and 70 per cent of outpatient services, creates an environment where unregulated costs for diagnostics, consumables, medicines, and intensive care persistently push vulnerable households into indebtedness. The Committee further notes that outpatient treatment, being predominantly composed of consultation and medicine costs, remains the segment least protected by existing insurance architecture, which is overwhelmingly weighted towards hospitalization. Consequently, the Committee is of the view that 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.

(Para 2.2.10)

22. The Committee is of the view that a stark paradox exists wherein India, globally recognized as the 'pharmacy of the world' for its robust generic pharmaceutical industry, still leaves its citizens to bear massive financial burdens for medicines. The Committee notes with concern that Total Pharmaceutical Expenditure constitutes nearly 30 per cent of Current Health Expenditure, with pharmacies alone accounting for over 21 per cent of CHE by provider, making medicines the single largest identifiable component of the nation's healthcare spending. The Committee is of the view that since such pharmaceutical expenditure is disproportionately financed directly by households rather than through insurance or government schemes, thereby constituting one of the foremost structural drivers of India's persistently high OOPE. The Committee believes such compulsion of patient is a major driver of impoverishment, particularly for households managing chronic illnesses. The

Committee, therefore, recommends the Government to aggressively expand and strictly monitor initiatives ensuring the uninterrupted provision of free essential medicines across all tiers of public health facilities. Additionally, the Government must consider to enforce more rigorous price controls on life-saving drugs and over-the-counter medicines in the open market to shield consumers from exploitative pricing, and must actively work to bring pharmaceutical expenditure within the ambit of prepaid and insured health financing rather than leaving it as a direct household cost.

(Para 2.2.11)

23. The Committee finds that the prolonged, recurring nature of treatments for non-communicable diseases (NCDs) consistently drives low-income families into catastrophic health expenditure, effectively neutralizing broader systemic gains in financial protection. The Committee believes that such chronic care is inherently medicine-intensive, requiring sustained and often lifelong pharmaceutical therapy, and that this recurring medicine expenditure, being largely excluded from episodic hospitalization-based insurance coverage, is a principal reason why OOPE remains elevated among NCD-afflicted households, given their limited inclusion under existing public financing and insurance mechanisms, translates directly into household out-of-pocket payments. The Committee, therefore, 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. These safety nets must guarantee lifelong, heavily subsidized access to required diagnostics, therapeutics, essential medicines, and medical consultations for patients suffering from long-term ailments.

(Para 2.2.12)

24. The Committee is of the view that the apparent progress in Government Health Expenditure (GHE), which peaked at 1.84 per cent of GDP in 2021-22, was an anomaly driven by one-off COVID relief and vaccination spending. Relying on this pandemic-year figure created a misleading impression of advancement toward the 2.5 per cent target, a distortion only corrected when the delayed 2022-23 estimates revealed a sharp reversion to 1.43 per cent, perilously close to the pre-pandemic baseline. The Committee believes that the statutory target envisaged under the National Health Policy 2017 must be insulated from emergency fiscal cycles. The Committee, therefore, 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, moving beyond a mere aspirational target, detailing how GHE will move forward from the current levels, *i.e.*, 1.43 per cent, to 2.5 per cent of GDP by a revised goal but with binding timeline. This glide path must be secured by ring-fenced, multi-year budgetary commitments rather than single-year allocations that are vulnerable to cutbacks, with progress strictly reported to Parliament on an annual basis.

(Para 2.2.13)

UNCORRECTED
Signifying Compliance

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.

(Para 2.2.14)

26. The Committee is of the view that the financial protection gains witnessed during the pandemic were fundamentally non-structural. The reduction of Out-of-Pocket Expenditure (OOPE) to 39.4 per cent of Total Health Expenditure (THE) in 2021-22 was highly dependent on emergency-level public spending crowding out private costs; consequently, OOPE rebounded to 43.4 per cent in 2022-23 as government spending receded. The Household health expenditure, as a percent of THE, followed the same reversing pattern from 44.10 in 2021-22 to 49.10 in 2022-23. The Committee believes that genuine affordability requires shielding citizens from these fluctuating cycles exposing to volatile out-of-pocket costs, particularly in the unorganized private sector. 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.

(Para 2.2.15)

27. The Committee takes into account that Capital Health Expenditure is the sole metric demonstrating sustained, consistent improvement, rising steadily from 9.5 per cent to 13.0 per cent of THE, reflecting investment in hospitals, equipment, research and development, and medical education/training. The robust investments in medical education, physical infrastructure, and research and development are the bedrock of long-term healthcare accessibility. 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.

(Para 2.2.16)

28. The Committee believes that effective policy formulation is fundamentally compromised by delayed and insufficiently disaggregated data, as evidenced by the delayed release of the 2022-23 NHA estimates in May 2026 and the continued reliance on 2013-14 survey extrapolations for enterprise expenditures. The Committee is of the view that such time lags create misleading fiscal impressions regarding the true state of healthcare affordability. Furthermore, the Committee finds that the current methodology (National Health Accounting & Practice) fails to adequately capture private-sector, dental, and rehabilitative care spending. 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 to automate healthcare data collection. Such technological overhauling must ensure that NHA estimates are published by the final quarter of the subsequent financial year. Furthermore, comprehensive, updated surveys must be commissioned to accurately capture expenditures in the private sector, dental care, rehabilitative care, and by autonomous bodies.

(Para 2.2.18)

Insurance Penetration and Financial Protection

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.

(Para 2.2.25)

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, as they possess the financial capacity to pay nominal premiums but remain excluded by both fully subsidized government schemes and prohibitively expensive private products. The Committee believes that relying solely on existing frameworks will not suffice for this demographic, which predominantly comprises informal sector and self-employed workers. The Committee, therefore, recommends the introduction of a well-designed,

voluntary, and contributory insurance model through a collaborative effort between the Government and the private sector. Specifically, the Committee recommends developing a modified, highly standardized product building upon the Aarogya Sanjeevani plan, structurally priced between Rs. 4,000 to Rs. 6,000 per family annually. To ensure widespread uptake, this product must strictly minimize waiting periods for disease coverage and explicitly include out-patient (OPD) benefits.

(Para 2.2.26)

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.

(Para 2.2.27)

32. The Committee is of the considered view that, while India has made significant progress in expanding health insurance coverage and reducing out-of-pocket expenditure through initiatives such as AB-PMJAY, increased public investment and affordable medicines programmes, however, substantial gaps in financial protection persist. The continued burden of expenditure on medicines, diagnostics and outpatient care, inadequate insurance penetration among informal-sector workers and the "missing middle", and concerns relating to claim management and private healthcare costs underscore the need for sustained policy interventions. 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.

(Para 2.2.35)

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. The Committee, therefore, recommends an evidence-based expansion of Health Benefit Packages (HBP) under public Insurance schemes to formally encompass comprehensive OPD services, psychiatric disorders, chronic non-communicable disease (NCD) management, and rehabilitation, thereby preventing the systemic diversion of patients to costlier private care avenues.

(Para 2.2.36)

34. The Committee emphasizes that the current private insurance market is heavily skewed toward high-income groups, with unacceptably low penetration in rural and informal sectors, and a rigid focus on inpatient care. Furthermore, widespread inefficiencies, such as slow claim settlements and selective denial of services, severely undermine public trust. The Committee believes that arbitrary pricing and claim manipulation by insurers or empanelled hospitals must be met with stringent regulatory penalties. The Committee, therefore, recommends the mandatory integration of all stakeholders-insurers, TPAs, and healthcare providers-into the National Health Claims Exchange (NHCX) to guarantee real-time, transparent claims processing. Furthermore, the Committee recommends that the National Anti-Fraud Unit (NAFU) continuously leverage AI-driven triggers to heavily penalize deliberate delays and ensure that all private insurance products align with the broader vision of Universal Health Coverage.

(Para 2.2.37)

35. The Committee is of the view that the foundation of affordable healthcare relies on fully functional public infrastructure and the strict regulation of pharmaceutical costs. The Committee believes that the exorbitant OOPE driven by branded medicines, pharmacy malpractices, and irrational antibiotic use requires aggressive, sustained intervention. The Committee, therefore, recommends the immediate execution of a national audit utilizing the Drugs and Vaccines Distribution & Management System (DVDMS) to assess the availability of National List of Essential Medicines (NLEM) drugs and the user costs of diagnostics at all central institutes. Concurrently, the Committee recommends that State Health Agencies utilize the Indian Public Health Standards (IPHS) 2022 web-based dashboard to ensure 100% of healthcare facilities comply with essential service delivery benchmarks, while strictly monitoring the mandate for generic prescribing across all clinical establishments. The Committee recommends that the Governemnt should make provision for upgrading and strengthening infrastructure to meet IPHS standards, maintenance, ensure availability of medicines at these centres, strengthen the diagnostic servies wherever required through PPP mode also, promote universal annual health check-ups, strengthen the AYUSH based arms, ARogya Mandirs.

(Para 2.2.38)

36. The Committee is of the view that while there is a pressing need to equip Health and Wellness Centres (HWCs), Community Health Centres (CHCs), and district hospitals in tribal and rural areas with advance affordable medical equipment. 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 the uninterrupted supply of safe, novel, and affordable indigenous medical technology to all tier-2 and tier-3 public health facilities all across the country.

(Para 2.2.39)

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. Furthermore, the Committee believes that the unregulated, over-the-counter sale of antibiotics driven by these profit motives accelerates the critical threat of Antimicrobial Resistance (AMR). The Committee, therefore, recommends the deployment of strict, multi-sectoral audits targeting retail pharmacy supply chains to cap unjustified trade margins and penalize fake billing practices. Concurrently, 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.

(Para 2.2.40)

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. The Committee, therefore, recommends the rigorous, coordinated enforcement of Food Safety and Standards Authority of India (FSSAI) notifications that prohibit the use of 19 specified antibiotics across all stages of meat, poultry, and seafood processing. Furthermore, the Committee recommends strict national audits to ensure total compliance with Rule 97 of the Drugs and Cosmetics Rules, 1945, which mandates explicit labeling of withdrawal periods for drugs administered to food-producing animals. In addition to regulating pharmaceutical contents, the Committee believes that the physical integrity of medicines is equally vital. The Committee, therefore, recommends that the Central Drugs Standard Control Organisation (CDSCO) strictly enforce statutory standards for primary packaging, specifically promoting and regulating the use of glass bottle containers to ensure the chemical stability and safety of dispensed drugs.

(Para 2.2.41)

UNCOMMITTED
Simplifying Compliance

39. The Committee is of the view that the reported 33% gap in AB-PMJAY fund utilization highlights systemic bottlenecks that restrict the scheme's potential to deliver Universal Health Coverage. Furthermore, the Committee believes that constrained public health expenditure inevitably diverts approximately two-thirds of individuals to seek treatment in the private sector. The Committee, therefore, recommends the Government to grant greater budget flexibility to State Health Agencies, enabling them to adapt benefit packages to localized epidemiological needs and accelerate fund deployment. Concurrently, 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 mandated by the Clinical Establishments Act, 2010.

(Para 2.2.42)

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 and IT platform to address all the issues. The Committee specifically recommends provision for simultaneous application of multiple packages in emergency and multi-speciality cases, introduction of appropriate package codes for critically ill ICU patients requiring surgical intervention, bilateral procedures and patients with concurrent medical and surgical conditions. The Committee also recommends that annual utilization limits for high-cost investigations such as MRI and CT scans be displayed transparently on the portal and that the pending implementation of the 2022 package revisions across all States and Union Territories be expedited to ensure uniformity in reimbursement and service delivery.

(Para 2.2.43)

41. The Committee highlights the need for strengthening the AB-PMJAY portal by enhancing file attachment capacity for complex cases, establishing a robust query management system with real-time tracking and detailed reasons for claim rejections, and designating nodal officers for addressing inter-State and out-of-State beneficiary-related issues. Considering the increasing burden of outstanding payments and delays in claim settlements, the Committee urges the Government to institute a time-bound mechanism for claim processing and reimbursement to safeguard the financial sustainability of empanelled hospitals. The Committee believes that greater transparency through real-time display of package eligibility, utilization limits, claim status and query resolution would significantly improve administrative efficiency, reduce disputes and further strengthen the effective implementation and inclusiveness of the Scheme.

(Para 2.2.44)

42. The Committee believes that while the Employees' State Insurance Corporation (ESIC) remains a cornerstone of India's social security framework, the rapid proliferation of the gig economy and informal labor necessitates an immediate, comprehensive modernization. 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. To rectify these structural deficits and transition toward a technology-driven, patient-centric ecosystem, the Committee, therefore, recommends the immediate execution of strategic administrative and digital reforms to restore stakeholder trust and reduce out-of-pocket expenditures.

(Para 2.2.45)

43. The Committee, further, recommends the phased inclusion of unorganized and platform workers via national databases like e-Shram, supported by flexible contribution structures. Furthermore, the Committee is of the view that the Corporation must implement an end-to-end digital architecture for automated, time-bound claim processing, establish interoperable electronic health records with AI-driven fraud detection, and mandate market-aligned treatment package rates to incentivize premier private healthcare providers. Through enhanced administrative autonomy, robust multilingual grievance redressal, and total transparency in performance metrics, these interventions will decisively align the Corporation with India's universal health coverage objectives.

(Para 2.2.46)

GEOGRAPHICAL DISTRIBUTION OF FACILITIES AND REGIONAL DISPARITIES

44. The Committee is of the view that the Government should first and foremost define the criteria of functional arm of Ayushman Bharat i.e Arogya Mandir. The Government needs to come out with technical specification in terms of infrastructure, HR, availability of supplies and the level of services etc. to ensure uniform understanding and implementation across State services. Need is to ensure implementation of all 12 service packages and strengthen under served services viz. Mental Health, Senior, palliative, dental and ophthtalmic care in all Arogya Mandirs. The Government should fill up critical vacancies, introduce incentives and career path, especially for CHOs and strengthen competency base training. There is further need to enhance community engagement by expanding localized IEC comapigns and strengthn participation of Panchaats, Jan Arogya Samiti (JAS), Mahila Arogya Samiti (MAS) and frontline workers to improve service uptake. The Committee further recommends the Government to ensure availability of reliable ABDM compliant IT infrasturctuve and use of Ayushman Bharat Health Account (ABHA) and Electonic Health Record (HER)

for continuum of care and referrals. Moreover, there is need to Digitize Community-base Assessment Checklist (CBAC), integrate with ABHA and NCD portals, and build frontling worker capacity for effective screening and follow-up and integrate Ayush services.

(Para 2.3.9)

DIGITAL HEALTHCARE INITIATIVE

45. The Committee observes that, notwithstanding the considerable expansion of healthcare infrastructure and digital health services, regional disparities in healthcare accessibility continue to persist across the country. The concentration of specialist services and advanced healthcare facilities in urban areas, coupled with shortages of healthcare personnel and infrastructure in rural and remote regions, continues to constrain equitable access to healthcare. The Committee strongly recommends for posting of post graduate specialists like surgeons, Gynaecologist, Paediatricians, Orthopedicion at CHC levels. The Committee is of the considered view that sustained investment in public healthcare infrastructure, geographically balanced distribution of health facilities and human resources, strengthening of referral and emergency transport systems, expansion of digital health services, incentivizing private sector participation in underserved regions, and targeted interventions for underserved regions are essential for ensuring equitable access to quality healthcare across the country.

(Para 2.3.15)

46. The Committee is of the view that while the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), with its outlay of ₹64,180 Crores, has initiated crucial structural corrections, the profound urban-rural asymmetry in healthcare infrastructure requires expedited intervention. The operationalization of 1.80 lakh Ayushman Arogya Mandirs, alongside the targeted establishment of 3,382 Block Public Health Units (BPHUs), 730 District Integrated Public Health Labs (IPHLs), and 602 Critical Care Hospital Blocks (CCBs), provides a robust foundation. Furthermore, the Committee notes the significant expansion under the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), including the establishment of 22 new AIIMS and the upgrading of 75 Government Medical Colleges.The Committee believes that the corresponding surge in medical colleges and the exponential increase in undergraduate and postgraduate seats must be strategically harnessed to correct regional human resource deficits by improving health care access by posting trained past graduate doctors at CHC level. The Committee, therefore, recommends that the Government implement a geographically responsive deployment policy, linking the increased output of medical professionals directly to mandatory service periods in deficit States, tribal regions, and aspirational districts. Furthermore, infrastructural gaps in the targeted 17,788 building-less Sub-Centres must be prioritized for immediate construction to ensure physical accessibility. The Committee recommends for enchanced facilities for these medical professionals in these areas.

(Para 2.3.16)

47. The Committee is of the view that the Ayushman Bharat Digital Mission (ABDM) has fundamentally transformed the accessibility landscape, evidenced by the creation of over 82.84 crore ABHA IDs, the registration of 4.33 lakh health facilities on the Health Facility Registry (HFR), and the linking of 77 crore health records. The monumental success of eSanjeevani, which has delivered over 425 million consultations through a Hub-and-Spoke model across 1.36 lakh Ayushman Arogya Mandirs, proves that digital interventions can effectively bridge geographical divides. The rollout of the U-WIN portal for immunization and the transition of AarogyaSetu into a comprehensive National Health App further solidify this ecosystem.The Committee believes that maintaining the momentum of digital adoption requires continuous incentivization and advanced technological integration. The Committee, therefore, recommends that the Digital Health Incentive Scheme (DHIS) be significantly expanded to function as a robust "cashback" and financial reward mechanism for doctors and hospitals, thereby lowering adoption costs and encouraging the generation of Electronic Health Records (EHR). Additionally, the Committee recommends accelerating the deployment of Artificial Intelligence, leveraging the Clinical Decision Support System (CDSS) and partnerships with institutions like IIT Kanpur and the Wadhwani Institute, to enable early screening, smart diagnostics, and ambient listening tools for seamless prescription generation in both urban and remote settings.

(Para 2.3.17)

48. The Committee is of the view that the concentration of advanced healthcare facilities in urban areas paradoxically leaves urban slum and vulnerable populations exposed to prohibitive out-of-pocket expenditures and corporate healthcare monopolies. The interventions under the National Urban Health Mission (NUHM) are critical to addressing such disparity. The operationalization of 7,998 Urban Sub-Health Centres (USHCs), 5,401 Urban Primary Health Centres (U-PHCs), 1,373 Polyclinics, and 240 Urban Community Health Centres (U-CHCs) demonstrates a vital commitment to community-embedded urban healthcare.The Committee believes that to truly ensure affordability for migratory and slum populations, the public urban health infrastructure must be aggressively scaled to outpace the reliance on private providers for primary and secondary care. The Committee, therefore, recommends the rapid scaling of 100-bedded U-CHCs in all metropolitan cities, coupled with specialized funding under the National Health Mission (NHM) to manage overcrowding in urban public hospitals. Simultaneous policy frameworks must be introduced to provide low-interest loans and tax incentives to private sector entities willing to establish tertiary care and diagnostic facilities exclusively in Tier-2 and Tier-3 cities, thereby redirecting private investment away from saturated metropolitan hubs to deficit regions.

(Para 2.3.18)

49. The Committee expresses concern to find that regional disparities are acutely exposed during health emergencies, infectious disease outbreaks, and disasters. The establishment of Metropolitan Public Health Surveillance Units (MSUs) and the expansion of the Integrated Health Information Platform (IHIP) across all 36 States and UTs, achieving over 70% reporting, are commendable milestones in real-time disease surveillance. The deployment of BHISHM (Bharat Health Initiative for Sahyog, Hita,

and Maitri) cubes and the establishment of 15 Health Emergency Operation Centres (HEOCs) significantly bolster rapid response capabilities.The Committee believes that proactive biosecurity and epidemic preparedness must be a localized reality rather than a centralized luxury. The Committee, therefore, recommends the expedited completion and operationalization of the five Regional Centres for Disease Control and the National Centre for Disease Control (NCDC) upgrades, particularly the specialized divisions for Antimicrobial Resistance (AMR), One Health, and Climate Change. The Government must ensure that the surveillance networks established at Points of Entry (PoE) and regional laboratories are fully integrated with the ABDM infrastructure to provide immediate, predictive data modeling for localized health interventions.

(Para 2.319)

50. The Committee is of the view that the burden of healthcare costs disproportionately impacts vulnerable demographic segments. The data explicitly highlights that poorer households, older adults, and individuals with lower education levels incur significantly higher Out-of-Pocket Expenditure (OOPE). Furthermore, women face pronounced barriers to access and suffer from lower insurance claim settlement rates, which fundamentally contradicts the vision of Universal Health Coverage. This inequity is compounded by stark regional variations in treatment costs—where hospitalization expenses in southern states like Tamil Nadu and Telangana (~₹50,000–₹55,000) are more than double those in Odisha (~₹22,000).The Committee believes that the digital health infrastructure must evolve beyond data interoperability to become a proactive instrument for financial protection and ethical healthcare delivery. The Committee, therefore, recommends the immediate implementation of an AI-enabled National Digital Health Ecosystem, supported by a dedicated AI-enabled National Health Fund. Such framework must institutionalize AI-driven financial surveillance tools to monitor billing anomalies, audit exorbitant out-of-pocket costs, standardize tertiary care pricing across the private sector, and ensure swift, equitable claim settlements for marginalized groups.

(Para 2.3.20)

51. The Committee, further, recommends the Government to expand the assisted and offline modes of ABHA ID creation in low-connectivity regions, capitalizing on the momentum that women currently constitute 49.15% of ABHA holders. This must be coupled with targeted capacity-building programs, localized community outreach, and the expansion of multilingual support via the 14477 toll-free helpline to foster digital literacy. To further build trust and ensure patient-centric care, the Committee believes that adopting specific technological safeguards, such as leveraging AI and subscription models in ultrasound diagnostics to eradicate sex-determination fears, must be prioritized. These targeted interventions will ensure that technological advancements in healthcare directly safeguard the financial and social security of the most vulnerable citizens.

(Para 2.3.21)

Availability of Human Resources: Persistent Challenges

52. The Committee, having examined stakeholder submissions and the Ministry's progress on capacity building through the SASHAKT portal, strongly recommends that the Ministry of Health and Family Welfare formulate a comprehensive strategy to strengthen health human resources in rural and tribal regions by expediting recruitment processes, establishing uniform pay scales for specialist doctors, and ensuring the prompt, uninterrupted payment of remuneration to ASHA and NHM personnel. To immediately alleviate critical shortages in under-resourced areas, the Committee is of the view that the Ministry must institutionalize flexible hiring mechanisms, such as part-time engagements for super-specialists and consultant appointments at taluka and sub-district hospitals, while simultaneously expanding the role of allied health and paramedical professionals. Furthermore, the Committee recommends further scaling the SASHAKT digital ecosystem to continuously track, upgrade, and standardize training modules for all frontline and medical cadres across expanded healthcare service packages.

(Para 2.4.9)

53. The Committee is of the view that despite commendable efforts to expand medical education capacity, evidenced by the 151% increase in MBBS seats, the 163% increase in PG seats, the establishment of 818 medical colleges, and the induction of over 5.23 lakh personnel under the National Health Mission, the severe shortfall of specialists at Community Health Centres fundamentally compromise equitable healthcare access. The physical infrastructure of Primary Health Centres and premier institutes alike is rendered ineffective without a stable, adequately distributed workforce. While the induction of nearly 25,000 AYUSH doctors and the formalization of 57 allied professions under the National Commission for Allied and Healthcare Professions (NCAHP) Act, 2021 are positive steps, they must be matched with aggressive retention strategies and safe working environments. The Committee, therefore, recommends that the Government immediately mandate all States to establish dedicated Health Recruitment Boards to drastically fast-track the filling up of vacant posts in strict accordance with IPHS 2022 norms. To counter rural attrition and correct inter-State disparities, it is imperative to regularize contract doctors, expand the "You Quote, We Pay" scheme, implement uniform pay scales for specialists. Furthermore, the mandatory District Residency Programme (DRP) must be rigorously monitored to guarantee a sustained specialist presence at the secondary level, particularly within aspirational and tribal districts.

(Para 2.4.10)

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. Finally, the Committee appreciates the March 2025 increase in ASHA fixed incentives to ₹3,500 and recognition awards up to ₹50,000, but recommends that systemic delays in remuneration to ASHA and NHM workers be eliminated through seamless and timely disbursement mechanisms. Public hospitals must also be mandated to appoint dedicated biomedical engineers and physiotherapists to bolster comprehensive care.

(Para 2.4.11)

Infrastructure Development and Essential Services

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 to restore rural public facilities, specifically prioritizing Primary Health Centres and Health and Wellness Centres based on local demographic needs and disease burdens. Furthermore, the Committee believes it is imperative to accelerate the deployment of 15th and 16th Finance Commissions health grants for rehabilitating dilapidated sub-district infrastructure, ensure the immediate rollout of the proposed 200 Day Care Cancer Centres across district hospitals, and mandate that public medical institutions establish dedicated vascular and endovascular surgery departments to combat complex, emerging disease burdens. The Committee further recommends that the Government should implement in letter and spirit the budget announcements (2026-27) pertaining to the Health Sector, including Health and Family Welfare, Health Research and Ayush intended to ensure the accessibility and affordability of health care facilities.

(Para 2.4.18)

56. The Committee believes that to supplement public expenditure and alleviate the severe overburdening of tertiary public hospitals, public capital must be synergized with private capabilities without heavy upfront capital demands. 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. Concurrently, the Committee is of the view that the Ministry must adopt Operational Expenditure (OPEX)-based Public-Private Partnership (PPP) models, facilitate the regulated deployment of high-quality pre-owned equipment in smaller cities, and establish urban PPP clinics tailored to middle-income populations. Furthermore, 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.

(Para 2.4.19)

57. The Committee is of the view that access to advanced medical technology remains heavily concentrated in urban corporate centers, and immediate structural interventions must be taken to decentralize these essential services. The Committee, therefore, recommends deploying mobile diagnostic units equipped with portable X-ray, ultrasound with liver scan facility to assess fatty liverand other diseases like pancreatitis etc., ECG machinery portable ventilators for life saving directly to rural and remote populations, while simultaneously leveraging Public-Private Partnerships to scale high-quality diagnostic services across all public healthcare facilities. To ensure seamless operational execution and timely medical interventions, the Committee believes the Ministry should mandate the expansion of the hub-and-spoke telehealth model across all districts. Additionally, the 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.

(Para 2.4.20)

58. Beyond immediate infrastructure and diagnostic coverage, the Committee believes that long-term healthcare resilience requires systemic policy innovation and rigorous accountability. The Committee, therefore, recommends increasing strategic investments in research and development to promote the indigenous manufacturing of medical devices and specialized hardware, thereby neutralizing import dependencies and significantly lowering overall patient treatment costs. Finally, to ensure transparent resource distribution and actively eliminate geographic inequities across the country, the Committee is of the view that the 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.

(Para 2.4.21)

Accessibility for Vulnerable and Disadvantaged Groups

59. The Committee is of the view that socially and geographically marginalized segments, specifically Scheduled Castes (SC), Scheduled Tribes (ST), Particularly Vulnerable Tribal Groups (PVTGs), and migrant laborers, encounter persistent structural barriers that severely compromise their right to timely healthcare. The Government's decision to relax population norms for setting up public health facilities in tribal and hilly areas (establishing a Sub-Health Centre for every 3,000 population, a PHC for every 20,000, and a CHC for every 80,000) and the deployment of 30,593 Ayushman Arogya Mandirs (AAMs) across 178 tribal-majority districts are highly progressive policy recalibrations. The Committee believes that the immense capital outlays under the ₹79,156 crore DhartiAabaJanjatiya Gram Utkarsh Abhiyan and the ₹24,104 crore PM JANMAN Mission serving PVTGs have the potential to fundamentally transform tribal health equity, but must be translated into immediate, resilient last-mile delivery mechanisms to counter high out-of-pocket expenditure and localized health crises. The Committee, therefore, recommends that the Ministry of Health and Family Welfare must expedite the deployment and rigorous tracking of the

envisioned 1,694 Mobile Medical Units (MMUs) under these schemes to systematically cover villages situated beyond 5 km in hilly terrains and 10 km in plain regions.

(Para 2.4.26)

60. The Committee recommends that the Government must establish dedicated public Centres of Excellence within high-burden tribal belts to anchor the screening, counselling, and therapeutic targets of the 7 crore population mandated under the Sickle Cell Anaemia Elimination Mission. Furthermore, to safeguard the health of floating labor populations, the Ministry must also cross-link the U-Win platform's portable digital vaccination record system with inter-State labor registries to guarantee that children of migrant families receive uninterrupted, contiguous immunization coverage regardless of relocation. Also, PM-JAY's expansion to 12 crore families, ASHA workers, and all senior citizens aged 70 and above must be backed by aggressive grassroots awareness campaigns.

(Para 2.4.27)

61. The Committee recommends extending the coverage under the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to all children below five years of age and all senior citizens aged 60 years and above, irrespective of their socio-economic status or geographical location. The Committee considers this universalization a pivotal step toward advancing Universal Health Coverage (UHC) and mitigating the disproportionate financial burden associated with childhood and geriatric illnesses. To operationalize this effectively, the Committee further recommends that the Ministry ensure adequate financial provisioning, establish seamless enrolment mechanisms, and build robust synergy with existing child and elderly health programs to guarantee equitable, timely, and affordable healthcare services to every eligible beneficiary.

(Para 2.4.28)

Quality Assurance and Regulatory Oversight

62. The Committee is of the view that while the scaling of 1.8 lakh Ayushman Arogya Mandirs (AAMs) and the delivery of over 425 million consultations via the eSanjeevani platform through 18,000 hubs have significantly transformed primary healthcare and contributed to reducing Out-of-Pocket Expenditure (OOPE) from 64.2% to 43.4%, a persistent and troubling gap remains between policy formulation and ground-level execution. Reports of recurrent shortages of mandated essential medicines (172 drugs) and diagnostic capabilities (63 tests) at sub-centres and rural primary health facilities continue to force vulnerable populations to seek expensive private care, thereby diluting the impact of the National Health Mission's free initiatives. The Committee believes that structural institutionalization and supply-chain resilience are paramount. The Committee, therefore, recommends that the Government immediately strengthen the hub-and-spoke tele-health network by integrating the extensive logistics network of the Department of Post to ensure the uninterrupted, real-time supply of medicines and diagnostic reagents to remote spokes. The Ministry must expand the fleet of Mobile Medical Units (MMUs) beyond the current ceiling of five units per district in high-demand areas, equipping them with portable X-ray, ultrasound, and ECG machines for

comprehensive rural coverage. Furthermore, the Committee recommends the development and implementation of a standardized Health Facility Access Index to continuously audit and map physical, operational, and structural barriers at public facilities, thereby ensuring absolute accountability, compliance with National Quality Assurance Standards (NQAS), and zero stock-outs of mandated essential medicines and diagnostic reagents at the grassroots level.

(Para 2.4.36)

63. The Committee is of the considered view that socio-economic vulnerabilities uniquely distort health outcomes for low-income households, women, the elderly, and persons with disabilities. Although women constitute 49 per cent of Pradhan Mantri Jan Arogya Yojana (PM-JAY) card users, and targeted schemes like the Janani Shishu Suraksha Karyakram (JSSK) and LaQshya have significantly compressed maternal healthcare delivery liabilities, delayed health-seeking behaviors and rising out-of-pocket spending on chronic non-communicable diseases (NCDs) remain critical concerns. The Committee believes that the expansion of universal PM-JAY coverage to all citizens aged 70 years and above, marked by the issuance of over 86 lakh cards providing a ₹5 lakh cover, demands structured physical and clinical institutionalization to avoid becoming a mere financial mechanism. The Committee, therefore, recommends that the Government scale up decentralized palliative and geriatric care infrastructure across all operational AAMs to manage the long-term chronic needs of the aging demographic. The Ministry must mandate the time-bound establishment of a Physical Medicine and Rehabilitation (PMR) Centre in every district of the country to ensure specialized, dignified care for persons with disabilities. To bridge the gap between policy intent and ground-level execution, the Committee further recommends that compliance with the NQAS and Indian Public Health Standards (IPHS) regarding physical access features, such as ramps and disabled-friendly toilets, be subjected to mandatory annual independent audits. Finally, the Government must launch a hyper-localized, multi-lingual Information-Education-Communication (IEC) campaign to raise community awareness regarding decentralized entitlements, including the National Dialysis Programme and free community-level NCD screenings.

