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REPORT
MARCH, 2026

Foreword

Ms. Ameera Shah
President, NATHEALTH, (Healthcare Federation of India)
Promoter & Executive Chairperson, Metropolis Healthcare Limited

India's healthcare sector is entering a phase where the conversation must move beyond expanding capacity to ensuring that quality care is financially accessible to all. While significant progress has been made in strengthening clinical capabilities and expanding healthcare services, the sustainability of this progress will depend on how effectively the country builds a financing ecosystem that supports both patients and providers.

For millions of Indian households, access to healthcare is still closely tied to their ability to pay at the time of illness. Strengthening financial protection therefore remains central to improving health outcomes and ensuring that advances in medical science and care delivery translate into meaningful access for the population at large.

Addressing this challenge requires coordinated action across the healthcare ecosystem. Policymakers, insurers, providers, and industry stakeholders must work together to expand financial protection, strengthen coverage, and develop financing models that support prevention, early diagnosis, and continuity of care. At the same time, advancements in digital health infrastructure create new opportunities to enhance transparency, improve operational efficiency, and enable more informed decision-making across the system.

As an industry platform representing diverse stakeholders across healthcare, NATHEALTH has consistently emphasized the need to strengthen the foundations of healthcare financing in India. Sustainable financing mechanisms are essential not only for protecting patients from financial hardship but also for enabling providers to continue investing in technology, innovation, and high-quality care.

In this context, NATHEALTH, in collaboration with Praxis Global Alliance, has developed this report to explore how India can strengthen its healthcare financing architecture and support the next phase of healthcare system development. By bringing together industry insights, global perspectives, and policy considerations, the report aims to contribute to a constructive dialogue on building a more resilient healthcare ecosystem.

I would like to acknowledge the Praxis team for their analytical leadership in developing this study and thank the many industry experts and institutions who contributed their perspectives. We hope this report serves as a useful reference for policymakers and industry leaders working toward a healthcare system that is more inclusive, sustainable, and responsive to the needs of India's population.

Foreword

Aryaman Tandon
Managing Partner & Co-founder
Praxis Global Alliance

Over the past two decades, India has made significant progress in expanding healthcare infrastructure, strengthening local manufacturing capabilities, and enabling greater private sector participation across the healthcare value chain. At the same time, rising incomes, changing disease patterns, and increasing healthcare utilization are placing new demands on the system. As India aspires to become one of the world's largest economies, the healthcare sector must evolve in parallel - expanding not only in capacity, but also in the depth and sophistication of its financing architecture.

Healthcare financing plays a central role in shaping how healthcare systems perform. It determines the extent to which patients can access care without financial hardship, how providers invest in infrastructure and clinical capabilities, and how efficiently resources are allocated. While India has made meaningful progress in expanding insurance coverage, significant opportunities remain to deepen risk pooling, improve efficiency within the insurance ecosystem, and strengthen coordination between payors and providers.

Praxis Global Alliance, in collaboration with NATHEALTH, has undertaken an effort to better understand the evolving landscape of healthcare financing in India. This report draws on industry data, global benchmarks, and structured discussions with stakeholders across the healthcare ecosystem including insurers, healthcare providers, policymakers, and experts. Our objective has been to present a forward-looking view of the opportunities for reform and innovation in healthcare financing.

The analysis highlights both the remarkable progress India has achieved and the structural challenges that remain. India's healthcare ecosystem is supported by strong foundations: expanding hospital infrastructure, a globally competitive pharmaceutical sector, growing digital health capabilities, and increasing policy momentum toward broader insurance coverage. At the same time, the system continues to face fragmentation across financing pools, uneven insurance coverage across population segments, variability in care quality, and infrastructure gaps that will require sustained investment over the coming decade.

Global experience demonstrates that well-designed financing frameworks can act as powerful catalysts for system-wide transformation. Drawing on international case studies and India-specific analysis, the report outlines practical pathways for strengthening healthcare financing in the country, from expanding risk pooling and addressing the "missing middle," to improving insurance efficiency, enabling digital integration, and mobilizing capital for healthcare infrastructure expansion.

As India's healthcare ecosystem grows in scale and complexity, collaboration across stakeholders will be essential. Policymakers, regulators, insurers, providers, investors, and technology innovators each have a role in shaping a healthcare system that is more accessible, efficient, and sustainable. By aligning incentives and strengthening institutional frameworks, India has the opportunity to build a healthcare financing architecture capable of supporting both economic growth and health outcomes.

At Praxis, we are grateful for the partnership with NATHEALTH and the industry leaders who contributed their perspectives and insights to this effort. We hope this report provides a foundation for dialogue and action as India continues its journey toward a more resilient, equitable, and well-financed healthcare system.

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Acknowledgements

NATHEALTH leadership
Ms. Ameera Shah, President NATHEALTH and Promoter & Executive Chairperson, Metropolis Healthcare Ltd.
Dr. Sangita Reddy, President-Elect, NATHEALTH and Joint Managing Director, Apollo Hospitals Group
Mr. Himanshu Baid, Vice President NATHEALTH and Managing Director, Poly Medicure
Mr. Varun Khanna, Secretary, NATHEALTH and Group Managing Director, Quality Care India Ltd.
Mr. Rishubh Gupta, Treasurer, NATHEALTH and Managing Director, Roche Diagnostics India Pvt. Ltd.

Domain experts
Dr. Indu Bhushan, Founder CEO, NHA & Additional Director, NATHEALTH Foundation (Board Member)
Shri C.K. Mishra, Former Health Secretary, Government of India
Dr. Nishant Jain, Human and Social Development Division, Asian Development Bank, South Asia Department
Dr. Nachiket Mor, Banyan Academy of Leadership in Mental Health
Mr. Krishnan Ramachandran, Managing Director (MD) and Chief Executive Officer (CEO) - Niva Bupa Health Insurance
Mr. Amit Chander, Principal Investment Officer, International Finance Corporation
Dr. Girdhar Gyani, Director General at Association of Healthcare Providers of India (AHPI)
Mr. Siddhartha Bhattacharya, Secretary General, NATHEALTH

NATHEALTH Team
Mr. Siddhartha Bhattacharya, Secretary General, NATHEALTH
Ms. Anvesha Pandey, Assistant Secretary General, NATHEALTH
Ms. Vrinda Chaturvedi, Director, NATHEALTH
Mr. Sachin Sharma, Director, NATHEALTH
Ms. Jayaa Siingh, Additional Director – Government Affairs, NATHEALTH
Ms. Jyotsana Saluja, Marketing & Communications Specialist, NATHEALTH
Ms. Shambhavi Yadav, Executive Assistant – Operations Executive, NATHEALTH

Steering group
Dr. Ashutosh Raghuvanshi, Past President NATHEALTH, MD & CEO Fortis Healthcare Ltd.
Dr. Sangita Reddy, President-Elect, NATHEALTH and Joint Managing Director, Apollo Hospitals Group
Mr. Varun Khanna, Secretary, NATHEALTH and Group Managing Director, Quality Care India Ltd.
Mr. Gautam, Council Member-CEO, PD Hinduja Hospital and Medical Research Centre
Dr. Ankit Thakker, Joint Managing Director & CEO, Jupiter Life Line Hospitals Ltd.
Dr. Mradul Kaushik, Governing Council Member, Senior Director Operations and Planning & Chief Operating Officer, Max Healthcare Institute Ltd
Mr. Rishubh Gupta, Treasurer, NATHEALTH and Managing Director, Roche Diagnostics India Pvt. Ltd.

Leadership support
Mr. Yogesh Kumar Sareen, Senior Director - Chief Financial Officer, Max Healthcare
Mr. Anand Apte, Chief Business & Strategy Officer, Jupiter Hospitals
Mr. Sivasis Sen, CFO, Jupiter Hospitals
Mr. Krishnan Akhileswaran, Group CEO, Apollo Hospitals
Mr. Krishna Kumar, Finance Controller, Hospitals Division, Apollo Hospitals
Mr. Mohit Kumar - Senior Vice President - Finance and Accounts, Apollo Hospitals
Ms. Sushmita Bandopadhyay, Vice President – Corporate Communications, Apollo Hospitals
Mr. Vivek Goyal, CFO, Fortis Hospital
Mr. Ashish Arora, Director Finance, Hinduja Hospitals
Mr. Naveen Narayanan, Head of Strategy & New Initiative, Quality Care India

Praxis Team
Mr. Aryaman Tandon (Managing Partner & Co-founder)
Mr. Vishal Bhave (Practitioner Partner, Financial Services)
Ms. Nikita Bansal (Senior Consultant)
Ms. Medhavi Nema (Consultant)

Glossary of terms

Acronym	Description
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
AB-HWCs	Ayushman Bharat Health and Wellness Centres
AEMT	Adverse Effects of Medical Treatment
ALOS	Average Length of Stay
ARPOB	Average Revenue Per Occupied Bed
CABG	Coronary Artery Bypass Graft
CBD	Common Bile Duct
CD	Communicable Diseases
CHE	Current Health Expenditure
CHC	Community Health Centre
CPI	Consumer Price Index
CPF	Central Provident Fund
CVD	Cardiovascular Diseases
DALY	Disability-Adjusted Life Years
DRG	Diagnosis-Related Group
EHR	Electronic Health Records
EPA	Electronic Health Card
ESIS	Employees' State Insurance Scheme
FFS	Fee-for-Service
FHS	Family Health Strategy
FTAs	Foreign Tourist Arrivals
GH	Government Hospitals
GI	General Insurer
GIPSA	General Insurance Public Sector Association
HAQ Index	Healthcare Access and Quality Index
HCA Healthcare	Hospital Corporation of America
HFR	Health Facility Registry
HIE	Health Information Exchange
HMO	Health Maintenance Organization
HPR	Healthcare Professionals Registry

Glossary of terms

Acronym	Description
HTA	Health Technology Assessment
IEC	Information, Education and Communication
IABP	Intra-Aortic Balloon Pump
MLR	Medical Loss Ratio
MSH	Multi-Specialty Hospital
MTI	Medical Tourism Index
NCD	Non-Communicable Diseases
NIK	National Identity Number
OECD	Organisation for Economic Co-operation and Development
OOPE	Out-of-Pocket Expenditure
PHC	Primary Health Centre
PHI	Private Health Insurance
PLI	Production Linked Incentive
PMJAY	Pradhan Mantri Jan Arogya Yojana
PTCA	Percutaneous Transluminal Coronary Angioplasty
PPP	Purchasing Power Parity
PROMs	Patient-Reported Outcome Measures
PVHI	Private Voluntary Health Insurance
SAHI	Standalone Health Insurance Companies
SHI	Statutory Health Insurance
SUS	Sistema Único de Saúde (Brazil Unified Health System)
TPA	Third-Party Administrator
UEBMI	Urban Employee Basic Medical Insurance
UHC	Universal Health Coverage
UPI	Unique Patient Identifier
URRBMI	Urban-Rural Resident Basic Medical Insurance
VHI	Voluntary Health Insurance

Executive summary

India's healthcare system is entering a phase of rapid expansion and structural transformation. With the current domestic healthcare ecosystem already totalling **~US$300 billion,** the sector today represents a major economic opportunity spanning healthcare delivery, pharmaceuticals, diagnostics, medical devices, insurance, and emerging digital health platforms. As India's economy continues to expand and is projected to become the **world's third-largest economy by 2030,** healthcare is expected to play an increasingly important role in supporting economic growth, employment generation, and social development.

At current growth trajectories, India's healthcare ecosystem is expected to expand to **~US$700 billion by 2030**, driven by rising healthcare demand, expansion of hospital infrastructure, growing healthcare need, rising income levels, and increasing adoption of health insurance. However, if structural challenges across financing, infrastructure, fragmentation, investments, and quality are addressed, the ecosystem could scale significantly further to become a **US$1 trillion opportunity by 2030,** generating millions of jobs while improving access and health outcomes across the population.

India already has several structural advantages that position it well to achieve this transformation. It will be critical to tap the opportunity created by these tailwinds to reach full potential.

First, strong macroeconomic momentum is increasing the country's ability to invest in healthcare. Over the past decade, **GNI per capita has grown at ~8%** annually, enabling greater household spending on healthcare services and insurance while accelerating the shift toward organized hospitals, diagnostic networks, and formal healthcare providers.

Second, healthcare demand is expanding rapidly due to India's evolving epidemiological profile. **Non-communicable diseases are projected to account for nearly 75% of deaths by 2030,** while chronic conditions such as hypertension have increased from **~89 million cases in 2001 to more than 220 million in 2021.** At the same time, India's elderly population **(65+ years)** has already crossed **104 million,** increasing both the scale and complexity of healthcare demand.

Third, policy momentum and digital infrastructure are strengthening the foundations of the healthcare ecosystem. **Ayushman Bharat – PMJAY now covers over 550 million beneficiaries and has empanelled more than 30,000 hospitals,** while **PLI schemes for pharmaceuticals and medical devices (with over US$1.7 billion in outlays)** are strengthening domestic healthcare manufacturing. In parallel, the **Ayushman Bharat Digital Mission (ABDM)** is building the country's digital health backbone, with **over 853 million ABHA health IDs created and more than 900 million health records linked.**

Fourth, the country has demonstrated the ability to deliver high-quality clinical outcomes at globally competitive costs. Healthcare services in India are typically **40–50% cheaper than comparable markets and more than 1/5th cheaper than other developed markets,** positioning the country as a major destination for medical value travel. International patient inflows have grown at ~**40% CAGR between 2020 and 2024,** supported by India's strong competitiveness **(ranked 3rd globally on cost of services, 6th on quality, and 10th overall on the Medical Tourism Index).**

Despite these strong tailwinds, several structural challenges continue to constrain the scale and efficiency of India's healthcare system. It will be paramount to address these headwinds in order to truly develop the world's third largest healthcare ecosystem by 2030.

First, healthcare remains highly fragmented. Of the **~55,000 hospitals in India, more than 80% operate as standalone facilities,** limiting scale efficiencies and coordinated care delivery. The regulatory environment along with financing pools, and patient demand is also extremely fragmented. **Overall, fragmented care has led to a significant inefficiency, patient pain, and unnecessary costs.**

Second, insurance coverage and pooled financing remain limited relative to healthcare demand. While headline figures suggest broader coverage through public schemes, pure **insurance coverage remains closer to ~20% of the population,** leaving a large segment of households reliant on out-of-pocket spending or government schemes.

Third, healthcare quality and standardization remain largely uneven. Only **~6% of hospitals in India are accredited,** compared with **over 70% accreditation coverage in many global health systems,** limiting consistent quality oversight and outcome transparency.

Fourth, infrastructure and workforce capacity remain below global benchmarks. India currently has **~1.6 hospital beds per 1,000 population,** alongside shortages in clinical manpower. Bridging these gaps may require **1.3-2.8 million additional hospital beds, roughly 1 million more doctors, and ~3.5 million additional nurses by 2030.**

Taken together, these tailwinds and constraints highlight both the scale of the opportunity and the urgency of reform. Unlocking the ecosystem's **US$1 trillion potential by 2030** will require coordinated action to strengthen financing mechanisms, expand infrastructure capacity, deepen insurance penetration, and improve system integration across the healthcare ecosystem.

However, realizing this potential will depend heavily on the strength of India's healthcare financing architecture. Healthcare financing determines how effectively health systems expand access, sustain provider capacity, and protect households from financial risk. While India's healthcare delivery ecosystem has expanded significantly over the past two decades, the depth of financing mechanisms supporting it remains relatively limited compared with the scale of the country's healthcare needs. India carries **nearly 20% of the global disease burden but represents only 1% of global healthcare expenditure,** highlighting a structural imbalance between healthcare demand and pooled financing capacity.

Strengthening health financing therefore represents one of the most powerful levers for transforming India's healthcare system. Financing mechanisms influence not only how healthcare services are paid for, but also how providers invest in infrastructure, how efficiently care is delivered, and how equitably patients can access treatment. Viewed through a system-wide lens, health financing can catalyse transformation across **critical dimensions of the healthcare ecosystem: access and availability, operational efficiency, long-term sustainability, quality of care, and digital enablement.**

First, improving access and availability requires deeper risk pooling and broader insurance participation. Although insurance coverage has expanded through government schemes and employer-sponsored programs, **insurance coverage remains low,** leaving a large share of households dependent on direct payments for healthcare services. As a result, **out-of-pocket expenditure still accounts for ~44% of total health spending,** significantly higher than in most mature healthcare systems. **Majority of the global comparable markets have universal coverage through a mandated health insurance policy,** which is currently missing in India, creating adverse selection and a smaller pooling population. Insurance coverage also remains concentrated in hospitalization benefits, while outpatient consultations, diagnostics, and chronic disease management, which account for a substantial share of healthcare expenditure, remain largely outside formal financing pools.

Second, strengthening efficiency within the insurance ecosystem is essential to ensure that financial resources translate effectively into healthcare services. Health insurance premium collections have grown rapidly in recent years, expanding at approximately **~19% CAGR between FY21 and FY25.** However, differences in risk pool structures across insurance segments create variations in claims realization and benefit delivery. Larger risk pools such as government schemes and employer-sponsored group insurance typically demonstrate higher claims payout ratios, while retail insurance products often operate with smaller and more fragmented risk pools and higher distribution costs, affecting how efficiently premiums translate into patient care. The patient underwriting journey is currently in need of greater efficiency and efficacy.

Third, sustainability of healthcare delivery requires stronger and deeper financing pools. Healthcare infrastructure expansion, advanced medical technologies, and workforce development require sustained capital investment. Yet healthcare financing depth remains limited, with **healthcare financing spend per capita** significantly lower than in both emerging and developed markets. Limited pooled spending constrains the ability of providers to expand infrastructure capacity and invest in advanced clinical capabilities as healthcare demand continues to rise. Healthcare today is not given a priority investment status, and to meet the growing demand, **the segment will need US$ 200B of capital investment over the next decade.**

Fourth, quality of care must increasingly be integrated into financing frameworks. Patient demand is gradually concentrating in providers with stronger clinical capabilities, yet reimbursement structures across payors often do not adequately differentiate between hospitals based on outcomes or quality standards. Limited outcome reporting and inconsistent accreditation frameworks further constrain the ability of financing systems to systematically incentivize quality improvements across providers and be able to create the right comparisons of quality. Moreover, the **patient journey is cumbersome and painful,** with long wait times and complex processes, not comfortable for the common man.

Finally, digital integration will play a critical enabling role in improving the efficiency and transparency of healthcare financing. Today, fragmented data systems and limited interoperability between providers, insurers, and claims administrators create friction across underwriting, pre-authorisation, and claims processing. Strengthening digital infrastructure and enabling interoperable health records can improve risk assessment, accelerate claims settlement, enhance fraud detection, and enable more transparent and data-driven healthcare financing systems.

Taken together, these structural gaps across **access, efficiency, sustainability, quality, and digital integration** highlight why health financing must evolve alongside healthcare delivery. Strengthening financing mechanisms will be essential to unlock India's healthcare potential, enabling broader coverage, more efficient care delivery, and sustained investment in infrastructure and clinical capacity.

Global experience provides important lessons on how healthcare financing systems can evolve to expand coverage, improve efficiency, and maintain sustainability. Several countries have successfully addressed challenges similar to those faced by India through targeted policy reforms, stronger risk pooling mechanisms, and better integration between insurers and healthcare providers.

Countries such as **Germany and Israel** demonstrate how structured insurance systems can deliver universal or near-universal coverage while maintaining efficiency. Germany's dual insurance model combines mandatory statutory insurance with private insurance options under a standardized reimbursement framework, ensuring broad coverage while allowing supplementary private participation. Israel's system illustrates how regulated competition among non-profit insurers with standardized benefit packages and risk-adjusted payments can improve efficiency while maintaining universal access and strong health outcomes.

Emerging markets such as **China, Brazil, and the Philippines** highlight additional pathways for expanding coverage. China achieved near-universal insurance coverage through strong public financing and large-scale risk pools, while Brazil demonstrates the role of tax-funded universal healthcare combined with private insurance options. The Philippines illustrates how automatic enrolment and subsidized coverage can expand financial protection for informal sector workers and lower-income populations.

At the same time, international experience also offers cautionary lessons. Highly evolved and market-driven systems of some developed markets (e.g., USA) also illustrate the risks of weak cost control mechanisms, where healthcare spending has grown significantly without proportional improvements in population health outcomes, where out of pocket healthcare benefits have become almost unaffordable for anyone. As we create the path for our future insurance and financing structure, we must learn both from success stories and risks from other market models.

For India, the key lesson is that **strong risk pooling with universal coverage, quality aligned provider incentives, and robust digital infrastructure** are essential to building a financing system that expands access while maintaining affordability and sustainability.

Looking ahead, India has the opportunity to build a **patient-centric, digitally enabled healthcare ecosystem** that aligns incentives across regulators, payors, and providers. Realizing this vision will require **coordinated reforms across policy, financing, and care delivery,** supported by stronger risk pooling, outcome-linked reimbursement, and interoperable digital infrastructure. India's transformation will depend on a combination of **immediate operational improvements and near-term structural reforms** that strengthen the foundations of health financing while improving how healthcare is accessed, delivered, and financed across the ecosystem.

Immediate priorities (1–2 years) should focus on improving the functioning of existing healthcare financing mechanisms and reducing operational frictions across the payer–provider ecosystem:

- **Accelerate ABDM-driven digital integration** through a time-bound adoption plan to enable near-universal cashless utilization and strengthen interoperability between insurers and providers.
- **Expand insurance coverage beyond hospitalization,** beginning with high-value areas such as primary care, diagnostics, advanced drugs, robotic surgery, and chronic disease management, better reflecting real patterns of healthcare utilization.
- **Strengthen clinical oversight in claims and admissions review,** ensuring that appropriately licensed and experienced medical professionals support insurer decision-making.
- **Improve transparency in public and private hospital outcomes** by publishing independently validated performance indicators and benchmarking provider quality, along with publishing of costs of public hospitals
- **Strengthen consumer awareness and grievance redressal systems**, including nationwide information and education initiatives that improve trust and insurance uptake.
- **Simplify healthcare licensing and practitioner mobility,** enabling single-window regulatory mechanisms that accelerate infrastructure expansion and workforce availability.

