RXINTEL · PHARMA INTELLIGENCE REPORT · INDIA 2026

The Hidden Hospital Cost

Why Patients Miss Procurement Savings

India's hospitals negotiate medicines and devices like institutional buyers — but patients rarely see those savings. This report examines the structural mechanism behind that gap, the regulatory accountability map, and what reform would address it most directly.

RxIntel Research Team · June 2026
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KEY INTELLIGENCE SUMMARY

Core mechanism	Hospitals negotiate medicine and device prices with institutional purchasing leverage, then dispense within a captive retail environment with no requirement to share the resulting procurement saving with the patient.
Documented spread	A 2016-17 Maharashtra FDA study found hospitals billing balloon catheters at 472% margin and guiding catheters at 529% margin over landed price. NPPA's own published data showed hospital trade margins on cardiac stents reaching 654% before price controls were imposed in 2017.
Regulatory gap	NPPA/DPCO govern manufacturer pricing. IRDAI governs insurers. NMC governs doctors. State Clinical Establishments Acts cover licensing. No single regulator currently owns the hospital-to-patient billing transaction.
Already on the record	The Supreme Court (Dalmia v. Union of India, March 2025) directed state governments to consider the issue of unreasonable charges and patient exploitation in private hospitals and take appropriate policy decisions. Parliament's Standing Committee on Chemicals & Fertilisers (Dec 2025) found PTS data undisclosed and recommended permanent trade-margin rationalisation. An information commission has separately recommended bringing private hospitals under RTI.
Proven cost-saving models	TNMSC-style pooled procurement (Tamil Nadu, Kerala, Rajasthan, Odisha, Bihar, UP) and Jan Aushadhi retail generics have each demonstrated 30%+ and 50-80% savings respectively at national scale.
Compounding factors	A specialist access gap (~1:836 doctor-population ratio per 2024 govt data), insurance-driven price insulation, and multi-brand price variation (apixaban 49.5x spread, semaglutide 25.8x) all intensify the underlying dynamic.
Most defensible reform	Mandatory disclosure of the procurement-to-patient spread — not a blanket discount mandate or price cap — is the more foundational and defensible starting point.

500–1,800%
Markups on branded generics reported in coverage of Parliament's Dec 2025 Committee review

472%
Hospital margin on balloon catheters over landed price (Maharashtra FDA, 2016-17)

43
Pharma-sector cases in CCI's 2021 market study

■40,000 Cr
Cumulative citizen savings from Jan Aushadhi since 2014 (PIB, March 2026)

01 / INTRODUCTION

The Mechanism Behind the Bill

Most coverage of hospital pricing in India lands on a familiar charge: hospitals overcharge. That is true, but it understates what is actually happening, and it points reform in the wrong direction. The sharper problem is structural. A corporate hospital sits on both sides of the same transaction — it negotiates bulk medicine and device purchases the way a large institutional buyer would, then dispenses those same products to an admitted patient who has no second supplier to compare against.

Put plainly: hospitals negotiate like institutional buyers and dispense within a captive retail environment. Nothing about that arrangement is illegal. The Drug Price Control Order (DPCO) sets ceilings on what manufacturers can charge for scheduled formulations, and the NPPA monitors compliance at that level. Neither has ever attempted to govern what a hospital bills a patient with no real alternative once admitted. The result is a market-structure failure dressed up as a pricing story.

Part of what makes the procurement advantage as large as it is comes from distribution channel elimination. Large hospital chains frequently bypass one or more layers of the conventional supply chain — negotiating directly with manufacturers rather than purchasing through the distributor and stockist layer that retail pharmacies depend on. The effect is that hospitals secure prices that reflect the absence of intermediary margins — savings that accumulate at procurement but are not required to be disclosed or transmitted to the patient. Institutional supplies already account for roughly 31% of the Indian pharmaceutical distribution market by value (IPA India / Pharmarack, 2024).

✦ RXINTEL INSIGHT

The affordability problem is not primarily a price-control failure. It is a discount transmission failure: the gap between what a hospital pays to procure a drug or device and what it bills the patient, with nothing in current policy requiring that gap to be disclosed or shared.

02 / REGULATORY ARCHITECTURE

The DPCO Myth and What Regulation Actually Covers

The Competition Commission of India's 2021 market study found the median retail pharmacy margin at roughly 28% of final price — above the 16% statutory cap on scheduled drugs. The Commission concluded directly: when purchase of prescribed drugs from the hospital pharmacy is effectively mandatory for in-patients, that pharmacy is insulated from retail competition altogether.