(Para 2.4.37)

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 within private hospitals continue to drive high out-of-pocket expenditure and severely exploit economically vulnerable patients. While the Ministry's implementation of the National Medical Commission (NMC) guidelines to regulate fees for 50% of seats in private medical institutions and deemed universities is a commendable step toward affordable medical education, the actual costs of clinical treatments and procedures in the private sector remain inadequately monitored. The Committee believes that absolute transparency and stringent accountability must be enforced to protect patients from commercialized exploitation. 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. The Ministry

must introduce mandatory compliance audits for private clinical establishments to monitor deviations from standard medical practices, such as unwarranted surgical interventions, and strictly audit private hospitals offering DNB and residency training to prevent exorbitant fee extraction. Concurrently, the government must enforce the mandatory availability and prescription of generic medicines in private hospitals.

(Para 2.4.38)

65. The Committee believes that the current institutional framework in the public sector unnecessarily burdens highly trained medical specialists with routine administrative and logistical operations, resulting in long patient wait-times and diminished quality of clinical care. The Committee believes that bridging the gap between macroeconomic outlays and ground-level healthcare delivery requires a structural separation of clinical and administrative workflows. 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.

(Para 2.4.39)

66. The Committee is of the view that to systematically dismantle regional imbalances in super-specialty treatment, the Ministry must implement a multi-tiered strategy that includes clustering groups of 5-6 medical colleges to share specialist resources and upgrading existing state medical institutions to function at par with AIIMS Delhi. Finally, the National Medical Register (NMR) portal, launched in August 2024, must be cross-leveraged alongside the enrolment portals of the NCAHP to maintain real-time, transparent oversight of the country's medical and allied health workforce credentials and transfers, ensuring that statutory standards are uniformly maintained across both the public and private sectors. The government must ensure the time-bound, rigorous execution of the Union Budget 2025-26 mandate to operationalize 200 additional Day Care Cancer Centres this year, maintaining strict oversight to guarantee that every single district hospital nationwide is equipped with fully functional oncology day-care facilities within the designated three-year horizon.

(Para 2.4.40)

67. The Committee is of the view that the recent Cabinet approval adding over 10,000 new medical and PG seats (scaling to 75,000 over five years) is a right step toward correcting the doctor-population ratio. Innovations like the mandatory Family Adoption Programme, the District Residency Programme (DRP), and Competency-Based Medical Education reflect a forward-looking academic vision. The Committee believes that while primary care is expanding, super-specialty care remains geographically concentrated, necessitating further decentralization. The Committee, therefore, recommends that alongside the 22 approved AIIMS, the Government must identify geographic clusters to develop existing state medical colleges at par with premier institutes. Furthermore, academic curriculum must be urgently modernized. Undergraduate and postgraduate curricula should be immediately updated to include strengthened, mandatory modules on respiratory medicine, and dedicated departments for endovascular/vascular surgery must be established. Finally, the Committee recommends increased R&D funding aimed at indigenizing specialized medical devices

and vascular hardware to reduce import dependencies. The Committee is, however, concerned to note that the rapid expansion of PG medical seats without adequate clinical exposure and proper training is severely diluting the quality of health care standards. The Committee recommends that the expansion of under graduate and post graduate seats should be done only after ensuring quality education, adequate training and clinical exposure.

(Para 2.4.41)

68. The Committee is of the considered view that strengthening public healthcare infrastructure, improving financial protection mechanisms, ensuring availability of affordable medicines and diagnostics, enhancing regulatory oversight of private healthcare services, expanding human resource capacity, and ensuring targeted interventions for vulnerable groups are essential for achieving affordable, accessible and equitable healthcare for all citizens.

(Para 2.4.42)

Development of Innovative and Cost-Effective Treatment Procedures and Technologies

69. The Committee appreciates the highly promising outcomes of the MedTech Mitra platform, which has already mentored over 400 innovators, and the establishment of Centres of Excellence (CoEs) across seven IITs, yielding 43 indigenous medical technologies and 16 start-ups. The Committee believes that achieving self-reliance in medical technology is the most sustainable pathway to significantly lower the cost of critical treatments, such as the drastically reduced prices already achieved for paediatric formulations like isotretinoin and PREVALL. The Committee, therefore, recommends a substantial expansion of the CoE scheme to other premier engineering and medical institutes across the country to follow the suit with intention to lower the cost of treatment. The Committee also recommends that the Government should establish a dedicated procurement quota within national health programs for indigenously developed, validated technologies to guarantee market access for start-ups and MSMEs navigating the "valleys of death" with a hope to cross over.

(Para 3.2.5)

70. The submission of DHR highlights the pivotal role of the Health Technology Assessment in India (HTAIn) in providing rigorous, evidence-based recommendations on the cost-effectiveness and safety of health interventions. Given the imperative to optimize government spending and reduce the out-of-pocket burden on citizens, the Committee is of the view that systematic evaluations must become the bedrock of all public healthcare expenditure. The Committee, therefore, recommends that HTAIn clearance be made a mandatory prerequisite for the inclusion of any new diagnostic tool, medical device, vaccine, or therapeutic procedure into the procurement lists of the National Health Mission and the Pradhan Mantri Jan Arogya Yojana (PMJAY). The Committee, further, recommends the establishment of state-level HTA nodes to ensure that cost-effectiveness thresholds are tailored to regional health priorities and economic realities to expand the length and breadth of health schemes of the programmes to the last miles.

(Para 3.2.6)

71. The proposed Medical Innovations Development Acceleration Council (MIDAC) represents a critical intervention for de-risking biomedical research in areas that lack lucrative commercial incentives but possess immense public health importance. Furthermore, the Model Rural Health Research Units (MRHRUs) and Tribal Health Research Network are essential for ensuring that innovations reach the most vulnerable populations especially rural, hilly and tribal region. The Committee believes that an equitable healthcare system cannot rely solely on market-driven research but must touch the poor population through welfare measures. The Committee, therefore, recommends the immediate operationalization and robust capitalization of MIDAC to foster public-private partnerships specifically targeting neglected tropical diseases and regional outbreaks. The Committee believes linking MRHRUs directly with the MedTech Mitra ecosystem, ensuring that new point-of-care diagnostics (such as the AI-enabled handheld X-ray devices and CRISPR-CAS kits) are field-tested and deployed directly in underserved rural and tribal corridors.

(Para 3.2.7)

72. The introduction of the Patent Mitra initiative in March 2025 is a commendable step, having already facilitated 24 patent applications and the successful transfer of one technology to the industry. However, to translate laboratory success into widespread accessibility, the bridge between patenting and commercial-scale manufacturing must be strengthened and expanded. The Committee is of the view that a robust intellectual property framework is only effective if it culminates in the rapid commercialization and deployment of affordable health solutions for all & irrespective of gender. The Committee, therefore, recommends creating a fast-track technology transfer mechanism within Patent Mitra that actively matches patent-holders with public sector undertakings (PSUs) and established private manufacturers. The Committee also recommends providing targeted financial subsidies or tax incentives to private sector entities that successfully license and mass-produce technologies protected under the Patent Mitra and CoE frameworks and intended to ensure accessibility and affordability of healthcare facilities.

(Para 3.2.8)

Effective Preventive Healthcare Strategies for Reducing Healthcare Costs

73. The Committee takes note of preventive healthcare strategies of DHR for reducing healthcare cost. The DHR clearly demonstrated that preventive interventions, such as rapid diagnostic tests for Sickle Cell Disease, universal neonatal hearing screening (Sohum), and tele-screening for diabetic retinopathy, have saved the exchequer thousands of crores while preventing irreversible disease progression. The Committee is of the view that shifting the healthcare paradigm from curative treatments to proactive, early detection is the most effective strategy to manage India's disease burden. The Committee, therefore, recommends the immediate integration and nationwide rollout of ICMR-validated syndromic diagnostic algorithms and point-of-care screening tools across all Ayushman Arogya Mandirs and Primary Health Centres (PHCs). The Committee is of the view that dedicated budgetary allocations be made for state governments to deploy decentralized screening models, similar to the successful

Hepatitis B & C screening in Tamil Nadu and ECG deployments in Gujarat, to intercept chronic diseases at their onset.

(Para 3.3.9)

74. The rational interpretation of DHR data reveals that targeted cost-effectiveness analyses, such as the Costing of Health Services in India (CHSI) and the optimization of Breast Cancer therapy (Trastuzumab) from a 1-year to a 6-month regimen, have vastly improved reimbursement efficiency and saved hundreds of crores annually. The Committee believes that standardizing treatment regimens based on synthesized, indigenous evidence (through platforms like SARANSH) is essential to prevent over-medicalization and ensure the financial sustainability of public health insurance. 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.

(Para 3.3.10)

Development of an Inclusive and Equitable Healthcare System through Health Research

75. The Committee considers that the current network of 118 Multi-Disciplinary Research Units (MRUs) and 36 Model Rural Health Research Units (MRHRUs) is not sufficient for adequate development of an inclusive and equitable healthcare system. While successful pilot projects like the DISHA surveillance system and the TAEI-SMART stroke management app have proven effective, the Committee is of the view that a footprint of just 36 MRHRUs is geographically inadequate to represent the diverse epidemiological profile of rural India. The Committee believes that rural populations must be actively included in clinical trials to ensure that medical research is genuinely equitable. The Committee, therefore, recommends a time-bound expansion plan to establish at least one MRU in every government medical college and one MRHRU in every district across the country. The Committee also recommends that these units be explicitly mandated to operate integrated environmental and disease surveillance systems (like DDESS) to track emerging outbreaks at the grassroots level and to conduct large-scale, multi-centric clinical trials directly within rural communities.

(Para 3.4.5)

Health Literacy for Informed Healthcare Decisions

76. The Committee observes that the DHR has initiated crucial steps to translate scientific research into accessible knowledge through state sensitization workshops and digital tools like the DARPAN dashboard. However, the Committee believes that scientific advancements and clinical evidence fail to achieve their full impact if the research remain confined to academic circles and are not systematically transferred to frontline health workers and the general public. The Committee, therefore, recommends the establishment of dedicated "Evidence Translation Cells" within State Health

Departments to systematically convert ICMR research findings and HTAIn evaluations into vernacular, highly accessible guidelines for ASHA and Anganwadi workers. The Committee believes in scaling up regional digital literacy programs to ensure that district-level public health functionaries are fully trained to utilize evidence synthesis tools and data dashboards for real-time, programmatic decision-making.

(Para 3.5.2)

Use of AI, Drones and IT in Disease Surveillance and Healthcare Delivery

77. The Committee takes into account the successful pilots under the i-DRONE initiative, ranging from vaccine distribution in hilly terrains of Nagaland and Himachal Pradesh to ultra-critical intraoperative biopsy transport in Karnataka, blood delivery in Delhi-NCR, and corneal transport in Haryana, demonstrate that drone technology can overcome severe geographical and logistical barriers. The Committee, however, views that transitioning from isolated pilot projects to a operationalized, nation-wide medical drone delivery system is paramount for achieving universal health accessibility. The Committee believes that reducing turnaround times for pathological testing and ischemic windows for organ transplants directly translates into lives saved. The Committee, therefore, recommends that the Department of Health Research collaborate with the Ministry of Civil Aviation to establish designated "Green Medical Air Corridors" connecting peripheral health centers to district and tertiary care hospitals across all hilly, island, and hard-to-reach regions. The Committee is of the view that the formal integration of drone-based logistics into the Universal Immunization Program (UIP), the National TB Elimination Program (NTEP), and the National Organ and Tissue Transplant Organization (NOTTO) to ensure the uninterrupted, rapid transport of vaccines, diagnostic samples, blood products, and tissue grafts.

(Para 3.8.5)

78. The Committee is assured that the creation of the ICMR-IISc Centre for Medical Image Datasets (MIDAS) and the release of ethical guidelines for AI in healthcare mark significant steps forward. The Committee believes that AI-powered point-of-care tools can democratize specialized diagnostic expertise in resource-constrained rural public health facilities. The Committee, however, observes that a lack of standardized, indigenous reference data often stifles private and academic medtech innovation in India. The Committee, therefore, recommends expanding the MIDAS initiative beyond oral cancer and dural lesions to include thematic reference datasets for high-burden conditions such as diabetic retinopathy, maternal-fetal anomalies, and chest radiographs. The Committee, further, recommends that AI-enabled be progressively procured and deployed at all Ayushman Arogya Mandirs to empower mid-level health providers with immediate, high-accuracy diagnostic capabilities.

(Para 3.8.6)

79. The Committee notes that ICMR has initiated AI-based predictive analytics for disease burden estimation and early warning systems for outbreaks such as Dengue, Malaria, and COVID-19 through the newly established ICMR-National Institute of Research in Digital Health and Data Sciences. The Committee is of the view that proactive, data-driven epidemic forecasting is far more cost-effective than reactive outbreak management, which severely strains healthcare infrastructure and public

finances. The Committee, therefore, recommends establishing real-time linkages between ICMR's AI early-warning predictive models and state public health management cadres to enable automated alerts for vector-borne and infectious disease surges. The Committee believes that dedicated funding for investigator-initiated AI/ML projects focusing on non-communicable disease (NCD) risk projection, enabling targeted lifestyle and clinical interventions long before acute hospitalization is required.

(Para 3.8.7)

80. The Committee appreciates the critical breakthroughs in cost reduction, such as providing pediatric formulations like PREVALL for childhood leukemia at one-tenth of international costs, alongside diagnostic solutions for occupational diseases like silicosis. The Committee believes that no family should face catastrophic health expenditure or impoverishment due to specialized childhood cancers or occupational hazards that afflict vulnerable labor populations. The Committee is of the view that public sector production and procurement must be leveraged to drive market prices down across all rare and high-cost conditions. The Committee, therefore, recommends that formulations like PREVALL and pediatric isotretinoin be included in the National Essential Medicines List (NEML) and guaranteed through centralized public procurement schemes to ensure zero-cost availability across all government pediatric oncology centers. The Committee also recommends launching targeted, mandatory screening drives using DHR-validated low-cost diagnostics for occupational diseases like silicosis in high-risk industrial, mining, and construction corridors across India.

(Para 3.8.8)

Optimal Use of Resources to Strengthen Health Services for Underserved Populations

81. The Committee is pleased to observe that the National Health Research Priorities (NHRP) focus on antimicrobial resistance (AMR), One Health, tuberculosis, vector-borne diseases, cancer and non-communicable diseases, with emphasis on high-burden and underserved regions. In this regard, the Committee recommends that under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), DHR-ICMR must continue for strengthening pandemic preparedness by upgrading Virus Research and Diagnostic Laboratories (VRDLs) to improve early pathogen detection, outbreak investigations and disease control.

(Para 3.9.3)

82. The Committee takes note of significant establishment of five BSL-3 facilities (in Kota, Rishikesh, Raipur, Rajkot, and Bibinagar), the deployment of mobile BSL-3 units, and the setting up of the National Institute of One Health (NIOH) at Nagpur alongside four regional National Institutes of Virology (NIVs). The Committee views that decentralized regional biosecurity infrastructure is essential to detect pathogen clusters early and prevent localized outbreaks from escalating into national crises. The Committee believes that cross-sectoral threats at the human-animal-environmental interface require a unified governance structure. The Committee, therefore, recommends the time-bound operationalization and full staffing of the four regional NIV hubs (Jammu, Jabalpur, Dibrugarh, and Bengaluru) and the National Institute of

One Health (NIOH) at Nagpur. The Committee, visualizes that expanding the deployment of Mobile BSL-3 diagnostic units to cover every geographically isolated, eco-sensitive, and international border zone would definitely ensure rapid on-site outbreak investigation and ensure immediate necessary medical interventions for needy patients.

(Para 3.9.5)

Research & Development Projects Enhancing Healthcare Affordability and Accessibility

83. The Committee applaudes that the R&D initiatives of DHR have significantly improved healthcare affordability and accessibility through the development of indigenous diagnostics, medical technologies and affordable treatments. Key innovations include AI-enabled TB screening devices, CRISPR-based diagnostic kits, rapid tests for infectious diseases, automated cervical cancer screening, brain injury assessment tools, and low-cost paediatric cancer therapies. DHR has also strengthened national programmes such as the India Hypertension Control Initiative (IHMI) and Anaemia Mukt Bharat, while Health Technology Assessment in India (HTAIn) has supported evidence-based adoption of cost-effective interventions under Ayushman Bharat and other public health programmes.

(Para 3.10.1)

Barriers to Health Innovation and Strategies to Overcome

84. The Committee commends that DHR has adopted an integrated strategy comprising risk mitigation support through the First-in-the-World Challenge and MedTech Mitra; Health Technology Assessment (HTA) for large-scale adoption of cost-effective interventions; Centres of Excellence at IITs and other academic institutions to accelerate affordable MedTech innovation; implementation of the National Health Research Priorities (NHRP) focusing on tuberculosis, antimicrobial resistance (AMR), cancer and non-communicable diseases; and promotion of the One Health approach to strengthen collaborative research across human, animal and environmental health sectors.

(Para 3.11.3)

85. The Committee highlights that the I-RISE portal, launched by ICMR in November 2024, has facilitated over 1,700 bookings for high-end research infrastructure, directly lowering compliance and validation hurdles for early-stage innovators. Furthermore, DHR proposes establishing a national network of Biobanks and Validation Centres under MIDAC a section 8 Company. The Committee believes that capital-intensive biomedical instruments in public institutions must be treated as national assets rather than isolated institutional property. The Committee is of the view that lack of access to biological samples and standardized testing facilities remains a major barrier for Indian MSMEs. The Committee, therefore, recommends making it mandatory for all central health institutions, AIIMS, and state medical colleges receiving government grants to list their advanced research equipment on the I-RISE portal for shared access. The Committee, further, recommends the immediate rollout of the proposed national network of accredited Biobanks and Validation Centres under

MIDAC to provide start-ups with seamless access to high-quality clinical samples and testing facilities.

(Para 3.11.4)

86. The Committee emphasizes DHR's efforts to tackle NCDs through the scale-up of the India Hypertension Control Initiative (IHMI) and nutritional advocacy by ICMR-NIN regarding High in Fat, Sugar, and Salt (HFSS) food labelling. The Committee, however, is of the view that curb-side clinical treatment alone cannot halt the growing burden of metabolic disorders, hypertension, and cardiovascular diseases. The Committee believes that strong, preventive public policy interventions are necessary to foster healthier population-level choices and minimize long-term chronic healthcare costs. The Committee, therefore, recommends that the Government expedite mandatory, standardized front-of-pack HFSS food labelling regulations, incorporating the scientific thresholds established by the ICMR-National Institute of Nutrition (NIN). The Committee also recommends expanding the India Hypertension Control Initiative (IHMI) framework into a universal protocol across every primary healthcare center in the country, ensuring protocol-based management and unbroken supply chains for essential anti-hypertensive drugs.

(Para 3.11.5)

87. The Committee understands that developing breakthrough biomedical technology involves high capital requirements, complex regulatory compliance, and significant market risk, often leading to limited private sector participation. Schemes like the "First in the World Challenge" and translational grant frameworks are designed to mitigate these financial "valleys of death." The Committee believes that relying exclusively on imported cutting-edge technologies exposes national health security to supply chain vulnerabilities and prohibitive pricing. The Committee is of the view that state-backed risk-sharing mechanisms are necessary to build indigenous global technology leaders. The Committee, therefore, recommends the creation of a dedicated, high-value 'National Biomedical Breakthrough Innovation Fund' under DHR to expand programs like the 'First in the World Challenge' for high-risk, high-reward translational research. The Committee believes establishing tax-incentivized co-developmental frameworks and matching-grant schemes to encourage private medtech and pharmaceutical enterprises to co-fund public R&D projects from prototype to market launch.

(Para 3.11.6)

Strengthening India's Global MedTech Ecosystem and Product Development

88. The Committee understands highlights the limitations of the current market-based drug pricing mechanism administered by the National Pharmaceutical Pricing Authority (NPPA) under DPCO 2013, particularly regarding innovative biologics, biosimilars, and high-cost therapies. The Committee is of the view that pricing based on average retailer margins fails to deliver fair, sustainable pricing for novel interventions. The Committee believes that pricing governance must strike a balance between the cost-based model and a value-based model to ensure both affordability and industry sustainability. The Committee, in this regard, recommends that Health Technology Assessment (HTAIn) outputs on clinical efficacy, social value, and cost-effectiveness be

formally integrated into NPPA's price-fixation guidelines for all high-cost biologics, orphan drugs, and biosimilars. The Committee, further, recommends that DHR collaborate with the NPPA to establish legal and economic policy frameworks for Value-Based Pricing and Managed Entry Agreements (MEAs), while strengthening capacity to utilize TRIPS flexibilities for critical, life-saving therapies.

(Para 3.22.2)

89. The DHR-ICMR Viksit Bharat Strategic Plan (2025–2029) sets ambitious targets to transition India into a high-value global innovation hub by advancing frontier research in synthetic organs, gene therapy platforms, and therapeutic vaccines. To support this, stage-wise funding mechanisms—such as the "First in the World Challenge" (offering ₹1 crore for PoC, ₹4 crore for prototype, and ₹10 crore for rollout)—have been structured. The Committee believes that India's long-term health security depends on shifting from low-cost generic manufacturing to pioneering transformative, cutting-edge therapies. The Committee, therefore, recommends dedicated annual budgetary outlays under the 2025–2029 Strategic Plan specifically earmarked for high-risk, frontier biomedical research in gene therapy and synthetic biology. The Committee also recommends for establishing specialized 'Frontier Health Accelerators' across leading research institutions to facilitate the seamless transition of projects through DHR's three-tiered funding framework from concept to nationwide market deployment.

(Para 3.22.3)

90. The Committee notes that in order to elevate the domestic MedTech sector within the global value chain, ICMR has operationalized a Phase-I First-in-Human trial network, the 79-centre INTENT network for Phase II/III trials, and the mPRAGATI Metal Additive Manufacturing facility at IIT Delhi. Furthermore, the Department of Expenditure has granted in-principle approval for establishing MIDAC. The Committee is of the view that a lack of affordable prototyping tools and delayed clinical validations remain the primary bottlenecks for domestic MedTech enterprises. The Committee, therefore, recommends replicating the mPRAGATI rapid-prototyping and additive manufacturing model across all major technical and medical hubs to give start-ups and MSMEs affordable access to advanced engineering tools. The Committee believes that establishing an expedited validation track within the 79-centre INTENT network under MIDAC would allow domestic manufacturers to conduct regulation-compliant preclinical and clinical evaluations within fixed, fast-tracked timelines.

(Para 3.22.4)

91. The Committee understands stresses that Universal Health Coverage (UHC) requires balancing the five dimensions of access: Affordability, Availability, Accessibility, Accommodation, and Acceptability. DHR has initiated R&D into assistive tech for the differently-abled, voice-based applications for low-literacy users, and scientifically validated AYUSH formulations (such as Punarnavadi Mandura for anemia). The Committee believes that equity cannot be achieved without customizing health delivery to the socio-cultural, physical, and literacy constraints of marginalized populations. The Committee, therefore, recommends that DHR launch a targeted grant scheme for digital and assistive innovations, prioritizing voice-assisted diagnostic tools

for low-literacy populations and AI-based triaging systems for primary health settings. The Committee is of the view to expand clinical trials under the AYUSH-ICMR Advanced Centres to evaluate, standardize, and scale cost-effective traditional formulations into mainstream national health programs to reduce out-of-pocket therapeutic expenditures.

(Para 3.22.5)

Ministry of Ayush

92. The Committee notes the proactive consultations held by the Ministry of Ayush with the Insurance Regulatory and Development Authority of India (IRDAI) and the subsequent advisory mandating 100 per cent reimbursement for cashless Ayush treatments. However, the Committee is of the view that true affordability for the most vulnerable sections of society can only be achieved if holistic healthcare is firmly integrated into robust public welfare schemes. The Committee believes that the ongoing consultations with the National Health Authority (NHA) must be concluded without further delay. The Committee, therefore, recommends that the Government immediately formalize the inclusion of comprehensive Ayush treatment packages under the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Furthermore, a strict monitoring mechanism must be established to ensure that private insurers comply seamlessly with the IRDAI directives, thereby minimizing administrative bottlenecks and reducing out-of-pocket expenditure (OOPE) for the public.

(Para 3.23.8)

93. The Committee acknowledges the ongoing efforts to expand access to Ayush healthcare through the empanelment of private institutions under the Central Government Health Scheme (CGHS). However, the Committee is of the view that restricting the empanelment of Ayush Day Care Centres to the Delhi-NCR region on a pilot basis creates geographic disparities in healthcare access for beneficiaries. The Committee, therefore, recommends that the Ministry swiftly approve and implement the proposal currently under consideration to expand the empanelment of private Ayurveda, Yoga & Naturopathy, Unani, and Siddha Day Care Centres, as well as IPD hospitals, across all CGHS-covered cities nationwide. This expansion must be closely tied to National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation to guarantee high standards of service delivery and equitable access to holistic healthcare across the country.

(Para 3.23.9)

94. The Committee observes with concern the Ministry's submission that no statutory price control mechanism currently exists for Ayush drugs in the open market. While acknowledging the price-vetting methodology applied to the central public sector undertaking (IMPCL), the Committee believes that leaving private sector Ayush pharmaceuticals unregulated exposes patients to arbitrary pricing, directly contravening the National Ayush Mission's objective of cost-effective healthcare. The Committee, therefore, recommends that the Ministry of Ayush, in coordination with the Ministry of Finance and relevant pharmaceutical pricing authorities, formulate and implement a comprehensive statutory price control framework. This mechanism should

cap the maximum retail prices of essential and widely prescribed Ayush medicines, ensuring they remain affordable for the general populace while curbing overall out-of-pocket expenditure.

(Para 3.23.10)

95. The Committee acknowledges the pivotal role of the National Ayush Mission (NAM) in establishing a holistic wellness model via Ayushman Arogya Mandir- Ayush [AAM (Ayush)] to promote preventive healthcare and reduce the overall disease burden. However, the Committee is of the view that the dependency on State Annual Action Plans (SAAPs) for grant-in-aid can often lead to procedural delays, hampering the timely deployment of human resources and the strengthening of critical healthcare infrastructure. The Committee believes that robust preventive and promotive healthcare at the grassroots level is the most effective strategy to sustainably lower out-of-pocket expenditure. The Committee, therefore, recommends that the Ministry establish a strict, time-bound framework for the evaluation and approval of SAAPs. Furthermore, a dedicated monitoring mechanism must be instituted to ensure prompt fund disbursement and execution by the State and Union Territory Governments, thereby accelerating the nationwide delivery of cost-effective and equitable Ayush services.

(Para 3.23.11)

96. The Committee notes with appreciation the outreach initiatives undertaken by the National Institute of Homoeopathy (NIH), notably the free healthcare camps organized in collaboration with Hindustan Copper Limited and the medical relief provided to over 2,000 patients during the Gangasagar Mela. The Committee is of the view that such public-private collaborations and targeted interventions during mass gatherings are highly effective in extending affordable Ayush healthcare directly to the masses. The Committee believes that this proactive outreach model should not remain an isolated effort but must be systematically replicated across all disciplines. The Committee, therefore, recommends that the Ministry formulate a structured policy mandating all National Institutes and autonomous bodies under its purview to actively partner with Central Public Sector Enterprises (CPSEs) and private stakeholders. By systematically leveraging Corporate Social Responsibility (CSR) funds, these institutes can permanently scale up the deployment of free healthcare camps and mobile clinics in remote and underserved regions, significantly enhancing grassroots accessibility.

(Para 3.23.12)

97. The Committee notes the decision taken during the Review Meeting chaired by the Hon'ble Prime Minister on 27 February 2025 to leverage Pradhan Mantri Bhartiya Janaushadhi Kendras for the promotion of Ayush medicines through appropriate co-branding. However, the Committee is of the view that merely "exploring further action" is an inadequate response to an executive directive aimed at reducing out-of-pocket healthcare costs. The Committee believes that utilizing the established nationwide retail network of Jan Aushadhi Kendras will exponentially increase the accessibility and affordability of essential, quality-tested Ayush pharmaceuticals. The Committee, therefore, recommends that the Ministry of Ayush rapidly finalize and execute this co-branding initiative in a strict, time-bound manner, ensuring that high-quality,

standardized Ayush medicines are made available across all Jan Aushadhi Kendras without further administrative delay.

(Para 3.23.19)

98. The Committee appreciates the diverse outreach strategies adopted by the National Institutes and Research Councils, such as the co-location of Unani and Siddha OPDs in major allopathic hospitals by CCRUM and CCRS, the adoption of rural villages by NEIAH, and the establishment of satellite clinics by ITRA. Concurrently, the Committee notes that the broader mainstreaming of Ayush through co-location at Primary Health Centres (PHCs), Community Health Centres (CHCs), and District Hospitals (DHs) is currently contingent upon the manpower support and demand projected by States and Union Territories in their respective Programme Implementation Plans (PIPs) and State Annual Action Plans (SAAPs). The Committee is of the view that relying entirely on the proactive requests of individual States leads to severe regional disparities in healthcare accessibility, and that highly cost-effective integrative models should not be restricted to specific autonomous institutes but must be universally adopted as standard operating procedure.

(Para 3.23.20)

99. The Committee believes that out-of-pocket expenditure can be most effectively minimized when patients have simultaneous, unhindered access to both conventional and holistic Ayush treatments under a single roof, directly within their communities. The Committee, therefore, recommends that the Ministry of Ayush, in strict coordination with the Ministry of Health and Family Welfare, formulate a mandatory baseline policy requiring a minimum percentage of all newly sanctioned and existing PHCs, CHCs, and DHs to feature operational, co-located Ayush facilities. The Central Government should aggressively leverage the National Ayush Mission (NAM) to actively incentivize States to meet these integration targets rather than passively awaiting proposals. Furthermore, the Ministry must institutionalize the satellite clinic model across all its institutes to systematically cover underserved areas, tribal regions, and vulnerable populations nationwide.

(Para 3.23.21)

100. The Committee takes positive note of the integration of digital health platforms, such as eSanjeevani, A-HMIS, and AYUSH NEXT- by institutions like CCRS and NEIAH to facilitate tele-consultations, e-prescriptions, and patient registration. The Committee is of the view that digital interventions are paramount in bridging the geographical divide, particularly for patients who face logistical and financial barriers to physical healthcare access. The Committee believes that expanding these tele-medicine services across all Ayush disciplines will drastically reduce the indirect costs of healthcare, such as travel expenses and wage loss. The Committee, therefore, recommends that the Ministry establish a centralized mandate to integrate eSanjeevani and comprehensive Hospital Management Information Systems (HMIS) across all Ayush dispensaries, peripheral institutes, and clinical units across the country to guarantee continuous remote access to affordable care.

(Para 3.23.22)

101. The Committee commends the National Institute of Homoeopathy (NIH) for providing highly subsidized and comprehensive healthcare- including a nominal ₹5 registration fee that covers medicines, and notes its planned expansion from a 100-bedded to a 250-bedded facility. Conversely, the Committee observes that developing institutions like the National Institute of Sowa-Rigpa (NISR) operate with a significantly smaller 10-bedded teaching hospital. The Committee is of the view that robust inpatient infrastructure is critical for the holistic management of complex, chronic, and non-communicable diseases. The Committee believes that the highly affordable fee structure and expanding inpatient capacity modeled by NIH must serve as the benchmark across the Ayush sector to ensure structural parity. The Committee, therefore, recommends that the Ministry urgently allocate targeted funding to upgrade the bed capacity and diagnostic infrastructure of smaller institutes like NISR. Simultaneously, the Ministry must ensure that a universally subsidized tariff structure, covering registration, diagnostics, and essential medicines, is implemented across all National Institutes to genuinely benefit economically disadvantaged populations.