Near-term reforms (3–5 years) should strengthen the structural foundations of healthcare financing and system sustainability:

- **Expand risk pooling through broader insurance participation,** including mechanisms to cover the "missing middle" population that currently remains uninsured or underinsured through either mandated or near mandated incentivized health insurance system
- **Establish a national health-risk fund** to support financing for vulnerable populations, including senior citizens and individuals with chronic diseases.
- **Introduce stronger pricing discipline and financial sustainability mechanisms,** including minimum medical loss ratio thresholds and measures to curb excessive premium growth.
- **Link hospital accreditation with payer empanelment and reimbursement frameworks,** creating incentives for improved quality and standardized care delivery.
- **Strengthen Centre–State coordination** to ensure consistent implementation of national reforms while enabling state-level innovation.
- **Provide priority-sector lending status for healthcare infrastructure and services,** expanding access to affordable capital for hospitals and healthcare providers.

Taken together, these reforms can enable the emergence of a **more integrated, patient-centric healthcare ecosystem,** where regulators, payors, and providers operate in alignment to expand financial protection, improve care quality, and sustainably scale India's healthcare system. While these reforms are not exhaustive in terms of needs for improvement and bringing efficiency in the health financing ecosystem, they represent a **careful and critical selection of recommendations validated through industry discussions, global benchmarks, and a fact-based assessment of current needs of patients, insurers, and providers.** These reforms will help health insurance become more effective and efficient, while near eliminating out of pocket healthcare expenditure in India which current stands at ~44%. This will prevent the large scale of population from moving into poverty each year from adverse health spends. Overall, it will also provide a **foundational backbone for the healthcare ecosystem to be a world class, highly efficient and "value-based care" focused infrastructure.** We hope all the key stakeholders in this – providers, payors, and other healthcare providers will embark on this journey as they represent a win-win set of initiatives for all participants in the ecosystem, and above all, **they create the required infrastructure for the growing needs of patients in a "patient first" objective.**

01

INDIA HEALTHCARE: **A $1T OPPORTUNITY IN 2030**

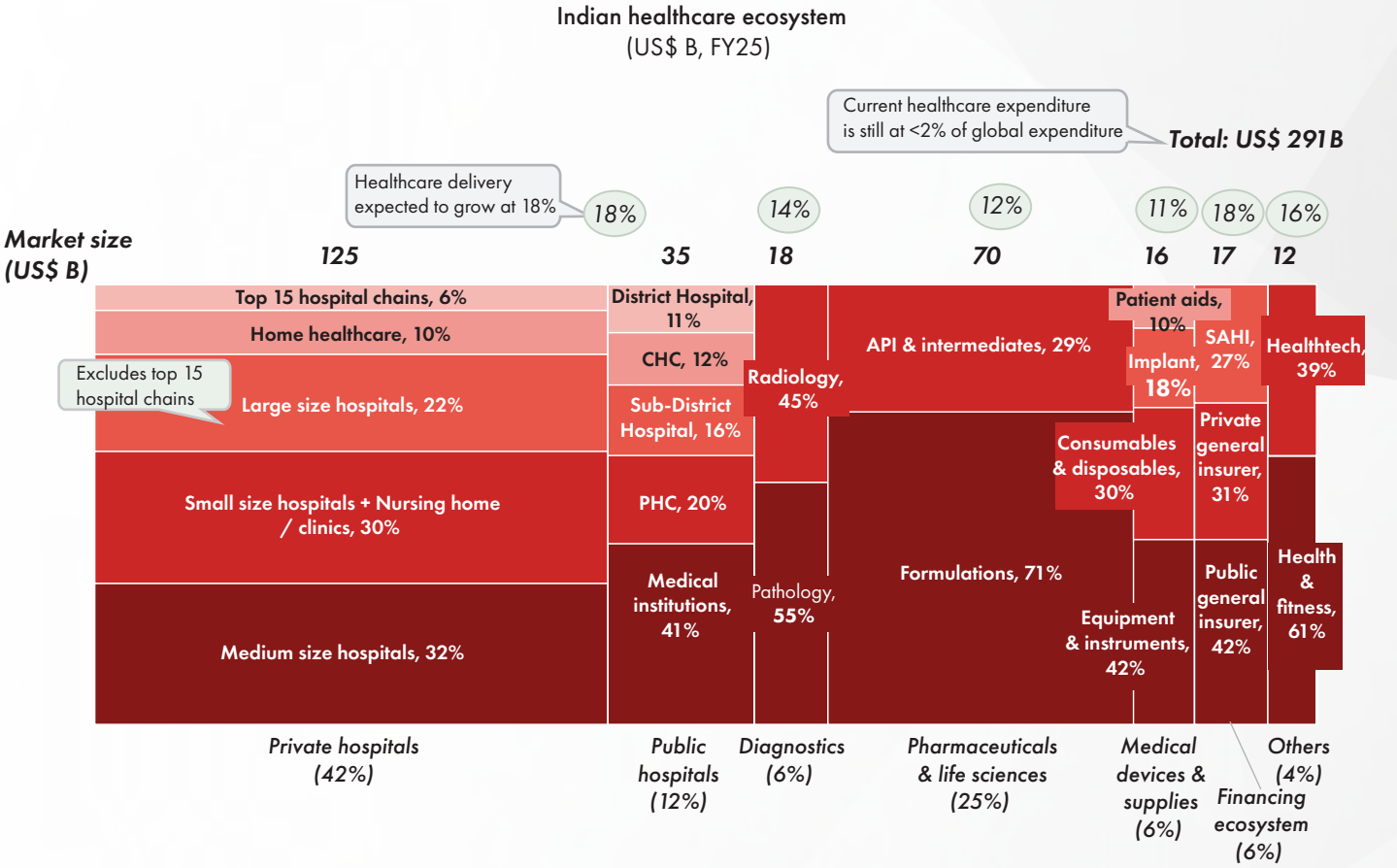
1 INDIA HEALTHCARE: A US$ 1T OPPORTUNITY IN 2030

India's healthcare system is at a structural inflection point. Over the past two decades, the country has expanded hospital networks, strengthened local manufacturing, increased medical education capacity, and enabled private sector participation across the value chain. With a healthcare ecosystem approaching US$300 billion (Exhibit 1.A) in size, healthcare today is not a peripheral social service - it is a major economic sector with deep linkages to employment, manufacturing, services, and technology.

India's healthcare ecosystem is already substantial in scale, with diversified components spanning healthcare delivery, pharmaceuticals, medical devices, diagnostics, financing, and emerging digital health platforms. This ecosystem operates through a complex network of public institutions, private providers, insurers, and technology platforms that together shape how healthcare services are financed and delivered.

Exhibit 1.A

Segment-wise composition of the Indian healthcare ecosystem



% private play	100%	0%	93%	100%	100%	58%	100%	~60%

Hospital type	Small + NH	Medium	Large	Large chains
Bed size	<100	100-300	>300	Top 15

xx% Growth CAGR FY25-30P

% private play in overall healthcare in ~60%

Note(s): Small hospitals and nursing homes have less than 100 beds, medium hospitals have 100-300 beds, large hospitals have 300+ beds; SAHI: Standalone Health Insurers focus solely on health insurance products – Aditya Birla Health Insurance, Care Health Insurance, Manipal Cigna Health Insurance, Niva Bupa Health Insurance, Star Health and Allied Insurance; US$ 1 = INR 82; The market for Health-tech includes telemedicine, personal health management products & services, remote diagnostic devices and healthcare IT; The market for Health & fitness includes both the fitness trackers and health & wellness coaching segments
Source(s): Govt. websites, HMIS, MoHFW, CareEdge, WHO, Secondary research, Praxis analysis

While this structure has enabled rapid expansion of healthcare capacity and innovation across multiple segments, it also underscores the importance of robust financing mechanisms, regulatory coordination, and quality oversight to ensure that system growth translates into equitable access and sustainable long-term development.

Beyond scale, India has also built a highly resilient healthcare value chain over the past two decades. Strategic investments in domestic pharmaceutical and medical devices manufacturing have strengthened supply chain security and reduced dependence on imports for critical medicines. At the same time, expansion of medical education capacity has steadily increased the availability of trained healthcare professionals, while digital health initiatives have begun creating the infrastructure needed for more integrated and data-driven healthcare delivery. Together, these developments have enabled India to deliver large volumes of healthcare services at relatively low cost, reinforcing the country's reputation as one of the world's most cost-efficient healthcare systems.

Exhibit 1.B

Key pillars supporting the rapid expansion of India's healthcare ecosystem

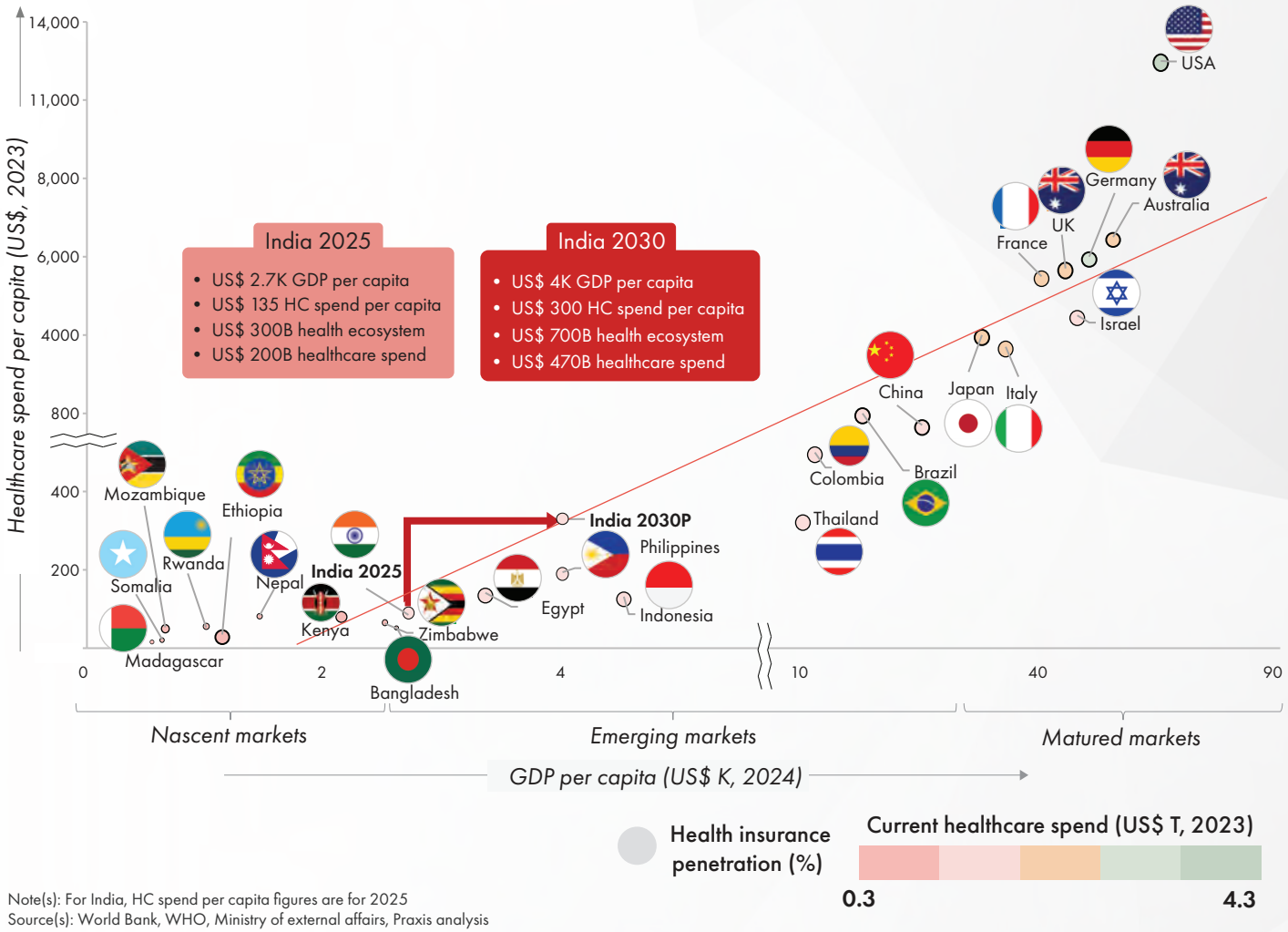
Infrastructure	Regulations & Govt. Initiatives	Pharma	Devices & Consumables (MedTech)	Innovation
30K+ *Hospitals empaneled under PM-JAY*	550 M *Beneficiaries covered under PM-JAY*	3rd *Ranked in global pharma volume / exports*	US$ 50B *Size of the medical devices sector by FY31*	US$ 50B *Size of health tech sector by FY33*
800+ *Medical colleges in India*	US$ 16B *Reimbursements authorized under PM-JAY*	US$ 25B *FDI inflows for drugs & pharmaceuticals*	4 *Approved medical device parks*	4K+ *Health tech startups*
130K+ *Diagnostic laboratories*	22 *New AIIMS approved*	US$ 600M *Fund for innovation in MedTech and Pharma (FY23-28)*	1K+ *Medical device companies in India*	US$ 9B+ *Funding in health-tech in last 10 years*
7.5M *Professionals supporting care delivery*	853 M *ABHA digital health IDs created*	US$ 30B *Pharma exports annually*	21+ *Manufacturing projects producing high-end medical devices*	5+ *Health tech startups became unicorns*
1.4M *Registered allopathic doctors*		US$ 1.8B *PLI Scheme incentivizing domestic manufacturing*		
75K *Domestically trained doctors working abroad*	• *Government is **incentivizing local manufacturing** through policies like Make in India*	• ***Operationalization of pharma MoUs** under PLI Bulk Drug Scheme are driving new API and **formulation capacity***	• ***Medical Devices PLI is offering ~5% incentives** to localize high-end device manufacturing*	• ***Growing ecosystem of ABHA-integrated startups** (e.g., Eka Care, Driefcase) are enabling digital health records and **interoperable healthcare platforms** under ABDM*
US$ 20B *PE investment in hospitals in last 10 years*	• *ABDM's QR based technology (scan & share) has **reduced OPD registration time** from **30-45 minutes** to **5-10 minutes***			

Source(s): Ministry of Chemicals & Fertilizers – National Medical Devices Policy, Ministry of Health and Family Welfare, IBEF, Press releases, Secondary research, Praxis analysis

Strategic investments in scale, localization, and technology have played an important role in strengthening India's healthcare ecosystem. Domestic pharmaceutical manufacturing has reduced dependence on imports, healthcare infrastructure has expanded across major cities, and digital platforms have increasingly begun connecting patients, providers, and insurers (Exhibit 1.B). Together, these developments have enabled the healthcare system to deliver large volumes of care while maintaining relatively low costs. These structural foundations position the healthcare sector for continued expansion.

Exhibit 1.C

Cross-country comparison of healthcare spending relative to income



Note(s): For India, HC spend per capita figures are for 2025
Source(s): World Bank, WHO, Ministry of external affairs, Praxis analysis

At current growth trajectories, India's healthcare ecosystem could expand to approximately US$700 billion by 2030. This growth will be driven by increased healthcare consumption, expansion of hospital infrastructure, rising healthcare demand, and broader adoption of health insurance.

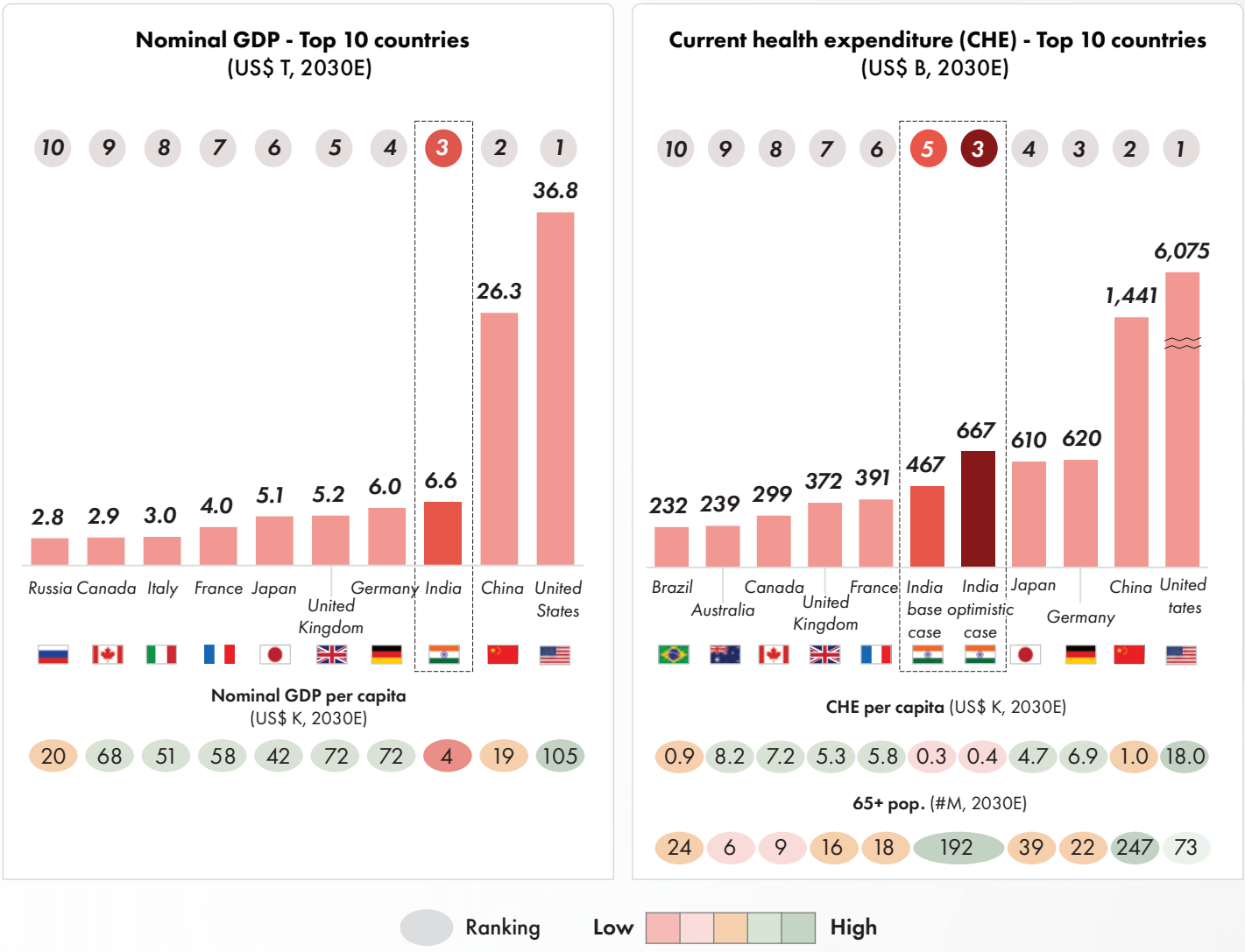
The comparative analysis in Exhibit 1.C highlights the strong relationship between national income levels and healthcare spending across countries. As economies grow, healthcare expenditure per capita typically rises in tandem, reflecting both increased public investment and greater private insurance coverage. While India currently sits within the emerging markets cluster with relatively low healthcare spending per capita (about US$130 in 2025), its projected economic growth suggests a trajectory toward the higher end of emerging markets range by 2030. However, peer economies at similar or slightly higher GDP levels, such as China, Brazil, and Thailand, already demonstrate significantly higher healthcare spending per capita, supported by broader insurance coverage and stronger pooled financing mechanisms.

As India's GDP per capita increases by 2030, healthcare financing will need to expand in parallel through greater insurance coverage, public program funding, and institutional investment. Without a corresponding rise in pooled spending, the healthcare system risks facing mounting financing pressures driven by demographic shifts and the growing burden of chronic disease.

In line with India's broader macroeconomic ambition of becoming the world's third-largest economy, the healthcare system will need to evolve proportionally in scale, financing depth, and institutional capacity.

Exhibit 1.D

Cross-country comparison of GDP size and healthcare expenditure



Note(s): 2030E- 2030 estimated
Source(s): IMF WEO, IHME, Praxis analysis

India is expected to emerge as one of the world's largest economies over the coming decade, with projections indicating that the country could become the third-largest economy globally by 2030 (Exhibit 1.D). However, healthcare spending remains relatively modest compared to other large economies, both in absolute terms and on a per-capita basis. This gap highlights the substantial headroom for expansion in healthcare spending as income levels rise and healthcare demand continues to grow. In line with India's broader economic trajectory, healthcare should also emerge as the world's third-largest ecosystem by 2030, reflecting the sector's underlying opportunity and potential, something that is not yet fully captured in its current scale and growth. As India becomes the world's third-largest economy, healthcare being a US$1T opportunity is both necessary and achievable.

