

Pharma & Healthcare Update

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PRICE CONTROL FOR HOSPITALS: A CLEAN BILL OF HEALTH?

- The central government is in the process of devising standardized rates for services and procedures offered by hospitals
- The Supreme Court has indicated that rates chargeable under the CGHS may be made temporarily applicable for non-CGHS patients as well if the central government fails to produce a proposal for notifying the rates
- The imposition of CGHS rates could compromise the commercial viability of hospitals in states where the rates are made applicable

INTRODUCTION

In response to a public interest litigation seeking the standardization of rates charged by hospitals for various procedures, treatments, tests and services, the Supreme Court of India has directed¹ the Department of Health ("Government") to fix the rates chargeable by hospitals. The court has also indicated that, if the Government fails to decide on a proposal for notifying standard rates before the next date of hearing², the rates that have been fixed under the Central Government Health Scheme ("CGHS") may be made applicable for all patients in the interim.

The Supreme Court's order has led to widespread panic amongst private hospitals and investors since the standardization of rates could substantially affect the revenue and commercial viability of hospital operations.

LEGAL BACKGROUND

In India, health is a state subject and each state has its own law and regulations to govern hospitals, nursing homes and clinics (collectively referred to as "healthcare institutions"). These state-level legislations have varying degrees of applicability: certain states' laws may only apply to private hospitals, bedded institutions, allopathic healthcare institutions, etc. The minimum standards and other compliances prescribed under these laws are also not harmonized, resulting in fragmented regulation of healthcare institutions across the country.

In an attempt to unify the framework for hospitals and ensure that certain minimum standards are being adhered to by all healthcare institutions across the country, a central-level law – the Clinical Establishments (Registration and Regulation) Act, 2010 ("CE Act") - was enacted. The CE Act is not automatically binding across the country, and the state governments are required to expressly adopt it. Pertinently, not all states have adopted (or indicated their intention to adopt) the CE Act: only 11 states and 7 union territories have adopted it as on date.³

Therefore, to the extent the directions issued by the Supreme Court in this matter are under the CE Act, the applicability would be restricted to the healthcare institutions situated in states that have adopted the CE Act.

REGULATION OF PRICES

The Clinical Establishments (Central Government) Rules, 2012 that have been enacted under the CE Act requires that the Government fix the range of rates that may be charged by healthcare institutions after consulting with the state governments.⁴ The Government has indicated that it has commenced the consultation process with state governments, but as on date, no prices or price ranges have been fixed.

Currently, hospitals are at liberty to determine the rates that they will charge basis commercial considerations, and the rates chargeable by different healthcare institutions may vary significantly basis factors such as the location of the hospital, the size of the institution, the level of care offered, the services and the facilities offered, whether it has received accreditation, etc. Hospitals may also offer differential rates for patients from lower economic strata or as part of government schemes.

The scrutiny that the pricing strategies of private hospitals are subject to is not new, and over the years there has been widespread discussion about regulating the prices of medical services similar to the manner in which drug prices are regulated. The Economic Survey 2017-18 report found huge disparities in the average price of medical diagnostic tests across cities, and recommended that the rates be standardised.⁵ The instant PIL was filed in 2020, and separately, a PIL was filed by the Jan Swasthya Abhiyan in 2021 seeking the implementation of the minimum standards and price transparency requirements under the CE Act.⁶

Separately, there have been attempts by state governments at capping the rates charged by hospitals. During the COVID-19 pandemic, the Maharashtra Government issued a circular imposing price caps⁷ for 80% of the operational bed capacity of the hospital, irrespective of whether they were being offered for treatment of COVID or not. The act of

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imposing price controls for non-COVID patients was challenged by the Hospitals' Association, Nagpur before the Bombay High Court⁸, and was quashed to the extent that it applied to non-COVID patients.⁹ Similarly, the West Bengal Clinical Establishment Regulatory Commission ("WBERC") had fixed rates for hospitals through a series of advisories and orders, which the Calcutta High Court subsequently held to be unconstitutional.¹⁰ Pertinently, the decision was based on the fact that the WBERC had failed to follow the due process stipulated under the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act, 2017 namely the WBERC was required to frame regulations with previous approval of the state government as a pre-condition for fixing rates.

The rates chargeable under the government schemes such as the CGHS are also often standardised. The rates that healthcare institutions are entitled to under the CGHS are fixed for all hospitals in a city¹¹. These rates are determined basis a tendering process, and may be 40-50% lower than the regular rates normally charged by the hospital.¹²

POTENTIAL IMPACT ON HOSPITALS

At present, the Supreme Court has only stated that it may consider implementing the CGHS rates if the Government fails to come up with a proposal for standardizing rates within the stipulated. Therefore, there is no immediate action required by hospitals in terms of the rates that are being charged.

In the event that CGHS rates are made temporarily applicable for all patients, it could have a detrimental effect on the hospitals' ability to carry on trade. The CGHS rates only differentiate between hospitals that have and have not received NABH accreditation for the purpose of fixing rates and do not take into consideration the multitude of factors that may be relevant for determining the rates chargeable by a hospital.