(Para 3.23.23)

102. The Committee acknowledges the ongoing capacity-building efforts under the Ayurgyan Scheme and the specific training programmes conducted by the All India Institute of Ayurveda (AIIA) and the North Eastern Institute of Ayurveda and Homoeopathy (NEIAH). However, the Committee is of the view that the current scale of training—benefiting approximately 5,000 personnel and a limited number of nursing and technical staff—is vastly insufficient to meet the nationwide demand for accessible Ayush healthcare. The Committee believes that a critical shortage of trained allied professionals, such as Panchakarma technicians and Ayush-specialized nurses, directly hampers the delivery of affordable, holistic care at the grassroots level. The Committee, therefore, recommends that the Ministry mandate all National Institutes and teaching hospitals under its purview to introduce formalized diploma and certificate courses for allied Ayush healthcare workers, emulating the NEIAH model. Furthermore, funding under the Ayurgyan Scheme must be substantially augmented to support a decentralized, nationwide training network.

(Para 3.23.33)

103. The Committee appreciates the formulation of specialized Ayush Public Health Programmes under the National Ayush Mission (NAM), such as SUPRAJA, VAYO MITRA, KARUNYA, and the deployment of Ayush Mobile Medical Units, directed at underserved, tribal, and remote areas. The Committee is of the view that these preventive and promotive interventions are vital for managing non-communicable diseases and reducing the long-term disease burden among the most vulnerable demographic segments. The Committee believes that the uninterrupted delivery of these specific outreach programmes is essential for ensuring national health equity. The Committee, therefore, recommends that the Ministry establish a dedicated, ring-fenced budget allocation within NAM explicitly for these targeted public health programmes and mobile medical units. Strict monitoring must be enforced to ensure that funds

intended for rural and tribal healthcare outreach are not diverted, thereby guaranteeing sustained accessibility to affordable Ayush care for marginalized populations.

(Para 3.23.34)

104. The Committee appreciates the constitution of a dedicated committee by the Drug Policy Section (DPS) to revise the "Guidelines for Insurance Coverage of Ayush Treatments and Settlement of Claims on the Basis of Benchmark Rates of Various Therapies/Interventions (2016)". The Committee is of the view that outdated benchmark rates and non-standardized therapy pricing lead to arbitrary claim settlements, forcing patients to pay out-of-pocket top-ups or face claim rejections by insurance providers. The Committee believes that transparent, actuarially sound, and updated tariff schedules are essential to ensure that private and public health insurance policies deliver genuine financial protection to policyholders seeking Ayush treatments. The Committee, therefore, recommends that the Ministry of Ayush expedite the finalization and rollout of the revised guidelines in a strict, time-bound manner. This revision must establish uniform, standardized benchmark rates across all recognized Ayush therapies and mandate their adoption by insurance underwriters to prevent out-of-pocket cost escalation during claim settlements.

(Para 3.23.41)

105. The Committee observes from the submissions of the research councils (CCRAS, CCRUM, and CCRS) that the high cost of Ayush care is heavily driven by raw material price volatility, seasonal supply shortages, and complex formulation processes. While noting initiatives such as the Siddha Medicinal Plants Garden at Mettur Dam and the promotion of MSMEs, the Committee is of the view that an unorganized raw material supply chain severely inflates input costs, which are ultimately passed on to the consumer. The Committee believes that stabilizing raw material pricing through structured, local supply chains and decentralized processing is a critical prerequisite for lowering the retail price of finished Ayush medicines. The Committee, therefore, recommends that the Ministry formulate a national strategy to establish regional herbal cultivation clusters in coordination with State Forest and Agriculture Departments. Furthermore, the Ministry must scale up support for decentralized, Good Manufacturing Practice (GMP)-certified small and medium enterprise (MSME) pharmacy units, guaranteeing a steady supply of affordable, high-quality raw materials and finished formulations.

(Para 3.23.42)

106. The Committee highlights the collaborative research initiatives undertaken by CCRAS, CCRUM, and CCRS, including drug standardization using modern analytical techniques like High-Performance Liquid Chromatography (HPLC), Centralized Instrumentation Research Facilities (CIRF), and the creation of Ayush–ICMR Advanced Centres for Integrative Health Research (AI-ACIHR) across various AIIMS facilities. The Committee is of the view that a lack of standardized quality controls and limited pharmacoeconomic data often result in prolonged treatment protocols and unnecessary resource expenditure. The Committee believes that establishing concrete clinical evidence and quantifying Quality-Adjusted Life Years (QALYs) will demonstrate the true cost-effectiveness of Ayush interventions and prevent wastage in

healthcare delivery. The Committee, therefore, recommends that the Ministry mandate systematic pharmacoeconomic studies for all widely prescribed classical and proprietary Ayush formulations. Additionally, the Ministry should expand the Ayush-ICMR AI-ACIHR network to all major tertiary medical colleges across the country to standardize treatment protocols, eliminate ineffective drug variations, and drive down long-term treatment costs through evidence-based integrative medicine.

(Para 3.23.43)

107. The Committee expresses concern over the constraints on affordability and accessibility arising from limited awareness and understanding of Ayush among healthcare service providers. While the Drug Policy Section (DPS) is currently developing Standard Treatment Guidelines (STGs) and standardized documentation for insurance claims, the Committee is of the view that the lack of institutionalized clinical protocols has historically led to skepticism among allopathic practitioners and private health insurers, resulting in arbitrary claim rejections or delayed treatments. The Committee believes that establishing evidence-based, universally recognized clinical benchmarks is essential to build provider trust, standardize care delivery, and ensure predictable reimbursement. The Committee, therefore, recommends that the Ministry of Ayush must accelerate the notification of comprehensive STGs across all recognized Ayush streams. Furthermore, the Ministry must make these guidelines mandatory for all empanelled public and private healthcare institutions and integrate them into cross-disciplinary CME modules to bridge the knowledge deficit among service providers and insurance underwriters.

(Para 3.23.48)

108. The Committee takes positive note of the Ministry's initiatives to position India as a global destination for traditional medicine, including the introduction of a dedicated Ayush Visa, the launch of the Advantage Healthcare India Portal, and the establishment of international MoUs and Ayush Information Cells worldwide. The Committee is of the view that while Medical Value Travel (MVT) brings significant foreign exchange and international recognition, the economic benefits of this growing sector must be strategically harnessed to bolster domestic healthcare equity. The Committee believes that high-margin international wellness and medical tourism can serve as a vital financial engine to support underfunded public health infrastructure. The Committee, therefore, recommends that the Ministry, in coordination with the Ministry of Health and Family Welfare, formulate a framework that requires accredited private and public MVT-empaneled Ayush hospitals to contribute a designated percentage of their revenue from foreign patients into an 'Ayush Public Healthcare Equity Fund'. This fund should be exclusively utilized to subsidize complex Ayush treatments, diagnostics, and essential medicines for economically disadvantaged domestic patients.

(Para 3.23.49)

109. The Committee observes the progress made in facilitating international and national quality benchmarks, such as the ISO Technical Committee (ISO/TC 249/SC 2) and the publication of IS/ISO 21426:2018 regarding medical spa service requirements. However, the Committee is of the view that without strict regulatory enforcement, the private wellness and Ayush sector remains susceptible to unstandardized service

quality, varying safety protocols, and commercial exploitation. The Committee believes that adherence to accredited quality standards is directly linked to patient safety and fair pricing. The Committee, therefore, recommends that the Ministry of Ayush, in collaboration with the Bureau of Indian Standards (BIS) and the Quality Council of India (QCI), institute a mandatory accreditation framework based on ISO/BIS standards for all commercial Ayush wellness centres and clinical spas operating in the country. To ensure affordability and prevent predatory pricing in the private sector, this accreditation must be strictly linked to public price disclosures and transparent tariff structures for all offered therapies.

(Para 3.23.50)

Strengthening Ayush Services

110. The Committee is of the view that true holistic healthcare necessitates seamless patient access to both traditional and modern medical systems under a single roof to facilitate cross-referrals and integrated management. The Committee, therefore, recommends the strict enforcement of a policy mandating the compulsory co-location of Ayurveda and other AYUSH dispensaries or hospitals alongside all government Allopathic centers, Primary Health Centres (PHCs), Community Health Centres (CHCs), and District Hospitals. The Committee believes that geographical equity in traditional healthcare delivery is paramount. The Committee, therefore, recommends the formulation and immediate execution of a definitive policy that ensures the establishment of population-based Ayurveda and AYUSH facilities uniformly across the country.

(Para 3.23.55)

111. While acknowledging the collaborative efforts between AYUSH research councils (CCRAS, CCRUM, CCRH, CCRS) and premier institutes like AIIMS, ICMR, and IITs, the Committee observes that the evidence base research and development must be pro-actively expanded to ensure treatment of diseases under Ayush System. The Committee believes that rigorous empirical validation is crucial for the mainstream and global acceptance of traditional practices of treatment under Ayush System. The Committee, therefore, recommends the allocation of dedicated, ring-fenced funding to accelerate the scientific validation of AYUSH interventions through robust academic and industry partnerships. The Committee is of the view that multiple branches of healthcare (Allopathy, Ayurveda, Yoga, Homeopathy, etc.) must be integrated with a strict research mindset to understand the emerging trends of diseases due to climate change and global ecological disaster and disorder. The establishment of Ayush-ICMR Advanced Centres for Integrative Health Research (AI-ACIHR) must be scaled to all major tertiary care centers, prioritizing joint clinical trials for non-communicable diseases (NCDs), cancer care, and geriatric health.

(Para 3.23.56)

112. The Committee acknowledges the progress made in establishing an AYUSH vertical within the Central Drugs Standard Control Organization (CDSCO) and the initiation of Standard Treatment Guidelines (STGs). The Committee, therefore, recommends the expedited finalization and nationwide enforcement of comprehensive STGs for all major disease classifications across all AYUSH disciplines to ensure safe,

evidence-based, and standardized integrative care. The Committee believes that domestic and international trust hinges upon uncompromising quality control. The Committee, therefore, recommends the continuous and speedy promotion and enforcement of WHO-CoPP (Certificate of Pharmaceutical Product) and Quality Council of India (QCI) certifications for all AYUSH pharmaceutical products.

(Para 3.23.57)

113. The Committee considers that the successful implementation of an integrative medical model relies entirely on a well-trained, multi-skilled, and unbiased healthcare workforce. The Committee, therefore, recommends the immediate development and deployment of competency-based, evidence-oriented training programs specifically designed to safely integrate AYUSH services into mainstream standard treatment workflows. The Committee believes that fostering mutual respect and practical synergy between allopathic and traditional practitioners is vital to reducing systemic bias. The Committee, therefore, recommends the immediate introduction of integrated curriculum modules, exchange fellowships, and cross-system Continuous Medical Education (CME) sessions across both Allopathic and AYUSH educational institutions so as to complement each other and capable of reducing rural-urban gaps in accessibility of medical facilities at the grass root level, especially rural, hilly and tribal regions.

(Para 3.23.58)

SWOT Analysis of the National Health Mission (NHM)

114. The Committee finds that NHM has substantially strengthened India's public health infrastructure and expanded access to essential health services over the past two decades. However, addressing remaining gaps in quality, equity, urban healthcare, human resources and system resilience through sustained investment, integrated planning and digital health will be essential for achieving the SDGs, Universal Health Coverage and equitable healthcare in the country.

(Para 3.24.3)

115. The Committee considers that while the transformation of primary care infrastructure under Ayushman Bharat is commendable, the failure to address fundamental human resource deficits, financial bottlenecks, and data fragmentation severely undermines the Mission's capacity to deliver equitable healthcare and combat the rising non-communicable disease (NCD) burden. The Committee believes that achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs) requires moving beyond incremental operational tweaks toward a synchronized strategy that integrates human resource parity, financial streamlining, and unified digital governance.

(Para 3.24.4)

116. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in close coordination with the Ministry of Ayush and State Governments, undertake a comprehensive overhaul of the NHM implementation framework through the following structured measures:

d) **Human Resource Rationalization and Staff Security: Formulate a uniform national policy to 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, and systematically scale up digital training modules for frontline health workers (ASHAs and ANMs).**

e) **Fiscal Streamlining and Absorptive Capacity: Institute a real-time, Direct Benefit Transfer (DBT)-linked fund disbursement tracking mechanism to eliminate administrative delays in releasing Central grants to States. Furthermore, the Ministry must provide specialized technical and administrative handholding to smaller, Union Territory, and North-Eastern States to enhance their fiscal absorptive capacity and ensure unhindered resource utilization.**

f) **Data Convergence and Continuity of Care: Rationalize and merge overlapping data reporting software into a single, unified architecture integrated with the Ayushman Bharat Digital Mission (ABDM). This platform must establish seamless digital referral pathways linking Ayushman Arogya Mandirs with Community Health Centres, District Hospitals, and AB-PMJAY tertiary care networks to guarantee end-to-end, lifelong continuity of care for every citizen.**

(Para 3.24.5)

AIIMS New Delhi

117. The Committee believes that technology-enabled healthcare solutions offer an unprecedented opportunity to bridge geographic divides, mitigate specialist shortages, and reduce patient congestion at apex tertiary care centers. The Committee is of the view that proven, cost-effective digital innovations developed by Institutes of National Importance (INIs) should not remain isolated successes but must be scaled nationally. The Committee, therefore, recommends the immediate establishment of a dedicated national programme to document, standardize, and replicate best administrative and clinical practices from AIIMS New Delhi across all state Government Medical Colleges (GMCs) and district hospitals. This must include structured mentorship, digital patient navigation systems, public dashboards, dynamic queue management, and integrated appointment modules.

(Para 3.25.9)

118. The Committee recommends scaling up validated AI platforms, specifically: (i) *MadhuNetrAI* for frontline screening and early detection of diabetic retinopathy in resource-constrained primary settings; (ii) *UPPCHAR* for AI-assisted health education, supportive care, and treatment adherence in advanced oncology; (iii) *AI-assisted Chest X-ray Triage* to prioritize high-volume diagnostic imaging within 5–10 minutes while preserving final validation by certified radiologists; and (iv) *"Never Alone"* digital mental health frameworks (WhatsApp-integrated) for round-the-clock screening and facilitated expert consultation. The Committee further recommends accelerating the full integration of e-prescriptions, clinical decision support systems (CDSS), and remote patient monitoring under the *Ayushman Bharat Digital Mission (ABDM)*.

(Para 3.25.10)

119. The Committee believes that the current unorganized patient flow severely strains tertiary institutions like AIIMS, leading to extreme congestion, prolonged waiting times, and indirect financial hardship for rural families traveling long distances. Furthermore, both public and private sectors must be viewed as complementary components of the health ecosystem. The Committee, therefore, recommends the implementation of a mandatory, technology-enabled referral framework linking *Ayushman Aarogya Mandirs (AAM)*, district hospitals, and tertiary/private institutions. Standardized electronic referral protocols and real-time feedback loops must ensure that tertiary care facilities entertain primary and secondary-level conditions only through structured, verifiable referrals, thereby reducing overcrowding.

(Para 3.25.11)

120. The Committee is of the view that private sector capacity, currently urban-centric and variably regulated, must be strategically leveraged to serve public health goals. The Committee recommends formulating robust PPP frameworks in high-capillary service areas, including advanced diagnostics, emergency ambulance networks, telemedicine, and medical education. To prevent commercial exploitation, all PPP initiatives must operate under strict price ceilings, defined Service Level Agreements (SLAs), and independent quality audits to ensure equitable access for vulnerable populations.

(Para 3.25.12)

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. The Committee, therefore, recommends that the Ministry mandate standardized baseline pricing and mandatory public disclosure of tariffs for common medical procedures, diagnostic panels, and surgical implants. Private hospitals must strictly adhere to national *Standard Treatment Guidelines (STGs)* to eliminate unwarranted investigations, unnecessary hospitalizations, and polypharmacy. The Committee also recommends the statutory enforcement of *Essential Diagnostics Lists (EDL)*, Antimicrobial Stewardship Programmes, and mandatory generic drug prescribing across all public and empanelled private facilities. Jan Aushadhi Kendras and AMRIT Pharmacies must be co-located within all secondary and tertiary hospital premises with guaranteed stock availability.

(Para 3.25.13)

122. The Committee is of the view that public hospitals must increase throughput by monitoring and publicly disclosing Key Performance Indicators (KPIs), such as Average Length of Stay (ALOS), Bed Occupancy Rates, Healthcare-Associated Infection Rates, and waiting times, alongside dynamic resource allocation and automated supply chain management. Enforcement of stringent audit mechanisms to curb over-investigation and excessive billing practices.

(Para 3.25.14)

123. The Committee believes that India's changing demographic profile necessitates an immediate pivot toward elder care, alongside a fundamental shift from volume-based care to patient-centric, value-based healthcare where patients are active, informed participants in their care journey. The Committee, therefore, recommends integrating dedicated geriatric medicine, palliative care, rehabilitation, and home-based care networks into primary (*Ayushman Aarogya Mandirs*) and secondary (District Hospital) care tiers. Specialized workforce training in geriatric nursing and allied health care must be fast-tracked to manage the rising burden of non-communicable diseases (NCDs) and age-related ailments. The Committee also recommends institutionalizing multi-lingual patient navigation desks and establishing formal *Patient Advocacy Groups / Patient Representative Organizations*. These platforms must actively educate patients not only on disease management but also on available government financial assistance schemes (such as AB-PMJAY and illness assistance funds) to eliminate catastrophic out-of-pocket expenditure.

(Para 3.25.15)

124. The Committee is of the view that health system financing should progressively transition toward value-based outcomes measured by standardized patient safety metrics and National Quality Assurance Standards (NQAS/NABH). Furthermore, robust, real-time digital grievance redressal mechanisms must be made mandatory across all empanelled institutions.

(Para 3.25.16)

125. The Committee believes that physical infrastructure alone cannot deliver care without an adequately trained, equitably distributed, and motivated health workforce. The severe shortage and stark urban-rural maldistribution of specialists, nurses, and allied health professionals at district and peripheral facilities remain fundamental barriers to healthcare access. 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.

(Para 3.25.17)

126. The Committee is of the view that postgraduate medical seats (MD/MS/DNB) and clinical training programs must be rapidly expanded at all district-level hospitals. Furthermore, statutory recognition and continuous professional development for nurses, paramedics, and allied health professionals must be institutionalized to support task-shifting and multi-skilled healthcare delivery. The Committee recommends establishing a dynamic, transparent National Health Workforce Registry under ABDM to track real-time staffing levels and prevent chronic vacancy gaps in underserved regions.

(Para 3.25.18)

127. The Committee believes that delay in emergency response and lack of real-time critical care coordination are major contributors to avoidable mortality and catastrophic out-of-pocket expenditure during medical crises. The Committee,

therefore, recommends the creation of a unified, technology-enabled Emergency Care Network linking basic/advanced life support ambulances, district emergency departments, trauma centers, and tertiary hospitals through a single national access line and GIS-based tracking.

(Para 3.25.19)

128. The Committee considers that public and empanelled private institutions must mandatorily publish live updates regarding ICU beds, ventilator availability, and emergency department occupancy on centralized public dashboards, preventing chaotic hospital-hopping by distress-ridden families. The Committee recommends the implementation of universal emergency triage guidelines and tele-ICU linkages, enabling district doctors to stabilize critically ill patients under expert consultation from apex institutions like AIIMS prior to or during transport.

(Para 3.25.20)

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.

(Para 3.25.21)

130. The Committee is of the view that public health procurement should shift toward "strategic purchasing," leveraging the market size of *Ayushman Bharat (AB-PMJAY)* to drive down cost tariffs, enforce strict clinical quality norms, and expand coverage to currently vulnerable populations exposed to catastrophic health spending. The Committee recommends expanding population-based screening, routine adult vaccination, lifestyle interventions, and early NCD diagnostics across all *Ayushman Aarogya Mandirs (AAM)*, thereby reducing the high long-term financial burden of advanced secondary and tertiary illness.

(Para 3.25.22)

Views of the Select Hospitals

STAR DENTAL

131. The Committee is of the view that oral and dental healthcare has not been accorded adequate priority within the national healthcare framework, resulting in a significant gap in both affordability and accessibility. Submissions received by the Committee indicate a stark absence of dental coverage in both public and private health insurance schemes, as well as a lack of collaborative initiatives between private dental organizations and public healthcare institutions. While organized private dental networks have successfully expanded into Tier-II cities and established transparent, software-integrated standardized billing practices, their complete absence in rural areas leaves a vast segment of the population underserved.

(Para 3.26.2)

132. The Committee believes that optimal public health outcomes cannot be realized until dental care is formally recognized and promoted on par with mainstream medical care. The existence of standardized treatment rates and transparent patient record-keeping within the private sector demonstrates that dental healthcare costs can be systematically structured, regulated, and monitored for insurance integration. The Committee, therefore, recommends that the Government take immediate, concrete policy measures to mainstream dental healthcare and explicitly incorporate comprehensive dental treatments into government-sponsored health insurance schemes. Additionally, the Government must proactively facilitate public-private partnerships to incentivize private dental healthcare providers to expand their clinical and operational footprint into rural regions, thereby ensuring that equitable, transparent, and affordable dental care becomes accessible to all citizens across the country.

(Para 3.26.3)

Jawaharlal Nehru Medical College

133. The Committee is of the view that the severe delays in claim settlements under government health schemes fundamentally undermine the accessibility of healthcare for vulnerable beneficiaries. While the acceptable turnaround time for claims processing under frameworks like Karnataka's Suvarna Arogya Suraksha Trust (SAST) is stipulated to be between 15 to 21 days, the actual average lead time of 6 to 8 months reported by institutions such as Jawaharlal Nehru Medical College is unacceptable. This systemic bottleneck, starkly contrasting the 25 to 30 days taken by private insurers, severely cripples the working capital of empanelled providers. When coupled with frequent bill rejections due to ambiguously defined "insufficient post-operative investigations," these delays actively discourage private sector participation and threaten the operational stability of participating medical colleges.

(Para 3.27.2)

134. The Committee believes that the structural rigidity of the current reimbursement matrix actively penalizes critical care providers and restricts patient access. The prevailing disparity, wherein government package rates remain an average of 30% lower than private insurance equivalents, challenges the sustainability of quality care delivery. More critically, the absence of separate ICU packages for critical patients requiring surgical interventions, alongside the illogical prohibition of bilateral surgical procedures under PMJAY, forces suboptimal clinical pathways, creating unnecessary financial burdens and requiring repeated hospitalizations for patients. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in strict coordination with the National Health Authority (NHA) and respective State Health Agencies (SHAs), immediately execute the following systemic interventions:

e) **Enforcement of Settlement SLAs: Institute a rigid, technology-driven 30-day maximum turnaround time for all government scheme claim settlements,**

mandating the automatic payment of penal interest to healthcare providers for any delays beyond this operational window.

f) **Rationalization of Benefit Packages: Undertake a comprehensive and immediate revision of the Health Benefit Packages (HBP) to introduce standalone, unbundled ICU packages for post-surgical critical care, while systematically aligning overarching package rates with the realistic operational costs of tertiary care.**

g) **Authorization of Bilateral Procedures: Allow the bilateral diseases treatment and simultaneous surgical procedures under PMJAY, permitting concurrent clinical interventions in a single operative setting to reduce patient trauma, mitigate risk, and lower the cumulative cost of care.**

h) **Standardization of Clinical Audits: Formulate and publish an exhaustive, standardized, and specialty-specific checklist of required post-operative investigations to eliminate arbitrary claim rejections by state schemes like SAST and streamline the adjudication process.**

(Para 3.27.3)

135. The Committee is of the view that the capital-intensive nature of establishing specialized oncology facilities, requiring investments of around ₹1,000 crore for a 500-bed hospital with a four-year gestation period, creates severe entry barriers and drives up operational treatment costs. The extreme scarcity and high acquisition cost of institutional land in Tier-I and Tier-II cities (ranging from ₹50 crore to ₹250 crore for five acres in the NCR region), coupled with the absence of priority-sector lending, forces healthcare providers into high-cost commercial financing or private equity, ultimately escalating financial burdens on patients. Furthermore, while healthcare services are currently GST-exempt, this status prevents tertiary hospitals from claiming Input Tax Credit (ITC) on heavy capital outlays for specialized construction, consumables, and advanced medical equipment (which attract an 18% GST burden and high import duties, making equipment nearly 35% costlier in India). The Committee, therefore, recommends that the Government undertake the following structural interventions:

d) **Priority Sector Financing and Concessional Land Allotment: Grant priority-sector lending status to healthcare infrastructure, particularly standalone, non-profit, and tertiary oncology centers, to enable access to low-cost institutional finance. State Governments must be mandated to allocate institutional land at concessional rates for public-interest healthcare projects in urban and semi-urban hubs.**

e) **Zero-Rating Healthcare under GST: Reclassify healthcare services from 'GST Exempt' to 'Zero-Rated GST (0%)' framework, enabling hospitals to claim Input Tax Credit on medical equipment, consumables, and specialized infrastructure, thereby directly lowering overall operational costs.**

f) **Customs Rationalization and Domestic Manufacturing: Rationalize import duties on non-indigenously manufactured high-end radiation and diagnostic**

equipment, while simultaneously providing targeted incentives under the 'Make in India' initiative to build indigenous manufacturing capabilities for advanced medical technology.

(Para 3.28.8)

136. The Committee expresses grave concern over the fact that nearly 70% to 80% of cancer treatment expenditure in India is met through out-of-pocket payments, with average treatment costs reaching ₹7.5 lakh per patient. The empanelment of premier specialized cancer hospitals under public health schemes like Ayushman Bharat (PM-JAY), CGHS, ECHS, and ESIC remains severely constrained because prevailing reimbursement package rates, often up to 70% lower than market costs, are fixed on marginal costing principles without accounting for capital investment, medical inflation, or operational sustainability. Moreover, despite price regulation under the Drug Price Control Order (DPCO), retail margins on anti-cancer drugs remain exorbitantly high (50–60%), with manufacturers frequently circumventing price caps by introducing alternate strengths or formulations. Crucially, Patient Assistance Programmes (PAPs) currently exclude beneficiaries covered under public health insurance, while unstandardized diagnostic pricing (PET-CT, MRI, genetic testing) further inflates costs. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in coordination with the National Health Authority (NHA) and the National Pharmaceutical Pricing Authority (NPPA), execute the following measures:

d) **Dynamic Package Rate Revision: Conduct a comprehensive, inflation-indexed revision of empanelment package rates under PM-JAY and government health schemes. Reimbursement structures must factor in capital depreciation, specialty infrastructure, and modern oncology protocols to ensure financial viability and encourage widespread private sector empanelment.**

e) **Enforcement of Trade Margin Rationalization (TMR) and DPCO Expansion: Expand the National List of Essential Medicines (NLEM) and DPCO coverage to include all alternate strengths, formulations, supportive therapies (such as anti-emetics and anti-infectives), and antifungal medicines. Strict Trade Margin Rationalization must be enforced across all anti-cancer molecules to eliminate artificial retail markups.**

f) **Ceiling Prices for Diagnostics and Universal PAP Access: Establish national ceiling prices for high-volume diagnostic procedures, including PET-CT, MRI, and genetic profiling, while encouraging shared diagnostic infrastructure among healthcare facilities. Additionally, issue clear guidelines enabling patients covered under public health schemes to access manufacturer-funded Patient Assistance Programmes (PAPs) without disqualification.**

(Para 3.28.9)

137. The Committee believes that mitigating the cancer burden requires a shift from isolated tertiary care to an integrated framework emphasizing Public-Private Partnerships (PPP), community screening, and early intervention. Past PPP models have often faltered due to misaligned incentives; however, a structured revenue-sharing

model, where the Government provides land and primary support while specialized private or non-profit institutes manage operations, mobile diagnostics, and technical training, presents a highly sustainable path for expanding tertiary care into underserved regions. The Committee, therefore, recommends that the Government execute the following joint action directives:

d) **Standardized Revenue-Sharing PPP Framework: Formulate a national policy framework for Public-Private Partnerships in oncology, under which the Government provides land and basic infrastructure while private entities manage hospital operations. A portion of the generated revenue should be directed to subsidize public health insurance and finance ongoing infrastructure expansion.**

e) **Integration of Cancer Screening in PM-JAY: Formally include comprehensive cancer screening (oral, cervical, and breast) within the preventive health packages of Ayushman Bharat.**

f) **Grassroots Screening and Immunization Collaboration: Institutionalize collaborative drives between state health departments and specialized oncology institutes to utilize ASHA and Anganwadi networks for community outreach. Establish regular diagnostic camps at Primary Health Centres (PHCs) and Community Health Centres (CHCs) using mobile diagnostic units, launch joint capacity-building programs for public healthcare personnel, and execute a national campaign for HPV vaccination among girls aged 9-26 years.**

(Para 3.28.10)

Institutionalizing Public-Private Partnerships (PPP) and CSR for Diagnostic and Specialized Services

138. The Committee notes that high Out-Of-Pocket Expenditure (OOPE) is largely driven by the exorbitant costs of diagnostic tests and specialized treatments. The Committee is of the view that the strategic Public-Private Partnership (PPP) models implemented by Punjab, providing high-end radio-diagnostic (MRI/CT) and laboratory services at steeply discounted Central Government Health Scheme (CGHS) rates, and Goa's collaboration for free dialysis services, are highly effective mechanisms for cost reduction. Furthermore, the Committee acknowledges the suggestion from the Municipal Corporation of Delhi (MCD) that the capital cost of expensive medical equipment can be supplemented by external funding. The Committee, therefore, recommends that the Union Government develop a standardized PPP framework to assist all States in outsourcing high-cost diagnostic and dialysis services at capped rates. Additionally, the Ministry should formulate guidelines to systematically channel Corporate Social Responsibility (CSR) funds toward procuring capital-intensive medical infrastructure for public hospitals.

(Para 3.32.1)

Overcoming Geographical Barriers in Remote Regions and Scaling Telemedicine

139. The Committee recognizes the severe accessibility challenges in remote, rural, and hilly terrains, as highlighted by the State of Manipur, where infrastructural deficits and a distinct shortage of specialist doctors disproportionately affect vulnerable populations. Concurrently, while telemedicine platforms like e-Sanjeevani offer a viable solution, their utilization often diminishes without sustained public awareness, as observed by the MCD. The Committee believes that physical infrastructure development in challenging terrains must be aggressively supplemented by digital outreach. The Committee, therefore, recommends the creation of a dedicated infrastructure fund to establish specialized hubs in geographically challenging districts. Furthermore, the Committee recommends that the Government launch intensive Information, Education, and Communication (IEC) campaigns to publicize telemedicine services, mandating the integration of district-level specialist hubs with primary rural clinics to minimize unnecessary out-of-pocket travel expenses for patients.

(Para 3.32.3)

140. The Committee observes that robust primary healthcare is the cornerstone of disease prevention and early management. The proactive approach of Andhra Pradesh, establishing Village Health Clinics for every 2,500–3,000 population, surpassing standard Indian Public Health Standards (IPHS) norms, and Kerala's transformation of Primary Health Centres into extended-hour Family Health Centres managed through decentralized local self-governments, constitute exemplary models of grassroots healthcare delivery. The Committee is of the view that increasing the density of primary care facilities drastically reduces the burden on tertiary hospitals. The Committee, therefore, recommends that financial incentives must be provided to States that successfully densify their primary care networks and empower local self-governments to allocate dedicated plan funds for grassroots health monitoring.

(Para 3.32.6)

141. The Committee notes with grave concern that life-threatening emergencies, such as strokes and myocardial infarctions (STEMI), often lead to catastrophic financial ruin for affected families. The Committee commends the State of Goa for its STEMI project and Stroke Programme, which utilize a hub-and-spoke model to ensure treatment within the "golden hour" and provide highly expensive clot-busting drugs (such as Tenecteplase) entirely free of cost. Similarly, Puducherry's strategy of signing MoUs with specialized private institutions for pediatric cardiac and cancer care effectively bridges public sector gaps. The Committee believes that no citizen should be denied life-saving critical care due to financial constraints. The Committee, therefore, recommends the establishment of a national corpus to subsidize high-cost, life-saving emergency drugs (such as newer thrombolytics) across all public district hospitals. Furthermore, the Government should encourage States to enter into strategic Memorandums of Understanding (MoUs) with specialized private and non-profit institutions to provide free or highly subsidized tertiary care for critical ailments like cancer and pediatric anomalies.