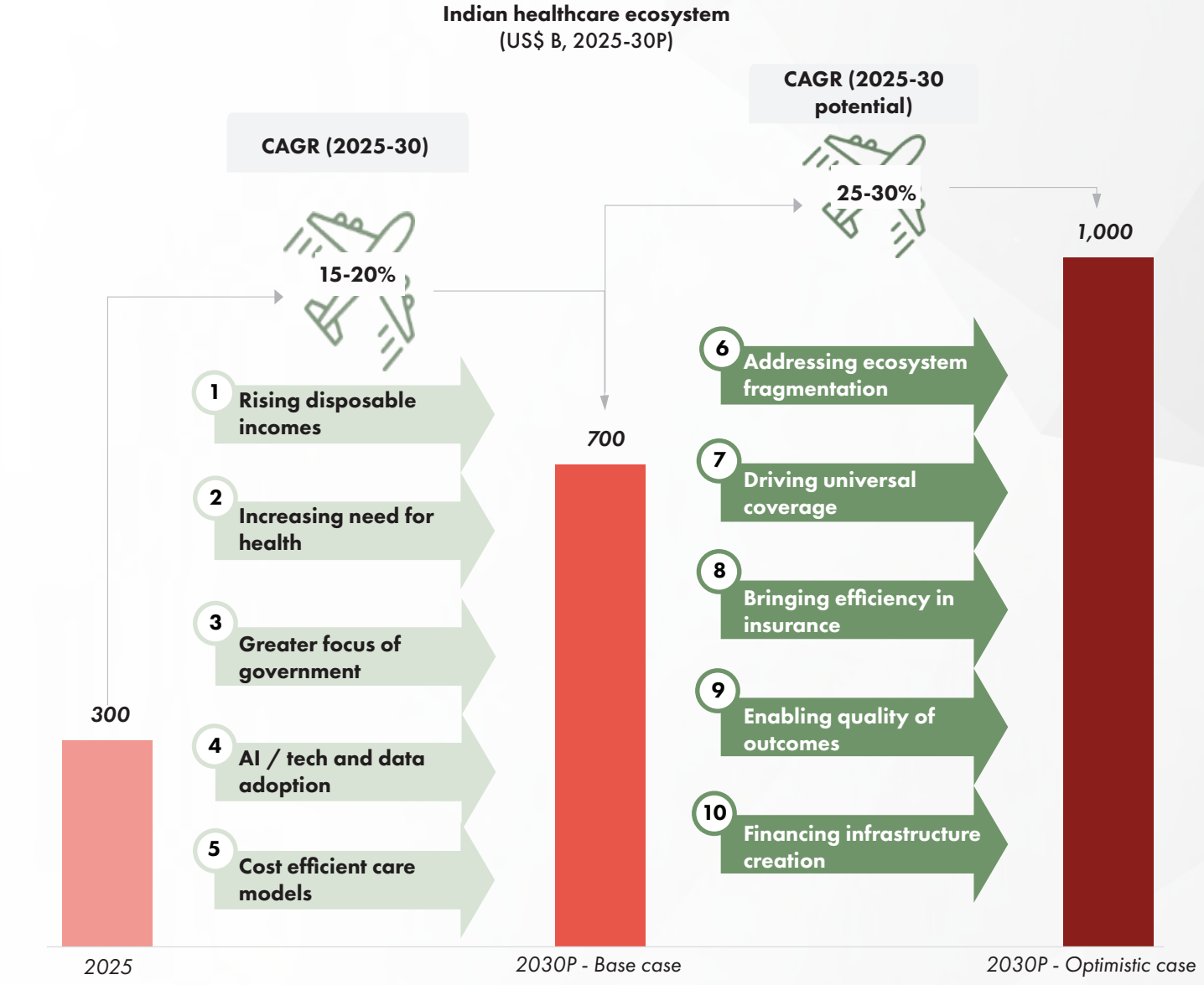
Closing this gap will require India to progressively increase healthcare spending and strengthen financing mechanisms to ensure that healthcare capacity expands in line with economic growth and rising healthcare demand.

1.1. INDIA'S STARTING ADVANTAGE

India's healthcare system enters the next phase of expansion with several structural advantages. Unlike earlier decades where healthcare growth was largely supply-driven and episodic, the coming decade is likely to be shaped by a combination of macroeconomic momentum, rising healthcare demand, policy support, digital transformation, and proven cost-efficient care models. Together, these factors create a strong foundation for expanding both the scale and resilience of India's healthcare ecosystem.

Exhibit 1.E

Tailwinds and headwinds influencing the expansion of India's healthcare ecosystem



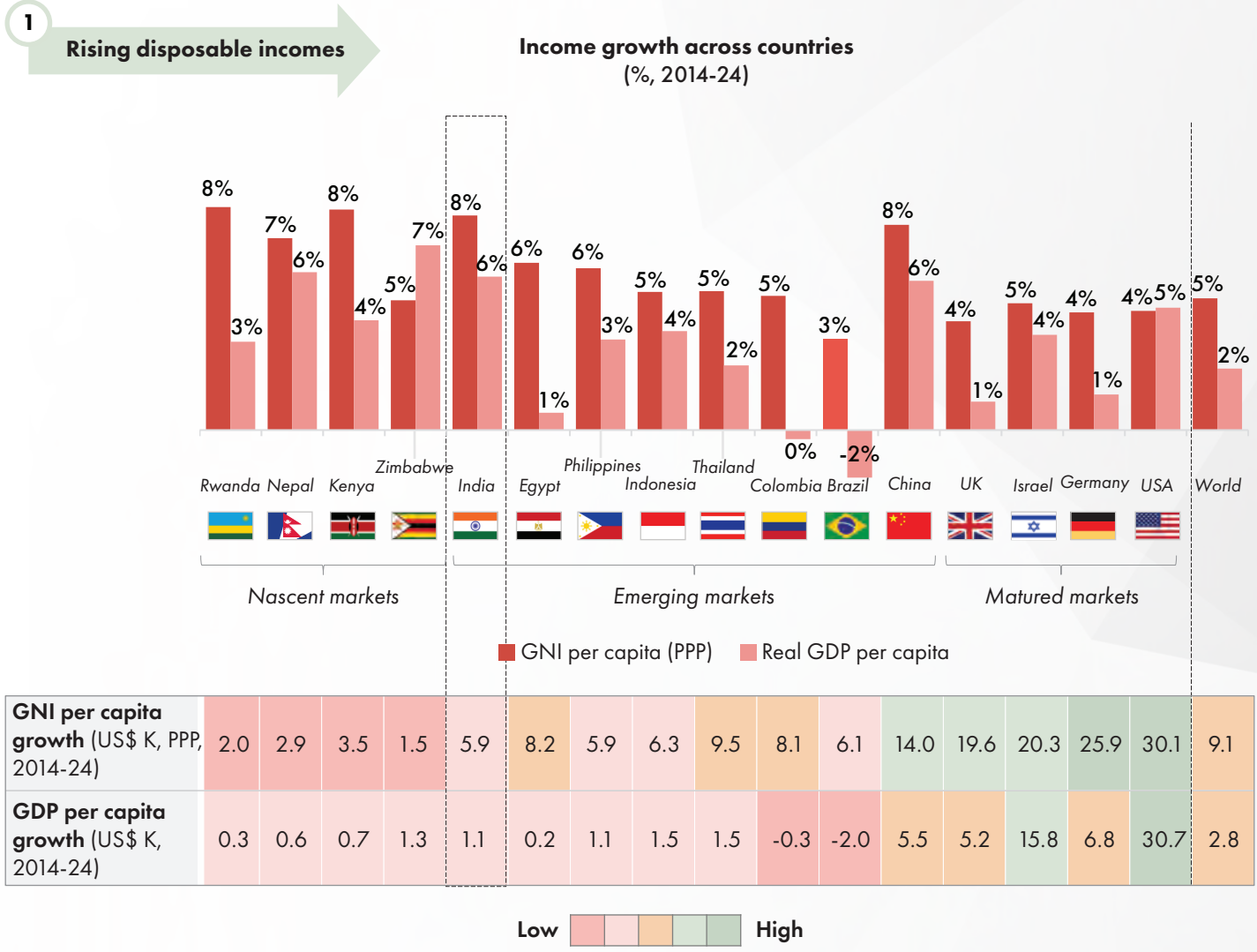
Note(s): 2030P- 2030 projected
Source(s): Secondary analysis, Praxis analysis

India's next phase of healthcare development will be shaped by a combination of strong growth drivers and persistent structural constraints. Powerful tailwinds, including economic growth, expanding healthcare demand, supportive policy momentum, increasing digital adoption, and globally competitive cost structures, are expected to drive the healthcare ecosystem toward a market size of roughly US$700 billion by 2030. At the same time, structural challenges such as fragmented delivery networks, uneven quality standards, shallow risk pooling, and infrastructure gaps continue to constrict system performance and scale. (Exhibit 1.E)

Addressing these structural headwinds could unlock significantly greater potential. With stronger financing mechanisms, a more integrated healthcare ecosystem, consistency in quality of outcomes, and sustained investments in infrastructure, India's healthcare market could approach US$1 trillion by 2030, reflecting deeper insurance coverage, expanded infrastructure capacity, and more efficient coordination across stakeholders. Achieving this scale will require greater insurance coverage, improved healthcare infrastructure, deeper risk pooling, and stronger integration across the healthcare value chain.

Exhibit 1.F

Cross-country comparison of income growth across nascent, emerging, and mature markets (2014–2024)



	Rwanda	Nepal	Kenya	Zimbabwe	India	Egypt	Philippines	Indonesia	Thailand	Colombia	Brazil	China	UK	Israel	Germany	USA	World
GNI per capita growth (US$ K, PPP, 2014-24)	2.0	2.9	3.5	1.5	5.9	8.2	5.9	6.3	9.5	8.1	6.1	14.0	19.6	20.3	25.9	30.1	9.1
GDP per capita growth (US$ K, 2014-24)	0.3	0.6	0.7	1.3	1.1	0.2	1.1	1.5	1.5	-0.3	-2.0	5.5	5.2	15.8	6.8	30.7	2.8

Low — High

Source(s): World Bank, Praxis analysis

Over the past decade, India has consistently remained among the fastest growing large economies, with gross national income (GNI) per capita growing at ~8% annually (Exhibit 1.F). This sustained income expansion has significantly increased household purchasing power, enabling a larger share of the population to spend on healthcare services and financial protection mechanisms. For the healthcare sector, this creates an important opportunity: the economic capacity for pre-paid and pooled healthcare financing is increasingly emerging at scale, supporting the growth of health insurance and organized healthcare services.

Rising incomes are also contributing to the formalization of healthcare consumption, as households shift from informal providers toward accredited hospitals and organized diagnostic networks. This transition improves care quality, standardization, and data capture, elements that are essential for actuarial pricing and outcome-based reimbursement. Higher-income cohorts are also more likely to utilize preventive and chronic care services such as diagnostics, wellness programs, and elective procedures, creating opportunities to expand outpatient coverage models and bundled care offerings.

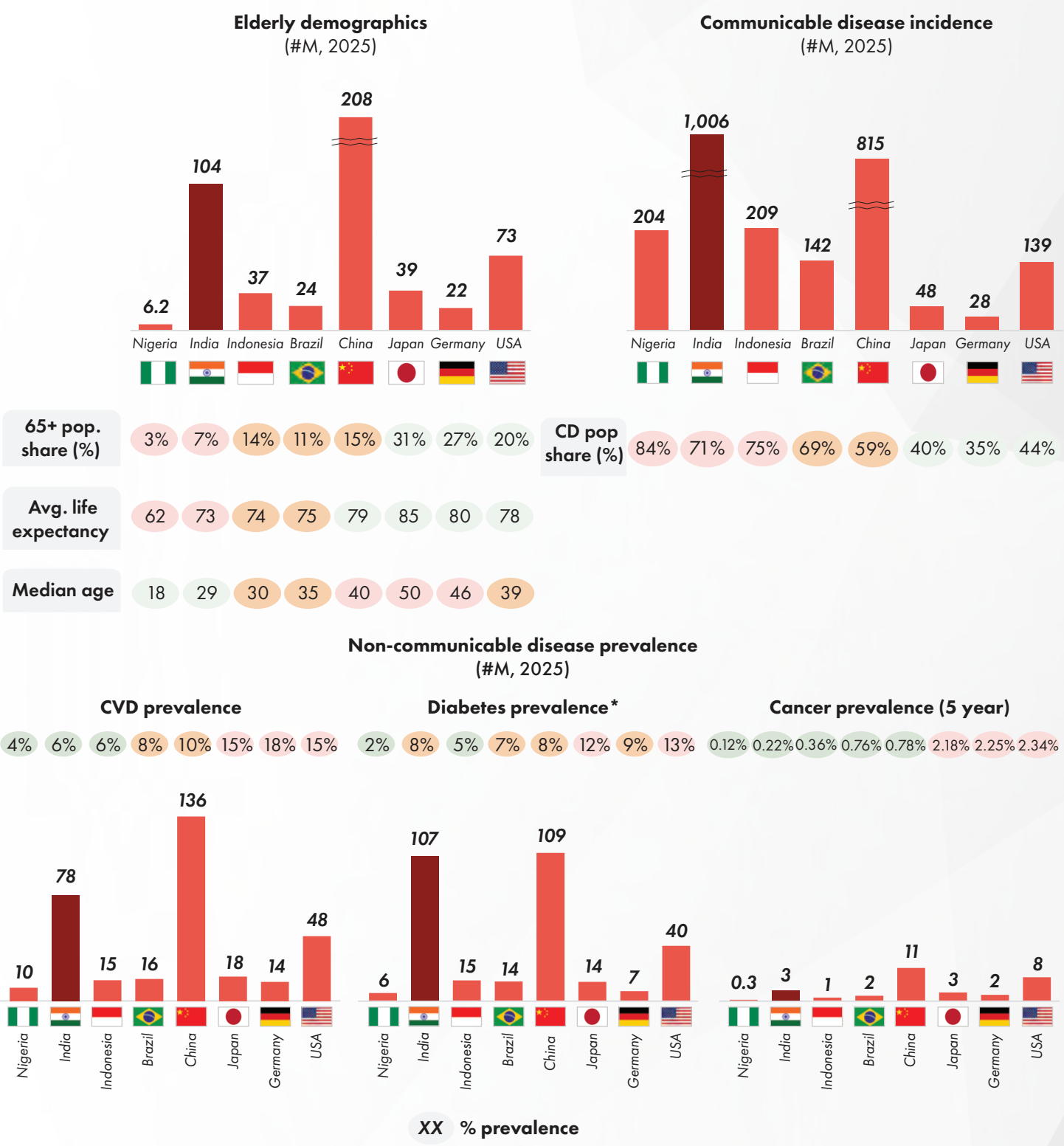
Ensuring that income growth translates into greater insurance coverage will be critical. Without stronger risk pooling, rising healthcare demand will continue to be financed largely through out-of-pocket spending. Converting economic growth into structured healthcare financing will therefore be essential for improving financial protection and strengthening the long-term stability of the healthcare system.

In parallel, India's healthcare demand is expanding due to the scale of its population and the evolving nature of disease burden.

Exhibit 1.G

Cross-country comparison of aging population and disease prevalence (communicable and non-communicable)

2 **Increasing need for health**



Note(s): NCD- non-communicable disease, CD- communicable disease, CVD- cardiovascular diseases; * Diabetes prevalence is a total of detected and undetected cases
Source(s): Global burden of disease, Globocan 2022, UNFPA, Praxis analysis

India's disease burden is both vast and evolving. Non-communicable diseases (NCDs) now account for the majority of mortality and morbidity, with conditions such as cardiovascular disease, diabetes, cancer, and chronic kidney disease rising rapidly. At the same time, India's elderly population is growing, with over 104 million people aged 65+ and expected to increase further significantly (Exhibit 1.G). Although India remains demographically younger than many developed economies, the scale of its ageing population, combined with the growing prevalence of chronic diseases, will significantly increase the complexity and volume of healthcare demand.

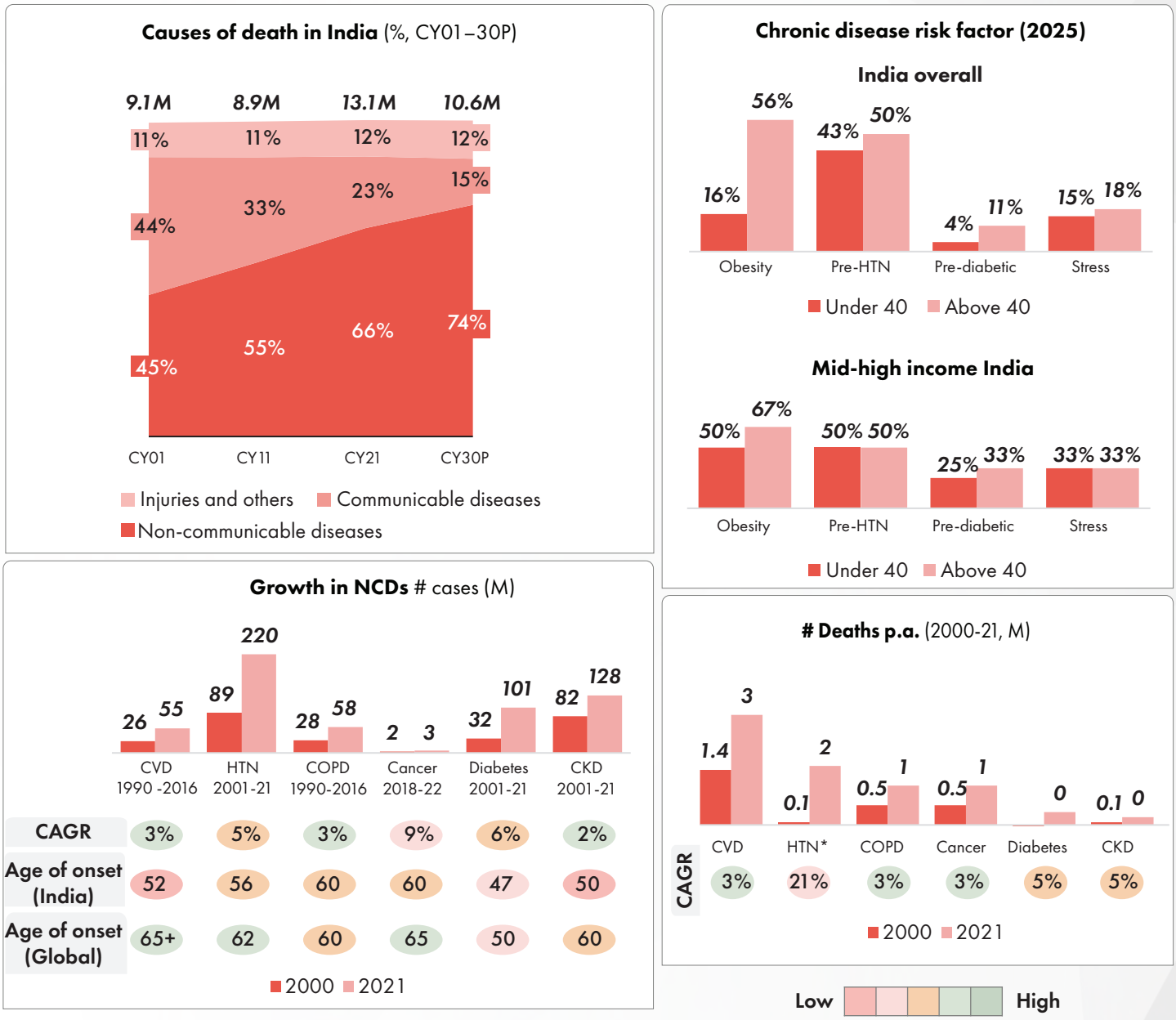
This shift has important implications for healthcare delivery and financing. Chronic diseases require long-term, continuous care rather than episodic hospitalization, creating a mismatch with largely inpatient-focused models. Effective management depends on early screening, outpatient care, and sustained treatment pathways.

At the same time, communicable diseases still affect a large share of the population in India (~70%), creating a dual challenge for the healthcare system. Without stronger preventive care and better risk pooling mechanisms, healthcare demand and financial pressures are likely to rise further in the coming decades.

Exhibit 1.H

Trends in causes of death, growth in NCD cases, and chronic disease risk factors in India

2 **Increasing need for health**



Note(s): *Recent data available for 2016
Source(s): Global Disease Burden Report 2021, National Family Health Survey-2021, WHO 2002-2025, WHO x GloboCan 2022 ICMR-INDIAB study, Health of Nation 2024, 2023, NFHS-5, NMHS 2019; Okui, T., Park, J. Difference in the prevalence of hypertension and its risk factors depending on area-level deprivation in Japan, SCIRP Health journal article (2021), Praxis analysis

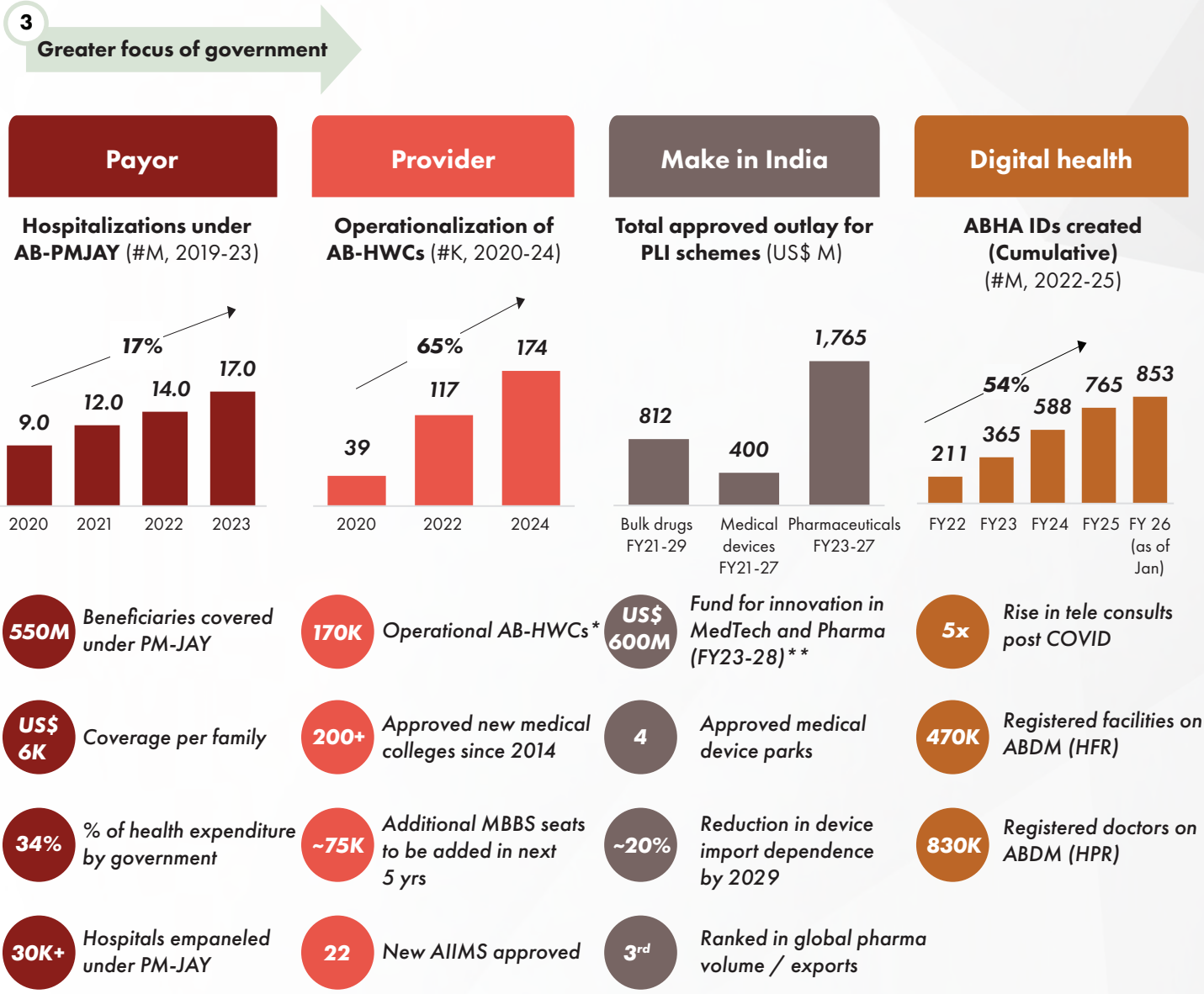
India's growing health need is not merely a healthcare challenge; it is also a macroeconomic risk. Non-communicable diseases are now the dominant cause of mortality in the country, accounting for roughly two-thirds of deaths today and projected to reach about 74% by 2030. At the same time, the prevalence of major chronic conditions continues to rise, with hypertension cases alone increasing from about 89 million to more than 220 million between 2001 and 2021 (Exhibit 1.H). Left unmanaged, these conditions can significantly affect workforce participation, household savings, and long-term economic productivity.