Given that the CE Act is not applicable to all states, the requirement that CGHS rates be imposed for all services would not be binding across the country, which could result in vast disparities between the prices chargeable in states that have and have not adopted the CE Act. Imposing CGHS rates for all patients could make it commercially unfeasible for hospitals to offer certain services, which could result in reduced access to care for patients within these states.

IMPLICATIONS FOR INVESTORS

The healthcare sector has, in the past year experienced a surge in both private equity and M&A activity. This has been driven by a myriad of factors including growing demand for healthcare (including preventive care), the push for universal health coverage, the return of medical tourism after the pandemic, evolution of the legal framework to support quality in healthcare, etc.

There has been a notable trend of corporate hospitals expanding their footprint to different geographies including smaller cities through acquisition of smaller healthcare institutions. Even though the rates charged by a healthcare institution would only be one factor that is taken into consideration, standardized pricing could result in states where it is introduced being viewed less favorably by investors or potential acquirers.

Investors may also increasingly look at the quality management systems, processes and practices if pricing becomes a level playing field for healthcare institutions. Institutions that are accredited, or at least have put in place documented standard operating procedures, robust risk mitigation systems, strong documentation practices, infection control policies, etc would be in an advantageous position.

KEY TAKEAWAYS

Irrespective of whether the CGHS rates are made temporarily applicable, it is clear that the Government intends to impose price ranges for different procedures and treatments. Hospitals should refrain from adopting the maximum price for all procedures and should critically evaluate the rates that they can justifiably charge for each procedure or service basis relevant commercial factors. It is recommended that the rationale for the pricing decision be duly documented.

It is evident that hospital pricing practices are being - and will continue to be - subject to scrutiny. Therefore, in states where the standard rates are not made binding, it would be prudent for hospitals to develop internal pricing policies where the rationale for pricing is recorded. If differential rates are charged at the hospital, the classification of patients and the decision matrix should also be duly documented. Certain pricing practices such as differential rates, packages, discounts, etc may attract scrutiny from a competition law perspective, and should be closely assessed from a risk mitigation perspective.

– Varsha Rajesh, Tanya Kukade, Eshika Phadke and Dr. Milind Antani

You can direct your queries or comments to the authors.

¹ Available at: https://main.sci.gov.in/supremecourt/2020/13006/13006_2020_3_28_50924_Order_27-Feb-2024.pdf

² The next date is likely to be April 10, 2024

³ Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, Bihar, Rajasthan, Uttar Pradesh, Uttarakhand, Jharkhand, Assam, Haryana and all Union Territories except the NCT of Delhi.

⁴ Rule 9 of the Clinical Establishments (Central Government) Rules, 2012

⁵ Available at: <https://economictimes.indiatimes.com/wealth/personal-finance-news/over-1000-difference-in-medical-test-prices-across-cities-will-govt-standardise-rates/articleshow/62696175.cms?from=mdr>

⁶ Available at: <https://timesofindia.indiatimes.com/india/pil-fix-minimum-healthcare-standard-and-rates-for-hospitals/articleshow/84810871.cms>

⁷ The power to impose price controls for treatment of COVID patients was derived from the Epidemic Diseases, Act, 1897, the Disaster Management Act, 2005, the Maharashtra Essential Services (Amendment) Act, 2011, the Maharashtra Nursing Homes Act, 2006, and the Bombay Public Trust Act, 1950

⁸The legislative competence of the state government to impose price controls was questioned

⁹Available at: <https://bombayhighcourt.nic.in/generatenewauth.php? bhcpa=cGF0aD0uL3dya XRlcmVhZGRhdGEvZGF0YS9uYWdqdWRnZW1lbnRzLzlwMjAvJm ZuYW1IPTlwMzlwMDAxOTM2MjAyMF8 5LnBkZiZzbWZsYWc9Ti ZyanVkZGF0ZT0mdXBsb2FkZHQ9MjMvMTAvMjAyMCZzcGFzc3B ocmFzZT0wNTAzMjQxMTQ1MzkmbmNpd GF0aW9uPSZzbWNpdGF0 aW9uPSZkaWdjZXJ0ZmxnPvkmaW50Z XJmYWNIQ==>

¹⁰Available at: https://hcservices.ecourts.gov.in/ ecourtindiaHC/cases/display_pdf.php? filename=zDLovBVSUw02H8XukOjXfAyhX5i isK3puaudOaZ8GqP0kby%2B1UU8FMgFeA3Tv qsE&caseno=WPA/3858/2022&cCo de=3&appFlag=

¹¹Higher rates may be fixed for hospitals that are NABH/NABL-accredited

¹²Available at: <https://www.cnbctv18.com/healthcare /private-hospitals-supreme-court -cost-govt-healthcare-price-premiums-standardised-impact-19166231.htm#:~: text=The%20CGHS%20rates%20are%2040, profits%20for%20private%20healthcare%20providers.>

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