(Para 3.32.8)

142. The Committee acknowledges the severe administrative and logistical bottlenecks impeding healthcare delivery, particularly the shortage of appropriately skilled professionals (radiologists, anesthesiologists) and critical delays in procuring essential medicines and surgical items, as underscored by the MCD. The Committee is of the view that a lack of agile procurement systems and inadequate upskilling budgets severely hamstring public healthcare infrastructure. The Committee, therefore, recommends that the Government immediately address the procurement delays on digital marketplaces by instituting mandatory, fast-tracked Rate Contract Agreements (RCAs) for life-saving medicines and surgical consumables. Additionally, the Committee recommends a targeted increase in budgetary allocations explicitly earmarked for the recruitment, upskilling, and reskilling of specialized medical and paramedical personnel.

(Para 3.32.10)

143. The Committee observes that leveraging technology is essential for achieving Universal Health Coverage (UHC). Initiatives such as Goa's AI-based interpretation of digital chest X-rays for early lung cancer detection, Kerala's deployment of digital pathology and robotic surgery, and Assam's proactive digital screening and national identity validation mechanisms to ensure scheme saturation, demonstrate the transformative potential of modern technology in public health. The Committee believes that artificial intelligence and centralized digital health records are critical for the early detection of non-communicable diseases (NCDs) and the prevention of scheme exclusion. The Committee, therefore, recommends that the Ministry launch a centralized initiative to deploy AI-driven diagnostic tools for cancer and NCD screening across all secondary and tertiary public health facilities. Concurrently, States should be technically supported to conduct proactive, door-to-door digital verification drives to ensure 100% saturation and inclusion of eligible beneficiaries under national health protection schemes.

(Para 3.32.12)

144. The Committee observes that public healthcare institutions often grapple with perennial budgetary constraints that impede the routine maintenance and upgradation of infrastructure. The Committee is of the view that the innovative strategy adopted by the State of Assam, whereby public hospitals retain and utilize the claims reimbursed under national health protection schemes (such as AB-PMJAY) for their own infrastructure development, is a highly pragmatic and replicable model. This mechanism effectively reduces institutional dependency on State grants and transforms public hospitals into self-sustaining entities capable of continuously upgrading their services. The Committee, therefore, recommends that the Ministry of Health and Family Welfare issue standard operating procedures to enable and encourage public hospitals across all States to reinvest a substantial portion of the funds generated through insurance claims directly into local hospital infrastructure, medical equipment procurement, and patient welfare initiatives.

(Para 3.32.14)

145. The Committee notes with appreciation the pioneering initiatives undertaken by the State of Kerala, notably the establishment of a statutory Senior Citizens Commission, the deployment of AI-based surveillance for bedridden patients, and the mandate for local governments to allocate 5% of their plan funds specifically for elderly care. Furthermore, the Committee acknowledges the suggestion made by the Municipal Corporation of Delhi (MCD) to consider elevating health to the status of a Fundamental Right. The Committee believes that as the demographic profile of the nation evolves, the healthcare system must proactively cater to the complex and specialized needs of an aging population. The Committee, therefore, recommends that the Union Government formulate a comprehensive national policy specifically targeting geriatric and palliative care. Furthermore, the Ministry must incentivize States to mandate their local self-governments to ring-fence a fixed percentage of their budgetary allocations exclusively for elderly care, home-based palliative support, and the provision of free medicines for senior citizens.

(Para 3.32.16)

Optimizing Tertiary Bed Capacity through 'Step-Down' Care Protocols

146. The Committee acknowledges the severe strain on tertiary and super-specialty hospitals, where a significant number of acute-care beds remain occupied by patients who have stabilized but require prolonged, lower-intensity recovery care. The Committee is of the view that the strategy proposed by the MCD, to establish formalized collaborations wherein stabilized post-operative patients are seamlessly transferred from specialized hospitals to smaller, peripheral health centres, is vital for optimizing the availability of tertiary beds for new, critical patients. The Committee, therefore, recommends that the Government establish a formal 'Step-Down Care' referral framework. Such a framework should facilitate the smooth transition of stabilized patients from apex tertiary institutions back to secondary or district hospitals, backed by integrated electronic health records and a robust ambulance network. This will ensure that highly specialized healthcare infrastructure is utilized optimally and primarily for critical and complex interventions.

(Para 3.32.17)

147. The Committee observes that while flagship health insurance schemes have significantly widened coverage, practical and financial challenges persist that threaten their long-term efficacy. The Committee takes serious note of the concerns raised by the State of Assam regarding the inadequacy of the central premium of ₹1,052 per family under AB-PMJAY, which has remained stagnant despite rising treatment costs and expanded health benefit packages. Concurrently, the Committee appreciates Assam's robust anti-fraud mechanism, which utilizes District Medical Officers and third-party auditors for rigorous clinical and infrastructure audits. The Committee believes that financial viability and strict vigilance are twin pillars for the success of universal health coverage. The Committee, therefore, recommends that the Union Government urgently

undertake a comprehensive actuarial review to upwardly revise the central premium under national health protection schemes, aligning it with current medical inflation. Simultaneously, the Ministry must mandate all States to institute rigorous, multi-tier clinical and beneficiary audits to eliminate malpractices and ensure that scheme benefits exclusively reach the rightful beneficiaries.

(Para 3.32.20)

148. The Committee envisages that comprehensive health assurance is instrumental to reduce OOPE and to make healthcare affordable to all. Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has fundamentally altered the healthcare financing landscape by covering over 11 crore hospital admissions and empanelling 38,038 public and private hospitals. The Committee believes that the substantial benefits realized through AB-PMJAY, which has authorized treatments worth ₹1.57 lakh crore, must be structurally insulated from medical inflation and unchecked technological cost escalations. The Committee, therefore, recommends that the government institute a statutory mechanism to periodically revise package rates under all government insurance schemes, factoring in regional economic variations to ensure continued and active participation of private sector hospitals without compromising the quality of care. Furthermore, the Committee is of the view that unwarranted variations in private healthcare costs create unpredictable out-of-pocket burdens that undermine financial protection. The Committee, therefore, recommends mandating transparent, standardized treatment packages across all healthcare providers to ensure cost predictability, reduce catastrophic health expenditure, and safeguard patient trust.

(Para 4.1.3)

149. The Committee observes that the middle-income demographic, often excluded from publicly funded schemes, requires robust, accessible safety nets to prevent sudden impoverishment due to medical emergencies. The Committee, therefore, recommends the accelerated expansion of standardized, low-cost health insurance products, akin to Aarogya Sanjeevani, featuring simplified policy terms and wider demographic coverage. Concurrently, the Committee believes that the strict enforcement of the recently introduced IRDAI regulatory reforms, specifically the removal of upper age limits for purchasing policies and the reduction of waiting periods for pre-existing diseases to three years, is critical to enhancing patient inclusion and customer satisfaction. The Committee, therefore, recommends for the optimal utilization of the National Health Exchange platform to ensure expeditious, transparent cashless claim settlements and strict adherence to these modernized insurance mandates across all providers.

(Para 4.1.4)

150. The Committee acknowledges the savings of over ₹45,000 crore generated by the 19,200 Jan Aushadhi Kendras and ₹8,400 crore by AMRIT pharmacies. The Committee believes that affordable generics and implants are the cornerstone of equitable healthcare. The Committee, therefore, recommends establishing Jan Aushadhi Kendras in all remaining block-level public health facilities and encouraging private tertiary hospitals to host AMRIT pharmacies to extend discounted implants and surgical consumables to a wider patient base.

(Para 4.1.5)

151. The Committee notes that the Pradhan Mantri National Dialysis Programme (PMNDP) has already generated ₹10,102 crore in patient savings.The Committee is of the view that end-stage renal disease remains a significant financial drain. The Committee, therefore, recommends exploring public-private partnerships to expand free or highly subsidized haemodialysis centers beyond District Hospitals to sub-district levels.

(Para 4.1.6)

152. The Committee believes that to sustain and expand the massive decentralized infrastructure of 19,200 Jan Aushadhi Kendras and over 1,816 PMNDP dialysis centres, state governments must proportionally elevate their fiscal commitments alongside the central government. The Committee, therefore, recommends that the Union Government actively incentivize States to enhance their respective health allocations to a minimum of 8% of their aggregate state expenditure.

(Para 4.1.7)

153. The Committee, furthermore, is of the view that holistic wellness must be integrated seamlessly into the nation's primary financial protection frameworks to offer citizens a comprehensive continuum of care. The Committee, therefore, recommends the formal inclusion of Ayush treatment packages within the ambit of AB-PMJAY to provide beneficiaries with regulated, traditional therapeutic options while maintaining zero out-of-pocket expenditure.

(Para 4.1.8)

154. The Committee appreciates that the operationalization of over 1.86 lakh Ayushman Arogya Mandirs (AAMs) and the proactive screening of over 41 crore citizens for non-communicable diseases constitute a monumental and necessary shift toward preventive and promotive healthcare at the grassroots level. Furthermore, the Committee believes that the targeted investments under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) with accelerated pace of implementation, to establish Integrated Public Health Laboratories and Critical Care Hospital Blocks are paramount for fortifying decentralized pandemic preparedness. The Committee, however, recommends strict administrative monitoring to ensure the timely completion of all pending infrastructural projects under PM-ABHIM. Since without skilled manpower, the infrastructure and equipments keep lying idle and instead become a burden over the exchequer, the Committee further recommends alongside a mandate to continuously upskill frontline healthcare workers at AAMs, thereby ensuring standardized, high-quality primary care delivery from the village to the district level.

(Para 4.1.10)

155. The Committee takes into account that the exceptional penetration of digital health initiatives, evidenced by the creation of over 93 crore ABHA accounts, 104 crore digital health records, and the execution of 45 crore eSanjeevani teleconsultations, has

fundamentally dismantled geographical barriers to specialized healthcare. The Committee believes that sustaining this trajectory of improved continuity of care requires comprehensive participation across the entire healthcare spectrum. 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, while simultaneously expanding regional Tele-MANAS and eSanjeevani hubs to guarantee that specialized psychiatric and medical consultations are uninterruptedly accessible in the most remote areas. The Committee further believes that the teleconsultation interface should by user-friendly and easy to use with smooth functioning. Also to harvest the optimal potential of digital initiatives, the Government should strengthen the internet network in rural and remote areas on a mission mode with proper digital training to ASHA workers and healthcare volunteers, along with basic digital literacy to population.

(Para 4.1.11)

156. The Committee believes that the unprecedented expansion in medical education infrastructure over the last decade, marked by the growth of medical colleges to over 820 and a near-tripling of undergraduate and postgraduate medical seats, addresses a critical historical deficit in human resources. The Committee, however, is of the view that generating educational capacity must be matched with strategic deployment to effectively reduce regional disparities in tertiary care as envisioned by the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The Committee, therefore, recommends the urgent formulation of a targeted national deployment strategy that integrates robust rural service incentives, enhanced infrastructural support for newly established nursing colleges, and preferential professional development pathways to ensure the equitable distribution of skilled medical, nursing, and Ayush practitioners across underserved districts.

(Para 4.1.12)

157. The Committee is of the view that the unprecedented quantitative expansion of medical infrastructure, evidenced by the growth of medical colleges from 387 to over 820, the increase of AIIMS institutions to 23, and the planned addition of 75,000 medical seats and 157 nursing colleges, must be strictly commensurate with the highest standards of clinical excellence. The Committee believes that merely augmenting physical infrastructure and seat capacity without stringent, continuous evaluation risks diluting the operational proficiency of the national healthcare framework. 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 to ensure uncompromised educational and healthcare delivery standards.

(Para 4.1.13)

158. The Committee understands that while the empanelment of 38,038 public and private hospitals under AB-PMJAY represents a monumental stride in providing secondary and tertiary care, maintaining uniform quality across this vast network requires intense regulatory scrutiny. The Committee is of the view that periodic

legislative and financial oversight is essential not only to prevent fund leakage but also to ensure that the private sector adheres strictly to evidence-based clinical guidelines rather than profit-driven diagnostic redundancies. 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.

(Para 4.1.14)

159. The Committee has come across the heavy reliance on tertiary hospitals for continuous treatments, trauma response, and mental healthcare compromises accessibility and affordability for rural and district-level populations. The Committee believes that the recent policy mandates to decentralize specialized care, specifically the approval of 297 Day Care Cancer Centres (DCCCs) for FY 2025–26 and the 50% capacity expansion of 24×7 Emergency and Trauma Care Centres in district hospitals, constitute a vital structural correction. Furthermore, expanding advanced psychiatric infrastructure through the proposed establishment of NIMHANS-2 in North India and the upgradation of the National Mental Health Institutes in Ranchi and Tezpur into Regional Apex Institutions addresses a critical geographic deficit in mental healthcare.The Committee, therefore, recommends that the Government institute a stringent, centrally monitored timeline for the operationalization of the approved DCCCs and trauma care expansions to guarantee a seamless continuum of care without administrative delays. Furthermore, the Committee recommends proactive inter-ministerial coordination to expedite land acquisition and foundational deployment for NIMHANS-2 and the regional apex institutions, ensuring these centers are systematically integrated with district-level community screening and digital counseling networks to maximize early intervention.

(Para 4.1.16)

160. The Committee is of the view that the physical infrastructure for specialized care cannot function optimally without a proportionally scaled and highly skilled technical workforce. The Committee believes that the Union Budget announcement to create one lakh allied health professionals through a five-year national roadmap is critical to addressing systemic gaps in diagnostics, peri-operative care, and post-treatment rehabilitation. To effectively navigate demographic and epidemiological transitions, evolving disease patterns, and the broad vision of Viksit Bharat @2047, the scope of these disciplines must transcend the initial Ten Priority Areas.The Committee, therefore, recommends the immediate execution of the five-year national roadmap with an expanded curriculum framework that formally incorporates advanced disciplines, including Critical Care, Respiratory & Cardiac Care, Molecular Diagnostics, Nuclear Medicine, Health Informatics, Geriatric Care, Rehabilitation & Palliative Care, Nutrition Science, and Public Health Laboratory Sciences. The Committee further recommends establishing robust accreditation protocols to ensure these expanded disciplines align strictly with Indian Public Health Standards (IPHS), thereby directly enhancing the operational functionality and quality of both public and private healthcare facilities.

(Para 4.1.17)

161. The Committee feels that while public healthcare infrastructure is expanding at an unprecedented rate, a significant proportion of the populace remains reliant on the private sector for advanced diagnostic and tertiary care. The Committee believes that true affordability cannot be achieved if private healthcare costs remain fragmented and largely unregulated outside of the government insurance ecosystems. The Committee, therefore, 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) to prevent unethical practices, unwarranted diagnostic testing, and arbitrary pricing in private medical facilities, thereby shielding citizens from medical impoverishment.

(Para 4.1.18)

162. The Committee considers that the ambitious targets set by flagship initiatives, including the rollout of Day Care Cancer Centres, the PM-ABHIM infrastructure projects, and the addition of 75,000 medical seats, are heavily contingent upon sustained and optimally utilized capital outlays. The Committee believes that the mere allocation of central funds is insufficient if systemic administrative bottlenecks at the state level lead to the underutilization of budgetary estimates and subsequent delays in project execution. The Committee, therefore, recommends the institution of a dedicated, multi-tier financial oversight mechanism to rigorously audit quarterly fund utilization by State health departments. This mechanism must strictly link future tranches of central health grants to the verified, on-ground infrastructural progress of the preceding allocations.

(Para 4.1.19)

163. The Committee notes with satisfaction that the Out-of-Pocket Expenditure (OOPE) has witnessed a precipitous decline to 43.40% of Total Health Expenditure (THE), heavily correlated with the Government Health Expenditure (GHE) increasing its share to 43.70%. The Committee is of the view that the ongoing expansion of essential diagnostics and the massive scale-up of Jan Aushadhi Kendras to 19,200 units have fundamentally transformed affordability for the common citizen. However, acknowledging the critical need for optimal fund utilization across health departments, the Committee believes that sustaining these positive outcomes, including the notable reductions in the Maternal Mortality Ratio and Infant Mortality Rate, requires insulating these financial gains from future inflationary pressures.The Committee, therefore, recommends the formulation of a statutory, multi-year financial outlay roadmap to systematically peg the per capita Government Health Expenditure (currently standing at ₹2,786) to medical inflation and evolving demographic health requirements. Furthermore, the Committee recommends the institution of stringent financial tracking and utilization audits for the expanded medicine procurement networks.

(Para 4.1.21)

164. The Committee recognizes the unprecedented and aggressive augmentation of the nation's medical education framework, highlighted by the exponential growth of medical colleges from 387 to 818 and the near-tripling of both Undergraduate (128,875) and Postgraduate (82,059) medical seats. The Committee believes that this capacity building, alongside the operationalization of 23 AIIMS institutions, is indispensable for bridging historical deficits, as evidenced by the corresponding surge in registered allopathic doctors to 13.88 lakh and nurses to 42.94 lakh.However, the Committee is of the view that such exponential quantitative growth must be strictly matched with high operational proficiency, adequate faculty deployment, and uncompromising statutory compliance. The Committee, therefore, 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. Additionally, the Committee recommends the creation of a specialized deployment policy to strategically integrate this augmented workforce into rural and underserved tier-3 districts, ensuring that the enhanced bed capacity of 8.40 lakh translates directly into accessible, high-quality patient care.

(Para 4.1.22)

165. The Committee views that while flagship schemes like AB-PMJAY comprehensively protect the economically vulnerable bottom 50% of the population, a substantial segment, comprising approximately 30% of the demographic, often referred to as the "missing middle", remains devoid of structured financial health protection. The Committee believes that addressing this systemic gap is paramount for achieving true Universal Health Coverage.The Committee, therefore, recommends the urgent design and collaborative rollout of low-cost, comprehensive voluntary health insurance products specifically tailored for this demographic. Furthermore, the Committee recommends that the Government utilize robust digital exchange platforms to drive consumer awareness, enforce the regulatory standardization of these new insurance products, and facilitate operational efficiency across both public and private insurers.

(Para 4.1.23)

166. The Committee takes note of the fact that the private sector manages a dominant share of hospitalized cases across the country, yet its geographic distribution remains disproportionately skewed towards metropolitan centers. The Committee is of the view that highly decentralized regulatory standards, where a vast majority of compliance mandates vary drastically by state, create significant administrative bottlenecks that deter private healthcare investment in Tier-2 and Tier-3 cities.The Committee, therefore, recommends a systemic overhaul of the existing regulatory framework to institute a "Single Window Clearance" mechanism for hospital registrations, blood bank licensing, and medical device manufacturing. The Committee believes that standardizing Clinical Establishment regulations nationally is crucial to improving the ease of doing business, thereby encouraging the expansion of affordable private care into underserved geographies.

(Para 4.1.24)

Role of Regulatory Bodies

167. The Committee opines that the National Health Authority (NHA) has successfully driven healthcare equity through the world's largest public health assurance scheme, generating an estimated ₹1.91 lakh crore in out-of-pocket expenditure (OOPE) savings and authorizing 12.59 crore hospital admissions as of mid-2026. To sustain this momentum and eliminate persistent geographic inequities, a more aggressive approach to hospital network expansion is required.The Committee believes that while the empanelment of 37,413 hospitals (including 17,265 private institutions) has vastly improved tertiary care utilization, significant access gaps remain in underserved and rural districts. The Committee, therefore, recommends that the NHA actively collaborate with state health authorities to prioritize the empanelment of private healthcare facilities in aspirational and remote districts. Furthermore, the Committee is of the view that underutilized healthcare infrastructure managed by various central ministries and Public Sector Undertakings (PSUs) represents an immediate opportunity to scale capacity. The Committee, therefore, also recommends that the NHA institute a fast-track compliance framework to seamlessly empanel all eligible PSU and federal ministry hospitals into the AB-PMJAY network.

(Para 4.2.19)

168. The Committee further acknowledges the rapid rollout of 1.27 crore Ayushman Vay Vandana cards for senior citizens aged 70 and above, and believes that the NHA must proactively expand specialized health benefit packages (HBPs) to include comprehensive geriatric and palliative care protocols, thereby ensuring that the unique epidemiological needs of the elderly demographic above the age of 60 years are fully met without out-of-pocket vulnerabilities.

(Para 4.2.20)

169. The Committee appreciates view that the establishment of the Ayushman Bharat Digital Mission (ABDM) has laid down a robust foundation for a modern digital public infrastructure, as demonstrated by the creation of 93.98 crore ABHA accounts and the linking of 105.27 crore health records by July 2026,however, the true potential of an interoperable health ecosystem can only be realized through universal adoption across both public and private sectors.The Committee believes that the low-cost digital tools developed by the NHA, such as *e-Sushrut@Clinic* and the AIIMS-validated Clinical Decision Support System (CDSS), are vital instruments to digitize smaller clinics and primary facilities without placing an administrative burden on clinicians. The Committee, therefore, recommends that the NHA mandate a phased, nationwide integration of all private diagnostic centers and hospitals into the National Health Claims Exchange (NHCX) and Unified Health Interface (UHI) gateways. The Committee is assured that such approval would further standardize digital health claims, accelerate cashless settlements, and reduce information asymmetry for patients booking consultations or locating generic medicines.

(Para 4.2.21)

170. Furthermore, the Committee is of the considered view that the revamped Aarogya Setu 2.0 app must be utilized as the central, citizen-facing node for longitudinal health records. The Committee, therefore, recommends intensive localized awareness campaigns to ensure citizens actively utilize consent-based data sharing, thereby avoiding the repetitive costs and logistical challenges associated with lost physical diagnostic reports.

(Para 4.2.22)

171. The Committee understands that primary healthcare units serve as the critical gatekeeper of the national healthcare framework, and their optimal performance directly mitigates the overcrowding of tertiary facilities. While the deployment of over 1.86 lakh Ayushman Arogya Mandirs (AAMs) has registered an impressive 540 crore patient visits, standardizing the quality of care across all regions remains an unfulfilled mandate.The Committee believes that primary care must transcend basic consultations to deliver the full spectrum of the 12 Comprehensive Primary Health Care (CPHC) service packages, with a particular focus on underserved domains like mental health, eye care, and oral hygiene. The Committee, therefore, recommends that the government establish rigid, uniform criteria for an "IPHS-Compliant Functional AAM," explicitly binding central fund disbursements to the verified availability of human resources, essential drugs, and functional diagnostic tools.

(Para 4.2.23)

172. To achieve a seamless continuum of care, the Committee envisages that localized screening data must be structurally linked to advanced treatment platforms. The Committee, therefore, recommends that the NHA completely digitize the Community-Based Assessment Checklist (CBAC) used by frontline workers, integrating it directly with ABHA IDs and the National Non-Communicable Diseases (NCD) portal to establish automated, digital referral pathways from village sub-centers directly to empanelled secondary and tertiary hospitals.

(Para 4.2.24)

173. The Committee is of the view that specialized oncological, trauma, and psychiatric care must be aggressively decentralized to shield rural citizens from catastrophic travel and treatment costs. The budget mandates for FY 2025–26 and 2026–27, including the approval of 297 Day Care Cancer Centres (DCCCs), a 50% capacity expansion of Emergency Care in district hospitals, and the establishment of NIMHANS-2, represent vital policy interventions that require rapid execution.The Committee believes that specialized physical infrastructure cannot function in a vacuum without a parallel, highly specialized workforce. The Committee, therefore, recommends that the government implement the Union Budget announcement for the creation of one lakh allied health professionals through a strict, time-bound 5-year national roadmap.

(Para 4.2.25)

174. The Committee is of the further view that to align with evolving disease patterns and the overarching vision of Viksit Bharat @2047, the training curriculum must expand beyond basic health roles. The Committee, in this regard, 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. This diversification will ensure that both newly constructed Critical Care Hospital Blocks under PM-ABHIM and private tertiary centers are permanently equipped with a world-class, IPHS-compliant workforce.

(Para 4.2.26)

175. The Committee understands that the long-term financial sustainability and affordability of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) are intrinsically linked to robust regulatory oversight and the absolute prevention of resource leakage. The Committee notes that the National Health Authority (NHA) processes massive volumes of daily claims and has proactively deployed Artificial Intelligence (AI) and Machine Learning (ML) models, including an Auto-Adjudication Engine (AAE), to detect anomalous clinical scenarios, document forgery, and deepfake medical records.The Committee believes that minimizing fraud, waste, and misabuse is paramount to ensuring that finite public funds are strictly utilized for genuine beneficiaries rather than unscrupulous entities. The Committee, therefore, recommends that the NHA aggressively scale up its AI-driven National Anti-Fraud Unit (NAFU) algorithms to proactively flag irregular treatment patterns, inflated billing, and manipulated radiological images across all empanelled public and private hospitals.

(Para 4.2.27)

176. Furthermore, the Committee is conscious of the fact that technological deterrence must be matched with strict administrative action. The Committee, therefore, recommends instituting stringent, real-time punitive protocols, including immediate de-empanelment and heavy fiscal penalties, for clinical establishments engaged in fraudulent practices. Concurrently, the Committee recommends that these advanced auto-adjudication mechanisms be optimized to significantly reduce claim settlement turnaround times for compliant healthcare providers, thereby maintaining a high degree of trust and incentivizing wider private sector participation in the scheme.

(Para 4.2.28)

National Pharmaceutical Pricing Authority (NPPA)

177. The Committee is of the view that the "trade margin rationalisation" (TMR) pilot projects executed by the National Pharmaceutical Pricing Authority (NPPA) have proven effective in enhancing healthcare affordability. Capping trade margins at 30% for 42 non-scheduled anti-cancer medicines and at 70% on the price to distributor (PTD) for critical medical devices (including oxygen concentrators, pulse oximeters, and glucometers) has yielded cumulative annual savings exceeding ₹1,984 crore for consumers. The Committee, however, believes that expanding this framework is vital to combat predatory markups, given that the collective average markup for common

dosage forms currently stands at approximately 43%.The Committee, therefore, recommends that the Government should establish a permanent statutory framework for trade margin rationalisation under the Drugs (Prices Control) Order (DPCO), 2013, extending price caps to a broader spectrum of high-cost, non-scheduled chronic disease formulations. However, the Committee notes the legitimate operational concerns raised by micro, small, and medium enterprises (MSMEs) that heavily rely on traditional trading channels for market access. The Committee, therefore, recommends that the finalized TMR framework may incorporate a graded markup structure that shields low-cost MSME manufacturers from institutional displacement while consistently protecting the end consumer.

(Para 4.2.35)

178. The Committee is of the view that the mandate of the NPPA extends beyond capping expenditure to ensuring the continuous, unhindered market availability of life-saving therapeutics. The Committee notes that the historic implementation of DPCO, 2013 has driven down Indian medicine costs to among the lowest globally, generating annual savings of ₹26,055 crore. The Committee, however, believes that extreme pricing pressures must not lead to commercial unviability, which inadvertently forces critical formulations off the market and compels patients to resort to high-cost alternatives.The Committee notes that the NPPA has periodically exercised its emergency powers under Paragraph 19 of DPCO, 2013, most recently in June 2026 via S.O. 3004(E) & 3005(E), to grant one-time 50% upward revisions on essential ceiling prices to preserve supply lines. The Committee, in this regard, recommends that the Government formalize a fast-tracked, data-driven institutional mechanism within the NPPA to monitor raw material costs (such as Active Pharmaceutical Ingredients) allowing for the proactive, temporary invocation of Paragraph 19 before market scarcities manifest. Concurrently, the Committee recommends that the strict enforcement of guidelines governing the discontinuation of scheduled formulations be coupled with strategic production directives under Paragraph 3 to prevent artificial or structural drug shortages.

(Para 4.2.36)

179. The Committee is of the view that the formulation-based, market-data average pricing approach under DPCO, 2013 ensures fairness and objectivity, yet its success ultimately relies on absolute implementation compliance at the retail level. While the NPPA has established a clear ceiling price for 935 formulations and fixed 3,845 retail prices for new drugs as of July 2026, information asymmetry remains an operational challenge for the average citizen.The Committee believes that digital public infrastructure is the most potent weapon to bridge this gap. The Committee, therefore, recommends that the Government must mandate the real-time synchronization of the Integrated Pharmaceutical Database Management System (IPDMS 2.0) with state drug control portals to enforce the 10% annual price-increase cap on non-scheduled drugs. Furthermore, the Committee recommends that the *Pharma Sahi Daam* mobile application be proactively promoted through nationwide public health networks. The Committee, moreover, views that strict compliance audits must be instituted to enforce the statutory mandate requiring retailers to conspicuously display official manufacturer

price lists, ensuring that the financial benefits of NPPA price regulations are transparently and fully passed on to patients at the point of purchase.

(Para 4.2.37)

180. The Committee is of the view that the definition of healthcare accessibility has evolved significantly, making advanced medical devices and complex combination formulations fundamental to modern tertiary treatment. The historical inclusion of coronary stents, knee implants, condoms, and intra-uterine devices within the National List of Essential Medicines (NLEM) has directly protected millions from catastrophic medical debt, with coronary stent price caps alone generating an unprecedented ₹13,353 crore in annual consumer savings.The Committee believes that as technology advances, the scope of the NLEM must dynamically expand to match emerging epidemiological realities. The Committee, therefore, recommends that the Standing National Committee on Medicines (SNCM) systematically evaluate and incorporate high-volume diagnostic and therapeutic medical devices, such as advanced pacemakers, ophthalmic lenses, and implantable pumps, into the scheduled list of the DPCO. Additionally, noting that the NPPA has successfully regulated 3,845 "new drugs" (including 1,380 anti-diabetic and 677 cardiovascular formulations) to control cost variations in altered dosages and combinations, the Committee, in this direction, recommends that the scrutiny of fixed-dose combinations (FDCs) be intensified to prevent manufacturers from bypassing ceiling price regulations through minor structural changes to scheduled drugs.

(Para 4.2.38)

181. The Committee is of the considered view that while pro-active price regulation is paramount for patient protection, the regulatory framework must concurrently stimulate domestic pharmaceutical research and the development of advanced therapeutic delivery systems. The Committee notes that under Paragraph 32 of the Drugs (Prices Control) Order, 2013, the National Pharmaceutical Pricing Authority (NPPA) has successfully incentivized innovation by granting critical price control exemptions to 14 newly patented or indigenously researched products.The Committee believes that such strategic exemption serves as a vital catalyst for the Indian pharmaceutical sector to transition from generic manufacturing to pioneering advanced drug discovery. The Committee, therefore, recommends that the Government should establish a dedicated, fast-track evaluation cell within the NPPA and the Department of Pharmaceuticals to objectively assess and expedite these Paragraph 32 exemptions, explicitly prioritizing breakthrough treatments in oncology, rare diseases, and antimicrobial resistance.

(Para 4.2.39)

182. The Committee, however, is of the view that this commercial incentive must not inadvertently foster prolonged monopolies that lock out vulnerable patient demographics. The Committee, therefore, recommends the enforcement of a strict, automated statutory transition protocol. This mechanism must ensure that immediately upon the expiration of the mandated five-year exemption window, these innovative formulations are seamlessly brought under standard DPCO retail price caps without administrative delay, thereby guaranteeing that the benefits of scientific advancement ultimately translate into affordable, mass-market access.

(Para 4.2.40)

Insurance Regulatory and Development Authority of India (IRDAI):

183. The Committee is of the view that while the National Sample Survey (NSS) 80th Round (2025) indicates notable progress with 46% of the population covered under at least one health insurance or financing scheme, expanding coverage alone cannot guarantee affordability if private sector healthcare costs remain uncontained. The Committee notes with concern that households continue to face massive financial strain when accessing private healthcare, where the average out-of-pocket expenditure (OOPE) per hospitalization episode stands at ₹34,064, substantially higher than the protective, low-cost environment of public hospitals. This problem is severely compounded by an annual medical inflation rate of 10-13% that significantly outpaces general inflation, driven by a lack of standardized treatment protocols and exploitative differential billing practices, such as room rent-linked pricing for clinical procedures. The Committee believes that collaborative regulatory intervention between the Insurance Regulatory and Development Authority of India (IRDAI) and healthcare providers is imperative to stabilize the ecosystem. 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.