This epidemiological shift requires a corresponding evolution in healthcare financing. Chronic diseases demand long-term management rather than episodic treatment, yet financing systems remain heavily oriented toward inpatient hospitalization. Expanding coverage for preventive services, early detection programs, outpatient care, diagnostics, and integrated chronic care pathways will therefore be essential. Risk factors such as pre-hypertension affecting roughly half of adults above 40 years further underscore the importance of preventive financing frameworks.

Aligning healthcare financing with these long-term care needs can reduce catastrophic health expenditure, improve population health outcomes, and stabilize system costs over time. India's rising health need should therefore be viewed not only as a challenge, but also as a predictable demand signal capable of anchoring sustainable expansion of healthcare financing.

Exhibit 1.I

Government initiatives across payer, provider, manufacturing, and digital health segments in India



Note(s): *AB-HWCs: Ayushman Bharat health and wellness centers; **Promotion of Research and Innovation in Pharma MedTech Sector (PRIP)" scheme launched by the Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers, Government of India
Source(s): PIB, Secondary research, Praxis analysis

The Indian government has significantly expanded its role in healthcare over the past decade. India's healthcare transformation has been anchored by strong policy interventions and institutional expansion aimed at widening insurance coverage, strengthening public health infrastructure, accelerating digital health architecture, and supporting domestic healthcare manufacturing. Flagship initiatives such as Ayushman Bharat have already extended health coverage to over 550 million beneficiaries, while the number of hospitalizations under PM-JAY has steadily increased in recent years. Together, these initiatives are helping expand access to care while laying the foundations for a more integrated healthcare ecosystem.

Government action has been particularly visible across three areas. First, risk pooling for lower-income populations has expanded through PM-JAY, which has empanelled more than 30,000 hospitals across the country and is beginning to incorporate private providers into publicly financed care delivery. Second, industrial policy initiatives such as the Production Linked Incentive (PLI) schemes, supported by over US$1.7 billion in approved outlays for pharmaceuticals, are strengthening domestic pharmaceutical and medical device manufacturing, improving supply chain resilience and reducing import dependence. Third, the Ayushman Bharat Digital Mission (ABDM) is creating a national digital backbone, with over 853 million ABHA health IDs generated to enable interoperable health records and consent-based health data exchange (Exhibit 1.I).

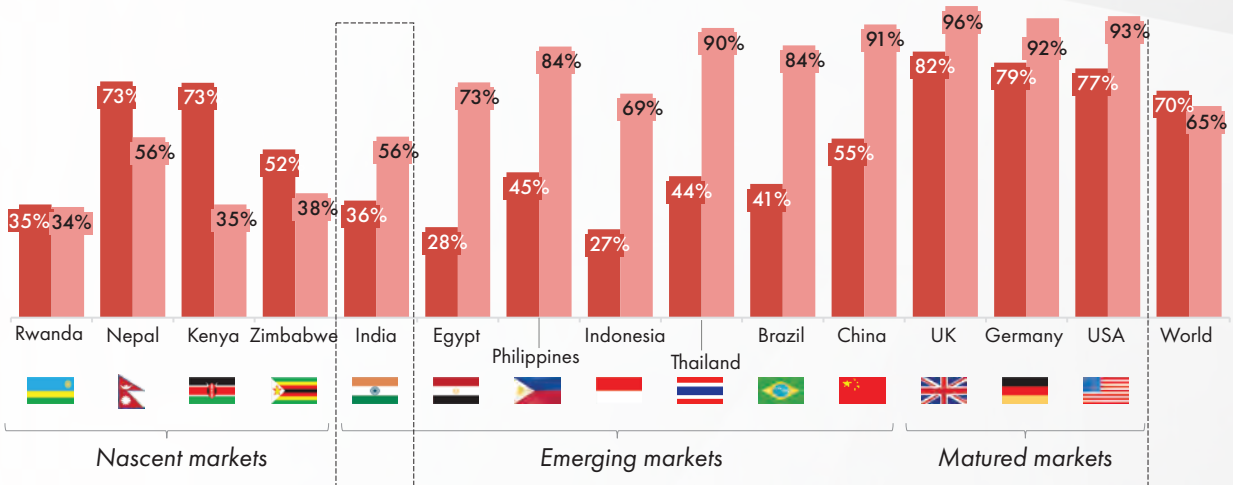
Alongside these policy initiatives, digital adoption is also beginning to reshape both patient behaviour and healthcare delivery, creating opportunities for more connected, efficient, and data-driven healthcare services.

Exhibit 1.J

Cross-country comparison of digital penetration, including smartphone and internet usage rates across nascent, emerging, and mature markets (2023)

4 **AI, tech, and data adoption**

Digital penetration across countries
(% of population, 2023)



	Rwanda	Nepal	Kenya	Zimbabwe	India	Egypt	Philippines	Indonesia	Thailand	Brazil	China	UK	Germany	USA	World
Smartphone user base (M, 2023)	4.8	21.7	39.4	8.4	516.0	31.5	51.2	76.1	31.3	86.9	788.1	55.7	65.6	263.0	
Internet user base (M, 2023)	4.9	16.5	27.4	6.5	806.0	96.3	97.5	212.0	65.4	183.0	1,110.0	67.8	78.9	322.0	

Low High

Source(s): International Telecommunication Union, Bankmycell, MTN, Country wise data reportal reports, Praxis analysis

India possesses one of the world's largest digital consumer bases, with over 800 million internet users and over 500 million smartphone users (Exhibit 1.J). This digital infrastructure provides fertile ground for the diffusion of health technology across the healthcare ecosystem. Increasing digital access has also reshaped patient expectations around transparency, convenience, and real-time access to healthcare services. Patients are no longer passive recipients of care; they are becoming more informed participants in the healthcare journey, using digital platforms to access information, compare providers, and manage health decisions.

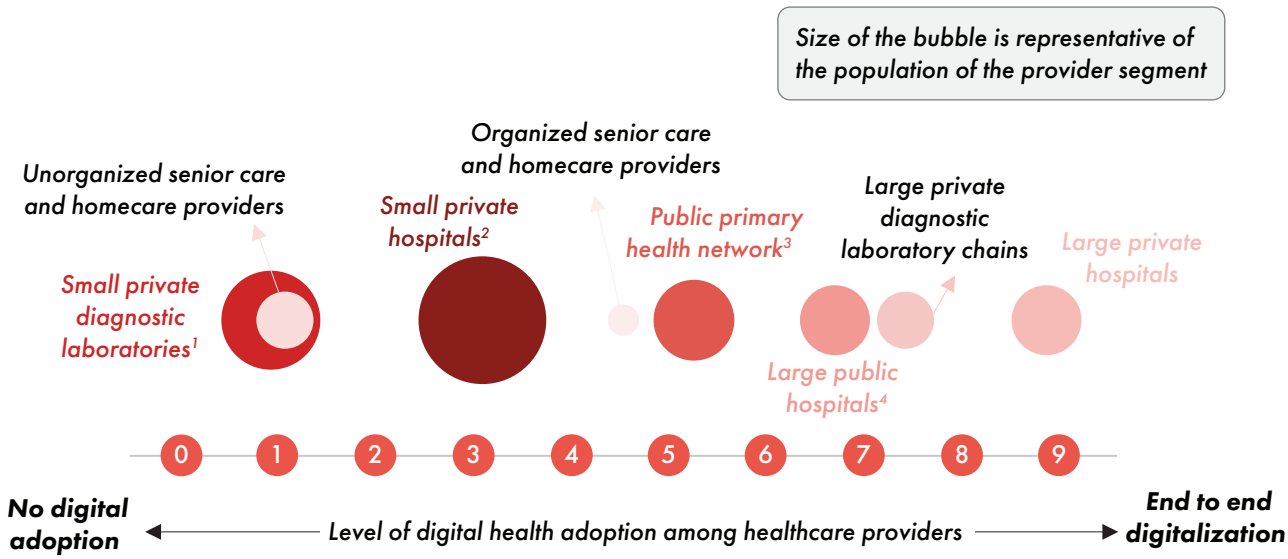
The supply side of the healthcare ecosystem is also responding to this shift.

Exhibit 1.K

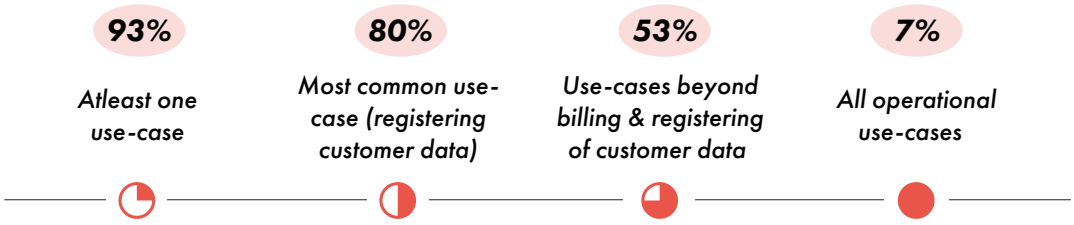
Digital health adoption among providers and ABDM uptake in India

4 **AI, tech, and data adoption**

Spread of providers across digital health adoption index



Extent of digital health adoption among private players



ABDM uptake levels

Adoption	Utilization	Public sector role
59% Penetration of ABHA IDs with more than 853M ABHA created	900 Million health records linked to ABHA	75% Of health facilities registered on the HFR are from public sector
38% Penetration of HFR with more than 470K registrations	150K+ Tokens generated daily for "Scan and Share"	83% Of health professionals registered on the HPR are from public sector
32% Penetration of HPR with more than 830K registrations	135K+ HWCs digitalized for providing eSanjeevani consultations	~100% Of the "Scan and Share" tokens are generated in the public sector

Note(s): Data as of March 2023; [1]Standalone diagnostic centers whose offerings are limited to basic pathology/ micrology/ radiology tests; [2]Hospital size is less than 100 beds; [3]Includes CHCs, PHCs, SCs and HWCs; [4]Includes national institutes, district hospitals and medical colleges
Source(s): Pathways to scale adoption of digital health in India – NATHEALTH and Arthur D little

The Ayushman Bharat Digital Mission (ABDM) is establishing the foundational digital architecture for India's healthcare system through the creation of unique health identifiers, provider and facility registries, and consent-based health data exchange frameworks. Adoption of this digital backbone is expanding steadily, with over 853 million ABHA health IDs created and more than 900 million health records already linked to the system (Exhibit 1.K). At the same time, digital adoption across providers is increasing, particularly among large private hospital chains and diagnostic networks that are integrating electronic health records, digital claims processing, and interoperable data systems.

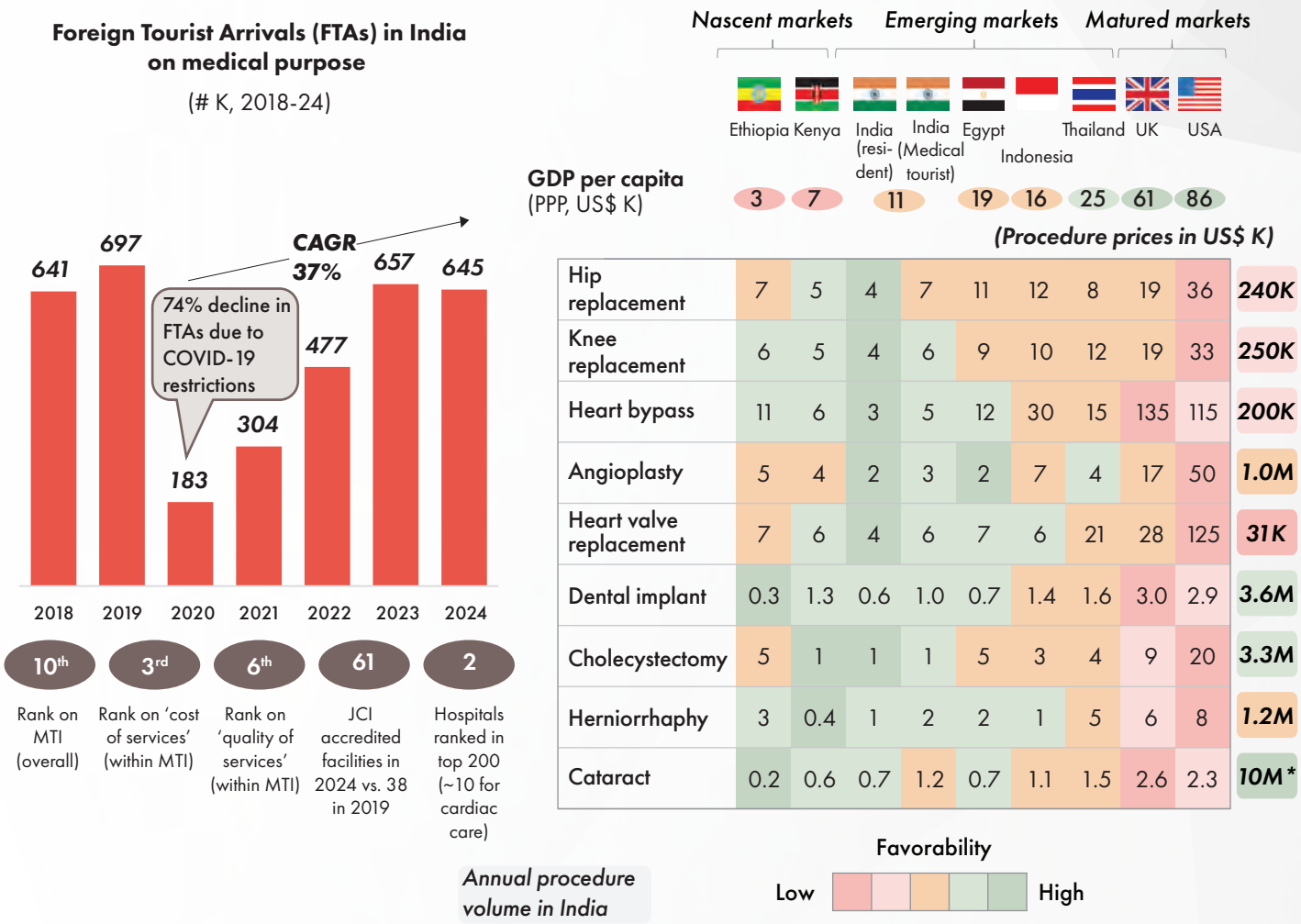
Digital integration is not merely an efficiency improvement but an enabling layer for more transparent and data-driven healthcare financing. Interoperable health records can enable continuity of care and improve chronic disease management, while digital claims processing can reduce administrative overhead, detect fraud, and accelerate reimbursement cycles. At scale, aggregated health data, when appropriately anonymized and governed, can improve actuarial pricing and support innovation in insurance product design.

Telehealth platforms have also demonstrated the scalability of distributed care models, enabling consultations to reach remote populations while reducing pressure on physical infrastructure. Together, this emerging digital health architecture provides the institutional backbone required to support large-scale insurance expansion and more integrated healthcare delivery across the system. Another defining feature of India's healthcare ecosystem is its ability to deliver care at globally competitive costs.

Exhibit 1.L

Medical tourism inflows and cross-country comparison of procedure costs

5 **Cost efficient care models**



Note(s): *Surgeries performed under National Programme for Control of Blindness and Visual Impairment (NPCB&VI)
Source(s): India Tourism Statistics, Medical Tourism Index, MedIQ (Praxis proprietary database), News articles, Secondary research, Praxis analysis

India has developed a highly cost-efficient healthcare delivery model across hospitals, pharmaceuticals, and diagnostics. The cost of complex procedures such as joint replacements, cardiac surgery, and angioplasty in India remains 60–90% lower than in many developed healthcare systems, while also remaining competitive with other emerging markets (Exhibit 1.L). This cost advantage reflects a combination of lower input costs, high procedural volumes, and efficient provider operating models.

India's cost competitiveness has also strengthened its position in global medical value travel. The country ranks among the top global destinations for medical tourism, placing 10th overall and 3rd on cost competitiveness of healthcare services in the world. A growing network of accredited tertiary hospitals and specialized centres has enabled India to attract international patients seeking high-quality care at affordable prices. Lower treatment costs also improve the fiscal feasibility of expanding insurance coverage while maintaining sustainability in healthcare financing.

However, cost advantage should not be mistaken for under-investment. Sustaining quality improvements will require continued reinvestment in infrastructure, workforce training, accreditation expansion, and advanced medical technologies to ensure that affordability is maintained alongside clinical excellence.

Exhibit 1.M

Comparison of health outcomes and healthcare expenditure across countries

5 **Cost efficient care models**

Health outcomes & expenditure across countries
(2003 - 23)

		India	Indonesia	Brazil	China	Mexico	South Korea	United Kingdom	Germany	United States
Health outcomes	Life expectancy growth (# years)	7.9	4.0	5.0	4.6	1.8	6.2	2.8	2.2	1.3
	Mortality rate growth (%)	-1.0%	0.1%	0.8%	1.0%	0.6%	0.8%	-0.3%	0.9%	0.5%
	Neonatal mortality growth (%)	-4.2%	-3.4%	-3.5%	-8.6%	-2.0%	-4.1%	-1.3%	-0.8%	-1.5%
Health expenditure	CHE per capita growth (US$)*	58	102	595	616	239	2,364	2,246	3,030	6,702
	CHE per capita growth (%)*	7.0%	8.8%	6.6%	13.9%	2.4%	8.2%	3.2%	3.6%	4.2%

Favorability: Low — High

Note(s): *CHE data considered for 2022 due to data availability
Source(s): World bank, Praxis analysis

India's healthcare system has demonstrated the ability to deliver improving health outcomes despite relatively modest levels of spending. Over the past two decades, life expectancy in India has increased by nearly eight years, while key indicators such as neonatal mortality have continued to decline. During the same period, the increase in healthcare expenditure per capita has been approximately US$58, significantly lower than the spending growth observed in many advanced healthcare systems (Exhibit 1.M). These improvements have occurred even as healthcare spending per capita remains substantially lower than in most advanced healthcare systems, reflecting the efficiency of India's healthcare delivery models.

This combination of improving outcomes and relatively modest growth in healthcare spending highlights the structural efficiency of India's healthcare ecosystem. While countries such as the United States and Germany have experienced much larger increases in per capita health expenditure over the same period, India has continued to expand access to diagnostics, specialized treatments, and tertiary care. Sustaining these gains will require continued investment in infrastructure, workforce training, accreditation systems, and advanced medical technologies to ensure that affordability is preserved alongside improvements in care quality and access.