For non-DPCO drugs — branded specialty medicines, patented molecules, specialty injectables and consumables — the gap is wider still. Pooled procurement evidence confirms the leverage is real: Tamil Nadu's TNMSC model delivers ~30% procurement savings, replicated across Kerala, Rajasthan, Odisha, Bihar, and Uttar Pradesh. A National Cancer Grid pilot achieved 23-99% savings (median 82%) across 40 oncology drugs. Individual hospitals wield comparable leverage — but no regulator currently has a mandate over what happens to those savings once the product crosses into a patient's bill.

REGULATORY ACCOUNTABILITY MAP

REGULATOR	COVERS	DOES NOT COVER
NPPA	Manufacturer ex-factory pricing; MRP ceiling on scheduled drugs	*Hospital margins for dispensed medicines*
IRDAI	Insurance products, premiums, and claim conduct	*Hospital pricing or billing practices*
NMC	Doctors' professional and ethical conduct	*Hospital billing or institutional pricing*
State Clinical Establishments Acts	Hospital licensing (in adopting states); Maharashtra and Delhi NCT excluded	*Procurement-to-patient pricing spreads*

03 / CONSUMABLES & DEVICES

Documented Margins on Uncapped Medical Products

The table below uses only figures traceable to the same Maharashtra FDA regulatory submission — a study conducted December 2016 to April 2017, submitted to NPPA for action. These are not estimates; they are margins a state drug regulator documented and put on official record.

ITEM	BASIS	DOCUMENTED MARGIN
Balloon catheter	Over landed price	**472%**
Guiding catheter	Over landed price	**529%**
Urinary bag	Over procurement price	**500%**
Oxygen bag	Over procurement price	**300%**

Intraocular lens	Hospital to MRP	**200-300%**
Cardiac stent (pre-2017, before price control)	Over landed price (NPPA's own published data, cited by Minister of Chemicals & Fertilizers, Feb 2017)	**Up to 654%**

Source: Maharashtra FDA study (Dec 2016–Apr 2017), Business Standard (July 2017); NPPA published stent margin data / Minister of Chemicals & Fertilizers statement, Feb 2017. Devices in this table, other than stents, remain outside any price-control net today.

04 / MULTI-BRAND PRICE VARIATION

Same Molecule, Wildly Different Prices — Even Outside the Hospital

RxIntel's PriceIQ tracker monitors 541 branded formulations across 10 molecules and currently flags significant price variation in 7 of them. A peer-reviewed Cureus/PMC study of the anticoagulant/antiplatelet drug class (directly relevant to apixaban and ticagrelor) found cost variation as high as 2,455% for prasugrel 5mg across competing Indian brands. Brand proliferation in India does not compress prices — peer-reviewed evidence finds more competing brands of a molecule are associated with greater price dispersion, not less.

MOLECULE	PRICE RANGE	SPREAD	BRANDS
Apixaban (stroke/DVT prevention)	■2 – ■93 per tablet	**49.5×**	61
Dydrogesterone (female infertility, PMS)	■5 – ■164 per tablet	**31.9×**	217
Semaglutide (diabetes, weight loss / GLP-1)	■219 – ■5,660 per mg	**25.8×**	30
Ferric carboxymaltose (anaemia)	■1 – ■13 per mg	**15.8×**	93
Ticagrelor (antiplatelet, blood thinner)	■8 – ■70 per tablet	**8.9×**	126

Source: RxIntel PriceIQ, live tracker, priceiq.rxintel.link

05 / INSURANCE DYNAMICS

Removing the Last Check on Price

Out-of-pocket spending accounted for 43.4% of India's total health expenditure in 2022-23 (National Health Accounts, latest available), up from 39.4% the year before — reversing nearly a decade of decline. IRDAI's 2024-25 Annual Report recorded 3.26 crore health insurance claims settled, with insurers paying ■94,248 crore. Aon's 2026 Global Medical Trend Rates Report projects India's employee medical plan costs will rise 11.5% in 2026 — roughly 2.5 times India's general consumer inflation rate.

◆ **A STRUCTURAL FEEDBACK LOOP, NOT AN ACCUSATION**

When the immediate patient is shielded from the bill by insurance, price discipline at the point of care weakens. Insurers can and do exert downward pressure through package-rate negotiations and network contracting — but the terms of those arrangements are rarely visible to the patient they ultimately protect.

06 / THE GAP IS ALREADY ON THE RECORD

Courts, Parliament, Audit Institutions, and Transparency Law

This is not a gap this report is the first to notice. It has already reached the Supreme Court, Parliament, and India's audit and transparency institutions — and each has pointed at the same hole. It is worth noting that public attention on this issue has reached Parliament before: in 2012, Aamir Khan's Satyamev Jayate aired an episode on medical malpractice and overcharging that prompted an invitation for Khan to testify before the Rajya Sabha's Standing Committee on Commerce. That episode aired fourteen years before this report. The structural problem it raised remains, in 2026, largely intact.