(Para 4.2.46)

184. The Committee is of the view that the health insurance ecosystem has become an indispensable pillar of financial protection, as demonstrated by the settlement of 3.26 crore health insurance claims amounting to ₹94,248 crore during FY 2024–25. However, the Committee notes that the financial sustainability of this risk-pooling framework is heavily undermined by integrity risks, including provider-induced demand, fraudulent or fictitious billing, and ineligible beneficiaries, which systematically drive up claim costs and insurance premiums. The Committee believes that robust, unified digital infrastructure is the most effective mechanism to introduce absolute transparency and efficiency into claims management. 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). Concurrently, the Committee recommends that IRDAI expedite the full deployment of the Public Insurance Registry (PIR) as a foundational Digital Public Infrastructure to facilitate secure, consent-based information sharing, minimize late-stage claim settlement disputes, and eliminate systemic leakages.

(Para 4.2.47)

185. The Committee is of the view that making health insurance accessible to an aging population undergoing an epidemiological transition requires the absolute removal of systemic entry barriers that have historically penalized vulnerable demographics, particularly senior citizens of 60 years of age and above individuals with chronic non-communicable diseases (NCDs). The Committee commends the landmark consumer-centric reforms introduced by IRDAI, including the removal of maximum entry age caps, the reduction of pre-existing disease (PED) waiting periods from four years down to three years, the reduction of the moratorium limit to five years, and the mandate for universal AYUSH coverage. The Committee believes that these progressive guidelines must be backed by strict regulatory penalties to prevent insurance companies from creating artificial compliance bottlenecks or hidden exclusions. The Committee, therefore, recommends that IRDAI institute a rigorous compliance audit framework to ensure absolute adherence to the mandated three-hour turnaround time for cashless discharge approvals to eliminate hospital exit delays. Furthermore, the Committee recommends that the Sub-Committee of the Insurance Advisory Committee be directed to design affordable, micro-insurance model products specifically calibrated for late-entrants and low-income households to solidify universal health coverage.

(Para 4.2.48)

186. The Committee is of the view that the traditional health insurance model, which primarily covers secondary and tertiary hospitalization, is fundamentally misaligned with India's ongoing epidemiological transition. The Committee notes from the provided data that the rising prevalence of non-communicable diseases (NCDs), such as diabetes, hypertension, and cardiovascular diseases, necessitates continuous, lifelong medical management rather than episodic hospitalization. The Committee observes that the average out-of-pocket expenditure (OOPE) for outpatient care currently stands at ₹861 per treatment episode. The Committee believes that relying exclusively on hospitalization-centric insurance products leaves policyholders vulnerable to the compounding, long-term financial burden of routine chronic care.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. Furthermore, the Committee recommends that insurers design specialized products that explicitly subsidize the recurring costs of lifelong diagnostics, pharmacy bills, and specialist consultations for NCDs, thereby, securing financial protection across the entire continuum of care.

(Para 4.2.49)

187. The Committee is of the view that the financial burden of childbirth within the private healthcare sector remains disproportionately high, directly undermining the broader objective of healthcare affordability. The Committee notes that the average expenditure for childbirth across all hospitals is ₹14,775, which is substantially higher than the corresponding out-of-pocket expenditure in public health facilities. The Committee believes that maternity care is a fundamental healthcare requirement and must not be a source of structural financial distress for households.The Committee, therefore, recommends that IRDAI introduce regulatory guidelines compelling insurers

to offer standardized maternity benefits as a core, accessible component of base health insurance products, rather than categorizing them as heavily restricted or premium add-on riders. Concurrently, the Committee recommends that the multi-stakeholder Working Groups explicitly prioritize the standardization of maternity and childbirth treatment protocols across empanelled private hospitals, ensuring that institutional delivery costs are stringently regulated and transparently priced.Recognizing the need for coordinated reforms, IRDAI, in collaboration with CII, has constituted multi-stakeholder Working Groups to examine healthcare costs, treatment standardization, fraud mitigation, common empanelment, NHCX adoption, transparency and consumer protection. In parallel, IRDAI is developing the Public Insurance Registry (PIR) as a Digital Public Infrastructure to enable secure, consent-based sharing of insurance information, simplify policy servicing and improve transparency and efficiency. The Committee strongly recommends for transparency in claim settlements through a Public Insurance Registry so that inflated claims are reduced by corporate hospitals and there is a check on such malpractices.

(Para 4.2.50)

Interpreting National Health Accounts Estimates for India 2022-23 on "Health Insurance Expenditures"

188. Health Insurance constitutes health-financing schemes financed by contributions/ premiums collected from individuals or Governments and pooled to actively purchase services from healthcare providers either by the Government (health department or government-governed Corporation/Trust/Society) and/or insurance company. The Committee observed from the National Health Accounts Estimates for India 2022-23 that expenditures of the following five types of health financing schemes are considered health insurance expenditures: (i) Social health Insurance (Central Government Health Scheme, Employees' State Insurance Scheme, and Ex- Servicemen Contributory Health Scheme); (ii) Government Financed Health Insurance Schemes (of both Union and State Governments); (iii) Employer-based insurance - other than enterprise schemes (Private Group Health Insurance); (iv) Other primary coverage schemes (Private Individual Health Insurance); and (v) Community-based health insurance.

(Para 4.2.51)

189. The Committee has thoroughly analyzed the data derived from the National Health Accounts Estimates regarding Health Insurance Expenditure (2022-23). The Committee is of the view that the overwhelming dominance of private health insurance expenditure, standing at ₹81,012 crores and substantially dwarfing both Social Health Insurance (₹32,090 crores) and Government-Financed Insurance, exposes a massive segment of the population to unregulated medical inflation and exorbitant out-of-pocket costs due to exclusionary policies. 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.

(Para 4.2.52)

190. The Committee believes that the extraordinarily negligible expenditure of merely ₹10 crores in Community-Based Health Insurance represents a severe underutilization of grassroots financial risk protection, particularly for the vast informal sector that remains largely ineligible for employer-based private insurance or specific central schemes. The Committee, therefore, recommends that the government aggressively catalyze the expansion of community-level cooperative insurance models. The Committee is of the view that the Ministry of Health should introduce a formal "matching grant" framework to systematically inject public capital into these local community pools. This structural subsidization will empower rural and marginalized collectives to collectively pool risks and negotiate affordable, localized healthcare rates with regional medical facilities.

(Para 4.2.53)

Central Drugs Standard Control Organisation (CDSCO)

191. The Committee is of the view that ensuring the availability of high-quality, safe, and effective medical devices across both public and private health institutions is paramount to building public trust and avoiding substandard clinical outcomes. The Committee notes that under the risk-based classification framework of the Medical Devices Rules (MDR), 2017, the Central Drugs Standard Control Organisation (CDSCO) has successfully licensed 3,480 manufacturing units for Class A & B devices, 1,100 manufacturing units for Class C & D devices, and approved 12,866 import license applications as of July 1, 2026. Furthermore, to secure the supply chain, the Committee notes that CDSCO issued a circular on November 25, 2025, mandating that all procurement agencies, hospitals, and health institutions must require a valid CDSCO or State Licensing Authority (SLA) license for the procurement of medical devices. The Committee believes that structural accountability must be institutionalized through technology without human interface to ensure that uncertified or non-compliant equipment does not penetrate the healthcare delivery network.The Committee, therefore, recommends that the Ministry of Health and Family Welfare should impress upon the concerned State Government to stringently monitor the compliance of the November 25, 2025 Procurement Mandate across all public and private entities to verify that only legally licensed, globally compliant technologies reach patients. The Committee, furthermore, recommends the Government to encourage the State Governments to fully utilize the powers delegated under the MDR, 2017 to establish and notify additional Medical Device Testing Laboratories (MDTLs), expanding beyond the currently registered 84 MDTLs and 18 Notified Bodies. The Committee is of the firm view that expanding this public testing infrastructure and deploying the pool of 258 notified Medical Device Officers (MDOs) will drive robust domestic quality assurance, ultimately making safe medical technologies accessible to all socioeconomic strata. The Committee recommends for greater autonomy to State Licensing Authorities forlicensing of medical devices as per quality approved by notified laboratorieswhich are approved by the QCI.

(Para 4.2.57)

192. The Committee is of the further view that the heavy financial dependency on high-cost, imported medical technologies significantly inflates out-of-pocket expenditures for patients across India. The Committee notes that the "MedTech Mitra" program, a collaborative ecosystem co-launched by NITI Aayog, ICMR, and CDSCO, has emerged as a vital mechanism for domestic indigenization, having received 856 applications, conducted 53 Technical Advisory Committee (TAC) meetings, and provided structured lifecycle handholding to 798 innovators. This end-to-end facilitation spans crucial operational areas, including regulatory strategy guidance for 611 innovators, test license facilitation for 74 innovators, and the establishment of 21 proofs of concept. The Committee believes that systematically addressing technical, clinical, manufacturing, and market-entry barriers via indigenous innovation is the most sustainable approach to introducing cost-effective alternatives into the market. The Committee, therefore, recommends that the Government to significantly scale up the budgetary and institutional capacity of the MedTech Mitra platform to accelerate the commercialization of domestic technologies. The Committee is of the considered view that CDSCO must streamline its processes to fast-track test license facilitation, funding support for pre-clinical/clinical trials, and final manufacturing licenses for innovators transitioning through designated platform. The Committee understands that by fostering a highly competitive domestic manufacturing ecosystem, the resulting market competition will naturally reduce medical device acquisition costs for both public and private hospital networks.

(Para 4.2.58)

193. The Committee has been given to understand that protracted regulatory timelines, administrative redundancies, and high compliance burdens inadvertently inflate the final market cost of medical devices, thereby hurting healthcare accessibility. The Committee takes into account that CDSCO has instituted progressive digital transformation measures under the MDR, 2017 policy measures, including the automated allocation of applications to reviewers, the auto-generation of regulatory certificates, and centralized online modules for compliance management. The Committee recommends the policy reforms aimed at reducing manufacturing license timelines, specifically cutting Class B approval timelines from 140 days to 115 days, and Class C & D timelines from 105 days to 90 days. The Committee believes that maximizing efficiency through digital framework is fundamental to improving the ease of doing business without diluting safety parameters.The Committee, therefore, recommends that the Government formally notify and implement the shortened manufacturing license timelines (115 days for Class B; 90 days for Class C & D) to eliminate operational delays. The Committee further recommends that CDSCO expand its centralized online portal to integrate automated post-approval changes (PACs) and finalize clear, distinct regulatory pathways for digital health and artificial intelligence-based medical software. The Committee is of the view that lowering these entry barriers will incentivize greater private sector investment in manufacturing, optimize supply chain timelines, and translate administrative savings into reduced treatment costs for

patients. The Committee strongly believes that undertaken policy reforms and action plan would definitely promote indigenization and import substitution, thereby promoting accessibility and affordability of healthcare facilities. The Committee hopes that Medical Device Rules, 2017 would further strengthen India's healthcare sytem by ensuring safer high quality medical devices, of course, promoting greater affordability and wider access to healthcare services. The need of the hour is to provide quality care at an affordable cost to the cross-section of the society.

(Para 4.2.59)

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 observes that CDSCO holds the definitive statutory mandate under the Drugs and Cosmetics Act, 1940 to prescribe drug standards and regulate the safety, efficacy, and quality of imported and domestically produced medical products. The Committee believes that the strategic deployment of regulatory fast-tracks for generic variants represents the most direct public health mechanism to democratize access to critical therapies. The Committee, therefore, recommends that CDSCO drastically speed up its clinical trial evaluation and licensing framework specifically tailored for generic medications. 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 Committee believes that coordinating closely with State Drug Control Authorities for uniform enforcement will ensure that these affordable, generic alternatives maintain impeccable therapeutic equivalence, protecting both patient pocketbooks and clinical safety standards.

(Para 4.2.60)

195. The Committee visualizes that since India scales its domestic medical device ecosystem, there is urgent need for maintaining long-term regulatory agility and market trust that requires the continuous strengthening of administrative human capital and the decentralization of oversight mechanisms. The Committee notes that critical institutional steps have already been taken, such as the delegation of Post-Approval Change (PAC) and Risk-classification decisions to Deputy Drugs Controllers (DDCs) to accelerate regulatory throughput. Furthermore, the regulatory framework has sought to build technical capacity through the recruitment of additional manpower, targeted training programs for inspectors, and active collaboration with international regulatory bodies to achieve alignment with global best practices. The Committee believes that ensuring uniform enforcement of the Medical Devices Rules (MDR), 2017 across all jurisdictions is vital for preventing regulatory fragmentation and maintaining high safety standards. The Committee, therefore, recommends the Ministry of Health and Family Welfare should establish a permanent, mandatory training and capacity-building framework for the expanded pool of 258 Medical Device Officers (MDOs) and State inspectors, focusing heavily on advanced risk-based classifications and Quality Management System (QMS) audit techniques in coordination with the 18 registered Notified Bodies. Concurrently, the Committee recommends that the Medical Device

Technical Advisory Group (MDTAG) be mandated to hold fixed, quarterly statutory assemblies to drive continuous policy reforms, systematically evaluate international regulatory updates, and formalize global harmonization pathways. The Committee is of the view that these proactive governance measures are essential to eliminating localized regulatory delays, reducing compliance errors for domestic enterprises, and solidifying India's position as a highly credible, globally compliant manufacturing hub for affordable medical technologies.

(Para 4.2.61)

196. The Committee is of the considered view that genuine indigenous manufacturing, rather than the mere assembly of imported components, is vital to securing healthcare self-reliance and reducing lifecycle costs. The Committee notes reports indicating the potential misuse of the 'Make in India' clause by entities that simply assemble imported components, particularly from China, to secure government contracts. The Committee believes that relying exclusively on current self-certification requirements and statutory documentation is insufficient for verifying the origin of high-value medical technologies. The Committee, therefore, recommends the implementation of a rigorous, mandatory verification mechanism for companies participating in Government procurement. This comprehensive framework must require a minimum of 40% local value addition, enforce component-level traceability, and mandate the submission of digital Bills of Materials (BoM). Furthermore, the Committee recommends that such mechanism include periodic third-party audits, strict country-of-origin disclosures for critical components, and independent verification of local content to ensure complete supply chain integrity and foster true domestic technology development.

(Para 4.2.62)

197. The Committee is of the view that centralized, shared infrastructure models, which provide design, precision manufacturing, testing, validation, and clinical research facilities under one roof, significantly reduce capital investment requirements for individual companies and accelerate product development timelines. The Committee notes that the original 270-acre campus of the Visakhapatnam MedTech Park (AMTZ) is entirely allotted and fully utilized, necessitating immediate expansion to meet the growing demands of the industry and advance the strategic goal of contributing 25–30% of India's medical device market. The Committee, therefore, recommends the expedited acquisition and allocation of an additional 300–350 acres of contiguous land adjoining the existing AMTZ campus to support facility expansions and accommodate new investments. The Government should also replicate the success of Visakhapatnam MedTech Park in other such parks in Odisha, Jharkhand, West Bengal, Bihar and Uttar Pradesh for medical devices and increase the number of MedTech Parks in different regions of the country viz. Odisha, Jharkhand, West Bengal, Bihar and Uttar Pradesh to promote local manufacturing and to provide world-class facilities to Medical Device industry in India by replicating AMTZ model. To further catalyze the growth and global competitiveness of the domestic medical device sector, the Committee recommends the formal introduction of an "Innovation Passport" mechanism designed to provide faster regulatory approvals and seamless access to global markets. Additionally, the Committee believes that the Government must deploy targeted

financial and operational incentives, specifically including stamp duty and registration fee exemptions, capital and research subsidies, and duty exemptions on critical components.

(Para 4.2.63)

198. The Committee, in nutshell, desires that the government must continue to strengthen the regulatory eco-system through simplified compliance procedures, expansion of notified testing laboratories and regulatory personnel, including institutions such as MedTech Mitra. The Committee believes that continuous policy measures including simplified licensing for low-risk devices enhanced testing infrastructure and procurement of only licensed devices by hospitals and Government agencies would further instill regulatory compliance and market confidence. The Committee is of the considered view that when implemented on ground level it would definitely promote domestic manufacturing increase competition reduced regulatory burden and improved availability of safe, quality assured and affordable medical devices across both public and private healthcare sectors, thereby ensuring India's position as an global MedTech hub and leader.

(Para 4.2.64)

199. The Committee is of the view that the technical rigour and specialised expertise required for evaluating increasingly complex drug formulations and biologics cannot be sustained through the existing generalist administrative structure of the Central Drugs Standard Control Organisation (CDSCO). The Committee notes that persistent vacancies in the cadre of Drugs Controllers have continued to constrain the organisation's day-to-day regulatory throughput. The Committee believes that a dedicated technical workforce, distinct from general administrative staff, is essential to keep pace with global scientific and regulatory developments. The Committee, therefore, recommends that the Government expeditiously create a Specialist Core Cadre and a Scientific Review Cadre within CDSCO to institutionalise domain-specific technical evaluation capacity. 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.

(Para 4.2.65)

200. The Committee has been given to understand that the sequential nature of laboratory testing and clinical trial processes has been a significant contributor to delays in bringing new drugs to market, thereby indirectly raising costs and restricting timely access to therapies. The Committee believes that regulatory speed can be substantially improved without compromising scientific scrutiny by re-engineering the processes to run concurrently rather than in sequence. The Committee, therefore, recommends that CDSCO introduce parallel processing of laboratory testing and clinical trial evaluation, supported by a Single-Window Clearance System, to eliminate redundant procedural handoffs and reduce the cumulative time taken for testing and trial approvals. The Committee also recommends the Government to substantially expand the authorised testing ecosystem by empanelling additional public and private laboratories, covering both drugs and all categories of medical devices, that meet

accreditation and competency benchmarks prescribed by Quality Council of India &CDSCO, besides existing CDSCO-affiliated laboratories must be upgraded in a phased manner under defined annual plans to keep testing infrastructure aligned with rising demand and evolving product complexity. The Committee strongly recommends for decentralization of A&B medical devices to State Level Authority (SLA) so that respective State Government can be empowered to create a positive regulatory mechanism and also to increase competition amongst various State Governments to attract Global companies to set up manufacturing base in their States helping the entire country in turn. As both Health and Industry are State subject, it would be appropriate for the State Government to regulate A&B medical devices to notified laboratories.

(Para 4.2.66)

201. The Committee is of the view that regulatory approval alone is insufficient to guarantee drug quality unless it is matched by robust oversight of the distribution chain through which medicines reach patients. The Committee believes that gaps in traceability create vulnerabilities for the entry of substandard or spurious drugs into the supply chain. The Committee, therefore, recommends that the Government enforce end-to-end traceability of pharmaceutical products and mandate strict compliance with Good Distribution Practices (GDP) across manufacturers, distributors, and retailers. The Committee further recommends the creation of a unified Digital Drug Regulatory System (DDRS) that seamlessly connects Central and State drug regulators on a common technology platform, with an inbuilt Risk Management System to enable real-time monitoring, early identification of quality risks, and coordinated enforcement action. The Committee is of the view that these measures, taken together, will yield a strengthened, transparent, and technology-enabled drug regulatory framework marked by faster approvals, enhanced quality assurance, expanded testing capacity, and improved safety of drugs for the public.

(Para 4.2.67)

Quality Council of India (QCI)

202. The Committee is of the view that while the quality ecosystem in India has grown significantly, hospital and laboratory accreditation remains largely voluntary and driven by market pull. To uniformly strengthen the safety, reliability, and quality of healthcare services, a standardized baseline must be established across both public and private sectors. However, this transition must not result in regulatory choking or administrative delays. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, in coordination with QCI, formulate a phased roadmap to transition to mandatory entry-level quality certification. To prevent operational bottlenecks, such transition must be powered by QCI's newly announced Single, Paperless, Modular One-stop Accreditation Platform to replace legacy multi-portal systems, alongside the Quality Setu ticket-based system for time-bound grievance redressal. This transition should prioritize clinical establishments sequentially, so that benchmarks are progressively elevated to full NABH and NABL standards. To support this massive scaling, the Committee recommends expanding the national assessor pool by lowering entry barriers to bring in young experts, thereby, ensuring robust last-mile reach and drastically reducing turnaround times.

(Para 4.2.72)

203. The Committee believes that the stark urban-rural divide in healthcare infrastructure can be effectively bridged by leveraging low-cost certification structures. However, rigid compliance norms and capital strain have historically prevented smaller, semi-urban facilities from entering the formal quality ecosystem. The Committee, therefore, recommends that the government continuously expand the NABH "Entry-Level Certification" programs, specifically targeting smaller facilities in tier-2, tier-3, and rural areas by operationalizing QCI's relaxed accreditation norms that allow hospitals with even 20% occupancy to apply. To accelerate adoption without placing capital strain on smaller entities, the enforcement framework must shift from blanket bans to graded penalties coupled with guidance and course correction. Furthermore, direct and hands-on lifecycle support must be provided through NABH's MITRA programme, utilizing trained and officially empanelled mentors to actively guide small-town hospitals. This must be supplemented by the Gunvatta Pathshala initiative to provide role-based skilling for doctors, nurses, and technicians in patient safety, while utilizing AI-assisted desktop surveillance and desk-based monitoring for consistently performing hospitals to minimize the friction of physical inspections.

(Para 4.2.73)

204. The Committee is of the view that institutionalizing efficiency and eliminating waste are critical parameters for optimizing public expenditure and making tertiary care accessible to the masses. The partnership between QCI and the National Health Authority (NHA) to fast-track empanelment for certified hospitals under Ayushman Bharat (PM-JAY) is an excellent mechanism, but it requires deeper structural optimization to transition from an inspection-heavy model to a trust-based ecosystem. The Committee, therefore, recommends that such digital health certification framework be deeply integrated into all central and state government insurance schemes, deliberately pivoting from rigorous inspection to a high-trust, low-friction environment characterized by reduced paperwork and shorter processing timelines. State governments should mandate that any private or public medical institution seeking public empanelment must possess a verified QCI quality certification. By utilizing technology-driven systems to accelerate processes, such integration would maximize the fiscal efficiency of public health budgetary allocations and fast-track cashless care delivery for vulnerable populations.

(Para 4.2.74)

205. The Committee believes that diagnostic accuracy is the bedrock of affordable healthcare, as spurious or incorrect laboratory results lead to repetitive testing, misdiagnoses, and compounding medical costs. While scaling up legitimate laboratories, the state must simultaneously empower consumers and eliminate the administrative lag that keeps quality labs outside the accredited network. The Committee, therefore, recommends strict regulatory clampdowns on unaccredited, self-declared commercial

testing labs. To rapidly expand the network of verified labs, QCI's NABL reforms must be fully deployed, including the introduction of a model scope for medical testing laboratories to ensure nationwide uniformity, a 48-hour self-declaration window for approving authorized signatories, and 48-hour scope extensions for similar testing methods to eliminate long waiting periods. Additional fees for product-based accreditation must be eliminated where test parameters are already covered. To ensure the technical sustainability of laboratory ecosystem, the government must support the technical skilling initiatives aimed at training 5,000 laboratory personnel in 2026. Furthermore, to protect citizens from fraudulent, substandard clinics, the government must systematically scale up the newly unveiled "Q Mark – Desh ka Haq" reform. This QR-coded Mark of Quality must be prominently integrated into public health portals and physically mandated at the entrance of every clinical laboratory, ensuring full public disclosure, eliminating fake certificates, and allowing ordinary citizens to instantly verify a facility's authentic certification status.

(Para 4.2.75)

National Medical Commission (NMC)

206. The Committee believes that keeping medical education affordable is absolutely critical to preventing the commercialization of healthcare delivery. Under the current regulatory structure managed by the Medical Assessment and Rating Board (MARB), the evaluation of new institutions relies on strict compliance documentation, including an Essentiality Certificate from the respective State or Union Territory valid for three years, a Consent of Affiliation from a recognized university, and definitive proof of a corpus fund and financial solvency certified by a Chartered Accountant.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.The Committee further recommends that these mandatory baseline financial tracking mechanisms must be leveraged to audit institutional cost structures, ensuring that hidden capitation fees do not circumvent the mandate for socio-economic inclusivity in medical education training.

(Para 4.2.80)

207. The Committee is of the view that expanding national training capacities must be paired with operational relaxations that allow quick scaling without compromising educational integrity. The transition from legacy MSR 1999 guidelines to the modern Minimum Standard Requirements (MSR) 2023 regulations represents a significant systemic reform. For instance, a 100-seat undergraduate institution now requires 420 beds and 85 faculty members compared to the historic requirement of 500 beds, while a 250-seat institution has seen its bed requirement optimized from 1,100 to 900 beds, balanced against an elevated mandatory bed occupancy rate of 80% to maintain rigorous clinical exposure. The aggregate capacity across the country now boasts approximately 80,000 postgraduate seats inclusive of AIIMS, Institutes of National Importance (INIs), and NBEMS tracks. 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.

(Para 4.2.81)

208. The Committee further recommends that government medical institutions be permitted to initiate postgraduate courses concurrently with their undergraduate launch only after ensuring adequate cinical exposure, while private medical colleges should be cleared to introduce PG specialties from their third operational year using streamlined resource models requiring as few as two faculty members—specifically one Professor and one Associate or Assistant Professor as per specialty subject to proven clinical exposue and real hands on training. Most significantly, the Committee strongly recommends NMC to ensure cheaper cost medical education and proficiency pursuit to enhance inclusivity and expanding opportunity for candidature of weaker section of society. The Committee also recommends tapping non-traditional public clinical resources, such as specialized Railways and Mines hospitals, to rapidly expand regional specialty training footprints in underserved zones viz. hilly and tribal regions. To ensure quality, the Committee recommends for an Exit examination for both graduate and post-graduate students.

(Para 4.2.82)

209. The Committee believes that legacy five-year periodic recognition inspections created systemic vulnerabilities and structural inefficiencies in medical education monitoring. Under the Maintenance of Standards of Medical Education Regulations (MSMER) 2023 and the Graduate Medical Education Regulations (GMER), the NMC has executed a sweeping digital transformation toward a continuous monitoring model based on annual self-declarations submitted via a centralized portal. Routine seat renewals and institutional approvals are now managed through standardized virtual inspections to mitigate subjective biases and eliminate assessor exploitation, while physical assessments for new applicants require real-time final assessment reports to be jointly signed and instantly uploaded via an IT-enabled module.

(Para 4.2.83)

210. The Committee, therefore, recommends the absolute consolidation of the centralized, Aadhaar-enabled biometric attendance system (AEBAS), which tracks over 4 lakh enrolled faculty, students, interns, and tutors across the nation. The Committee stands for ensuring universal compliance with the face-authentication upgrades introduced via the geo-fenced National Informatics Centre (NIC) mobile application to systematically eradicate "ghost faculty" and capture absolute employment logs. The Committee, in this regard, furtherfor recommends scaling the pilot Hospital Management Information System (HMIS) API integration module to bind all clinical material assessments directly to unique patient ABHA IDs. Such digital mapping, combined with live classroom and hospital area CCTV surveillance streamed through shared Network Video Recorder (NVR) links, will permanently prevent the manipulation of clinical workloads or the utilization of fake patients during institutional evaluations.

(Para 4.2.84)

211. The Committee understands that the structural architecture of the NMC—specifically the functional coordination between the Under-Graduate Medical Education Board (UGMEB), the Post-Graduate Medical Education Board (PGMEB), and the Ethics and Medical Registration Board (EMRB)—must remain anchored to public health priorities. The Committee, in this connection, recommends that the UGMEB continuously refine the Competency-Based Medical Education (CBME) curriculum to emphasize primary and preventative clinical competencies. The Committee strongly believes that the strict enforcement of the Village and Family Adoption Programmes within undergraduate training will ensurethe future medical cohorts tuned with structurally and culturally oriented to address the unique healthcare accessibility barriers faced by rural communities.

(Para 4.2.85)

212. The Committee is of the firms opinion that pharmaceutical expenditures represent the largest component of catastrophic out-of-pocket spending for patients in India. Shifting clinical practice from expensive branded medicines to unbranded generic equivalents is one of the most effective ways to lower healthcare costs for the public. The Committee, therefore, 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. The Committee strongly desires that the government must integrate the National Medical Register with public procurement data and establish automated grievance mechanisms through State Medical Councils to track, review, and audit prescribing patterns across both public and private hospital ecosystems.

(Para 4.2.86)

National Testing Agency (NTA)

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. While it does not directly control medical tariffs or drug pricing, its entry-level oversight of human capital directly shapes the quality, equity, and long-term delivery costs of national healthcare. The administrative challenges observed in 2024 and May 2026 examination cycle highlight those vulnerabilities in paper-based logistics threaten the sanctity of merit-based selection. If compromised, the system risks tilting admissions back toward arbitrary commercialization, thereby inflating the downstream cost of medical professionals and hurting public trust. The Committee, therefore, recommends that the Ministry of Education and the Ministry of Health and Family Welfare jointly expedite the implementation of the High-Level Committee of Experts (HLCE) roadmap. The government must prioritize a phased, conditional transition of the National Eligibility-cum-Entrance Test (NEET-UG) from a Pen-and-Paper Test (PPT) to Computer-Based Testing (CBT) to completely eliminate vulnerable physical print-and-transport supply chains. The Committee further recommends that during the transitional phase, the NTA must institutionalize the proposed Computer-assisted Secure PPT (CPPT) model—utilizing encrypted, candidate-randomized papers printed locally within secure rooms—

alongside robust, multi-layered biometric authentication and live AI-enabled CCTV analytics to guarantee a zero-error, tamper-proof testing environment.

(Para 4.2.90)

214. The Committee believes that achieving true equity in healthcare delivery requires a socio-economically and geographically diverse medical workforce. Aspirants from rural, remote, and economically weaker backgrounds are statistically more inclined to serve underrepresented provincial regions later in their medical careers. By providing a single, standardized gateway into heavily subsidized government institutions, the NTA has successfully curbed exploitative "donation seats" and diminished the out-of-pocket financial burden of writing dozens of separate institutional exams. However, physical and economic barriers to testing centers still restrict lower-income candidates. The Committee, therefore, recommends that the NTA, in close coordination with State Governments, drastically scale up the creation of secure, government-owned testing centers by retrofitting Kendriya Vidyalayas, Navodaya Vidyalayas, and state universities. To eliminate the logistical and financial strain on rural candidates, the Committee recommends the deployment of specialized mobile testing units in underserved districts. This infrastructure expansion must be supported by a highly rationalized fee structure and priority-based center allocations for female, differently-abled, and economically vulnerable students to ensure no qualified candidate is excluded from the medical education pipeline due to geographic or financial distress.

(Para 4.2.91)

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. Standardizing entry-level quality for these streams is vital to preventing misdiagnoses and subsequent medical complications that drive up catastrophic out-of-pocket healthcare expenditures for vulnerable populations. The NTA's mandate to make NEET-UG the uniform entrance test for BAMS, BHMS, BUMS, and nursing courses is a major regulatory step toward uniformizing human capital quality across all medical disciplines.

(Para 4.2.92)

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. Such collaboration should introduce hybrid Classical Test Theory and Item Response Theory (CTT-IRT) models to evaluate candidates on both fundamental aptitude and practical reasoning. 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, the government will level the playing field for candidates who rely solely on public school curricula, ensuring that primary healthcare across rural India is managed by highly competent, merit-selected professionals.

(Para 4.2.93)

217. The Committee understands that the persistent vacancies and inequitable distribution of healthcare personnel, particularly in remote and underserved regions, fundamentally undermine the efficacy of primary healthcare delivery. The Committee believes that overcoming such systemic retention barriers requires states to abandon rigid, centralized human resource models in favor of innovative, localized, and incentive-driven workforce strategies.The Committee, therefore, recommends that state governments immediately transition to decentralized recruitment frameworks, empowering district and local authorities to hire personnel based on localized clinical needs. The successful digitalized, district-level recruitment of Community Health Officers (CHOs) executed in Karnataka must be adopted as a structural benchmark to streamline timelines and reduce rural vacancies.The Committeestrongly appeals the Government for the implementation of robust, incentive-linked rural postings to attract and retain health professionals in difficult-to-reach areas. 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.