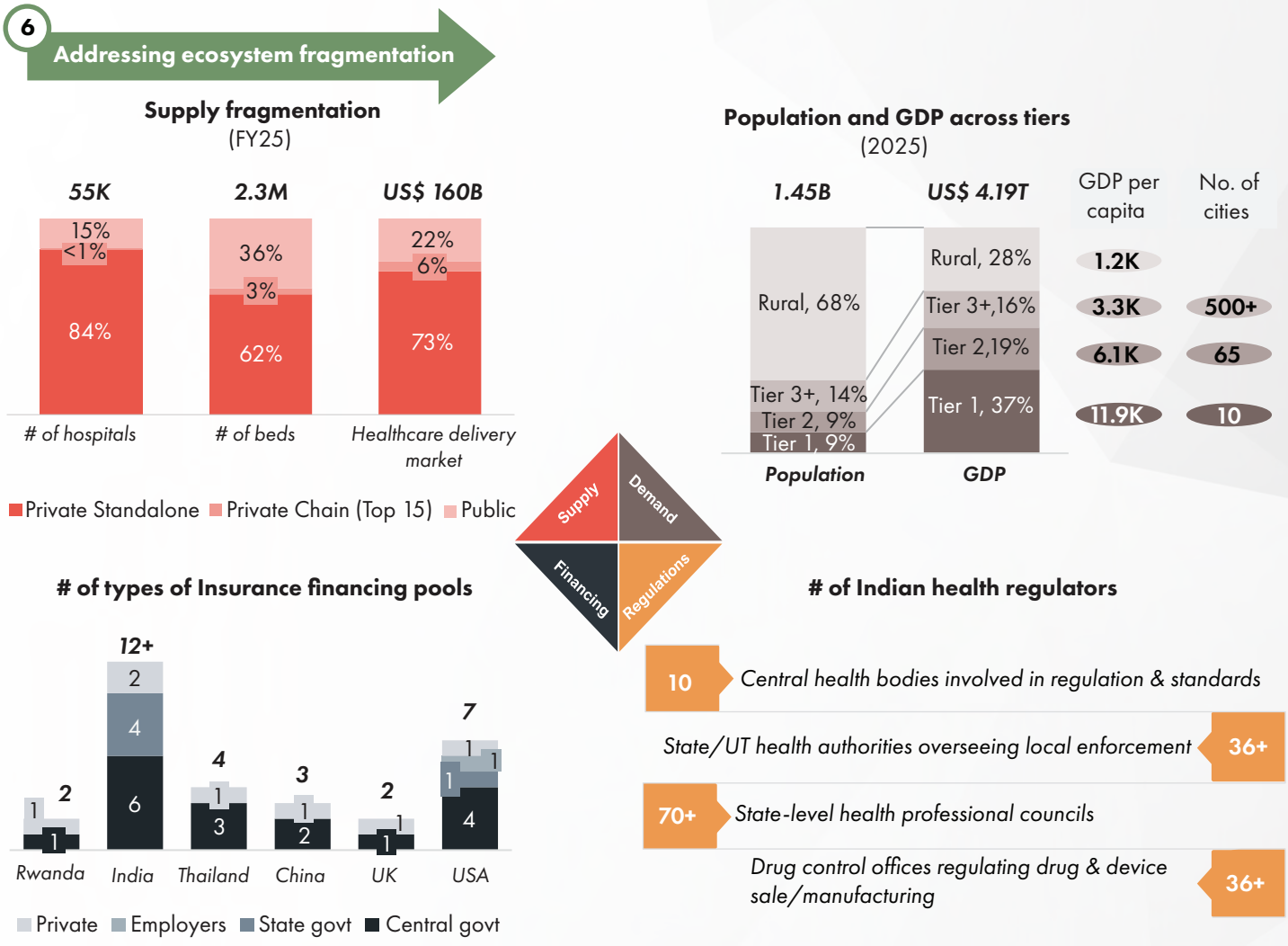
Taken together, these structural advantages, economic growth, rising healthcare demand, policy support, digital infrastructure, and cost-efficient care models, create a powerful platform for expanding India's healthcare ecosystem. However, realizing the full potential of these tailwinds will require addressing several structural constraints that continue to limit scale, financing depth, and system-wide efficiency.

1.2 ADDRESSING THE STRUCTURAL CHALLENGES

While India enters the next phase of healthcare expansion with several structural advantages, the system continues to face a set of structural constraints that limit its ability to scale efficiently and equitably. Over the past two decades, India has expanded healthcare capacity across hospitals, diagnostics, pharmaceuticals, and medical education. However, this expansion has largely occurred in parallel layers rather than through coordinated system design or integrated policy architecture. Public health programs, private insurers, corporate hospital chains, standalone facilities, state-level schemes, and emerging digital platforms have evolved simultaneously, but not always in alignment.

Exhibit 1.N

Segment-wise composition of the Indian healthcare ecosystem



Source(s): Govt. websites, HMIS, MoHFW, CareEdge, WHO, Secondary research, Praxis analysis

India's healthcare ecosystem remains fragmented across multiple dimensions, including provider networks, financing structures, demand, and regulatory oversight. Healthcare delivery has evolved through parallel growth across public hospitals, private providers, charitable institutions, and a large number of small standalone facilities. Of the ~55,000 hospitals in India, more than 80% operate as independent standalone institutions rather than organized chains (Exhibit 1.N). While this diversity has enabled rapid expansion of healthcare access, it has also created structural silos that limit coordination across providers, payors, and regulators.

Fragmentation is particularly visible in the interactions between providers and payors. Hospitals frequently negotiate with multiple insurers and government schemes, each operating with different reimbursement rates, treatment packages, documentation requirements, and claims processes. At the same time, India operates more than a dozen distinct health financing pools across central schemes, state programs, employer insurance, and private insurers. This complexity is further compounded by regulatory fragmentation. Health is constitutionally a state subject in India, meaning both central and state governments exercise authority over different aspects of healthcare policy and implementation. As a result, over 70 state-level professional councils and more than 30 state drug control offices operate alongside central regulatory bodies, often creating overlapping regulatory frameworks across jurisdictions.

For providers, fragmentation increases administrative burden and introduces variability in reimbursement timelines and pricing structures. For insurers, fragmented provider networks complicate risk assessment, claims management, and pricing models. For patients, the consequences are even more direct, care pathways can be disjointed, coverage eligibility uncertain, and quality standards inconsistent across facilities. Digital health systems across providers and insurers also remain largely non-interoperable, limiting the seamless exchange of patient data and claims information.

Another aspect of fragmentation is the demand and cost pressures associated with fragmentation. Tier 1, Tier 2, Tier 3+ and Rural India are completely different markets requiring a completely different healthcare infrastructure across the cost and volume curve. Moreover, fragmented supply can lead to inefficiencies in care delivery. Patients may incur avoidable duplicate costs across providers and spend additional time navigating the system, often adding to the overall burden of seeking care.

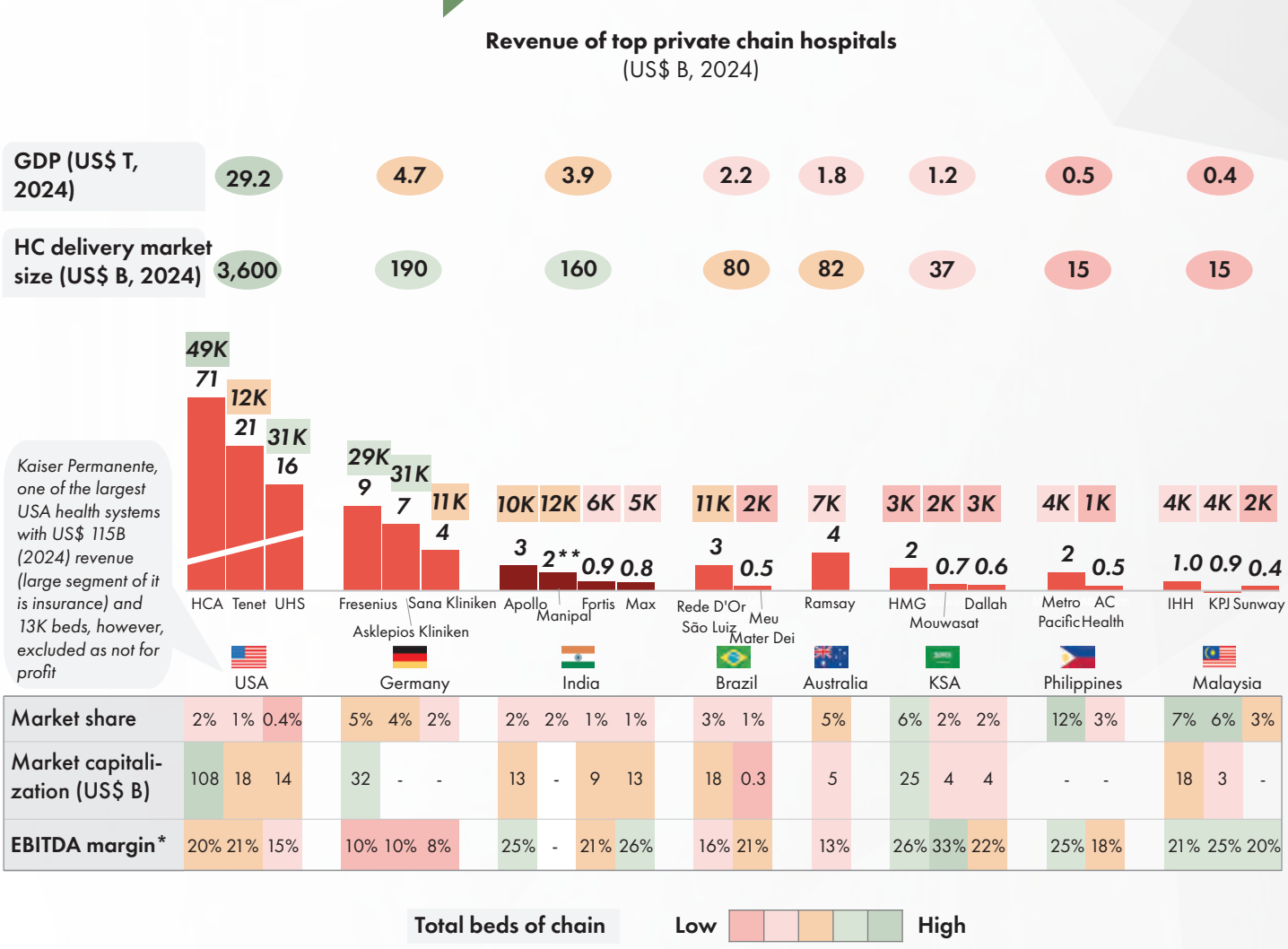
As India's healthcare system scales, this fragmented structure becomes increasingly inefficient. Fragmentation may be manageable in a low-coverage environment, but it becomes destabilizing as insurance coverage expands and patient volumes grow. Addressing these structural gaps will therefore require greater coordination across regulators, consolidation within provider networks, more unified financing pools, and stronger digital interoperability frameworks.

A key component of this effort involves enabling the emergence of larger, integrated healthcare delivery networks.

Exhibit 1.O

Comparison of revenues and scale of major global private hospital chains

6 **Addressing ecosystem fragmentation**



Note(s): Market cap as of 3rd Nov'25, Revenue from hospital operations, Indian hospital financials and market size basis FY25, Australian hospital financials and market size basis FY24 (1st July-30th June), *basis latest publicly available data **Based on estimations
Source(s): Company annual reports, Industry reports, Praxis analysis

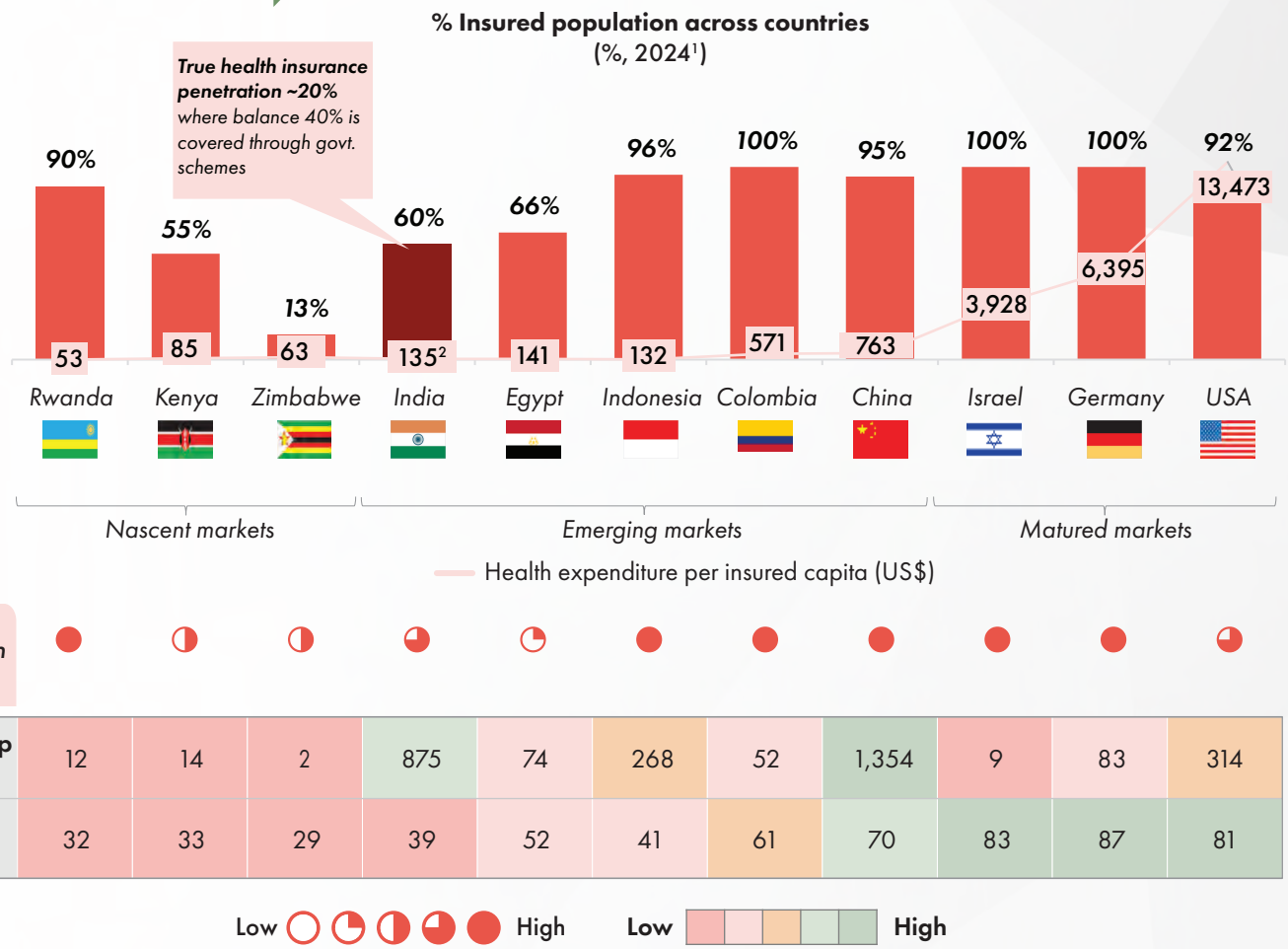
India's organized private hospital sector remains relatively small in scale compared with global peers despite the country's large healthcare market. While India's healthcare delivery market is estimated at around US$160 billion, the revenues of leading hospital chains remain modest in comparison with international health systems. For example, the largest private hospital networks in India generate revenues of roughly US$3 billion, significantly smaller than major global providers such as HCA Healthcare in the United States, which generates more than US$70 billion in annual revenue (Exhibit 1.O). This gap highlights the significant opportunity in terms of scale of organized hospital networks in India relative to the size of the underlying healthcare demand.

The relatively smaller scale of Indian provider networks also affects their ability to invest capital and expand infrastructure. Large international hospital systems operate thousands of beds across multiple regions, enabling them to invest heavily in clinical technology, specialized care programs, and operational standardization. In contrast, most Indian hospital chains still operate significantly smaller bed networks and rely heavily on internal accruals or periodic capital raising to fund expansion. As India's healthcare demand continues to grow, building larger provider platforms capable of operating 20,000+ bed networks, attracting long-term investment, and reinvesting profits into expansion will be critical to strengthening healthcare capacity and improving system-wide efficiency.

Exhibit 1.P

Cross-country comparison of insured population and health insurance coverage

7 Achieving universal coverage



	Rwanda	Kenya	Zimbabwe	India	Egypt	Indonesia	Colombia	China	Israel	Germany	USA
Cashless penetration (%)	●	◑	◑	◕	◔	●	●	●	●	●	◕
Insured pop (in M)	12	14	2	875	74	268	52	1,354	9	83	314
HAQ[3]	32	33	29	39	52	41	61	70	83	87	81

Low ○ ◔ ◑ ◕ ● High Low High

Note(s): [1]2024 or the earliest available, [2]CHE per capita for India is for the year 2025, [3]HAQ index – Healthcare access and quality index for 2019
Source(s): Lancet Global health, Industry reports, Government websites, Research publications, Praxis analysis

Despite recent progress, insurance coverage in India remains limited relative to the size of its population and healthcare demand. While headline figures suggest that around 60% of the population is covered through some form of insurance or government scheme, the level of true health insurance coverage is closer to 20%, with the remaining 40% coming from government schemes (Exhibit 1.P). As a result,a significant portion of healthcare spending continues to be financed directly by households through out-of-pocket payments.

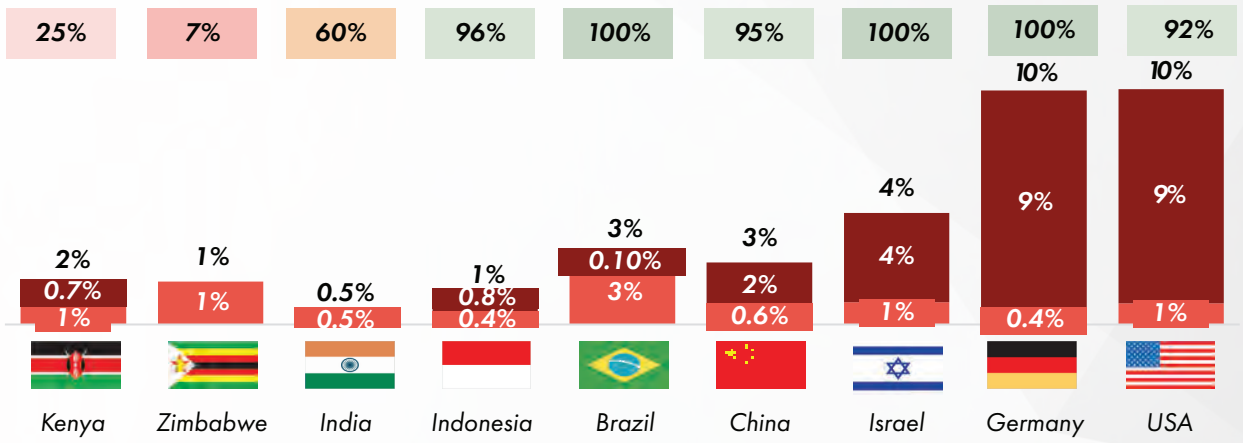
India has made meaningful progress in expanding coverage for economically vulnerable populations through programs such as the Pradhan Mantri Jan Arogya Yojana (PM-JAY). However, a substantial segment of the population, the "missing middle", remains inadequately protected. These households typically earn too much to qualify for government-supported coverage but lack stable employer-sponsored insurance and often find retail health insurance products unaffordable or insufficient.

Exhibit 1.Q

Cross-country comparison of health insurance premium and medical loss ratios

8 **Bringing efficiency in insurance**

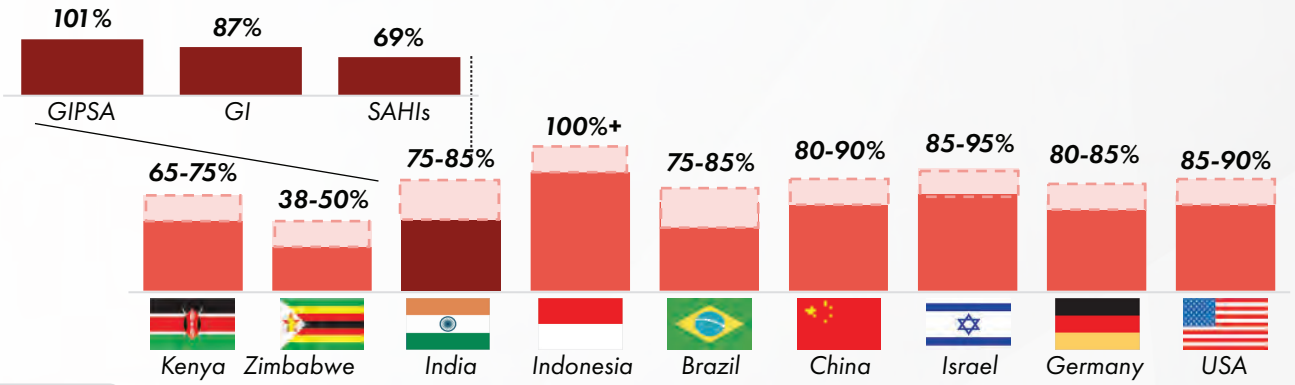
Healthcare premium collected (voluntary +mandatory)
as % of GDP (2023)



Total insured population (#M)	Kenya	Zimbabwe	India	Indonesia	Brazil	China	Israel	Germany	USA
	14	2	875	268	211	1,354	9	83	314

Insurance coverage (%)

MLR of voluntary health insurers (2024)



	Kenya	Zimbabwe	India	Indonesia	Brazil	China	Israel	Germany	USA
Average EBIT margins	3-7%	4-6%	3-7%	<0%	8-15%	<5%	<5%	6-9%	4-5%
Distribution cost (as % of premium collected)	30-40%	20-25%	15-30%	15-20%	5-10%	5-10%	15-20%	3-6%	5-15%
Players (#)	21	30+[1]	29	77	668	100+	9+	96	1.1K

Note(s): [1]Includes medical aid societies
Source(s): IRDAI, Company annual reports, News articles, Praxis analysis

Beyond expanding coverage, India's healthcare system must also address structural inefficiencies within the insurance ecosystem. Health insurance premiums in India account for only around 0.5% of GDP, significantly lower than mature insurance markets where health premiums can be as high as 9–10% of GDP (Exhibit 1.Q). This reflects both limited insurance coverage and relatively small risk pools across the system.