Supreme Court March 2025	Siddharth Dalmia & Anr. v. Union of India (W.P.(C) No. 337 of 2018). Court directed state governments to consider the issue of unreasonable charges and patient exploitation in private hospitals and take appropriate policy decisions. As of this report, no comprehensive state policy has been documented in response.
Parliamentary Standing Committee, Dec 2025	"Price Rise of Medicines in the Pharmaceutical Sector Impacting the Lives of Ordinary Citizens Adversely — A Review." Found PTS data undisclosed to the public. Recommended amending DPCO 2013 to permit permanent trade-margin rationalisation.
CAG Report No. 17 of 2022	Performance audit of CGHS drug procurement and supply. Documented overcharging patterns including inadmissible charges and costs improperly folded into package rates.
Information Commission observation	Recommended bringing private hospitals within the ambit of the Right to Information Act through state-specific amendment, arising from a patient's family being unable to obtain satisfactory billing information.
AHPI Supreme Court petition (ongoing)	Association of Healthcare Providers India seeking to exempt medical professionals from the Consumer Protection Act, relying on a 2024 precedent that exempted lawyers. The issue is actively contested in multiple directions, not just slowly evolving.

07 / WHAT MEANINGFUL REFORM LOOKS LIKE

Eight Reform Proposals, From Disclosure to Reference Pricing

■ Require Disclosure of the Procurement-to-Patient Spread

Before mandating specific discount percentages, the more foundational reform is visibility: require hospitals to disclose the gap between institutional purchase price and patient billing for high-value drugs and devices.

■ Itemised Bills with Purchase Price Disclosure

Every discharge bill could state the hospital's purchase price for major drugs and consumables alongside the amount billed — creating audit grounds for insurers and regulators without presupposing what the right margin is.

■ Pilot Margin Caps on Consumables

NPPA's 2019 trade-margin cap on anti-cancer drugs restricted margins to 30%, cut prices up to 85%, and is credited with roughly ■984 crore in annual patient savings. A similarly piloted cap on high-volume hospital consumables is a defensible next step.

■■ Expand Government-Run Low-Margin Pharmacy Models

The AMRIT Pharmacy initiative — commended by Parliament's own Standing Committee — sells medicines and devices ~15% below market on a 5% margin across 207 hospital-based stores. Jan Aushadhi's 18,000+ stores have saved citizens ■40,000+ crore since 2014.

■■■■ Invest in Paramedical Education & Scope

In some healthcare settings, workforce shortages result in tasks being escalated to physicians that could otherwise be handled by nursing, pharmacy, or allied health professionals. Expanding paramedical capacity reduces systemic cost pressure.

■ Expand Medical Education Capacity

Closing India's persistent specialist and rural-access gaps requires sustained expansion of MBBS and specialist (DNB) seats, alongside incentives for rural and semi-urban specialist practice.

■ Strengthen the NHCX Infrastructure Already Being Built

The National Health Claims Exchange (NHCX) already standardises hospital-insurer claim data and is moving toward tighter joint IRDAI-Finance Ministry oversight. Extending NHCX with pattern analysis to flag hospitals with systematically elevated billing versus clinical peers builds on existing infrastructure.

■ IRDAI Reference Pricing on Insured Hospital Billing

IRDAI could require insurers to reimburse hospital-dispensed drugs and devices at a multiple of a published reference price rather than at whatever the hospital bills. Montana's state employee health plan saved an independently verified $47.8 million over two years using an equivalent Medicare-referenced model. This is squarely within IRDAI's existing authority.

08 / CLOSING

The Closing Account

The same medicine, in the same box, can carry the same printed MRP whether you buy it at your local chemist or receive it through a drip in a private hospital. But one of those transactions occurs in a market with some degree of competition and price transparency. The other occurs when you are admitted, dependent on the institution treating you, and structurally unable to compare prices or walk away.

The retail chemist who discounts that box is operating under competitive pressure that keeps some of the procurement saving flowing back to the customer. The hospital that buys the same product at a steep institutional discount and bills it at full MRP is not breaking any law in doing so — it is simply operating in a space where no law currently requires it to share that saving.

✦ RXINTEL INSIGHT

The single insight worth carrying away is not a high MRP. It is discount transmission failure: the gap between what a hospital pays to procure a drug or device and what it bills the patient, with nothing in current policy requiring that gap to be disclosed or shared. Disclosure of the procurement-to-patient spread, not a deeper argument over MRP, is the more defensible starting point for reform.

◆ A NOTE ON LIMITATIONS

Hospital-level procurement pricing is not publicly disclosed in a standardised manner in India, which means many of the market-wide patterns discussed here cannot yet be quantified systematically. The documented examples in this piece illustrate the mechanism; they are not a verified national average.