(Para 4.2.94)

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 to deliver targeted public health services under defined supervisory guidelines.The Committee, therefore, recommends for the establishment of specialized, dedicated public health management cadres at the State level to systematically strengthen disease surveillance, emergency preparedness, health promotion, and evidence-based fiscal planning.The Committee,in this regard, recommends for fostering institutional partnerships between established medical colleges and grassroots primary healthcare facilities. Such collaborations are essential to provide regular specialist mentoring, tele-mentoring, continuing medical education, and structural capacity building for all frontline healthcare workers.

(Para 4.2.95)

219. The Committee visualizes that expanding the national pool of available medical doctors requires a decisive dismantling of legacy regulatory bottlenecks that artificially constrain the growth and operational efficiency of medical education. The Committee believes that transitioning from a restrictive compliance framework to a rationalized, resource-optimized model is imperative to accelerate the production of medical professionals and maximize the utility of existing clinical infrastructure.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, thereby removing a significant bureaucratic hurdle to institutional

entry. The Committee further recommends for removing the administrative requirement for the annual renewal of the letter of permission from the Medical Assessment and Rating Board (MARB) thereby adoption of user regulatory mechanism. The Committee is of the view that regulatory oversight should instead be maintained through a robust mechanism of mandatory annual online disclosures.

(Para 4.2.96)

220. The Committee recommends permitting the strategic sharing of institutional infrastructure across multiple colleges within the same university or across different universities, formalized through mutual agreements and Memorandums of Understanding (MoUs), to prevent the redundant duplication of capital assets.

(Para 4.2.97)

221. The Committee is of the opinion that qualified visiting faculty be explicitly counted toward the fulfillment of minimum institutional faculty requirements, subject to their strict adherence to the stipulated thresholds for minimum class delivery.The Committee, therefore, recommends reducing the mandatory minimum duration requirement for hospital leases or formal MoU arrangements from 30 years to 25 years to significantly lower long-term real estate and capital barriers for new medical institutions.

(Para 4.2.98)

Rationalization of Treatment Cost

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. Furthermore, the Committee believes that such a framework must rigorously uphold the welfare motive of the public sector while concurrently encouraging and incentivizing private sector hospitals to play a complementary, ethical role, thereby ensuring holistic affordability and accessibility of healthcare facilities to the low- and middle-class population. The constitutional provision of the welfare nature of the State and socialistic pattern of society cherished in the Directive Principle of State Policy under Part IV of the Constitution of India entrust the Government of the day to make the healthcare accessible and affordable for the people of the country in compliance with the direction of the Supreme Court of India under Article-21 of the Indian Constitution interpreting thereon inherent provision of Fundamental Right to Health. On the other hand, today's economy is the democratic and competitive driven liberal economy where market forces fixes/determines the rates. The need of the hour is to strike a balance between the constitutional provision and the prevailing market economy in order to ensure quality, cost-effectiveness, accessibility and affordability of healthcare. 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.

(Para 5.1.1)

Drugs (Prices Control) Order, 2013

223. As regards the issue of trade margin, the Committee has come across that the average mark up for common dosage forms of non-scheduled drugs, namely, tablets, capsules, sachet, gums and strips, is around 43% for distributors, stockists, wholesalers and retailers collectively. Such instances indicates that incidence of high trade margins is generally not the norm, however, the Committee desires that Government must look into the matter of high trade margin in the noticeable cases. In this regard, the Committee recommends that the Government should initiate consultation with stakeholders for making suitable policy and regulatory provision for trade margin rationalisation. During the consultation process, there is need to pay attention to the legitimate concerns raised, especially by low-cost micro, small and medium enterprises (MSME) manufacturers who rely mainly on the trading channel for market development to ensure that their low-cost drugs reach consumers.

(Para 5.3.2)

224. The Committee is pleased to observe that the existing pricing and policy framework has resulted in the prices of both non- scheduled and scheduled drugs in India being generally the lowest across categories and across both manufacturing and non-manufacturing countries. However, the Committee believes that the aim behind formulating essential medicine list must ensure that these medicines are available in adequate amounts, in appropriate dosage with assured quality. This is so because essential medicines are those medicines that satisfy the priority health care needs of any population, based on efficacy, safety, quality and includes total cost of the treatment. The NLEM must be basically a list of medicines that are safe, efficacious and collectively address a majority of the public health concerns of India and are cost-effective.

(Para 5.3.3)

National Pharmaceutical Pricing Authority (NPPA)

225. The Committee is of the view that price control mechanisms on formulations alone are insufficient to guarantee universal healthcare accessibility across all demographics. As recognized by the foundational principles of the National Pharmaceuticals Pricing Policy (NPPP), 2012, regulatory control over drug prices represents only a single element within a much broader strategy required for affordable healthcare. The Committee believes that alternative infrastructure for delivering low-cost therapies must be aggressively expanded to shield the vulnerable populace from exorbitant out-of-pocket expenditures. The Committee, therefore, recommends that the Government should exponentially scale up the well-spread, low-cost Jan-Aushadhi pharmacy chain programme, prioritizing penetration into unserved rural and semi-

urban districts. The Committee is of the view that the Government must also seamlessly integrate these pharmacy chains with direct Government healthcare and state insurance programmes, ensuring that affordable generic medicines serve as the frontline choice for public health delivery. The Committee recommends for a quality check mechanism to remove apprehensions regarding quality of medicines delivered through Jan Aushadi Kendras.

(Para 5.4.6)

226. The Committee is of the view that the statutory provision under Paragraph 16 of the DPCO, 2013, which allows for the annual revision of ceiling prices for scheduled formulations based on the Wholesale Price Index (WPI), is a necessary mechanism to account for macroeconomic inflation. However, the Committee believes that since the WPI-based increase explicitly represents the maximum permissible hike and is not a mandatory increment, there is a risk of manufacturers routinely and uniformly availing the highest allowable price increase regardless of their actual, localized production costs. 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. The Committee is of the view that such heightened regulatory vigilance will prevent routine, arbitrary price inflations of scheduled medicines and ensure that the foundational objective of the DPCO, delivering required medicines at reasonable and fair prices, remains strictly uncompromised.

(Para 5.4.7)

Sankara Nethralaya

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. The hospital does not adopt a variable tariff structure and ensures uniformity in treatment costs across patient categories. It has established well-defined package rates for common surgical procedures, covering surgeon's fees, consumables, investigations and post-operative care, thereby eliminating ambiguity and enabling patients to plan their medical expenses in advance. Unlike many private hospitals, the institution does not practice differential pricing based on demand, timing or urgency, ensuring fairness and equity in service delivery. Prior to surgery, patients are informed of the applicable package rates along with a detailed break-up of charges, while any exclusions, such as post-discharge medications, extended hospital stay or special investigations, are clearly communicated in advance. The Committee observes that consultation charges, day-care services and surgical package rates are displayed at the hospital reception and are made available to patients upon request, thereby promoting transparency and safeguarding patients' rights. The hospital management, in a written submission to the Committee, emphasized that the hospital does not levy exorbitant charges for diagnostic or treatment services and that all costs are standardized, transparent and aligned with its objective of making quality eye care accessible irrespective of a patient's financial status. The Committee understands that other centers for excellence like the Sankara Nethralaya in eye treatment be treated as a gold

standard on the parameters of quality, affordability and public trust and the other hospitals in both the private and public sector should follow suit.

(Para 5.5.2)

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 believes that absolute transparency is the first step toward effective cost rationalizing. 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. Such mandatory packages must comprehensively include surgeon fees, diagnostic investigations, consumables, and standard post-operative care. The Committee believes that such measures would lead to self-regulating and rationalization of treatment cost by the hospital. The Committee further believes that by measure of legally eliminating hidden charges and differential pricing, would act as a de-facto capping of treatment cost and would also ensure that patients can precisely plan their medical expenses without fear of arbitrary billing inflation.

(Para 5.5.8)

229. The Committee believes that the long-term sustainability of affordable healthcare delivery, particularly by private and not-for-profit hospitals, is heavily reliant on the efficiency of government health assurance schemes like Ayushman Bharat. The Committee is of the view that chronic administrative delays and inconsistencies in claim settlements actively discourages private institutions from dedicating beds to economically weaker sections. 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. The Committee firmly believes that the process of making Ayushman Bharat cards and process of settlement of claims by the hospitals needs to be simplified for better interest of needy patients as well as operational proficiency of the treating hospital. Furthermore, a provision for penal interest on delayed payments must be introduced to ensure mutual trust, accountability, and the uninterrupted participation of private providers in subsidized healthcare initiatives.

(Para 5.5.9)

230. The Committee visualizes that genuine accessibility requires taking specialized, high-quality healthcare directly to rural and underserved populations, thereby eliminating the catastrophic indirect costs associated with travel, accommodation, and wage loss. The Committee believes that decentralized care models, such as Mobile Eye Surgical Units (MESU), have proven highly effective in bridging the urban-rural healthcare divide. The Committee, therefore, recommends that the government must provide targeted policy recognition, logistical assistance, and capital subsidies to both public and private institutions that deploy fully equipped mobile surgical and diagnostic units. These mobile units must be formally integrated into national rural health

programs, ensuring that standardized treatment reaches the most marginalized demographics without compromising on clinical safety or quality.

(Para 5.5.10)

231. The Committee considers that redundant and repetitive compliance requirements impose an unnecessary administrative and financial burden on healthcare providers, particularly not-for-profit organizations operating on cross-subsidy models. The Committee is of the opinion that reducing such operational friction is essential to lower the overarching cost of healthcare delivery. The Committee, therefore, recommends the urgent deployment of a centralized, single-window digital portal for all statutory compliance and reporting required from hospitals, effectively eliminating repetitive physical documentation. Additionally, the Committee believes that the most effective method to rationalize long-term healthcare costs is through early screening, diagnosis, detection and treatment, if required. 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 which significantly mitigate the future economic burden of advanced and complex diseases on both the state and the citizen. Moreover, awareness program amongst the school/college going children and community awareness as well needs to be emphasized in the policy action.

(Para 5.5.11)

Views of the Private Healthcare Sector on the Cost of Treatment

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.

(Para 5.6.3)

233. The Committee believes that the exorbitant capital required to procure sophisticated medical technology, a significant proportion of which must be imported, acts as a primary driver of high diagnostic and surgical costs. 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. To ensure this financial relief translates into affordable care, the Committee is of the view that tax exemptions on such equipment must be strictly contingent upon the importing healthcare facilities committing to standardized, capped pricing for the diagnostic tests and procedures utilizing that specific machinery.

(Para 5.6.4)

234. The Committee understands that the prohibitive commercial cost of real estate acquisition severely restricts the expansion of affordable healthcare infrastructure, forcing private institutions to recover land investments through higher treatment tariffs. The Committee, therefore, recommends that the Ministry of Health and Family Welfare coordinate with State Governments to draft a unified national policy for the concessional or preferential allotment of land for the establishment of new healthcare facilities. The Committee believes that such preferential land grants to private investors in healthcare must be legally bound to entrust sense and responsibility of robust social obligations for providing treatment to the needy patient at the concessional/subsidized rates. Hospitals benefiting from subsidized land must be mandated to dedicate a fixed percentage of their beds capacity upto 20% of the total beds capacity of the hospital for outpatient services, especially to economically weaker sections at strictly capped and Government-approved rates.

(Para 5.6.5)

235. The Committee has been given to understand that unilateral rate-setting for Government-sponsored health schemes generally skip the accounting for the practical realities of infrastructure investments, specialized manpower, and technology adoption required by the private sector. While empirical data collection is vital, the Committee believes that the interpretation of such data requires practical industry context. 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. By ensuring that compensation under health schemes accurately reflects the true cost of delivering quality care. The Committee firmly believes that the Government can ensure the financial sustainability of these programs and prevent private hospitals from compensating for scheme losses by inflating the treatment costs of general-category patients.

(Para 5.6.6)

Jawaharlal Nehru Medical College (JNMC)

236. The Committee is of the view that the rigid imposition of predefined package durations disproportionately penalizes healthcare institutions handling complex, acute cases. Treatments involving high-cost specialties, such as Neurosurgery, Cardiovascular and Thoracic Surgery (CVTS), Orthopaedics, and critical care, frequently necessitate prolonged Intensive Care Unit (ICU) stays that exceed standard package parameters. The Committee believes that forcing hospitals to absorb these outlier costs acts as a severe deterrent to the admission of critically ill scheme beneficiaries. The Committee, therefore, recommends the immediate unbundling of prolonged critical care from

standard surgical packages. Clear clinical parameters must be defined to categorize "outlier events." 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.

(Para 5.7.11)

237. The Committee believes that functional limitations and rigid procedural algorithms within the Ayushman Bharat–PMJAY IT portal and analogous state portals actively generate avoidable claim rejections and administrative delays, which ultimately drive up the operational cost of healthcare delivery. The Committee, therefore, recommends a comprehensive technological overhaul of all national and state health Insurance IT portals. The upgraded infrastructure must provide real-time visibility of annual utilization limits for high-cost diagnostic investigations (such as MRI and CT scans) at the family level to enable accurate treatment planning. Furthermore, the Committee recommends the immediate expansion of digital storage capacities on these portals to allow for the seamless uploading of voluminous medical records associated with prolonged ICU stays. A transparent, bidirectional tracking mechanism must also be instituted, compelling health authorities to provide detailed justifications for claim rejections and affording hospitals a fair appellate window beyond the current restrictive 15-day limit.

(Para 5.7.12)

238. The Committee is of the view that the mandatory, hierarchical routing of critical patients through primary and district-level hospitals before such patients can access tertiary care introduces fatal delays, exacerbates the patient's clinical condition, and ultimately inflates the cost of treatment upon admission. The Committee, therefore, recommends the immediate deployment of a real-time, digital referral system that connects all tiers of healthcare facilities. Clear clinical triage protocols must be established to allow lower-level medical officers to bypass intermediary district hospitals and generate direct referrals to empanelled tertiary care institutions for complex, life-threatening conditions. The Committee believes that streamlining this pathway will significantly shorten overall hospital stays, minimize the need for redundant diagnostic testing across multiple facilities, and drastically lower the cumulative cost of care.

(Para 5.7.13)

239. The Committee considers that achieving true affordability in specialized treatments, particularly in orthopaedics and cardiology, is impossible as long as the sector remains highly dependent on imported implants and medical devices. Furthermore, treating hospitals as commercial industries for the purpose of licensing and utility tariffs unnecessarily escalates their baseline operating costs. 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. Simultaneously, the Committee is of the view that state governments must be directed to comprehensively review and rationalize the institutional licensing costs imposed on healthcare facilities. 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.

(Para 5.7.14)

240. The Committee is of the view that the existing disparity between the package rates offered under the Ayushman Bharat–PMJAY and various State-run health insurance schemes, such as the Ayushman Bharat Arogya Karnataka (AB-ArK), creates a fragmented healthcare financing ecosystem. The Committee notes the submissions of tertiary care providers highlighting that current PMJAY rates for several high-cost specialties are inadequate, which actively disincentivizes private sector participation and limits beneficiary access to complex procedures. 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' tasked with the scientific rationalization and periodic revision of standard package rates across all national and state health insurance schemes. This Board must ensure that package rates are dynamically indexed to actual regional procurement costs, inflation, and standardized clinical protocols, thereby harmonizing central and state tariffs while safeguarding equitable remuneration for healthcare providers.

(Para 5.7.15)

241. The Committee is of the view that information asymmetry regarding scheme eligibility, utilization limits, and complex documentation requirements often leads to severe operational friction and avoidable disputes between beneficiaries and hospital administrations. The Committee believes that dedicated institutional facilitation, as demonstrated by the successful deployment of Public Relations Officers (PROs) and counselors at JNMC, can dramatically improve scheme uptake and protect vulnerable patients from exploitation. Furthermore, the Committee is of the view that a robust, accessible grievance redressal infrastructure is vital for public trust. The Committee, therefore, recommends that the Government mandate the establishment of dedicated 'Patient Navigation and Grievance Redressal Cells' across all tertiary care hospitals empanelled under national health schemes. These cells must be fully staffed with trained counselors and equipped with multi-modal communication platforms—including digital tracking, WhatsApp interfaces, and physical complaint boxes—to proactively educate beneficiaries, assist with seamless documentation, and ensure the time-bound, transparent resolution of patient grievances.

(Para 5.7.16)

RIMS hospital, Imphal

242. The Committee is of the view that establishing transparent institutional procurement mechanisms is foundational to reducing the baseline cost of medical treatments. Taking note of the highly successful integration of the Government e-Marketplace (GeM) alongside the deployment of AMRIT and Jan Aushadhi centres at public institutions like RIMS, the Committee believes that such models significantly

curtail exorbitant out-of-pocket expenditures on pharmaceuticals and consumables. The Committee, therefore, recommends that the Government should mandate the establishment of AMRIT and Jan Aushadhi pharmacies within the premises of all AB-PMJAY empanelled hospitals, both in the public and private sectors. Furthermore, the Committee recommends that the Government formulate regulatory guidelines requiring private empanelled hospitals to adopt centralized, transparent tender-based procurement systems to strictly cap the internal mark-ups levied on life-saving consumables and medical devices at a mutually agreed-upon ceiling, such as the 20 percent margin observed in proactive institutions.

(Para 5.8.7)

243. The Committee understands that the foundational objective of entirely free public healthcare is severely undermined when patients are compelled to procure surgical consumables and diagnostics from private vendors out-of-pocket due to institutional stockouts. The Committee observes with concern that even in public institutions offering ostensibly free major surgical procedures, patients frequently bear substantial financial burdens for critical items, such as oncology consumables or specialized dialysis tubing. The Committee believes that comprehensive healthcare accessibility dictates that no patient seeking treatment in a government tertiary facility should face catastrophic secondary costs for essential surgical supplies. The Committee, therefore, recommends that the Government augment the budgetary allocations specifically earmarked for the continuous, uninterrupted stocking of high-value consumables and surgical implants in public hospitals. The Committee further recommends the implementation of an automated 'Zero-Stockout Policy' supported by digital inventory management systems that trigger expedited government procurement long before critical supply thresholds are breached.

(Para 5.8.8)

Containing the Cost of Rare Disease and Cancer Care

244. The Committee is of the considered view that while the public display of standard package rates is necessary, the management of complex, multi-stage diseases like cancer requires highly individualized treatment plans, making total cost anticipation difficult for the average citizen. The Committee believes that patients must be insulated from financial unpredictability and mid-treatment billing shocks. The Committee, therefore, recommends that the government institute a statutory mandate requiring all tertiary care hospitals to provide a comprehensive, legally binding upfront cost estimate to the patient prior to the initiation of any complex or prolonged medical intervention. Furthermore, hospitals must be mandated to deploy dedicated 'Financial Navigators', specialized counselors who guide patients and their families through these estimates, available philanthropic support, and health assurance limits, thereby enabling fully informed financial planning.

(Para 5.9.7)

245. The Committee is of the considered opinion that some private hospitals levy or charge large amounts for hospital stays especially in metropolitan cities. Having analysed the break up of the hospital billing structure the Committee believes that rationalizing of room charges needs to be done on an emergent basis.The Committee

understands that hospital room charges are not uniform and vary across geographic regions and even among hospitals within the same area due to differences in infrastructure, service levels and operating costs. 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. The Committee recommends for making this benchmark mandatory for all private hospitals in large metropolitan cities. The resident doctor cost, Nursing cost, disposable costs of consumables, meal charges, laundry charges can be added to the basic room tariff so that the entire cost is rationalized.

(Para 5.9.8)

246. The Committee firmly believes that the current ecosystem often limits financial capping to acute interventions or surgical procedures, leaving patients highly vulnerable to unregulated out-of-pocket expenses during extended follow-ups, rehabilitation, or end-of-life care. The Committee is of the view that true affordability must encompass the entire lifecycle of disease management. The Committee, therefore, recommends the formulation and regulatory enforcement of 'Continuum of Care' packages. These advanced packages must comprehensively bundle preventive screening, diagnostic, curative, and palliative services under a single, capped financial umbrella, ensuring that economically disadvantaged patients are not forced to abandon care during the critical palliative or supportive phases.

(Para 5.9.9)

247. The Committee is of the view that novel, highly efficacious treatment modalities, such as immunotherapy, genomic therapies, and targeted therapies, remain prohibitively expensive. Integrating these directly into standard capped packages currently risks overwhelming the financial sustainability of health assurance schemes. The Committee believes that the fragmented mobilization of Corporate Social Responsibility (CSR) and philanthropic funds by individual hospitals, while commendable, is insufficient for achieving national scale. 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. These pooled resources must be strictly earmarked to subsidize or entirely fund advanced, high-cost therapeutics for eligible patients, thereby bypassing standard commercial pricing barriers without burdening the hospital's operational budget.

(Para 5.9.10)

248. The Committee knows that the intense psychological and emotional toll of catastrophic illnesses frequently leads to severe depression, loss of livelihood, and ultimately, treatment abandonment. Such abandonment not only jeopardizes patient survival but also results in a massive wastage of medical resources and financial investments already expended. The Committee is of the view that mental health and psychosocial support are not auxiliary luxuries, but clinical necessities that directly improve treatment adherence and optimize outcomes. The Committee, therefore, recommends that structured psychological counseling, emotional support services, and patient support groups be formally integrated as mandatory, zero-cost components

within all approved treatment protocols and capped financial packages for severe, chronic, and terminal diseases across both the public and private sectors.

(Para 5.9.11)

249. The Committee is of the view that the structural reliance on imports for 70 to 80 percent of medical device components, such as medical-grade electronics, sensors, semiconductors, and precision-engineered parts, severely constrains India's global competitiveness and structurally inflates the baseline cost of healthcare. The Committee believes that conventional financing mechanisms remain fundamentally inadequate to support the high capital intensity, long gestation periods, and technology risks inherent in medical device component manufacturing. The Committee, therefore, recommends that the Government immediately operationalize the proposed National Medical Device Component Financing Framework (NMDCFF) under the National Medical Devices Policy, 2023. This framework must deploy a lifecycle-based financing approach, utilizing targeted instruments such as long-term concessional loans, credit guarantee schemes, and R&D grants, to transition the domestic industry from mere assembly operations to high-value, indigenous manufacturing of critical inputs.

(Para 5.11.7)

250. The Committee dwells upon the view that while capital and technological support are vital for capacity building, creating a predictable and assured domestic market is equally essential to ensure the commercial viability of indigenous medical device component manufacturers. The Committee believes that without guaranteed demand, domestic manufacturers will struggle to achieve economies of scale against established global supply chains. The Committee, therefore, recommends that the Government should pro-actively implement the 'Market Development & Demand Assurance' pillar of the NMDCFF by instituting strict preferential public procurement policies. Procurement platforms and agencies under the Ministry of Health and Family Welfare, prominently including GeM, PMJAY, CGHS, and ESIC, must be mandated to enforce stringent domestic value-addition criteria and offer long-term procurement commitments to domestic manufacturers, thereby structurally incentivizing self-reliance.

(Para 5.11.8)

251. The Committee opines that the successful execution of the NMDCFF necessitates seamless synergy across multiple administrative, scientific, and financial domains, rather than allowing ministries to function in isolated bureaucratic silos. The Committee believes that addressing complex challenges, ranging from pilot manufacturing and technology transfer to global market expansion, requires a unified and dynamic institutional architecture. The Committee, therefore, recommends the formal establishment of a coordinated, multi-agency apex mechanism spearheaded by the Department of Pharmaceuticals. This body must systematically integrate financial institutions like SIDBI and NABFID for risk-sharing, scientific bodies like DBT, DST, and ICMR for research and innovation, and the Ministry of Commerce & Industry for

export promotion, ensuring a holistic, end-to-end ecosystem that permanently secures India's medical device supply chain.

(Para 5.11.9)

252. The Committee is of the view that the historical reliance on ad-hoc or purely reactive decision-making for rationalising medical device prices is inadequate for a complex, modern healthcare system. The Committee, therefore, recommends the formal institutionalization of a multi-criteria, evidence-based prioritization framework, structured similarly to the 100-point Medical Device Price Regulation Score (MDPRS). The government must establish a statutory mandate to evaluate all unregulated medical devices across critical dimensions, prominently including disease burden, annual procedure volume, and out-of-pocket burden. The Committee believes that deploying this transparent, reproducible methodology will enable regulatory authorities to systematically identify and prioritize devices that urgently warrant intervention, thereby shielding regulatory actions from industry opacity and arbitrary policymaking.

(Para 5.11.10)

253. The Committee believes that medical devices categorized under the highest public health urgency, specifically those scoring more than 80 on the MDPRS framework, represent the most significant financial risk to vulnerable patient populations. The Committee, therefore, recommends immediate and absolute statutory price capping for all medical devices classified as 'Priority I'. This categorization must trigger automatic regulatory intervention to fix the maximum retail price, similar to the successful interventions previously applied to coronary stents and knee implants. The Committee is of the view that targeting high-volume, high-disease-burden devices will instantly alleviate the most severe instances of catastrophic health expenditure borne by the low and middle-income demographic.

(Para 5.11.11)

254. The Committee is of the view that excessive and unregulated trade margins, often occurring between the manufacturer or importer and the final point of care, are primary drivers of the massive price variations observed across different healthcare providers. The Committee, therefore, recommends that for devices falling into the 'Priority II' bracket (MDPRS 60–79), or those demonstrating high import dependency, the government must impose strict trade margin rationalization. Rather than a flat price cap, the regulatory authority must cap the maximum permissible percentage markup from the first point of sale (price to distributor) to the maximum retail price (MRP). The Committee believes this targeted approach will eradicate exploitative profiteering in the supply chain while maintaining market viability for a diverse range of specialized clinical tools.

(Para 5.11.12)

255. The Committee believes that while cost rationalization is a primary objective, price regulation must not inadvertently stifle medical innovation, restrict the availability of cutting-edge therapies, or compromise clinical outcomes. The Committee, therefore,

recommends that the regulatory framework structurally integrate Health Technology Assessments (HTA) and robust clinical evidence before finalizing the degree of price regulation for any specific device. A dedicated expert committee must evaluate the clinical superiority and availability of therapeutic alternatives for devices under review. The Committee believes that ensuring regulatory decisions, if, remain rigorously evidence-informed, would balance the dual imperatives of accessibility & affordability of treatment at rationalized cost on the one hand and the maintenance of world-class clinical standards within both the public and private healthcare sectors, on the other hand.

(Para 5.11.13)

256. The Committee opines that the success of a medical device park can take place only when it has got its own World Class testing laborarities which are notified and certified for quality benchmark by the Quality Council of India. These laboratories need to be empowered to check all kinds of medical devices ranging from Category A, B, C and D. The Committee strongly recommends that the licensing mechanism also needs to be decentralized to various State Governments for even category A & B Medical Devices. This will inculcate a healthy competition within States to attract medical device manufactures from all across the Globe creating huge employment and saving on precious foreign exchange besides making the country Atam Nirbhar in the field of Medical Devices in the shortest possible timeframe.

(Para 5.11.14)

257. The Committee further recommends that Government should chalk-out Inter-Governmental Action Plan by selecting consumable end products under National Health Mission (NHM) and thereby transforming demand into an engine growth to invite global investment. The Committee feels that there is need to target the products under National Health Mission (NHM) and in tandum with the Ministry concerned should manufacture the product in the country itself to make the product and medical devices affordable that would be beneficial to the needy patients.

(Para 5.11.15)

258. The Committee realizes India has huge growth potential in manufacturing of medical devices. Well-coordinated inter-ministerial and inter-governmental (central and state) strategies aimed at offering manufacturers competitive advantage in manufacturing in India will result in importers finding it more profitable to manufacture in India than to import it. The Committee believes that logistical support in shared manufacturing facilities like Medtech parks would significantly reduce capital expenditure of manufacturers and thus giving a boost to manufacturing in India. The Mediparks should have NABL (National Accreditation Board for Testing and Calibration Laboratories) approved medical device testing laboratories to reduce time required in manufacturing a product.

(Para 5.11.16)

259. The Committee further recommends that some of the Mediparks should focus on manufacturing medical device components and thus make the country self reliant on spare parts with provision for extending necessary services. This can further strengthen into India emerging as hotspot for medical devices spare parts and hub for medical

devices repairing and service centres for other countries. Thus Medical Devices industry would have added advantage of huge employment generation capacity.

(Para 5.11.17)

260. The Committee is of the considered view that in order to encourage indigenous manufacturing, the Government should provide incentives or encourage preferential purchase for domestically manufactured products in Government procurement. In this regard, the Department should ensure that in all public procurement, the preference must be given to Indian manufactured medical devices having domestic content of at least 50%.

(Para 5.11.18)

Grievances Rederesal Mechanism

261. The Committee was apprised of incidents wherein NABH has on frivolous ground denied accreditation on the basis of false complaints resulting in harassment of small medical establishments. The Committee, therefore, feels the need for a suitable Grievance Redressal Mechanism to be institutionalized by Quality Control of India for all accreditation bodies like NABH/NABL so that they did not become another tool for corruption, high handedness and blatant harassment thus thereby increasing the cost of healthcare.

(Para 5.11.19)

262. In nutshell, the Committee desires that Government should make provision for sufficient number of Testing Labs to evaluate the quality of the product; ensuring availability of raw-material components by promoting indigenous production at reasonable cost; formulating and impementing component-based financing schemes for encouraging indigenous production of medical devices under PPP model to promote components start-ups in the country. The Committee desires that the Government should encourage through various incentives to the Start-ups for manufacturing medical devices like Implantable Cardioverter Defibrillators (ICDs), heart valve, cardiac cath labs, pacemakers and PET scan at the reasonable cost. The Committee underscores the pivotal role of regulatory bodies in reducing the gap between the landing cost and MRP because some of these implants are not covered under the Ayushman Bharat Scheme, thereby enhancing OOPE for the patients. The Committee also recommends for Single Window System to promote MeDTech park like AMTZ in Vishakhapatnam in other parts of the country.

(Para 5.11.20)

263. The Committee expresses serious concern over the huge difference between the landing costs of the medical devices or drugs and the MRP, despite the fact India is considered to be the pharmacy of the world. The Committee strongly believes that such gap needs to be reduced to the extent that the quality medical devices and the drugs are made available at the affordable cost to the needy patients. For example, the landing cost of Tenecteplase, a life-saving medicine for heart attack given in golden hour, is Rs. 18,000 but MRP is Rs. 50,000 and the billing cost is at MRP. The Committee appreciates

the decision of the Government for capping the price of the cardiac stent to Rs. 25,000 to Rs. 30,000 in 2017 which earlier used to be around Rs. 1,90,000. The Committee, therefore, recommends that the gap should not be more than 20% between landing price and MRP for medical devices and drugs for ensuring quality drugs and medical devices at the affordable cost. The Committee also recommends for rationalizing the cost of peripheral stents and drug-eluting ballons. Since medical devics are used directly in patient care, the Committee, therefore, recommends that manufacturers must operateunder strict Quality Management Systems such as ISO 13485 and FDA 21 CFR Part 820. The Committee further recommends that while rationalizing the price of high end medical consumables, the Government must ensure stringent quality control and uninterrupted market availability. Of course, the Government should design dynamic rationalizing mechanism for specialized consumables that balances aggressive consumer affordability with necessary manufacturing margin and prevent artificial market shortages and black marketing.

(Para 5.11.21)

264. The Committee has been given to understand that the cost of clear aligners ranges between Rs. 1.5 to 5 lakhs, therefore, the regulatory body should consider the standardization of cost of clear aligners and dental materials. The Committee is of the view that, along side affordability, availability of the drug is also critical, and pharma companies should not neglect availability of any medicine on account of less profit margin linked with that drug. The Committee comes to know that lithium is a very important drug to control bipolar disorder and its availability at the affordable cost should be ensured throughout the year.

(Para 5.11.22)

265. The Committee also recommends the Government to establish a a dedicated medical devices subsidy fund to complement existing manufacturing support schemes. The fund should partially offset the research, development and scaling cost of advanced medical equipment, enabling public hospitals to procure domestically produced devices at lower cast while systematically reduing dependence on import alternatives.

(Para 5.11.23)

Tata Memorial Centre

266. The Committee believes that the stark disparity in healthcare costs between public and private institutions severely compromises patient welfare. Without a unified framework, out-of-pocket expenditure remains unsustainably high for low- and middle-income demographics. The Committee, therefore, recommends the urgent formulation of a standardized, evidence-based treatment protocol mandate across all secondary and tertiary care hospitals. The Ministry of Health and Family Welfare must establish a national statutory body to determine and implement a rigid cap on essential procedures and diagnostics. To ensure compliance, the government must mandate all healthcare facilities to publish a unified, transparent 'Schedule of Charges' on their respective platforms, mirroring the TMC model, to prevent arbitrary pricing and unwarranted clinical investigations.