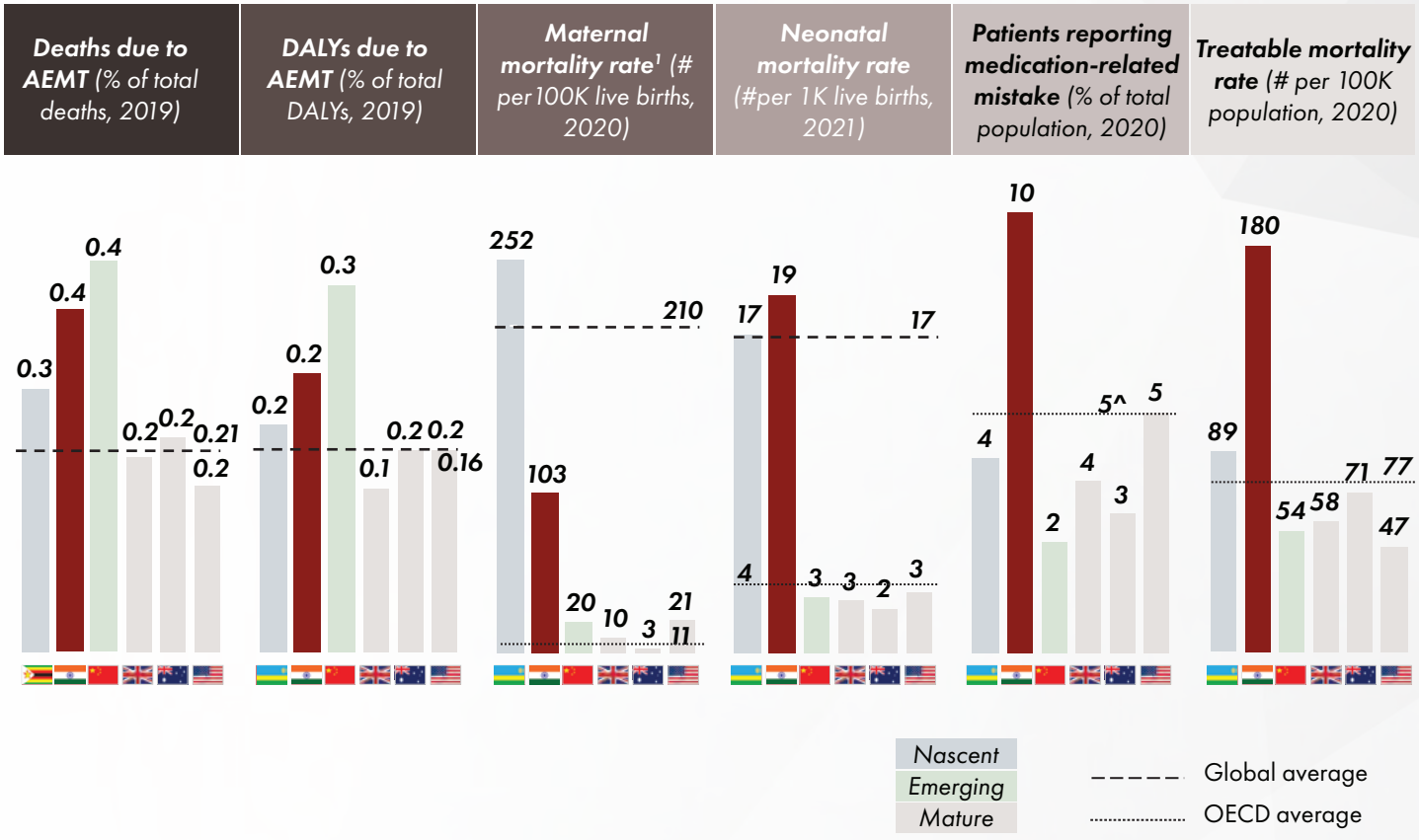
These structural limitations also affect how efficiently premiums translate into patient care. Medical loss ratios for health insurers remain in the 70-85% range, compared with 80–90% in several developed markets, indicating that a smaller share of premiums ultimately reaches patients. At the same time, distribution costs can account for roughly 15–30% of premiums in some segments, reflecting the complexity in sale of these products, fragmented risk pools, higher acquisition expenses, and operational complexity.

Improving insurance efficiency will therefore require deeper risk pooling, standardized product structures, and greater use of digital platforms for claims processing and fraud detection. Expanding larger shared risk pools, particularly through employer-based or aggregated coverage models, can improve actuarial stability and increase the proportion of premiums directed toward patient care.

Exhibit 1.R

Comparison of healthcare quality and safety outcome indicators across countries

9 **Enabling quality of outcomes**



Note(s) AEMT: Adverse effects of medical treatment; DALY: Disability-adjusted life years; [1]data as of 2018
Source(s): OECD, WHO, UNICEF, Secondary analysis, Praxis analysis

India's healthcare system has achieved significant cost efficiency, but cost efficiency alone does not guarantee consistent health outcomes. Several indicators suggest that quality outcomes can vary substantially across providers and care settings. For instance, maternal mortality remains above 100 deaths per 100,000 live births, while treatable mortality exceeds 170 deaths per 100,000 population, both significantly higher than levels observed in many mature health systems (Exhibit 1.R). Such variation reflects uneven adherence to clinical protocols, infection control standards, and treatment pathways across healthcare facilities. Another aspect of these outcomes is in the insistency of reporting these. While accredited hospitals (~6%) are required to report these, majority of the healthcare providers are not even reporting outcomes and they remain largely unknown.

This variability has important implications for both patient safety and healthcare financing. In the absence of widely enforced accreditation and standardized reporting frameworks, outcome transparency remains limited across providers.

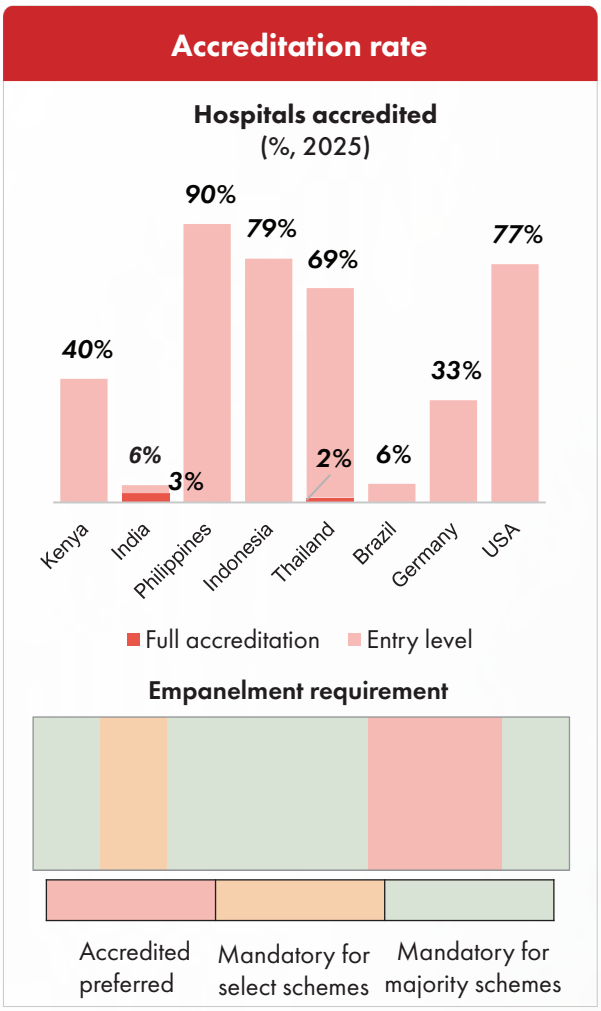
As insurance coverage expands and patient volumes increase, establishing minimum quality standards and mandatory reporting of key clinical outcomes such as mortality rates, complications, and patient safety indicators will become increasingly important to ensure that expanded healthcare access translates into consistent improvements in health outcomes.

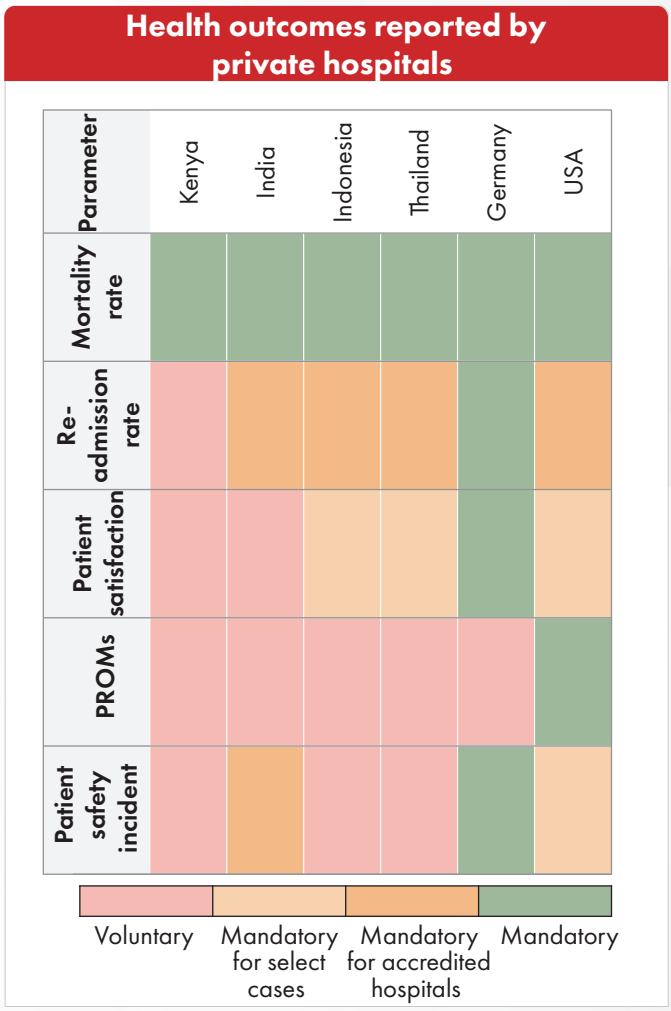
As insurance coverage expands and healthcare utilization increases, the need for standardized quality benchmarks becomes increasingly important.

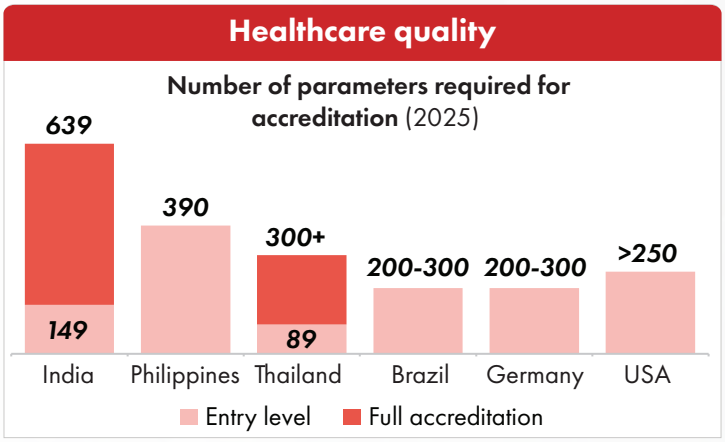
Exhibit 1.S

Comparison of hospital accreditation rates, reported outcomes, and quality standards across countries

9 Enabling quality of outcomes







Note(s): PROMs: Patient-Reported Outcome Measures are validated, standardized questionnaires completed by patients to measure their perception of their functional status, quality of life, symptoms, and health care experience directly, without clinician interpretation
Source(s): Accreditation body websites, Government websites, Public insurance (NHIP, UCS, Medicare, Medicaid) websites, Praxis analysis

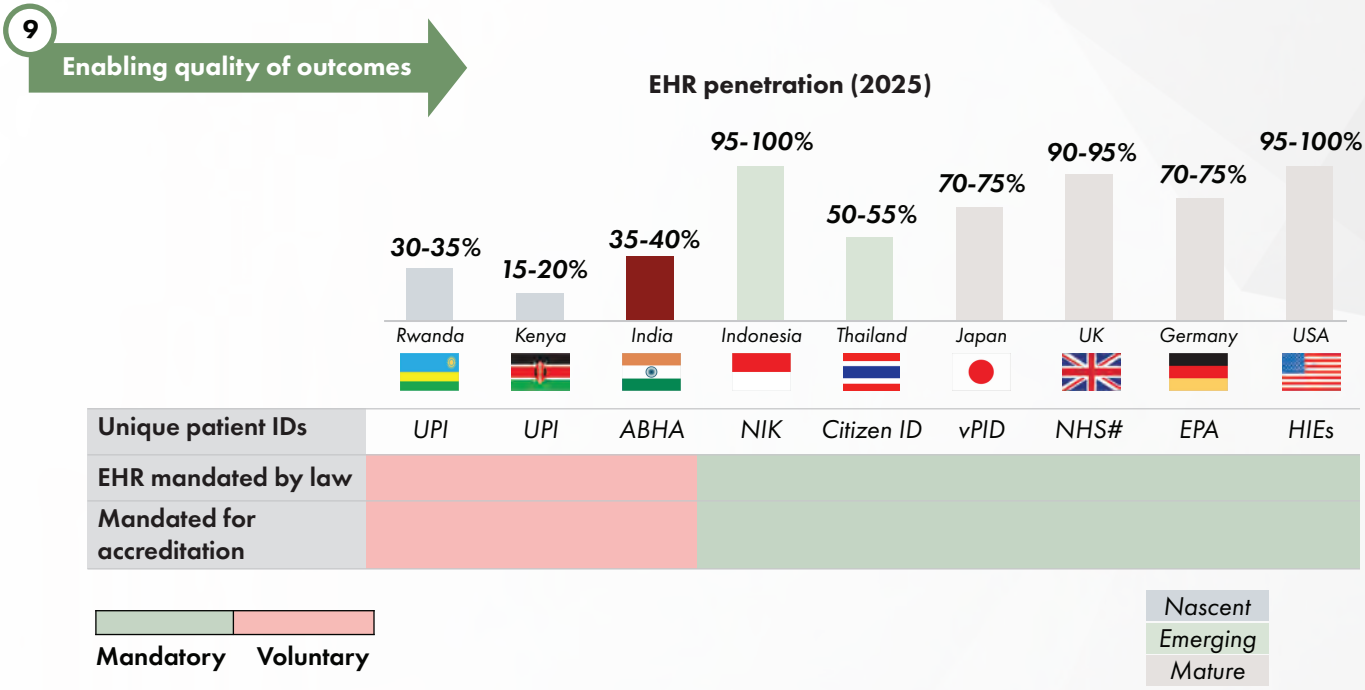
Accreditation frameworks play a critical role in ensuring consistent quality standards across healthcare systems, yet adoption varies widely across countries. In India, only around 3% of hospitals currently hold full accreditation, significantly lower than several emerging and mature health systems where accreditation coverage often exceeds 70-90% of hospitals (Exhibit 1.S). At the same time, the complexity of accreditation frameworks also differs substantially: India's accreditation system includes more than 600 quality parameters, compared with roughly 300-400 in several other countries, reflecting variation in how healthcare systems structure quality oversight.

These differences have important implications for healthcare transparency and accountability. In many countries, accreditation is closely linked to mandatory reporting of clinical outcomes such as mortality rates, readmissions, patient safety indicators, and patient-reported outcomes, helping establish system-wide visibility on quality of care. In India, however, outcome reporting by private hospitals remains limited and largely voluntary. Simplifying accreditation frameworks while linking them more directly to insurance empanelment and outcome reporting could help strengthen quality oversight while encouraging broader participation across providers.

Improving quality across the system is particularly important as healthcare demand expands into Tier 2 and Tier 3 cities, where infrastructure and workforce constraints are often more pronounced.

Exhibit 1.T

Comparison of EHR penetration across countries and the capabilities enabled by electronic health records



Note(s): UPI – Unique Patient ID, NIK – National identity number, EPA – Electronic health card, HIE - Health info exchanges
Source(s): Secondary research, Praxis analysis

Area	What EHR enables
Better clinical decisions	• Faster, safer decisions
Continuity of care	• Seamless care across OPD/IPD/home
Efficient care pathways	• Benchmark outcomes and drive efficient care (PROMs/CROMs capture)
Avoid unnecessary care	• Identify and prevent avoidable tests, admissions, and overuse
Smoother claims	• Verified clinical data enables faster settlements
Reward quality	• Better outcomes linked to higher payouts and incentives
Proactive chronic care	• Cohort tracking, proactive follow-ups, early intervention
Better product design	• Real-world data used to shape benefit plans and policies
Unified patient journey	• Single view and nationwide data exchange for seamless care alignment

Adoption in India

Strong Scaling Early

Digital integration is increasingly recognized as a foundational enabler of efficient and high-quality healthcare systems. Across several mature healthcare markets, electronic health record (EHR) adoption is ~90-100% of providers, often supported by national digital health architectures and regulatory mandates requiring standardized data exchange. In contrast, EHR penetration in India remains significantly lower at around 35–40%, reflecting both the fragmented provider landscape and the early stage of digital integration (Exhibit 1.T).

Initiatives such as the Ayushman Bharat Digital Mission (ABDM) are establishing the foundation for interoperable healthcare systems through unique patient identifiers (ABHA), health information exchanges, and standardized digital records. Beyond operational efficiency, interoperability is critical for outcome-based healthcare, enabling seamless data sharing, improving continuity of care, and reducing duplication of diagnostics. At a system level, linking clinical and claims data supports outcome benchmarking, fraud detection, and treatment review, while digital platforms facilitate capturing patient-reported outcome measures (PROMs) and satisfaction metrics.

As insurance coverage expands and patient volumes grow, accelerating ABDM adoption and real-time data exchange will be essential to improving transparency, accountability, and overall care quality across the healthcare system.

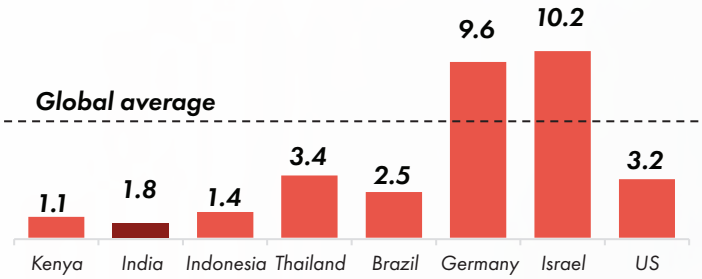
Exhibit 1.U

Primary care utilization, chronic disease progression, and outcomes from integrated care models

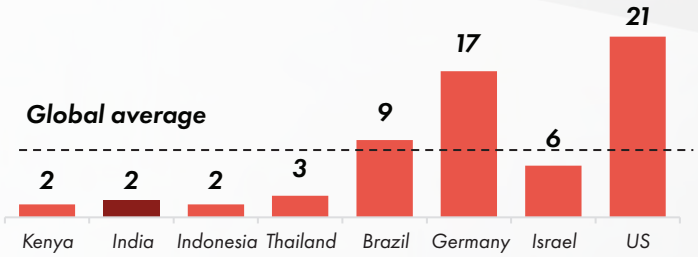
9 **Enabling quality of outcomes**

Low primary care penetration...

OPD consultations / capita
(2025)



Diagnostic tests done / capita
(2025)

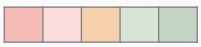


% of CHE on consultations

Kenya	India	Indonesia	Thailand	Brazil	Germany	Israel	US
37%	15%	30%	37%	40%	25%	45%	20%

Per capita outpatient medical care spend (US$, 2023*)

Kenya	India	Indonesia	Thailand	Brazil	Germany	Israel	US
-	28	41	124	204	882	1.5K	3.9K

Low  High

Lifecycle nature of diseases

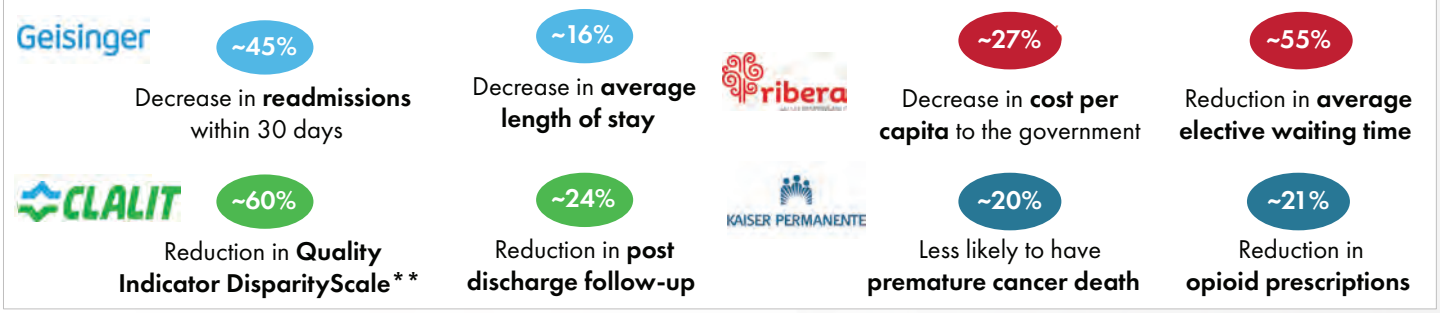
1 ***Type 2 Diabetes mellitus (T2DM)***
~100M cases, 2021

		% of T2DM
a	Chronic kidney disease	20-30%
b	Diabetic retinopathy	20-35%
c	Cardiovascular disease	20-30%
d	Stroke	3-10%
e	Diabetic neuropathy	>20%
f	Peripheral artery disease	2-20%

2 ***Hypertension***
~200M cases, 2021

		% of Hypertension	% mortality due to Hypertension
a	Chronic kidney disease	10-20%	
b	Hypertensive retinopathy	10-30%	
c	Ischemic heart disease		20-30%
d	Stroke		20-30%

Integrated care models showing better outcomes



Note(s): *Latest data is from 2022 for certain countries; **In a disparity-reduction programme targeting ~400K least affluent, the gap in a composite quality indicator score between the least-affluent and peer average was reduced by ~60% by Clalit
Source(s): National health accounts, PRB 2024 Industry reports, Hospital publications, Research publications, Medical publications, FICCI-EYP True accountable care Report 2025, Praxis Analysis

Healthcare utilization in India remains significantly lower than in many peer and mature health systems, particularly in outpatient care and diagnostics. Outpatient consultations average about 1.8 visits per capita annually, compared with 9–10 visits in several advanced health systems, while diagnostic utilization remains around 2 tests per capita versus more than 17–20 in mature markets (Exhibit 1.U). Lower engagement with primary care and preventive diagnostics limits early detection and continuous monitoring of disease, leaving much of the system oriented toward treating complications rather than managing conditions earlier in the care journey.