FREQUENTLY ASKED QUESTIONS

Is it illegal for an Indian hospital to bill a medicine at full MRP?

No. The DPCO and NPPA govern what manufacturers can charge and the MRP printed on the pack — they do not regulate what a hospital bills an admitted patient for that same product. Billing at full MRP, even after purchasing well below it, does not violate current law.

What is "discount transmission failure"?

The gap between what a hospital pays to procure a drug or device through institutional purchasing and what it bills the patient, with no policy currently requiring that procurement saving to be disclosed or shared.

Which regulator is responsible for hospital billing in India?

No single regulator currently owns this. NPPA covers manufacturer pricing, IRDAI covers insurers, the NMC covers doctors' professional conduct, and state Clinical Establishments Acts cover hospital licensing — but the hospital-to-patient billing transaction falls between mandates.

Has any court or Parliament actually addressed this?

Yes. The Supreme Court (Dalmia v. Union of India, March 2025) directed state governments to consider the issue of unreasonable charges and patient exploitation in private hospitals and take appropriate policy decisions. Parliament's Standing Committee (Dec 2025) recommended amending the DPCO for permanent trade-margin rationalisation. An information commission has recommended bringing private hospitals under RTI for billing transparency.

Are there working examples of lower-cost models already operating in India?

Yes. Tamil Nadu's TNMSC pooled-procurement model has delivered ~30% savings since 1994, replicated by Kerala, Rajasthan, Odisha, Bihar, and UP. Jan Aushadhi's network sells at 50-80% below branded prices and has saved citizens ■40,000+ crore since 2014.

SOURCES & EDITORIAL NOTE

• Competition Commission of India (2021): Market Study on the Pharmaceutical Sector in India

• Manu Kanchan (March 2017): "Hospital Pharmacies: Retail Shops within Corporate Hospitals," Economic & Political Weekly

• Maharashtra FDA (2016-17): Study on angioplasty consumable pricing, reported in Business Standard (July 2017)

• NPPA (February 2017): Notification S.O. 412(E) — ceiling price fixation for coronary stents under DPCO 2013

• Ananth Kumar, Minister of Chemicals and Fertilizers, public confirmation of NPPA's published 654% stent margin data, February 2017 (Deccan Herald)

• NPPA (February 2019): Trade margin rationalisation order on 42 anti-cancer drugs

• Supreme Court of India: Siddharth Dalmia & Anr. v. Union of India, W.P.(C) No. 337 of 2018, decided March 4, 2025

• Parliamentary Standing Committee on Chemicals & Fertilisers (December 2025): "Price Rise of Medicines in the Pharmaceutical Sector..." — PRS Legislative Research summary

• Comptroller and Auditor General of India: Report No. 17 of 2022, Performance Audit of Procurement and Supply of Drugs in CGHS

• Nishith Desai Associates: legal analysis of state-wise Clinical Establishments Act adoption

• Roy Chaudhury et al. (2005): "Quality medicines for the poor," Health Policy and Planning, Vol. 20

• National Cancer Grid pooled procurement pilot, PMC (2023) and Lancet Regional Health — Southeast Asia (2026)

• Tamil Nadu Medical Services Corporation; UPMSC case study, PMC (2025)

• Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP): PIB (March 2026); Observer Research Foundation analysis

• National Health Accounts Estimates for India 2022-23, Ministry of Health and Family Welfare

• IRDAI Annual Report 2024-25

• Aon plc: 2026 Global Medical Trend Rates Report, India findings

• Peer-reviewed study of catastrophic health expenditure in COVID-19 hospitalisations, Kerala, PMC (2022)

• National Medical Commission & Ministry of Health and Family Welfare: doctor workforce data (2024)

• "A Cost Variation Analysis of Drugs... for Management of Thromboembolic Disorders," Cureus/PMC (peer-reviewed)

• "Medicine affordability and access in India: lessons from Jan Aushadhi Scheme," PMC (peer-reviewed)

• IPA India / Pharmarack: Changing Dynamics of Indian Pharma Supply Chain (2024)

• CDSCO / Medical Buyer (June 2026): direct medical device import policy consultation

• Satyamev Jayate, Episode 4 "Every Life is Precious" (May 27, 2012); Aamir Khan testimony before Rajya Sabha Standing Committee on Commerce, June 21, 2012

• Information commission observation on bringing private hospitals within RTI ambit, Business Standard

• RxIntel PriceIQ: live multi-brand pricing tracker, priceiq.rxintel.link

• Montana State Employee Health Plan reference-based pricing analysis, NASHP (2019-2021)

This report represents editorial analysis and policy commentary by RxIntel Research. No specific hospital groups, insurers, or practitioners are named or alleged to have acted unlawfully. Figures presented as illustrative or as informed interpretation are clearly distinguished from sourced, documented findings.

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