(Para 5.12.9)

267. The Committee is of the view that private sector hospitals must be incentivized and structurally guided to play a complementary role to public welfare initiatives. The current purely commercial approach of many private entities restricts affordability & accessibility for economically disadvantaged patients. The Committee, therefore, recommends the introduction of a cross-subsidy model across major private and trust-run hospitals. The cross subsidy model has been successfully implemented across many South Asian Countries. 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. The government should offer tax incentives or capital subsidies to private hospitals that successfully demonstrate the earmarking of at least 20 percent of their bed capacity for highly subsidized or free treatment.

(Para 5.12.10)

268. The Committee believes that the unregulated pricing of pharmaceuticals, medical consumables, and equipment significantly inflates the overall cost of treatment. The Committee, therefore, recommends the establishment of a centralized digital procurement grid for all critical care medicines and high-end medical equipment. Private and public hospitals must be directed to utilize transparent tendering mechanisms to negotiate prices substantially lower than prevailing market rates. 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.

(Para 5.12.11)

269. The Committee is of the view that complex billing procedures and the deliberate obfuscation of health insurance benefits actively deter patients from seeking timely secondary or tertiary care. The Committee, therefore, recommends that all secondary and tertiary healthcare facilities install a fully integrated Hospital Information System linked directly to their approved Schedule of Charges to automatically generate non-manipulable bills. Every private hospital above a specified bed capacity must be mandated to establish a dedicated claims management cell to facilitate cashless treatment under government schemes such as Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Strict penal provisions should be introduced for hospitals that deny admission to patients eligible under these central or state-sponsored health assurance initiatives.

(Para 5.12.12)

270. Pooled procurement for high value and high cost medicines: Tata Memorial Centre (TMC) piloted pooled procurement to improve negotiability of high-value oncology and supportive care medicines. A total of 40 drugs were included in this pilot. The pooled demand for the drugs from 23 centres was equivalent to 15.6 billion Indian rupees (197 million United States dollars (US$)) based on maximum retail prices. The process included technical and financial evaluation followed by contracts between individual centres and the selected vendors. Savings of 13.2 billion Indian Rupees (US$ 166.7million) were made compared to the maximum retail prices. The savings ranged from 23% to 99% (median: 82%) and were more with generics than innovator and newly patented medicines. This process has made it possible to improve access to

effective but expensive medicines by making them affordable for majority of patients and reducing the stockout at smaller centres in geographically remote areas.

(Para 5.13.4)

271. The Committee believes that the establishment of unified, national disease-specific networks is pivotal in minimizing geographical and socioeconomic healthcare inequities. The Committee, therefore, recommends that the government replicate the National Cancer Grid (NCG) model to establish similar national grids for other high-burden non-communicable diseases, such as cardiovascular diseases and diabetes. The Committee is of the view that resource-stratified treatment guidelines developed by these expert grids must be explicitly linked with the reimbursement structures of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). Such integration will mandate the adoption of comprehensive Health Benefit Packages (HBP) across both public and private sectors, ensuring uniform, value-based care while curbing the economic burden on patients presenting with advanced disease stages.

(Para 5.13.13)

272. The Committee is of the view that the fragmented procurement of pharmaceuticals significantly inflates the operational costs of healthcare delivery, which is invariably passed on to the patient. The Committee believes that the monumental savings, achieving a median cost reduction of 82%, demonstrated by the pooled procurement pilot for high-value oncology medicines must serve as a foundational blueprint for national policy. The Committee, therefore, recommends the immediate institutionalization of a centralized, pooled procurement mechanism for all high-cost, life-saving, and supportive care medicines across all public healthcare institutions and empanelled private hospitals. This aggregated demand framework will maximize negotiating leverage against pharmaceutical vendors, thereby drastically reducing maximum retail prices and eliminating vital drug stockouts in geographically remote centers. The Committee, in turn, recommends that savings out of pooled procurement must be passed on to patients, to reduce out of pocket expenditure and utilized as source of cross-subsidy.

(Para 5.13.14)

273. The Committee believes that the indirect costs of healthcare, including travel, boarding, and loss of livelihood for patients seeking tertiary care in metropolitan centers, severely exacerbate catastrophic health expenditures. The Committee, therefore, recommends the aggressive expansion and decentralization of specialized healthcare through the mandatory implementation of Virtual Disease Boards and comprehensive teleconsultation facilities in all district-level hospitals. The Committee is of the view that digitally linking smaller, remote medical centers with apex tertiary institutions will facilitate expert multidisciplinary treatment planning and External Quality Assurance Schemes (EQAS) for diagnostics. This will ensure that complex clinical decisions are made accurately without necessitating the physical displacement of the patient.

(Para 5.13.15)

274. The Committee is of the view that seamless continuity of care and absolute financial transparency are fundamental right of the patient and critical components of an affordable healthcare ecosystem. The Supreme Court interprets Right to Health as a fundamental right under Article 21 of Indian Constitution i.e. Right to Life and in Part IV under Directive Principles of State Policy, thereby, Key constitutional pillars include Article 21, Article 47, outlining the duty of the State to improve public health, raise nutritional levels, and enhance the standard of living and Article 39(e), that directs the State to protect the health and strength of workers of Indian Constitution. The Committee, therefore, strongly believes that it is the constitutional responsibility of the Government to keep the citizens of the Country healthy by providing adequate healthcare facilities at the affordable cost. The Committee desires that the private sector hospital should voluntarily play the pivotal role of complementing the efforts of the public sector hospital in that direction.

(Para 5.13.16)

275. Moreover, the Committee believes that restricting a patient's access to their own medical records hinders their ability to seek localized care or second opinions, thereby locking them into potentially unaffordable care continuums. The Committee, therefore, recommends the accelerated, nationwide adoption of interoperable, specialty-specific Electronic Medical Records (EMRs) that grant patients secure, remote ownership of their clinical data via web portals. Furthermore, it must be made mandatory for all secondary and tertiary care hospitals to deploy real-time digital billing infrastructure. Systems utilizing smart cards and automated SMS alerts must be implemented to keep patients continuously apprised of generated bills and available fund balances, thereby eradicating opaque billing practices.

(Para 5.13.17)

276. The Committee is of the view that arbitrary or static rate setting for health benefit packages compromises provider participation and obscures the true operational expenditure of medical care. While standardizing benefit packages is critical, ensuring those packages reflect reality is paramount. The Committee, therefore, recommends the immediate deployment of a standardized National Cost Accounting System. The government must mandate this framework to collect empirical, real-world costing data from either all empanelled centers or a rigorously selected, representative cross-section of hospitals nationwide. The Committee believes that clinical guidelines must be meticulously mapped across every step of the patient pathway to ensure that health benefit packages are explicitly tied to actual, data-backed costs rather than estimates.

(Para 5.13.19)

277. Furthermore, 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. The Committee believes that instituting this level of structural transparency will guarantee fair and adequate compensation to healthcare providers, thereby significantly increasing their voluntary uptake of national health schemes. Concurrently, it will empower policymakers to

accurately identify systemic cost inefficiencies, isolate primary cost drivers, and conduct precise budget impact assessments prior to the integration of new medical technologies.

(Para 5.13.20)

278. The Committee is of the view that the development and deployment of Health Benefit Packages (HBPs) must transition from ad-hoc rollouts to a highly structured, well-documented standard operating procedure. While the packages exist, ensuring they reach the most vulnerable demographics requires rigorous oversight. The Committee believes that a robust monitoring and evaluation framework must be integrated into the national health infrastructure to continuously audit scheme efficacy and equity. The Committee, therefore, recommends the mandatory implementation of unified clinical procedure coding across all digital health and billing platforms. To ensure accountability without compromising patient privacy, the government must mandate all empanelled healthcare facilities to securely share predefined Key Performance Indicators (KPIs) with a central monitoring agency, thereby tracking the actual ground-level impact of these schemes.

(Para 5.13.22)

279. The Committee expresses serious concern regarding recent national and international reports questioning the quality standards of certain pharmaceuticals. Furthermore, the Committee is of the view that while aggressive price controls have undeniably expanded access for the masses, pushing manufacturing costs below viable thresholds risks systemic compromises in drug quality and industry sustainability. The Committee believes that an immediate and comprehensive review of the national drug approval and quality control regulatory framework is highly desirable to restore absolute confidence in medical supplies. The Committee, therefore, recommends the institutionalization of a formal, mutual dialogue mechanism between the Ministry of Health and the pharmaceutical industry. This forum must aim to establish rational price ceilings that balance mass affordability with uncompromising quality assurance and manufacturing viability. The Committee recommends leveraging this collaborative platform to negotiate national-level pricing for novel, highly effective therapeutics. Bringing advanced medications into the National List of Essential Medicines (NLEM) at negotiated rates will strategically drive high-quality procurement across the entire country.

(Para 5.13.23)

280. The Committee recapitulates its observation as made in its 139th Report on Cancer Care Plan & Management: Prevention, Diagnosis, Research & Affordability of Cancer Treatment. The Hub and Spoke Model is an efficient distribution model of providing comprehensive cancer care by creation of hubs and spokes in all the States of the country. The Committee notes that TMC has worked in close contact with the State Governments to create hubs and spokes in States. The Committee believes that such collaborations will enable in further strengthening the cancer care infrastructure along with knowledge, skill and resource sharing. The Committee appreciates the work done by TMC and DAE and advocates the need for establishing government funded hub and spoke model of cancer care across States. The Committee further believes that ensuring

adequate human resource in Cancer centers under the hub and spoke model is also crucial for complete operationalization of the Centers. The Committee reiterates its recommendation that the Ministry of Health and Family Welfare must work in close collaboration with the Department of Atomic Energy to decide a timeline for implementing the hub and spoke model in each State. The Committee urges upon the Government to ensure that the existing SCI/TCCCs are upgraded to hubs and spokes depending on their existing infrastructure and capabilities.

(Para 5.14.2)

Cross-subsidy Model to Mitigate rising cost of private healthcare

281. The Committee was apprised of the rising cost of private healthcare and the submissions before the Committee attributed much of the rising cost of private treatment to escalating infrastructure cost. Further world-class technology is concentrated in cosmopolitan cities and requires enormous capital outlay to install and maintain. Compounding this, super-specialist doctors command high compensation, adding further to hospital overheads. Because most private investment is profit-driven, patient care and outcomes are often treated as a secondary concern rather than the primary objective. With only around 14 percent of the population holding private insurance, the majority of patients are exposed to significant out-of-pocket spending. This is worsened by overbilling practices, where professional fees are inflated through the addition of procedural costs, and by the ever-present risk of complications, which can push a family into deep financial crisis and erode trust in the healthcare system even when the original treatment was appropriate.

(Para 6.2.2)

282. The Committee, to address the issue of overbilling, recommends strengthening ethical oversight through hospital-level ethics committees, which review professional fees and hold doctors accountable, with real consequences such as reprimand for non-compliance. The Committee also calls for a dedicated regulatory body to oversee public-private partnerships and verify that services genuinely reach the needy rather than remaining a formality. The Committee suggests cross-subsidy models, in which higher-paying private patients effectively help fund treatment for poorer patients, and encourages large industries to channel CSR funding directly toward covering treatment costs for indigent patients through formal partnerships with hospitals.

(Para 6.2.3)

283. The Committee observes that although the government has reserved a percentage of beds in private hospitals for free treatment of BPL cardholders and beneficiaries of schemes like Ayushman Bharat and PMJAY, many private hospitals simply opt out of these obligations, leaving the mandate poorly enforced in practice. A related problem is that the BPL eligibility criteria themselves are outdated and have not been revised in some time, which excludes many people who are genuinely poor, including a broader "upper-middle income poverty" group that faces very similar financial strain but has no formal recognition or protection. There is currently no strong regulatory body dedicated to ensuring that private hospitals meet these public-service obligations.

(Para 6.2.4)

284. The Committee recommends raising the mandatory bed-reservation quota for BPL, EWS, and PMJAY patients in private hospitals from the current ten percent to twenty percent, with strict and uniform enforcement across all private hospitals nationwide. Alongside this, the BPL eligibility criteria should be revised to reflect current economic realities and extended to cover the broader population living just above the poverty line who face comparable hardship. The Committee also suggests that hospitals should have an internal formal financial safety net for families facing unexpected cost escalation due to complications. The cost should be cross-subsidized towards the needy patients.

(Para 6.2.5)

Ensuring Healthcare Accessibility to Rural Population

285. The Committee finds that access remains a major issue for India's rural population, who often must travel long distances to reach a hospital, since high-quality treatment facilities are largely concentrated in cities and are absent from small towns and district centres. This problem is worsened by inefficiencies in Primary and Community Health Centres, where doctors do not always serve their full contracted duration or follow service guidelines. Most rural and daily-wage patients also cannot afford to lose a day of work to seek treatment, yet OPD timings rarely accommodate this reality. The difficulty is magnified further in hilly, desert, and forest terrain, where simply reaching the nearest hospital is a challenge in itself. The Committee has been informed that the incidental cost of accessing care, including travel, food, and lost wages, comes to roughly five hundred rupees per visit, a sum many rural poor households simply cannot absorb.

(Para 6.2.6)

286. The Committee calls for, to improved access in rural areas, investment in cheap and reliable transport so patients can reach the nearest hospital without sacrificing a day's income, building on the improvements already seen in emergency ambulance coverage for maternal and child health. The Committee also recommends stricter enforcement of PHC and CHC staffing requirements, ensuring doctors complete their full contracted duration and follow service guidelines, supported by biometric attendance tracking. To reinforce accountability, the Committee suggests surprise visits by senior bureaucrats and local elected representatives such as MLAs and MPs to verify that facilities are functioning as intended, which would also help rebuild public trust in local governance. Extending OPD hours into the evening is particularly valuable, allowing daily-wage earners and migrant workers to seek treatment without losing income, a model the Committee has seen apprised of that it works well through NGO-run OPDs that run from six in the evening past midnight, offering free consultation and medicines. Finally, hilly, desert, and forest regions should be prioritized for targeted infrastructure investment given how disproportionately access challenges affect them.

(Para 6.2.7)

287. The Committee was apprised of that liver transplantation costs anywhere between twenty-five and fifty lakh rupees across Indian hospitals, putting it out of reach

for all but high-earning professionals and business owners. Organ donation rates are also markedly uneven across the country, with the South donating more than the North, and the West performing somewhat better than the North. The Committee further notes that some private centres charge very large sums for organ transplantation, which runs counter to the spirit of organ donation as a public service rather than a profit opportunity for hospitals. The Committee recommends for detailed study of the rural health care model being provided under AB-PMJAY.

(Para 6.2.8)

288. The Committee finds the Maharashtra's approach as a model worth replicating nationally, in which senior private-sector surgeons are attached to municipal hospitals and oversee government-employed medical teams during complex operations, effectively extending high-end surgical expertise to public-sector patients. More broadly, the Committee suggests that public-private partnership should be treated as the long-term backbone of healthcare infrastructure development, rather than allowing the two systems to continue developing in isolation from one another.

(Para 6.2.9)

289. The Committee, on the cost of transplantation specifically, recommends rationalizing the price of liver transplants performed in government-sector hospitals at four to five lakh rupees, a benchmark already achieved at IKDRC in Ahmedabad and Stanley Medical College in Chennai, as brought to the knowledge of the Committee, which would bring the procedure within reach of India's working middle class. The Committee also would highlight the example of Pravara Institute of Medical Sciences, Loni, Ahmednagar, Maharashtra wherein affordable and accesable health care in rural setting is being provided to a significant population on a very large scale including a affordable organ transplant program. The same model can be extended to provide accessible and affordable healthcare in rural parts of the country. The Committee also recommends for scaling of AIIMS-standard organ transplant programs to more States. To address the low organ donation rates in North India, the Committee suggests adapting successful state frameworks, noting that Tamil Nadu's donation laws have already been shared with a NITI Aayog panel member for possible national replication. The Committee stresses that organ donation should remain strictly public-service oriented, with regulatory safeguards to prevent private hospitals from treating it as a profit centre.

(Para 6.2.10)

290. The Committee observes that the rising medical education costs are pushing many families toward education loans that take years to repay, and this financial burden shapes how newly qualified doctors approach their careers once they begin practising. At the same time, while new medical colleges are being established across many districts, staffing them with qualified faculty remains genuinely a challenge. Compounding this, the requirement that graduating doctors serve some time in rural, hilly, or tribal areas is sometimes circumvented by paying a fine, which undermines the very purpose the policy was meant to serve.

(Para 6.2.11)

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, without allowing a fine-based opt-out, so that the underlying intent of the policy is actually met. Beyond this, the Committee visualize real potential in the Indian medical diaspora and proposes that a streamlined registration pathway, building on the state medical council registrations which many NRI doctors already retain, would allow doctors of Indian origin nearing or post retirement to serve in district medical colleges. This would bring world-class exposure and language-matched care to patients closer to home, while broadening the learning opportunities available to local doctors and students.

(Para 6.2.12)

292. The Committee was apprised that age-related and lifestyle conditions, including diabetes, hypertension, high cholesterol, and obesity, are increasingly common and, left unaddressed, driving major complications along with significant financial strain on the whole family. The Committee was informed that even in the developed countries like the United Kingdom, despite treatment being free at the point of delivery, the system there is described as being in a difficult state, with long waitlists and patient mistrust. The Committee observes that funding alone does not guarantee accessible or trusted care.

(Para 6.2.13)

293. The Committee places strong emphasis on prevention, public health education on salt, sugar, and lifestyle-driven disease that has the potential to change patient behavior measurably. The Committee advocates promoting Yoga as a low-cost preventive practice, building on the platform created by International Yoga Day, positioned as a complement to clinical care rather than a replacement for it. More broadly, the Committee encourages replicating low-barrier community OPD models, offering free consultation and medicines during evening hours and delivered with an emphasis on dignity and self-worth, as a scalable way to reach street vendors, rickshaw pullers, and other daily-wage populations who are otherwise underserved.

(Para 6.2.14)

294. The Committee acknowledges that structural deficits must be rectified to support equitable healthcare delivery. The Committee recommends bridging existing gaps in Sub-Health Centres (SHCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs) in strict accordance with IPHS 2022 norms. The Committee also recommends developing a phased roadmap to upgrade Ayush facilities in alignment with Ayush IPHS 2024 norms.

(Para 6.2.15)

295. The Committee believes that strengthening procurement and supply chain management systems is critical to ensuring the uninterrupted availability of essential medicines and diagnostics across all healthcare levels. The Committee is of the view that Public-Private Partnerships should be promoted to expand diagnostic capacities,

improve biomedical waste management, and enhance access to specialized services where the public sector is constrained.

(Para 6.2.16)

296. The Committee believes that addressing child and adolescent health is foundational to long-term human capital gains. The Committee recommends significantly improving the screening quality and coverage of disease conditions by strengthening RBSK (Rashtriya Bal Swasthya Karyakram) teams. The Committee also recommends incorporating specific provisions for positive mental health and addressing mental ailments within the school ecosystem. The Committee is of the view that schools must promote yoga, meditation, physical activity, and comprehensive health and nutrition education through both curricular and extracurricular avenues, alongside ensuring the mandatory provision of first aid.

(Para 6.2.17)

297. The Committee notes that NQAS lacks statutory backing and NQAS certification is "voluntary and does not derive from a separate statutory enactment," even though 100% coverage of public facilities is the stated goal. The Committee recommends considering a phased move toward statutory or executive-order backing for NQAS, at minimum, making certification a binding precondition for PMJAY empanelment and NHM fund disbursement, rather than relying solely on incentive-linkage through NHA. The Committee further observes that human resource capacity forms a critical pillar of the quality governance framework and recommends deployment of more than 2350 National and over 10,500 State Trained Assessors across the diverse geographical settings facilitating harmonized implementation of standards and promoting peer learning and exchange of best practices.

(Para 6.2.18)

298. The Committee notes that there is fragmented multi-agency architecture with NQAS sits under MoHFW while NABH/NABL sit under QCI, which reports to DPIIT, a different ministry altogether. The Committee acknowledges this creates "potential for duplication of assessments, documentation requirements and administrative effort" for facilities pursuing multiple accreditations. The Committee recommends establishing a formal inter-ministerial coordination mechanism (MoHFW–DPIIT/QCI) to build a standards crosswalk or equivalence mapping between NQAS, NABH and NABL, so facilities aren't re-assessed against near-identical criteria. A shared digital evidence repository (leveraging the existing SaQsham platform) could let assessment documentation be reused across systems.

(Para 6.2.19)

299. The Committee observes that teaching/research/high-volume service delivery not reflected in standards. The current frameworks may not fully reflect the broader responsibilities and operational realities of Government Medical Colleges and public sector hospitals, including teaching, research, national health programmes, and high-volume service delivery. The Committee recommends developing a supplementary

NQAS module specifically for teaching/tertiary hospitals that captures academic and research functions, and coordinate this with National Medical Commission (NMC) recognition criteria so medical colleges aren't juggling contradictory or duplicative accreditation demands.

(Para 6.2.20)

300. The Committee finds that there is no data on disproportionate burden for small/rural/remote facilities. No consolidated national assessment has been carried out regarding differential burden, sustainability, or benefits across categories of healthcare institutions, despite acknowledging that small, rural, remote and underserved facilities likely face proportionately higher costs than large corporate hospitals. The Committee recommends commissioning of a study on structured national assessment comparing compliance cost, time-to-certification, and assessor availability across facility size/location/ownership. The findings should be used to design tiered timelines, additional mentoring support, or higher NHM incentive weighting for ADP/ABP and underserved facilities, rather than treating all facilities under one compliance bar.

(Para 6.2.21)

301. The Committee is of the view that, with NQAS running 2,350 + national and 10,500 + state assessors, rapid scale-up raises a natural question of scoring consistency even though there are standardised toolkits and objective scoring. The Committee recommends institutionalizing periodic inter-assessor calibration exercises and refresher cycles alongside the existing fortnightly learning series, and publish inter-rater reliability metrics as part of SaQsham's data analytics.

(Para 6.2.22)

302. The Committee believes that SaQsham's analytics capability should be used to publish a public, facility-level dashboard tracking certification status, time taken, and geographic/tier-wise disparities, turning the "digital ecosystem" already built into an accountability tool, not just a workflow system.

(Para 6.2.23)

Investment in Preventive Healthcare

303. The Committee observes that healthcare spending is predominantly directed toward treating advanced diseases rather than preventing illness, driving higher long-term costs. Tertiary care institutions face severe overcrowding by patients whose conditions could be effectively managed at primary or secondary facilities, which limits access for those requiring advanced specialist interventions. A significant proportion of patients bypass primary care to seek specialist consultation for manageable conditions. The Committee, therefore, recommends increasing investment in preventive healthcare, health promotion, and screening programmes to alleviate the burden on higher-tier hospitals. The Committee believes that tertiary care institutions must operate as true referral centres, evaluating non-emergency patients strictly upon referral while maintaining immediate access for emergencies. 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.

(Para 6.2.24)

Structured District Residency Clinical Posting

304. The Committee observes that Community Health Centres (CHCs) and Sub-District Hospitals remain underutilized as teaching facilities, restricting students' exposure to district-level healthcare. Current faculty norms and training capacities are likely insufficient to address the rising demand for super-specialists in chronic care, oncology, and critical care. Discrepancies between government and private medical colleges regarding bed and faculty requirements inflate the cost of postgraduate programmes without enhancing educational quality. There are localized shortages of specialist faculty alongside underutilized expertise in other institutions. The Committee recommends that all medical colleges affiliate with designated CHCs and Sub-District Hospitals to facilitate structured district residency and clinical postings for students and interns.

(Para 6.2.25)

305. The Committee believes that super-specialty (DM/MCh) training should be expanded by reintroducing appropriate flexibility in faculty norms. The Committee, therefore, recommends that DM/MCh faculty and their clinical beds be recognized as eligible teaching resources for undergraduate and postgraduate education to optimize resources and increase specialist manpower. 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.

(Para 6.2.26)

Clinical Audit to Promote Cost-effective Care

306. The Committee notes that corporate hospital charges lack transparency and vary widely for procedures and investigations. Out-of-pocket expenditure is heavily driven by the costs of medicines, implants, and diagnostics. Current healthcare financing mechanisms primarily reward service volume rather than clinical outcomes. Variations in clinical practice lead to unnecessary investigations and escalated costs. The Committee, therefore, recommends introducing standardized cost-accounting and transparent pricing to ensure charges align with audited costs and reasonable operating margins. The Committee believes centralized procurement must be strengthened, generic prescribing encouraged, and the prices of essential medicines and implants strictly regulated. The Committee is of the view that hospital reimbursement and incentives must be tied to quality indicators, patient safety, and efficiency rather than procedure volume. The Committee recommends implementing evidence-based national treatment protocols alongside regular clinical audits to promote cost-effective care.

(Para 6.2.27)

Digital Health Records

307. The Committee is of the view that fragmented health records and duplicated diagnostic investigations reduce systemic efficiency and increase costs. Advanced diagnostic and therapeutic equipment is highly expensive and often underutilized, yet inaccessible in many districts. Substantial private sector healthcare infrastructure remains underutilized for achieving national public health objectives. Numerous procedures requiring hospital admission could be safely executed as day-care surgeries. The Committee recommends establishing interoperable electronic health records, telemedicine services, and AI-supported clinical decision systems. The Committee believes that validated AI-assisted screening programmes must be scaled up to facilitate the early diagnosis of common diseases. The Committee, therefore, recommends the creation of regional shared-resource networks, allowing government and accredited private hospitals to schedule access to high-cost equipment such as PET-CT, MRI, and molecular diagnostics. The Committee is of the view that a structured framework must be established to require or incentivize accredited private hospitals to contribute to national health programmes, including disease surveillance and immunization. The Committee recommends expanding day-care surgery services through the deployment of standardized clinical protocols and appropriate reimbursement mechanisms.

(Para 6.2.28)

308. The Committee is of the view that the current commercial market for Electronic Medical Records (EMR) and Hospital Information Systems (HIS) restricts access to vital digital infrastructure due to prohibitively expensive licensing walls. The Committee, therefore, recommends that the Ministry of Health and Family Welfare, alongside MeitY, commission a dedicated fund to subsidize top-tier software enterprises in building an enterprise-grade, open-source digital healthcare platform. The Committee believes this platform must natively bridge the gap between all stakeholders and incorporate direct IoT integration with bedside equipment. Once finalized, the software must be released globally under an open-source license, entirely free of cost, to democratize access to modern digital workflows. The Committee, therefore, strongly recommends for an open source extremely affordable AI solution to interpret X-rays, specially portable X-rays so that interpretation can be done at the Community Health Centers (CHCs) or Primary Health Care Centers (PHCCs) level. The Committee strongly recommends, therefore, rationalizing/capping the cost of AI used to interprete such x-rays at CHCs and PHCCs.

(Para 6.2.29)

Strategic Action Plan of Health Savings Account (HSA)

309. The Committee observes that over 85% of the Indian workforce operates within the informal sector, entirely lacking institutional social security or structured healthcare coverage. While the government spends approximately 1.5% of its GDP on public healthcare, however the Committee has expressed that public financing alone cannot fully absorb the catastrophic out-of-pocket health expenditures (OOPE) faced by millions of families. Formalizing these employment relationships under standard

corporate health covers is an administrative bottleneck in the short term. The Committee, therefore, recommends that the Government must deploy the economic tool of Health Savings Accounts (HSAs), modeled after successful global precedent and frameworks and Singapore pioneered HSAs approach via the Medisave system in 1984, followed by China (covering over 300 million workers) and the United States with over $50 billion managed in consumer HSAs.

(Para 6.2.30)

310. The Committee, in this regard, finds that the Reserve Bank of India (RBI) has cleared the regulatory pathway for zero-balance HSAs (analogous to the Jan Dhan architecture), with the Bank of Baroda launching India's first dedicated HSA product on December 18, 2025. The Committee, therefore, recommends that Government to undertake Strategic action plan by mandating account creation, encouraging volunteery contribution and disintermediation of insurance. The Central Government should mandate that all temporary, gig, and informal sector workers be signed up for a zero-balance HSA. The administrative responsibility of on-boarding should rest on the immediate employer or contracting platform. To bypass employer resistance against mandatory payroll taxes for temporary labor, contributions should initially be voluntary. Employers should be systemically nudged to contribute a modest 100 to 200 per month per worker. Funds accumulated within these HSAs must be legally ring-fenced, usable only for health-related expenses and direct premiums for micro-health insurance policies. By linking insurers directly to HSA holders, the Government must intend to eliminate intermediaries and brokers who traditionally skim 30% to 40% off premium distributions, drastically lowering insurance costs for the poor.

(Para 6.2.31)

Transit to Global Medical Device Manufacturing Hub

311. Indian healthcare delivery is deeply reliant on imported medical technology. Many government tertiary center or private hospital, and the critical diagnostic and life-support infrastructure is almost exclusively manufactured by foreign conglomerates that creates a severe national security liability and ties the cost of domestic clinical procedures to foreign exchange volatility (USD/EUR). According to the Association of Indian Medical Device Industry (AiMeD), India currently imports nearly 70-80% of its medical devices, exposing the system to external supply shocks and high capital expenditure requirements. The Committee, therefore, views that the Government must transit from an import-dependent market to a global manufacturing hub for medical devices. There is an urgent need to replicate the phased manufacturing and technology-transfer models successfully utilized by the domestic automotive sector and China's industrial frameworks.

(Para 6.2.32)

312. The government should grant a complete 0-5 year corporate tax exemption to global medical equipment manufacturers that establish full-scale manufacturing facilities within India with the rider of mandating component localization. The policy must explicitly disincentivize simple "screwdriver assembly" plants. Tax concessions must be systematically tied to progressive localization schedules, requiring components,

sensors, and software architecture to be developed natively. The Committee understands that Collaborating with global giants will train cadre of Indian biomedical engineers and technicians and over time, these individuals will drive native enterprise, replicating the trajectory where domestic automotive firms evolved to successfully compete with global market leaders.

(Para 6.2.33)

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

313. 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.

(Para 6.2.34)

314. The Committee observes that Cardiovascular disease (CVD) remains India's leading cause of premature mortality. Super-specialists holding a DM in Cardiology require up to 14 years of rigorous training and rarely settle outside Tier-1 cities. The Committee has come across that eighteen years ago, the Indira Gandhi National Open University (IGNOU) launched the Diploma in Community Cardiology, a two-year structural program for MBBS doctors executed in partnership with India's premier cardiac institutes. It successfully trained over 2,500 non-interventional cardiologists who managed early heart attack interventions and conducted pediatric cardiac screenings across rural and semi-urban communities. Although, the NMC recently recognized the validity of those initial 2,500 practitioners, the training pipeline remains frozen due to legacy pushback from the erstwhile Medical Council of India (MCI). The Committee, therefore, desires the NMC for considering to re-institutionalize the Diploma in Community Cardiology to position non- interventional cardiac care specialists directly at the sub-district level.

(Para 6.2.35)

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

315. 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. The Lancet Commission on Global Surgery states that low- and middle- income countries face an immense surgical deficit. India performs roughly 25 million surgeries annually against an estimated true demand of 70 million, driven significantly by a lack

of localized diagnostic access. India has fewer than 12,000 registered radiologists. A significant portion focus primarily on reporting teleradiology CT and MRI scans remotely, as a standard physical ultrasound requires roughly 20 minutes of localized, direct physical engagement, reducing throughput. The Committee recommends for preventing screening on a mission mode to diagnose early liver diseases , in view of the fact that the country is facing an epidemic of fatty liver disease. Liver scanning fibroscan machines can be installed at CHC level wherein the medical professional can be trained to interpret the findings.

(Para 6.2.36)

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. To eliminate the risk of illegal fetal sex determination, the Indian government, via the Indian Council of Medical Research (ICMR), should collaborate with medical imaging manufacturers to mandate a dual-firmware market split i.e. technological safeguard. 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.