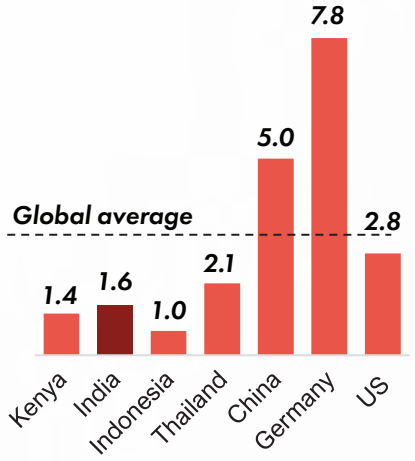
As India's disease burden shifts toward chronic conditions such as diabetes, hypertension, and cardiovascular disease, healthcare delivery must increasingly move toward lifecycle-oriented care models rather than isolated treatment episodes. Integrated care models emphasize early detection, preventive care, and coordinated disease management across primary, secondary, and tertiary settings. International experience shows that such models can reduce hospital readmissions, improve medication adherence, enable earlier detection of complications, and lower long-term healthcare costs. Strengthening primary care penetration, expanding outpatient engagement, and aligning insurance benefits with chronic disease management and diagnostic monitoring will therefore be essential to improving outcomes while maintaining the long-term sustainability of healthcare financing.

Exhibit 1.V

Comparison of healthcare infrastructure capacity and required scale-up in beds, workforce, and medical equipment

10 Financing infrastructure creation

 # Beds / 1K pop (2025)

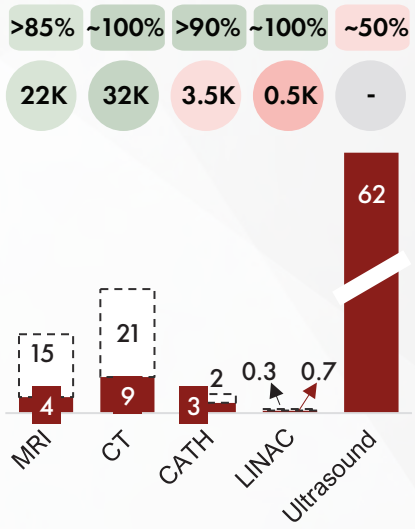


Incremental beds required (2030)

1.3M *At 2.5 beds per 1,000 population*

2.8M *At 3.5 beds per 1,000 population*

Installed equipment / 1M pop (2025)

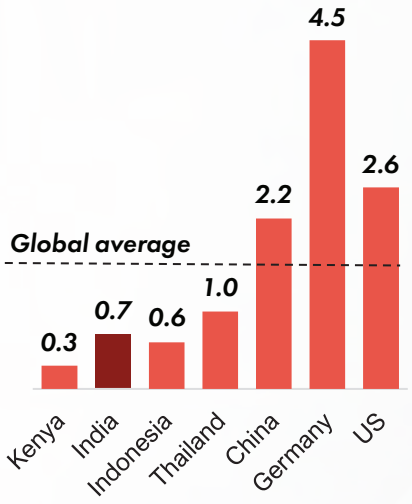


Incremental (global avg) India

Incremental machines required (2030)

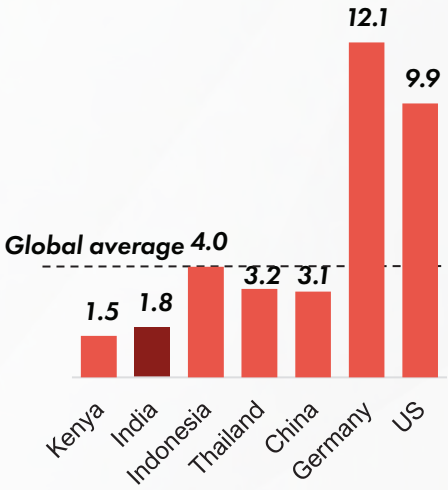
% machines imported in India

Doctors / 1K pop (2025)



~1M ***Incremental doctors required (2030)***

Nurses / 1K pop (2025)



3.5M ***Incremental nurses required (2030)***

Low High

Note(s): Incremental machines per 1M population calculated vs OECD medians for MRI and CT, WHO standards for LINACs, ESC high-income benchmarks for cath labs
Source(s): WHO, PRS India, Global economy, Medical buyer, Praxis analysis

India continues to face structural gaps in healthcare infrastructure relative to global benchmarks. Hospital bed availability in India is around 1.6 beds per 1,000 population, significantly below several peer and mature healthcare systems, while the availability of physicians remains close to 0.7 doctor per 1,000 population, compared with more than 2–4 doctors per 1,000 in many advanced economies (Exhibit 1.V).Bridging these gaps will require substantial expansion in both physical infrastructure and clinical workforce capacity over the coming decade.

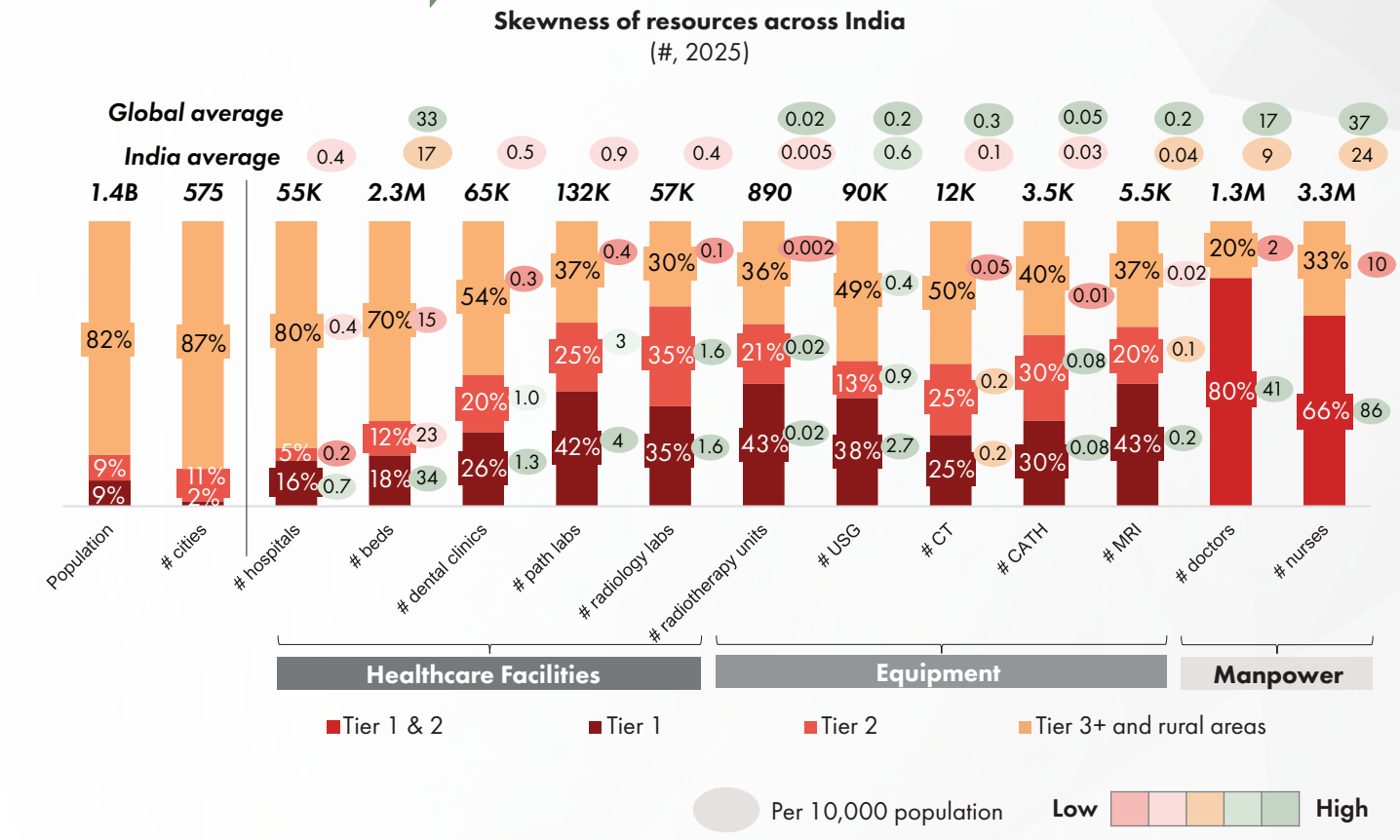
At the same time, India's epidemiological transition toward non-communicable diseases is increasing demand for higher levels of healthcare capacity. Chronic conditions such as cardiovascular disease, cancer, and diabetes require greater availability of intensive care units, oncology equipment such as LINACs and CATH labs, advanced diagnostics including MRI and CT imaging, and a larger pool of skilled clinical professionals. Without parallel expansion in infrastructure and workforce capacity, rising healthcare utilization driven by insurance expansion risks placing significant pressure on existing healthcare facilities.

Addressing these gaps will therefore require large-scale capital formation across hospitals, diagnostics infrastructure, and healthcare workforce development. Estimates suggest that India may require 1.3–2.8 million additional hospital beds, roughly 1 million more doctors, and around 3.5 million additional nurses by 2030 to approach global benchmarks. Closing this infrastructure gap will require coordinated investment across Tier 1, Tier 2, and Tier 3 geographies. Without such expansion, rising healthcare demand could lead to longer wait times, congestion in tertiary facilities, and higher system-wide healthcare costs. Expanding healthcare infrastructure is therefore foundational to achieving universal health coverage and improving long-term health outcomes.

Exhibit 1.W

Distribution of healthcare infrastructure resources across regions in India

10 **Financing infrastructure creation**



Note(s): # hospitals (and # beds) excludes PHCs and CHCs
Source(s): Govt. websites, HMIS, MoHFW, CareEdge, WHO, Secondary research, Praxis analysis

Healthcare infrastructure in India remains unevenly distributed across geographies when measured on a per-capita basis. While Tier 3 cities and rural areas account for more than ~70% of India's population, the availability of hospitals, beds, diagnostic infrastructure, and clinical manpower per 10,000 population is significantly higher in Tier 1 and Tier 2 urban centres (Exhibit 1.W). As a result, metropolitan regions have disproportionately higher concentrations of healthcare facilities, advanced equipment, and specialist providers, while smaller cities and rural districts remain relatively under-resourced.

This imbalance has important implications for both access and system efficiency. The concentration of advanced care infrastructure in metropolitan centres places sustained pressure on tertiary hospitals, while district-level systems often lack the capacity required to manage complex conditions. Patients frequently travel long distances to access specialized care, increasing out-of-pocket costs and delaying treatment.

Addressing this gap will require targeted capital deployment beyond major urban centres. Structured financing pathways, preferential credit access, and viability gap funding mechanisms can help make healthcare investments in underserved markets viable. Expanding infrastructure in Tier 2, Tier 3, and rural geographies will therefore be essential to improving equitable access and supporting the broader expansion of India's healthcare system.

Exhibit 1.X

Hospital bed capacity, investment requirements, and capital needs for healthcare infrastructure expansion in India

10 Financing infrastructure creation

		M / T1	T2	T3 & Rural	Total
Total hospital beds (2025, #K)		414	276	1610	2,300
% of private hospital beds (2025,%)		80%	70%	63%	67%
Total private hospital beds(2025, #K)		331	193	1,014	1,539
Total private quality hospital beds(2025, # K)		83 (25%)	29 (15%)	76 (7.5%)	188 (12%)
Required hospital beds (public + pvt) per 1K population (2035, #)		4.5 (3.1 in 2025)	3.5 (2.1 in 2025)	2.2 (1.3 in 2025)	2.5 (1.6 in 2025)
Total private hospital bed capacity required (2035, # K)	Corporate or equivalent[1]	210	90	430	730
	Small / individual setups	330	260	1,660	2,250
	Total	**540**	**350**	**2,090**	**2,980**
Incremental private hospital bed capacity needed (2035, # K)	Corporate or equivalent	125	60	360	540
	Small / individual setups	80	90	720	900
	Total	**215**	**150**	**1,080**	**1,450**
Average CAPEX required per bed (Private) (US$ K, 2030)	Corporate or equivalent	330	230	200	250
	Small / individual setups	200	130	100	120
Total CAPEX required (Private) (US$ B, 2026-35)	Corporate or equivalent	40	15	70	125
	Small / individual setups	15	10	70	100
	Total	**55**	**25**	**140**	**225**

~US$ 0.2B
Combined cash & cash eq. of top 15 hospital chains

~US$ 20B
Total PE investment in hospitals in last 10 years (2015-25)

Note(s): [1]Corporate or equivalent beds refer to beds of top hospital chains and large standalone centres
Source(s): Primary discussions, Tata Private Capital Investment Trends, News articles, Annual reports, Praxis analysis

Meeting India's healthcare infrastructure needs will require substantial capital investment over the coming decade. To reach targeted capacity levels by 2035, India may need close to 3 million total hospital beds, including roughly 1.45 million additional private beds, requiring around US$225 billion in capital expenditure across hospital construction, equipment, and supporting infrastructure (Exhibit 1.X). However, the financial capacity of the sector remains limited. The combined cash and cash equivalents of the top 15 hospital chains are only about US$0.2 billion, while private equity investment in hospital infrastructure over the past decade totals roughly US$20 billion, highlighting the scale of the financing gap relative to the infrastructure required.

Hospital infrastructure is inherently capital-intensive, with large upfront investments in land, construction, medical equipment, and workforce development. Sustaining expansion therefore requires predictable utilization, stable reimbursement frameworks, and operating margins sufficient to generate acceptable returns on capital employed. Today, many hospitals must operate at EBITDA margins of roughly 30% to achieve about 15% ROCE, which is a bare minimum return to investors, which limits the pace of capacity expansion.

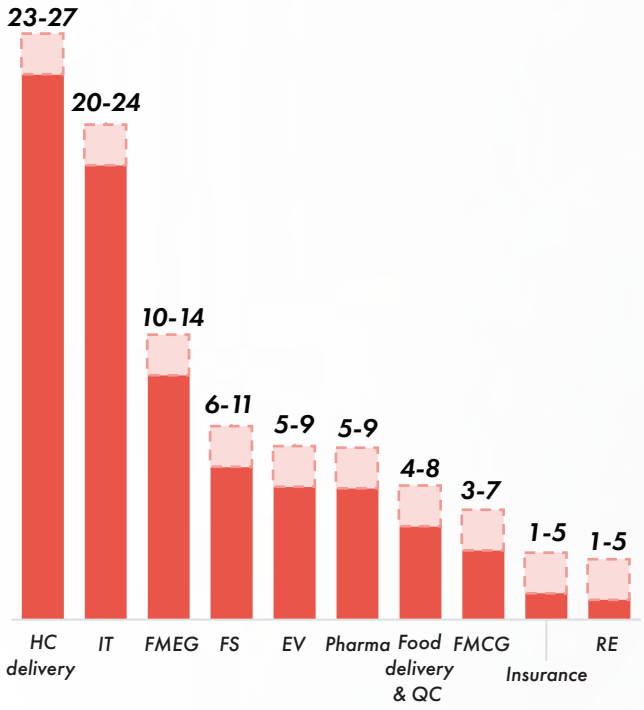
Mobilizing capital at the required scale will therefore require stronger financing pathways for healthcare infrastructure. Measures such as priority sector lending for healthcare projects, access to long-tenure infrastructure loans, and credit guarantee mechanisms to reduce borrowing costs could help make hospital investments more viable, particularly in Tier 2 and Tier 3 markets. Without improvements in financing frameworks and investment incentives, the scale of capital formation required to support India's healthcare expansion may be difficult to achieve in time.

Exhibit 1.Y

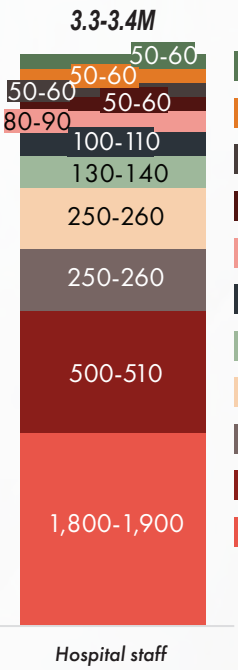
Employment generation potential from healthcare infrastructure investment and hospital bed expansion

10 **Financing infrastructure creation**

Employment generated per US$ 1M capital employed (for top 4-6 listed companies)
(#, 2025)



Employment generated by incremental 1.5M private hospital bed capacity
(# K, 2035)



	Average salary (US$)	Employment opportunity (US$)
Total	12K	41B
IT support	10K	600M
Kitchen staff	6K	350M
Pharmacist	7K	400M
Ambulance drivers	5K	270M
Security guards	4K	400M
Housekeeping*	6K	650M
Nursing supervisors	13K	2.0B
Admin staff	20K	5.0B
Support medical staff	5K	1.3B
Doctors	32K	16B
Nurse	8K	14B

Note(s): HC: Healthcare, QC: Quick commerce, RE: Renewable energy, *includes maintenance staff
Source(s): Secondary research, Praxis analysis

Healthcare delivery is one of the most employment-intensive sectors in the economy. Each US$1 million of capital invested in healthcare delivery can generate roughly 23–27 jobs, significantly higher than many other sectors such as pharmaceuticals, FMCG, or insurance, where job creation per unit of investment is considerably lower (Exhibit 1.Y).This reflects the inherently labour-intensive nature of healthcare services, which require a wide range of clinical, technical, administrative, and operational roles to support care delivery.

Expanding India's hospital infrastructure will therefore create substantial employment opportunities across the healthcare workforce. Achieving the required incremental private hospital bed capacity of around 1.5 million beds could generate approximately 3.3–3.4 million direct healthcare jobs, including doctors, nurses, allied health professionals, and hospital support staff. Beyond direct employment, healthcare infrastructure expansion also stimulates indirect economic activity across pharmaceuticals, medical devices, diagnostics, and digital health services, making healthcare investment both a public health priority and a significant driver of economic growth.

Exhibit 1.Z

Stages of health financing maturity and characteristics of healthcare systems across country groups

Health financing systems expand risk pooling, reduce out-of-pocket spending, and enable scale and integration of care delivery

Key characteristics	Transition phase	Key characteristics
	Role of regulators, providers, and insurers	
• Fragmented delivery ecosystem • Low insurance penetration • Limited role of govt as payer • Variable quality and care outcomes	• Drive quality of care consistently • Eliminate out of pocket expenditure • Enable financing of infra creation • Digitization and organization • Universal coverage	• Integrated care & patient well being • Standardization of quality • Highly scale and efficient insurance financing pools with universal coverage • Digitalization of patient records • Consolidation of delivery providers

Source(s): Secondary research, Praxis analysis

Taken together, these structural challenges highlight India's current position in the evolution of healthcare financing systems. While the country has built strong foundations, including economic growth, expanding healthcare demand, policy momentum, digital infrastructure, and cost-efficient care delivery, the system continues to exhibit characteristics typical of emerging healthcare markets, such as fragmented provider (Exhibit 1.Z).

Healthcare financing can and must play an extremely critical role in driving this transition and transformation. As healthcare financing systems mature, they expand risk pooling, reduce out-of-pocket spending, and enable greater scale and integration across care delivery. Progress along this transition typically requires coordinated action across regulators, providers, and insurers to strengthen quality standards, expand insurance coverage, support infrastructure financing, and accelerate digital integration. Advancing along this pathway will be critical for India to move toward a more integrated, scalable, and financially sustainable healthcare system.

02

HEALTH FINANCING: **A SNAPSHOT OF CURRENT SCENARIO**

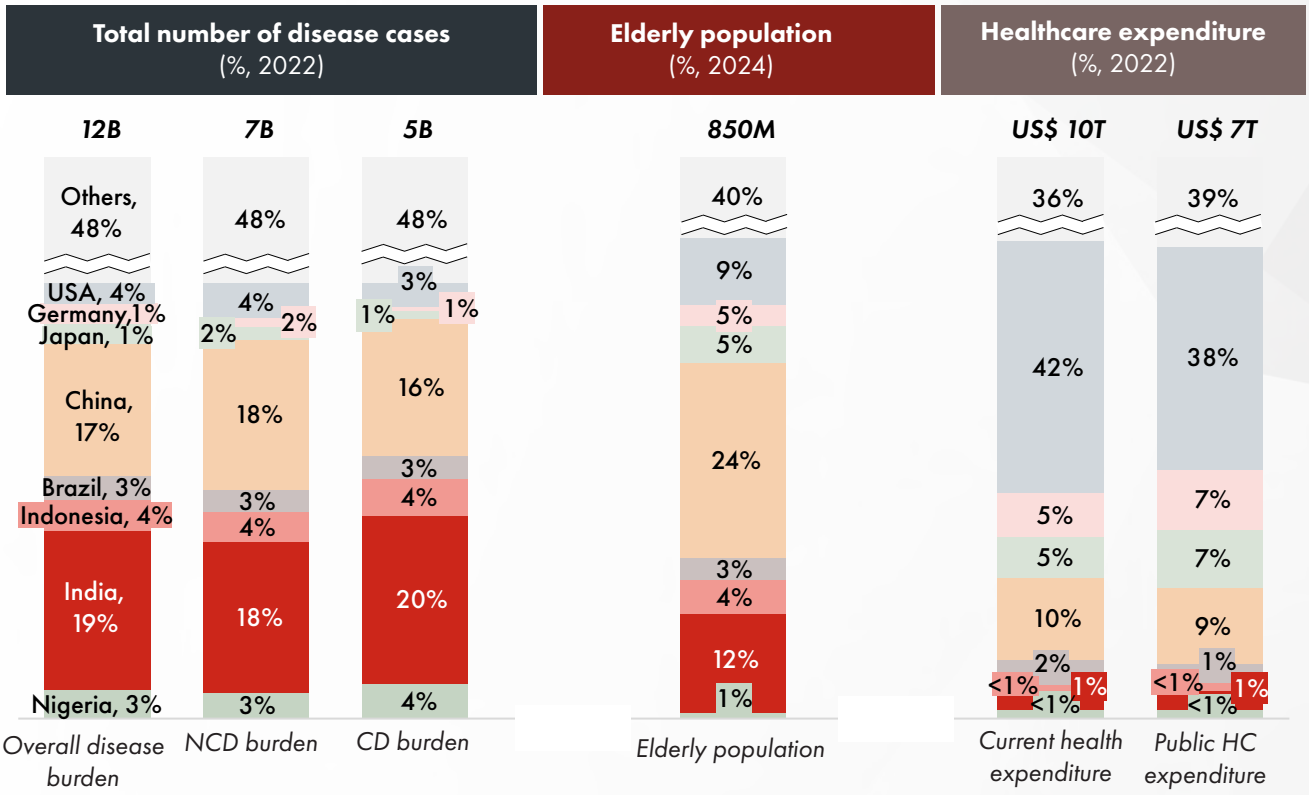
2 HEALTH FINANCING: A SNAPSHOT OF CURRENT SCENARIO

Healthcare financing determines how effectively health systems can expand access, sustain provider capacity, and protect households from financial risk. In India, the healthcare delivery ecosystem has expanded rapidly over the past two decades, but the depth of financing mechanisms supporting this system remains relatively limited compared with global benchmarks.