(Para 6.2.37)

317. The Committee believes that public resource allocation must pivot toward early detection to systematically mitigate premature mortality from cardiovascular diseases and oncological malignancies. The Committee, therefore, recommends provisioning an affordable annual diagnostic package for every citizen over the age of 40. This bundle must include standardized haematological profiles, an Electrocardiogram (ECG), a basic Echocardiogram, and Low-Dose Computed Tomography (LDCT) scans of the chest and abdomen to facilitate curative, low-cost interventions.

(Para 6.2.38)

Nursing Capacity Building

318. The Committee is of the view that the clinical proficiency deficit among entry-level nurses stems from standalone institutions lacking clinical exposure. The Committee, therefore, recommends that the Indian Nursing Council and State licensing boards legally bind nursing education to active clinical environments. The Committee believes no entity should be granted a license to operate a nursing college unless they own and operate a functional, baseline 100-bed general hospital. The Committee, therefore, recommends implementing a bedside learning framework. This will simultaneously improve immediate hospital nursing capacity and allow institutions to reduce tuition fees, making education more accessible while producing highly skilled graduates. The Committee recommends for creation of a ecosystem wherein Nursing Graduates can migrate for providing manpower for resource deficit countries.

(Para 6.2.39)

319. To address the chronic shortfall of primary care physicians in rural and semi-urban areas, the Committee is of the view that India must adopt an advanced practice nursing framework. The Committee, therefore, recommends the introduction of a certified Nurse Practitioner (NP) framework. Experienced nurses undergoing this certification must be granted limited independent prescription rights for a strictly defined formulary of 47 essential primary care medications. Stationing these certified NPs at the Health and Wellness Centre (HWC) level will instantly bridge the primary care deficit.

(Para 6.2.40)

GST Waiver a Health Insurance Premium

320. The Committee believes that the current fiscal logic—which taxes group health insurance at 18% while exempting individual retail policies—creates an unintended penalty for vulnerable workforces, such as gig workers and informal collectives. The Committee, therefore, recommends a full GST waiver on low-cost group health insurance premiums up to a specific designated cap per life covered. This adjustment will actively encourage platforms and cooperatives to secure essential safety nets for millions of low-income workers.

(Para 6.2.41)

Strengthening Healthcare Delivery through Integrated Medical Education and Rationalisation of Regulatory Norms

321. The Committee is of the view that affordable healthcare is intrinsically linked to the availability of an adequate, competent and well-trained healthcare workforce. It believes that optimal utilisation of existing teaching infrastructure, clinical resources and specialist expertise is essential for strengthening medical education and improving healthcare delivery. The regulatory framework governing medical education should, therefore, facilitate integration, efficient utilisation of resources and uniform standards while maintaining the quality of medical education.

(Para 6.3.1)

322. The Committee notes that varying statutory requirements for Government and Private Medical Colleges do not further the objective of maintaining uniform standards in medical education. Regulatory norms relating to faculty strength, bed strength, infrastructure and academic resources should be guided by educational requirements and patient care needs rather than the ownership of the institution. The Committee, therefore, recommends harmonisation of statutory standards applicable to Government and Private Medical Colleges.

(Para 6.3.2)

323. The Committee further notes that changing disease patterns, increasing disease complexity and advances in medical science require greater integration between Specialty and Super-specialty services. The Committee recommends greater integration of Specialty and Super-specialty Departments in undergraduate and postgraduate medical education through appropriate academic and clinical exposure, wherever

feasible. Such integration would optimise the utilisation of existing academic and clinical resources and strengthen multidisciplinary clinical training.

(Para 6.3.3)

324. The Committee further recommends that faculty and beds in relevant Super-specialty Departments may be considered towards the teacher-student ratio and bed strength requirements of the corresponding broad specialty, in accordance with the norms prescribed by the National Medical Commission. This would facilitate better utilisation of existing infrastructure and specialist expertise while strengthening medical education and promoting the expansion of Super-specialty education and healthcare services.

(Para 6.3.4)

325. The Committee is of the view that the requirement for separate faculty and bed strength for each Super-specialty programme may constrain the expansion of Super-specialty education and services. Rationalisation of these regulatory norms through recognition of shared academic and clinical resources would encourage greater utilisation of existing infrastructure, expand training capacity, improve access to specialised healthcare services and strengthen the specialist healthcare workforce.

(Para 6.3.5)

326. The Committee believes that these measures would promote efficient utilisation of available resources, strengthen medical education, facilitate expansion of specialised healthcare services and improve access to quality healthcare. This would contribute towards achieving the objective of affordable, equitable and quality healthcare.

(Para 6.3.6)

327. The Committee, therefore, 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, facilitating optimal utilisation of institutional resources, encouraging expansion of Super-specialty education and strengthening the healthcare delivery system without compromising the quality of medical education.

(Para 6.3.7)

CGHS facilities for Senior Citizens

328. The Committee is of the considered opinion that CGHS beneficiaries form a significant component of health beneficiaries seeking affordable and accessible health care in their post retirement phase. Logistical and administrative difficulties make it difficult for them to access referral from CGHS wellness centers for their treatment requirements. The Committee notes that beneficiaries above the age of 70 years can directly approach empanelled hospitals without going through the referral process for all consultations as well as procedures. Seeking treatment under the existing system in itself is time consuming with long queues and at times arbitrary and the beneficiaries can access the health care without referral only in case of emergencies. The Committee recommends that the 70 year age bar be reduced to 60 years so that all retired beneficiaries can approach empanelled hospital for their health care requirements

without going through a time consuming cumbersome process for all purposes. This would reduce unnecessary paper work besides providing ease of living for retired personnel.

(Para 6.4.1)

Climate change and Health

329. The Committee understands that India ranks among the countries most exposed on nearly every indicator the Lancet Countdown tracks having one of the largest absolute air pollution mortality burdens of any country, alongside China; it is warming in a way that is measurably increasing heatwave frequency and duration; and it is losing tree cover (about 2.33 million hectares between 2001 and 2023) that would otherwise buffer both heat and air pollution exposure. The Global Burden of Disease (GBD) 2019 study — carried out for India in partnership with UNEP at the invitation of the Ministry of Environment, Forest and Climate Change — found that air pollution accounted for 17.8% of all deaths in the country that year, split between ambient particulate matter and household air pollution.

(Para 6.5.2)

330. UNEP further submitted that Heatwave frequency and severity are set to keep rising through mid-century even under moderate emissions pathways, and climate-sensitive infectious diseases such as dengue are projected to expand geographically into currently low-risk states and shift seasonally, lengthening transmission windows in most parts of the country. Consequently, affordability and access are also affected. Out-of-pocket costs for treating heat illness, respiratory disease and vector-borne infection fall disproportionately on lower-income and informal-sector households who lack heat-safe workplaces or health insurance, and rural or hilly districts often face longer travel times to facilities equipped for climate-sensitive emergencies. Health financing planning has not yet systematically absorbed these climate-attributable costs, which the Lancet Countdown work suggests already run into tens of billions of dollars a year for India when premature mortality and lost productivity are counted.

(Para 6.5.3)

Vector-borne and water-borne disease

331. Dengue cases reported to the National Centre for Vector-Borne Disease Control rose from about 28,000 in 2010 to roughly 289,000 in 2023, a roughly ten-fold increase and modelling studies project further increases in transmission-suitable months as temperatures and monsoon patterns shift, with new transmission risk emerging in areas such as the upper Himalayas, parts of the Thar Desert, and north-eastern states that previously saw little dengue activity. Similar climate sensitivity applies to malaria, chikungunya, and water-borne diseases linked to flooding and water stress, though the strength of projected effects varies by region and emissions pathway.

(Para 6.5.4)

Non-communicable disease and mental health

332. Heat and air pollution both aggravate cardiovascular, respiratory and renal disease, and a growing evidence base links extreme heat and humidity to worsening mental health outcomes and, in some studies, increased interpersonal violence. Vulnerable groups — outdoor labourers, slum residents, the elderly, pregnant women, and people with pre-existing NCDs — carry a disproportionate share of this burden, which compounds existing health equity gaps.

(Para 6.5.5)

Policy and institutional

333. The Committee is of the view that the Government should undertake concrete to broaden targeted health strategies and outreach to the full range of climate-vulnerable groups, including children, pregnant women and urban poor populations, alongside the elderly and outdoor workers already prioritised and explicitly address climate-linked nutrition and food-security risks (undernutrition and micronutrient deficiencies arising from disrupted agricultural productivity) and the psychological distress associated with heat, disasters and displacement. Moreover, the Committee observes that the Government should formulate minimum-standard Heat Action Plans for all districts (not only cities) with defined triggers, cooling-centre and hospital-surge protocols, and independent evaluation, building on the Ahmedabad model. There is also a need to rormalise occupational heat-safety norms (work-rest cycles, shaded rest areas, hydration access) for outdoor and informal-sector workers, who bear a disproportionate share of heat-related morbidity. Besides that the Government must expand green healthcare guidelines into a comprehensive resilience framework: the existing guidelines focus more on climate change mitigation (reducing the health sector's own carbon footprint) than on adaptation, and should be broadened to also cover facility-level heat and flood preparedness, continuity of care during climate shocks, and workforce protection.

(Para 6.5.6)

Assuring Quality Healthcare at Grass-root Level

334. The Committee is of the view that uniform clinical practices are vital for equitable and safe patient care across all healthcare institutions. The Committee, therefore, recommends the strict enforcement of mandatory Standard Treatment Guidelines (STGs) across both public and private sectors. Treatment protocols and diagnostic criteria must be standardized and aligned with universally accepted evidence-based benchmarks, such as those prescribed by the World Health Organization (WHO) or the National Health Service (UK).

(Para 6.6.4)

335. The Committee is of the view that while recognizing the role of the National Council for Clinical Establishment (NCCE), grassroots monitoring and active oversight require immediate fortification. The Committee believes that localized administration is critical for timely interventions. The Committee, therefore, recommends the formalization of dedicated District-level Medical Committees to conduct periodic

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reviews, resolve local grievances, and coordinate directly with the Director General of Health Services (DGHS) and state officials. Strict annual audits of all healthcare services must be institutionalized. District Regulatory Authorities (DRAs) must be fully empowered to inspect, audit, and penalize non-compliance. 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.

(Para 6.6.5)

336. The Committee feels that although self-assessments *via* the IPHS dashboard and the widespread adoption of the Kayakalp initiative demonstrate progress, continuous infrastructural enhancement remains paramount. The Committee believes that preventive health is intrinsically linked to facility hygiene. Strict maintenance protocols for sanitation, specifically concerning wastewater management and environmental controls, must be rigidly enforced to prevent disease transmission emerging due to climate change and ecological disorders. Continuous capital and operational investments must be directed toward addressing basic infrastructure gaps to ensure 100% compliance with NQAS and IPHS benchmarks.

(Para 6.6.6)

337. The Committee recommends the progressive expansion of NABH and NABL accreditations across the broader healthcare ecosystem. The Committee is of the view that transparency drives institutional excellence. Therefore, public performance ratings for healthcare facilities must be published periodically to ensure direct accountability to the public. Building upon the National Health Policy 2017, all governmental policies must be continuously revisited refined and reformed to prioritize the patient experience. Healthcare delivery must remain demonstrably gender-sensitive, inherently safe, and strictly confidential at all points of care.

(Para 6.6.7)

Institutionalizing Community Level Healthcare Facilities and Monitoring System

338. The Committee is of the view that centralized planning sometimes fails to capture the nuanced realities of diverse demographic clusters. Facilities must be expanded based on empirical, grassroots data rather than uniform assumptions. The Committee, therefore, recommends that local panchayats, working in tandem with VHSNCs in rural areas and MAS in urban slums, be mandated to conduct comprehensive need-based analyses before any new healthcare facility is approved or existing infrastructure is expanded. The Committee believes that untied funds managed by these local bodies must be strictly appropriated and monitored to ensure that expenditures are directed toward locally identified priorities, bridging the gap between healthcare providers and the community.

(Para 6.7.4)

339. While recognizing the establishment of 35,870 Rogi Kalyan Samitis (RKS) and over 5.65 lakh VHSNCs, the Committee notes that mere constitution does not guarantee

effective oversight. The Committee believes that transparent accountability is the cornerstone of public trust. The Committee, therefore, recommends the formal institutionalization of Community-Based Monitoring systems across all public health facilities. Regular and mandatory Social Audits of all health programs must be conducted through RKS and JAS. The findings of these audits must be integrated into the performance reviews of the respective health facilities.

(Para 6.7.5)

340. The Committee acknowledges the monumental role of the 10.33 lakh ASHAs as the foundation of primary healthcare and public health mobilization. However, operational guidelines issued in the years 2013 and 2014 require modernization and revision. The Committee, therefore, recommends that the Ministry immediately revise and update the ASHA operational guidelines for both rural and urban contexts to reflect current epidemiological realities and emerging public health challenges due to climate change and global ecological and environmental disorder. ASHAs must be systematically capacitated through continuous training programs and capacity building to better educate and mobilize marginalized communities, focusing sharply on the social determinants of health and improving the utilization metrics of Ayushman Arogya Mandirs.

(Para 6.7.6)

341. The Committee is of the strongly view that sustainable health outcomes cannot be achieved by state machinery alone thereby requiring a paradigm shift in societal behavior. The Committee believes that public health must be universally recognized as a 'Personal, Familial, Community, and State Joint Responsibility.' The Committee, therefore, recommends the deployment of state-level, culturally calibrated Awareness Campaigns designed specifically to encourage proactive health-seeking behavior and reinforce absolute trust in government health services.

(Para 6.7.7)

Transforming Emergency Healthcare

342. The Committee is of the view that rapid, optimized medical transport is the bedrock of effective emergency intervention and disaster management. The Committee, therefore, recommends the immediate creation and deployment of highly optimized ground and air ambulance systems, ensuring equitable distribution across difficult terrains, rural settings, and high-density urban regions. To eliminate transit-to-treatment delays, the Committee recommends the strict formulation and enforcement of standardized ambulance-to-hospital handover protocols. The Committee believes that immediate public access to emergency transport must be drastically simplified. The Committee, therefore, recommends the widespread promotion and continuous provision of a unified, highly responsive centralized and operational helpline number.

(Para 6.8.5)

343. The Committee believes that casualty and emergency medical services must be expertly staffed and financially sound at the time of crisis. 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. Furthermore, greater institutional recognition must be afforded to these crucial departments. The Committee is of the view that financial constraints must never delay life-saving interventions. The Committee, therefore, recommends that emergency care be provided entirely free of cost at the point of care in both public and private hospitals. Such mandate must be supported by automated, prompt reimbursement mechanisms executed through government schemes.

(Para 6.8.6)

344. Recognizing the absolute necessity of sustained respiratory support, both during emergencies and post-discharge, the Committee is of the view that targeted infrastructural and policy enhancements are required. The Committee, therefore, recommends that the Government immediately establish district-level oxygen concentrator banks embedded within the existing public health infrastructure. The Committee believes that chronic respiratory care must be financially protected. The Committee, therefore, recommends bringing Long-Term Oxygen Therapy (LTOT) comprehensively under existing insurance schemes. Furthermore, mandatory follow-up and reassessment protocols for LTOT patients must be instituted to guarantee patient safety, clinical efficacy, and systemic cost-effectiveness.

(Para 6.8.7)

345. The Committee acknowledges the vital safety nets established by the Cashless Treatment of Road Accident Victims Scheme, 2025, and the ongoing infrastructure projects under the PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM). The Committee is of the view that robust hospital preparedness is non-negotiable. The Committee, therefore, recommends that the construction and operationalization of the approved 50-100 bedded Critical Care Blocks (CCBs) be expedited to guarantee readiness for pandemics, mass casualty events, and natural disasters.

(Para 6.8.8)

Need of Strong Accreditation Ecosystem

346. The Committee understands that NABH brings the principles from ISQua, which is a globally competitive accreditation body, and works with hospitals, clinics and Ayush facilities in implementing quality management system. The Committee takes note that QCI undertakes *Gunvattha Yatra* and conduct *Gunvattha Mitra* and inculcates capacity-building and skill development through gunvattha pathshala. Moreover, QCI promotes ease of doing business through *Gunvattha Manthan* and encouraged hospitals to adopt an attitude towards maintaining health quality at an affordable cost. The Committee desires that QCI should promote hospitals to acquire ISO 15189 in tier I, II and III cities which is the golden standard and globally recognized for diagnostic labs. The Committee believes that the *Gunvattha Chakra* activities and *Gunvattha Yatras* would definitely promote QCI to ensure global quality standard at affordable costs.

(Para 6.9.1)

Quality of Generic Medicine and Control over Spurious Medicine

347. The Committee has come across about the quality and efficacy of generic medicine, therefore, CDSCO needs to take concrete steps to ensure the quality and efficacy of generic medicine which are made available at Jan Ausdhi Kendra. Moreover, the Committee wishes to point out that sometimes there is concern over the availability of spurious and fake drugs in the market having detrimental impact on the health of the common man, therefore, the 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 to the branded medicine available at the market at the comparatively at the higher rate. Need is to win the public trust. The Committee strongly recommends for complet ban on spurious medicine.

(Para 6.10.1)

Reverse Brain Drain

348. The Committee has come across that a large number of Indian doctors who have migrated abroad and constitute our diaspora possess the latest skills and are ready to come back to nurture our manpower besides providing advanced health care. The number of such doctors who have although retired but are skilled senior doctors and living abroad, however, are willing to serve the nation provided those doctors are allowed to come and work in different parts of the country. The Committee, therefore, desires that such doctors may be given opportunity to register on the portal formed for the purpose and express their willingness in writing to serve the nation during the certain months of the year in different parts of the country, preferably in their home state, the benefits of their professional experience and expertise can be suitably utilized to ward off severe diseases in under served area/region of the country. Besides that the resident doctors in different hospitals will get additional benefits of gaining their experience in general public interest. Therefore, the Committee recommends the Government to undertake necessary steps in this direction.

(Para 6.11.1)

Health Expenditure and GDP Allocation

349. The Committee notes with deep concern the low budget allocation for the health sector, comprising the Department of Health & Family Welfare, the Department of Health Research, and the Ministry of Ayush, which has hovered between 0.28% and 0.33% of GDP over the past five years. Although GHE has increased from 1.35% of GDP in 2017–18 to 1.43% in 2022–23, the Committee is of the view that this financial trajectory is severely inadequate and falls significantly short of the National Health Policy (NHP) 2017 goal of raising Government Health Expenditure to 2.5% of GDP by 2025. Because the 2025-26 financial year has concluded without achieving this milestone, 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.

(Para 6.12.1)

Healthcare Pricing and Regulatory Integration

350. The Committee notes with serious concern that CAG in its Report of 2023 states *inter-alia* that the National Health Authority (NHA) formulated tertiary procedure rates by simply replicating existing central schemes and state averages rather than conducting localized, scientific clinical cost assessments. As highlighted by performance audits on the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY), systemic gaps in hospital empanelment remain a challenge, exacerbated by pricing procedures far below actual operational costs, which has driven premier private hospitals to refuse empanelment. Furthermore, the Committee believes that IRDAI's failure to enforce a strict policy against dual pricing, whereby private hospitals arbitrarily inflate charges for insured patients, and its inability to mandate the integrated National Health Claims Exchange (NHCX) IT interface by the June 2026 deadline represent severe regulatory lapses. 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.**
e) **Mandatory NHCX Integration: IRDAI must issue stringent regulatory directives mandating the immediate technical integration of the NHCX interface with corporate hospital billing desks, imposing penalties for further delays beyond the June 2026 target.**
f) **Elimination of Dual Pricing: IRDAI must formulate and enforce a robust, standardized policy framework that explicitly prohibits the unethical practice of dual pricing, ensuring equitable and transparent billing practices for all patients regardless of their insurance status.**

(Para 6.13.1)

Rural Healthcare Deployment and PM-JAY Expansion

351. The Committee observes with grave concern the critical 70-80% shortfall of specialist physicians in rural Community Health Centres (CHCs). The Committee is of the view that despite a 133% increase in postgraduate medical seats over the last decade, the absence of effective deployment strategies has completely failed to bridge this rural healthcare disparity. The Committee is of the view that India does not face an absolute shortage of medical professionals; rather, the core crisis lies in deeply skewed distribution, with practitioners heavily concentrated in urban centers while rural areas

remain severely underserved. To capitalize on this augmented educational capacity and establish a self-sustaining pipeline of medical professionals in underserved areas, the Committee believes that while augmenting postgraduate seats has expanded educational capacity, bridging this rural healthcare disparity requires robust retention and incentive frameworks rather than mere seat expansion. 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.

(Para 6.14.1)

352. The Committee believes that stringent retention and deployment policies are urgently required. Furthermore, recognizing that Out-of-Pocket Expenditure (OOPE) is primarily driven by outpatient (OPD) care and medicines, the current PM-JAY framework, which exclusively covers inpatient hospitalization, remains fundamentally inadequate. The Committee, therefore, recommends that the Ministry expanding PM-JAY to comprehensively cover OPD treatments and essential medical supplies.

(Para 6.14.2)

353. The Committee is of the view that the current Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) coverage limit of Rs. 5 lakhs per family is fundamentally inadequate, particularly given the recent inclusion of six crore senior citizens over the age of 70 who present high rates of comorbidities. Furthermore, the Committee believes that the omission of 600 high-end, complex medical procedures from the current framework actively misleads beneficiaries and inflicts unsustainable out-of-pocket expenditures on vulnerable families. The Committee, therefore, recommends an urgent collaborative intervention by the Department of Health and Family Welfare, the Department of Finance, and NITI Aayog to mandate the immediate coding of these 600 excluded procedures and enhance the annual AB-PMJAY financial package to Rs. 10 lakhs per family.

(Para 6.14.3)

Cashless Health Schemes, Inclusive Insurance, and Hospital Empanelment

354. The Committee is of the view that the systemic and prolonged delays in clearing financial dues under major cashless health schemes, such as PM-JAY, are actively driving private hospitals to suspend services, thereby exacerbating the severe shortage of empanelled facilities and leaving patients stranded during medical emergencies. Furthermore, the Committee believes that the widespread exclusion of Persons with Disabilities, characterized by an alarming 53% arbitrary rejection rate that leaves

approximately 16 crore vulnerable citizens without coverage, and the blatant failure of insurance providers to comply with the mental health parity mandated by Section 21(4) of the Mental Healthcare Act, 2017, represent a profound regulatory failure in delivering equitable healthcare. 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, which is essential for rapidly expanding the network of empanelled hospitals. Concurrently, the Committee strongly urges the regulatory authorities to issue stringent directives penalizing insurance companies that arbitrarily deny coverage to Persons with Disabilities or fail to provide comprehensive, equal-basis coverage for mental health conditions and outpatient (OPD) treatments.

(Para 6.15.1)

Upgrading Public Health Infrastructure and Expanding AIIMS

355. The Committee is of the view that the technology-driven best practices successfully demonstrated by AIIMS, such as AI-based diagnostics, digital grievance redressal, patient navigation, and advanced hospital management, must be rapidly standardized across the public healthcare system. The Committee believes that launching a 'National Hospital Programme' will effectively replicate these successful models across all Government medical colleges and major district hospitals, significantly elevating the quality and efficiency of patient care nationwide. Furthermore, the Committee notes with concern the glaring regional disparities in tertiary healthcare access. Despite the sanctioning of 23 AIIMS across the country, critical regions remain unrepresented, notably Mumbai, the nation's economic capital, and the State of Karnataka, particularly the high-need Aspirational District of Raichur in the Karnataka region. The Committee, therefore, recommends that the Government expedite the approvals and establishment of new AIIMS facilities in these geographically and demographically critical areas, while simultaneously executing the National Hospital Programme to ensure equitable, technology-enabled healthcare delivery across all states.

(Para 6.16.1)

Emergency Neonatal and Paediatric Referrals

356. The Committee is of the view that the severe deficiency of specialized neonatal and paediatric care facilities within district hospitals poses a grave risk to public health, particularly for newborns and infants. The Committee believes that the current administrative protocol, which mandates acquiring a formal consent letter from a district hospital before a critical patient can be transferred to an empanelled facility, is deeply flawed and life-threatening. Such bureaucratic hurdles cause inexcusable delays during the critical 'golden hour' of medical emergencies, inflicting profound and unnecessary suffering on vulnerable patients and their families. The Committee, therefore, recommends the immediate abolition of the prior-consent requirement for all emergency neonatal and paediatric referrals to ensure seamless and rapid medical intervention, alongside a targeted infrastructural drive to establish self-sufficient paediatric care units directly within all district hospitals.

(Para 6.17.1)

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Senior Citizen Insurance, Emergency Care, and Tertiary Infrastructure Expansion

357. The Committee is of the view that current healthcare delivery and insurance frameworks inadequately protect senior citizens and critically delay emergency medical interventions due to procedural financial barriers. The Committee believes that achieving equitable healthcare access requires both decentralized medical infrastructure and seamless, automated financial mechanisms. The Committee, therefore, recommends a multi-pronged intervention: first, the Insurance Regulatory and Development Authority of India (IRDAI) must mandate affordable insurance policies for citizens over 60 and deploy a dispute-free digital claim verification system; second, NITI Aayog and the Ministry of Health and Family Welfare must jointly establish autonomous tertiary healthcare centers in Tier-II and Tier-III cities, sustained by a cross-subsidization model where private ward revenues fund care for economically weaker sections; and third, a specific operational carve-out under PM-JAY must be instituted to guarantee immediate financial clearing for life-threatening emergencies, strictly enforcing a 'treatment first, payment later' protocol.

(Para 6.18.1)

358. The Committee is of the view that expanding advanced tertiary healthcare beyond metropolitan areas to Tier-II and Tier-III cities is critical for equitable medical access. The Committee believes this can be effectively achieved by incentivizing private sector participation through targeted tax holidays, coupled with a mandatory obligation for these private facilities to provide cashless treatment to all Ayushman Bharat beneficiaries and uninsured patients at standardized CGHS rates. The Committee, therefore, recommends that the Ministry formulate a strategic public-private partnership framework to establish subsidized tertiary care centers in smaller cities, ensuring that commercial incentives are directly aligned with universal healthcare affordability and public welfare.

(Para 6.18.2)

359. The Government should take steps to expand access to affordable bone marrow transplantation (BMT), which is presently largely available in private hospitals at a high cost of approximately ₹25–30 lakh per patient. All AIIMS should be equipped with dedicated BMT units, and, considering the large number of medical colleges in the country, one nodal BMT centre may be established for every five medical colleges to ensure wider geographical access. The facilities may be integrated with the existing framework of the National Organ and Tissue Transplant Organisation (NOTTO) and strengthened for the treatment of children suffering from Sickle Cell Disease and Thalassemia. Further, the Government may consider expanding empanelment of BMT centres under relevant public health schemes to reduce the financial burden on patients and ensure equitable access to this life-saving treatment.

(Para 6.18.3)

Market Regulation

360. The Committee is of the view that efficiently managed, high-quality public healthcare institutions play a critical role not only in delivering accessible patient care but also in acting as definitive market regulators that organically drive down exorbitant

private sector medical costs. The Committee believes that the current centralized model of healthcare delivery must be decentralized to reduce patient travel burdens, and that government facilities must urgently adopt a "corporate culture" characterized by operational efficiency, accountability, and robust public relations frameworks. 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, minimize travel time to capital cities, and actively regulate regional healthcare pricing through superior public service delivery.

(Para 6.19.1)

Regulating Foreign Direct Investment in Private Healthcare

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. While acknowledging that foreign capital is highly beneficial and should be actively encouraged in the manufacturing sector, specifically for medical devices, consumables, and specialized medicines for rare diseases, its unrestricted application in direct hospital operations is proving detrimental to affordable patient care. 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. Concurrently, the Government must introduce a targeted regulatory framework that explicitly redirects and incentivizes such foreign investments toward the domestic manufacturing of medical technologies and pharmaceuticals.

(Para 6.20.1)

Decongesting AIIMS Delhi

362. The Committee observes with deep concern the delays in operationalizing the memorandum of understanding signed in March 2024 between AIIMS New Delhi and the Central Armed Police Forces (CAPF) for the establishment of a specialized 970-bed facility at Maidan Garhi. The Committee recommends that the Ministry of Health and Family Welfare (MoHFW) expedite administrative clearances to ensure this state-of-the-art facility becomes fully operational without further delay. Furthermore, to alleviate the massive patient congestion and severe strain on the main AIIMS New Delhi campus, the Committee strongly supports utilizing available land resources in the National Capital Region. Specifically, the Committee recommends that MoHFW, in coordination with the Ministry of Housing and Urban Affairs (MoHUA) and the Delhi Development Authority (DDA), immediately evaluate and submit a formal proposal to

reserve a portion of the 400-acre vacant NTPC land near Badarpur Border, Sarita Vihar, for the establishment of a major new AIIMS branch. Given its direct connectivity to major highways, this strategic location will significantly improve healthcare access for the populations of South Delhi, Faridabad, Noida, and the wider NCR.

(Para 6.21.1)

363. The Committee is of the view that the existing infrastructure at AIIMS, New Delhi, is severely overburdened by a combination of a massive local population, an alarming rise in lifestyle diseases among younger demographics, and a relentless influx of patients from neighboring States. While acknowledging the relief provided by southern satellite institutions, the Committee believes that the northern periphery of the National Capital Region, including North Delhi, parts of northern Haryana, and western Uttar Pradesh, continues to suffer from a critical deficit in accessible tertiary healthcare, which perpetuates severe patient congestion and extreme stress on medical professionals at the main campus. The Committee, therefore, reiterates its recommendation in 172nd Report that the Government urgently evaluate and execute the establishment of an additional, independently administered AIIMS facility or a fully equipped satellite center in the northern outskirts of Delhi, to strategically decentralize the tertiary healthcare burden and ensure equitable, timely medical access for the broader region.

(Para 6.21.2)

Strengthening Human Resources in Medical Colleges and District Hospitals

364. The Government should undertake a comprehensive review of the availability and deployment of healthcare professionals, particularly non-clinical faculty in medical colleges and anaesthetists in district hospitals. Despite the substantial expansion of medical colleges, many institutions continue to face acute shortages of non-clinical teaching faculty, adversely affecting the quality of medical education. Similarly, several district hospitals serving populations of over 10 lakh reportedly have only one anaesthetist, making it difficult to ensure uninterrupted surgical services, particularly during leave or absence. The Government should, therefore, assess manpower requirements and ensure adequate, rational and equitable deployment of doctors and specialists through NHM and other appropriate mechanisms. At the same time, given the reported availability of doctors in certain States, efforts should focus on better distribution, appropriate remuneration and employment opportunities, rather than merely increasing the overall number of doctors.

(Para 6.22.1)

Strengthening Awareness and Outreach of Government Health Schemes

365. The Government should undertake a comprehensive and sustained awareness campaign to ensure that rural and underserved populations are adequately informed about various Government health schemes, programmes and available healthcare services. Despite the launch of numerous initiatives, lack of awareness often prevents eligible beneficiaries from accessing their entitled benefits. Radio, television, local media and other appropriate communication channels, including community-level outreach, may be effectively utilised to disseminate information in local languages. The

National Patient Navigation System

6.24.1 The Committee further recommends that the Government should establish Patient Navigation and Facilitation Desk in every Distrct Hopital and Medical College to assist patients with referral, disgnostics, AB-PMJAY benefits, medicine availability and grienvances redressal. There is further need to improve healthcare accessibility, especially for the elderly, women and economically weaker sections.

(Para 6.24.1)

National Healthcare Affordability Dashboard

6.25.1 The Committee understands that there is need to create a district-wise digital dashboard on healthcare affordability and accessibility to track treatment costs, waiting times, specialist vacancies, diagnostics, medicine availability and redressal of patient grievances and to promote transparency, accountability and evidence-based policy interventions.

(Para 6.25.1)

Outcome-Based Haspital Accreditation

1.26.1 The Committee feels that there is to complement infrastructure-based accreditation with outcome-based quality indicators. The need of the hour is to assess hospitals on patient safety, treatment outcomes, infection rates, waiting time, patient satisfaction and grievance resolution, besides, encourage quality improvement based on health outcomes rather then infrastructure alone.

(Para 6.26.1)

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