The country's healthcare financing architecture today is shaped by a combination of government programs, employer-sponsored coverage, and private insurance products. While these mechanisms have expanded significantly in recent years, the scale of pooled healthcare spending remains modest relative to the country's population size of 1.5 billion and a growing disease burden. Understanding the current structure of healthcare financing is therefore essential to identifying the opportunities for strengthening insurance coverage, improving efficiency, and supporting the long-term expansion of healthcare delivery.

Exhibit 2.A

Distribution of global disease burden, elderly population, and healthcare expenditure across countries



Note(s): NCD: Non-communicable diseases, CD: Communicable diseases, HC: Healthcare, Number of disease cases are measured using prevalence data (existing conditions among the current population), one person may be counted multiple times if they have multiple conditions
Source(s): Global burden of diseases, World bank data, UNFPA, Praxis analysis

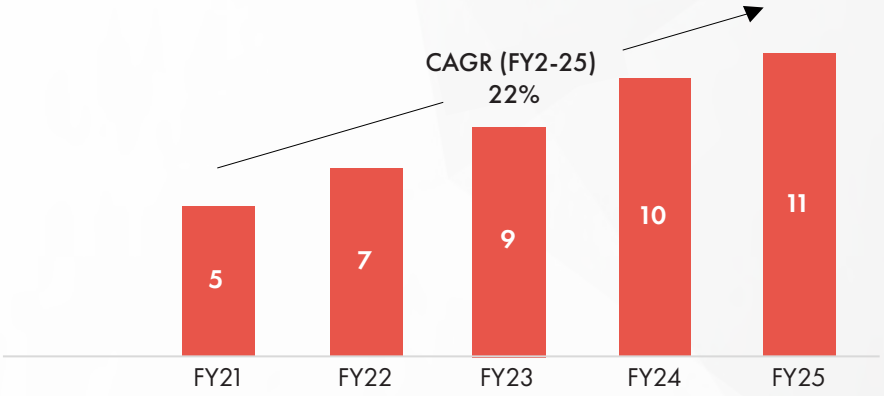
India's healthcare financing remains relatively shallow compared with the scale of its healthcare needs. Despite improvements in healthcare capacity and service delivery, pooled healthcare spending remains limited relative to the country's population size and disease burden. India accounts for roughly one-fifth of the global disease burden yet represents only a small fraction of global health expenditure (Exhibit 2.A). This imbalance reflects both income levels and historically limited investment in pooled healthcare financing mechanisms.

The consequences of this financing gap are structural. Lower levels of healthcare spending constrain investments in infrastructure, clinical workforce expansion, and advanced medical technologies, areas that become increasingly important as India's population ages and the burden of non-communicable diseases rises. Without deeper financing pools, the healthcare system risks facing growing pressure from rising demand while households remain exposed to high out-of-pocket costs. This financing imbalance contributes to India's relatively high out-of-pocket expenditure levels, which continue to account for a large share of total healthcare spending compared with many emerging and developed economies.

Exhibit 2.B

Growth in health insurance premiums in India and cross-country comparison of health financing indicators

Health insurance – Net premium collected in India
(US$ B, FY21- FY25)



MLR	94%	109%	89%	88%	87%
Avg. premium (US$)	13	16	18	21	23
Lives (#M)	515	520	550	573	581

Health financing-comparison across countries

	Nascent markets		*Emerging markets*				*Matured markets*		
	Kenya	*Rwanda*	*India*	*Indonesia*	*Brazil*	*China*	*Israel*	*Germany*	*USA*
GDP per capita (US$ K, PPP, 2024)	6.6	3.7	11.2	16.4	22.3	27.1	55.7	72.3	85.8
Total insured population (#M)	14	12	875[1]	268	211	1,354	9	83	314
Insurance coverage (% of population, 2024)	55%	90%	60%	96%	100%	95%	100%	100%	92%
Healthcare financing spend per capita[2] (US$, 2024)	64	50	48	91	745	518	3,066	5,688	12,001
OOP spend (% of CHE)	24%	4%	44%	33%	26%	32%	20%	11%	11%
MLR (Voluntary health insurers, 2024)	65-75%	70-80%	75-85%	100%+	75-85%	80-90%	85-95%	80-85%	85-90%

Note(s): [1]Difference between IRDAI reported lives and insured population for India can be attributed to the difference of PM-JAY eligible population v/s real beneficiaries and states selecting non-insurance models for PM JAY, [2]Healthcare insurance spend includes spend through government, mandatory and voluntary insurance schemes
Source(s): IRDAI, Company annual reports, News articles, Praxis analysis

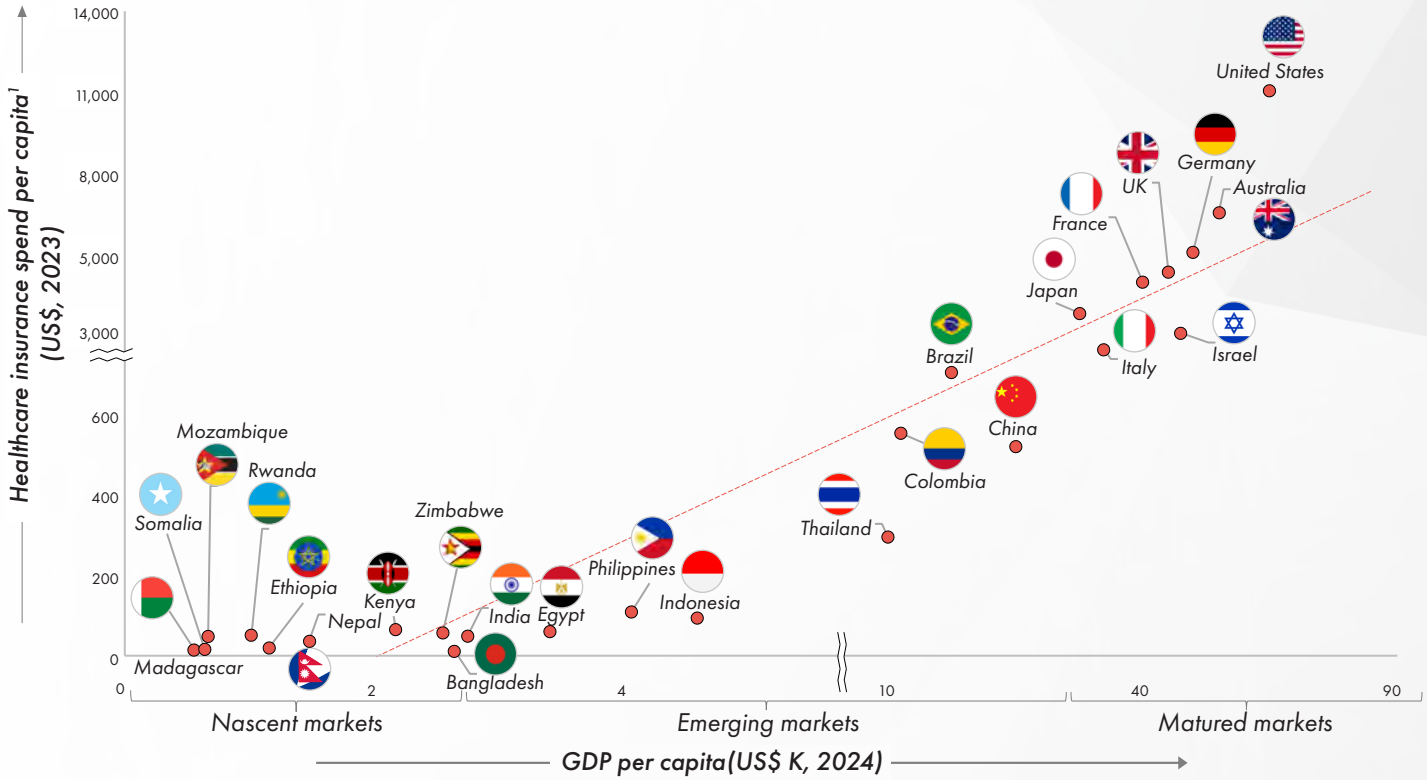
India's healthcare financing ecosystem has expanded meaningfully in recent years, driven by both public policy initiatives and growing private insurance participation. Health insurance premiums have grown rapidly, increasing at 22% CAGR between FY21 and FY25 as government-sponsored schemes expanded, employer-sponsored coverage increased, and retail health insurance adoption gradually rose among middle-income households (Exhibit 2.B).

Despite this progress, the depth of healthcare financing in India remains relatively limited compared with peer economies. Insurance coverage and healthcare financing spend per capita continue to lag many emerging markets, and a large share of healthcare costs is still financed directly by households. Out-of-pocket expenditure accounts for roughly ~44% of total health spending, significantly higher than most mature health systems.

These patterns reflect the early stage of development of India's health financing architecture. Expanding pooled financing, through broader insurance coverage, deeper risk pools, and more comprehensive benefit structures, will be essential to strengthening financial protection while supporting the sustainable expansion of healthcare delivery.

Exhibit 2.C

Cross-country comparison of healthcare financing spend per capita relative to GDP per capita



Note(s): [1]Healthcare insurance spend includes spend through government, mandatory and voluntary insurance schemes
Source(s): World Bank, WHO, Praxis analysis

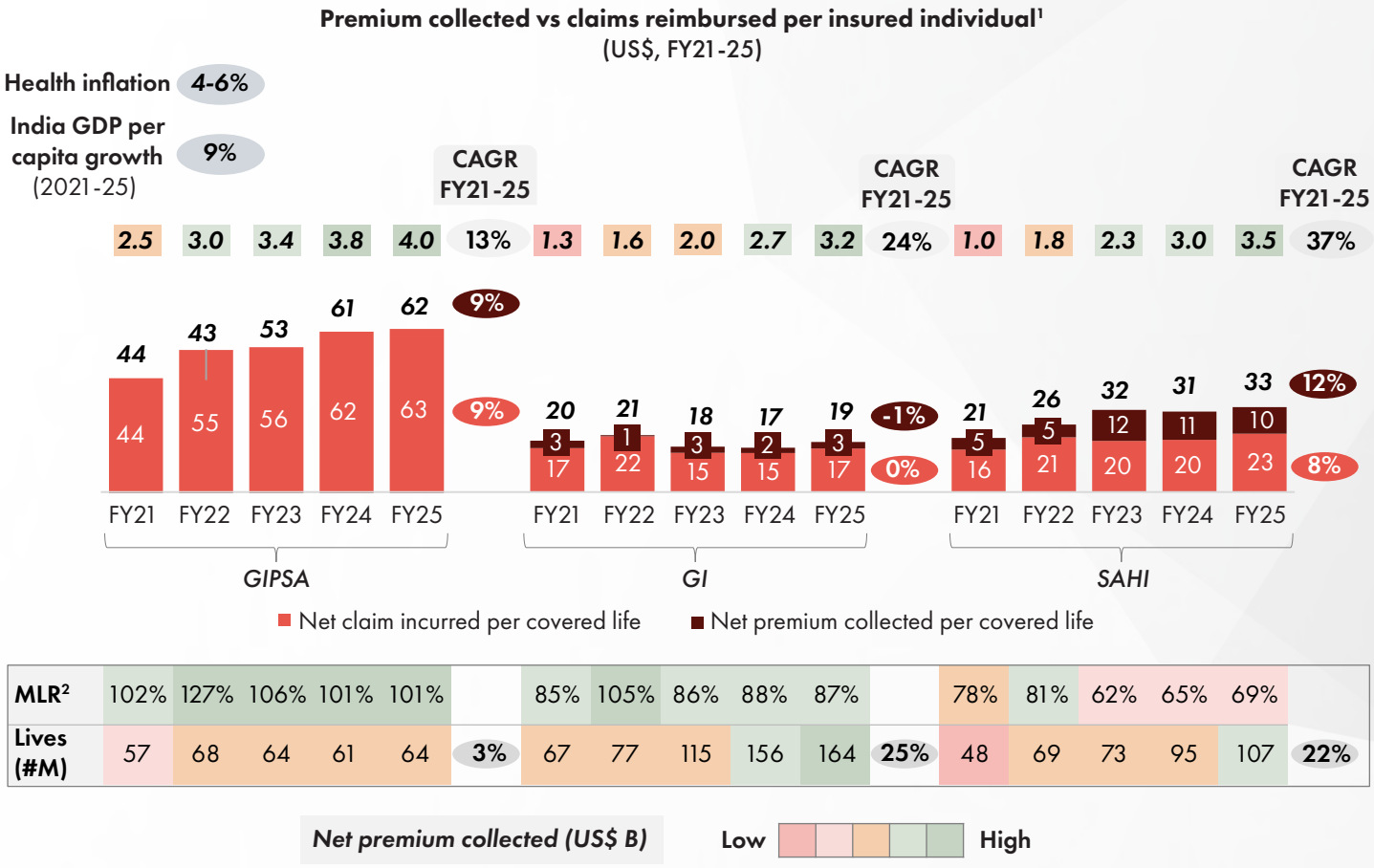
Health insurance adoption in India remains at an early-stage relative to the size of the country's population and healthcare demand. As illustrated in the cross-country comparison, healthcare financing spend per capita in India is approximately US$48, significantly below levels observed in both emerging and developed markets (Exhibit 2.C). While coverage has expanded through government-funded programs and employer-sponsored insurance, overall insurance density remains relatively shallow compared with peer economies.

India's insurance landscape today reflects a mix of government-sponsored schemes, employer-based coverage, and individual retail policies offered by private insurers. However, private insurance growth remains concentrated in corporate group coverage and urban salaried populations, while most policies remain heavily oriented toward hospitalization. Outpatient coverage remains limited despite outpatient services accounting for a substantial share of household medical expenditure, leaving a large portion of routine healthcare spending outside formal insurance coverage.

This structure limits the depth of risk pooling across the healthcare system and contributes to continued reliance on out-of-pocket spending. Expanding insurance participation, particularly among middle-income households and informal sector workers, will therefore be critical to strengthening financial protection and enabling more stable, long-term healthcare financing.

Exhibit 2.D

Premiums collected versus claims reimbursed per insured individual across insurer segments



MLR[2]	102%	127%	106%	101%	101%		85%	105%	86%	88%	87%		78%	81%	62%	65%	69%	
Lives (#M)	57	68	64	61	64	3%	67	77	115	156	164	25%	48	69	73	95	107	22%

Net premium collected (US$ B) Low High

Note(s): [1]Premium collected and claim reimbursed values have been considered for group schemes excluding government schemes, family floater schemes and individual schemes, [2]MLR has been calculated using net premium and net claims
Source(s): IRDAI handbook, MoSPI, Praxis analysis

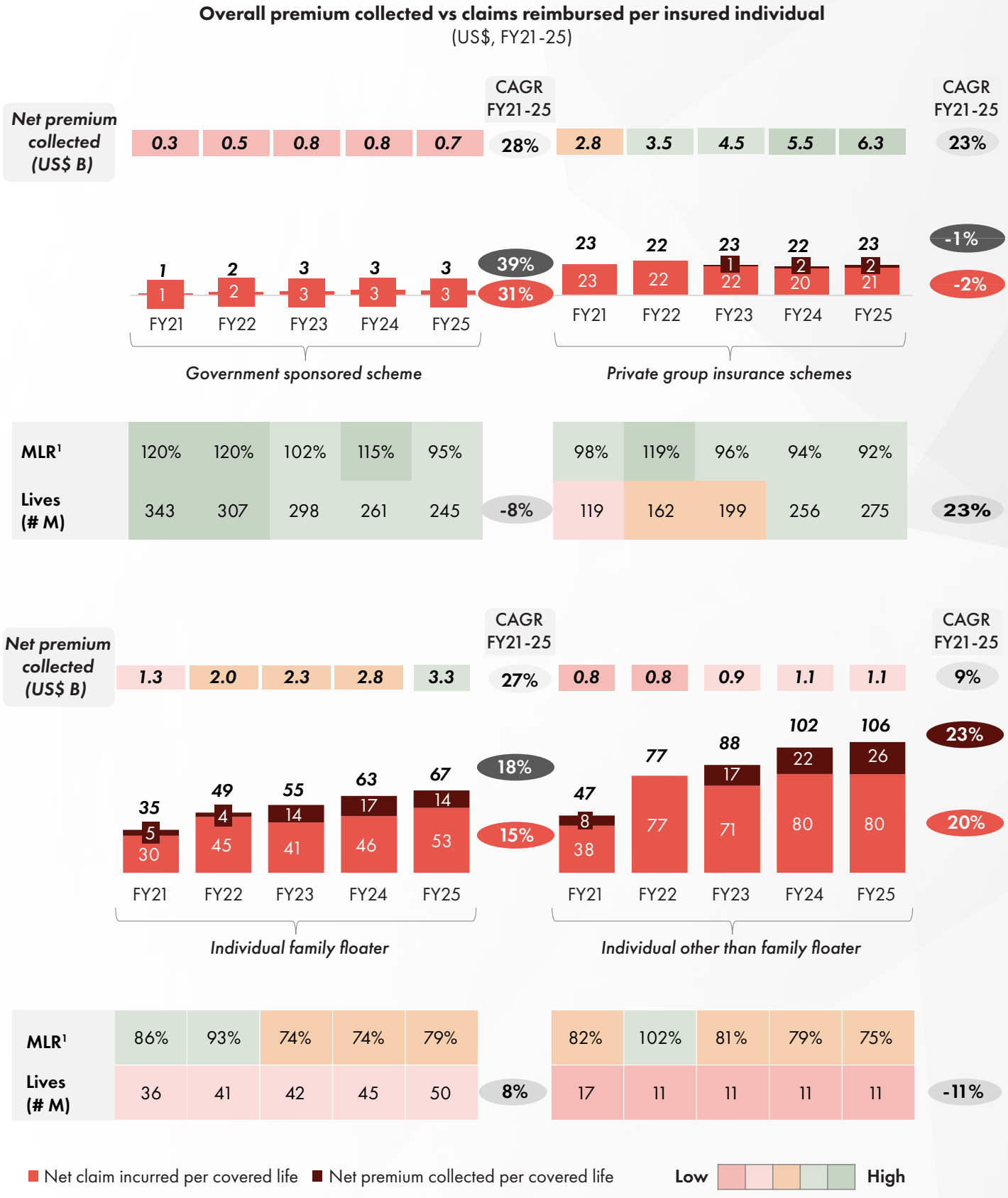
India's health insurance ecosystem comprises three primary categories of insurers: public sector general insurers, private general insurers, and standalone health insurance companies. The four public sector insurers, collectively referred to as GIPSA (General Insurance Public Sector Association), have historically been the largest providers of group health insurance, particularly through government schemes and employer-sponsored coverage. Private general insurers (GIs) operate diversified insurance businesses across multiple lines such as motor, property, and health, while standalone health insurers (SAHIs) focus exclusively on health insurance products and have expanded primarily through retail and individual policies.

Medical Loss Ratio (MLR), the proportion of premium income paid out as claims, is a key indicator of how effectively insurance premiums translate into healthcare benefits for policyholders. Higher MLRs indicate that a larger share of premiums collected is returned to members through claims reimbursements.

Across insurer categories, notable differences are visible in claims payout patterns. Public sector insurers and private general insurers have historically maintained relatively high MLRs, while standalone health insurers operate with comparatively lower levels, with MLRs of ~62–69% in recent years (Exhibit 2.D). These differences partly reflect variations in underwriting strategies, distribution structures, and portfolio mix across insurers. As the health insurance market continues to expand, improving the share of premiums translated into claims payouts will remain important for strengthening consumer value and trust in insurance products.

Exhibit 2.E

Premiums collected versus claims reimbursed per insured individual across health insurance scheme types



Note(s): [1]MLR has been calculated using net premium and net claims
Source(s): IRDAI handbook, Praxis analysis

Health insurance coverage in India is delivered through multiple scheme types, including government-sponsored schemes, employer-sponsored group insurance, and individual retail policies purchased directly by households. Each segment differs in terms of risk pool size, pricing dynamics, and claims behaviour.

Government-sponsored programs operate at significant scale, pooling risk across large beneficiary populations and therefore exhibiting relatively high claims payouts relative to premiums collected. Group insurance policies, typically provided through employers, also benefit from large and diversified risk pools, which results in more predictable claims experience and relatively stable medical loss ratios. Individual retail insurance plans, however, operate with smaller and more fragmented risk pools. These products often face challenges such as adverse selection, higher distribution costs, and greater variability in claims experience.

While premiums collected for individual family floater and other retail policies have grown steadily over recent years, claims payouts have not increased at the same pace (Exhibit 2.E). As a result, MLRs for individual health plans have been consistently lower (<80%) than those observed in group or government segments in the recent years. This suggests that a smaller proportion of premiums collected from individual policyholders is ultimately translated into healthcare reimbursements.

Hence, improving the efficiency and perceived value of individual insurance products is important for expanding retail insurance adoption. Stronger claims experience, more balanced pricing, and improved product design could help increase consumer trust and accelerate participation among middle-income households.

Taken together, these trends highlight an important structural characteristic of India's health insurance ecosystem. Segments with deeper and more diversified risk pools, such as government programs and employer-sponsored group coverage, tend to deliver higher claims payouts, while retail insurance markets remain more fragmented and cost-intensive. Expanding the depth and efficiency of retail risk pools will therefore be an important step toward strengthening the overall resilience and inclusiveness of India's health financing system, along with creating more scale and regulated universal coverage schemes.

03

OPPORTUNITIES IN INDIAN HEALTH FINANCING

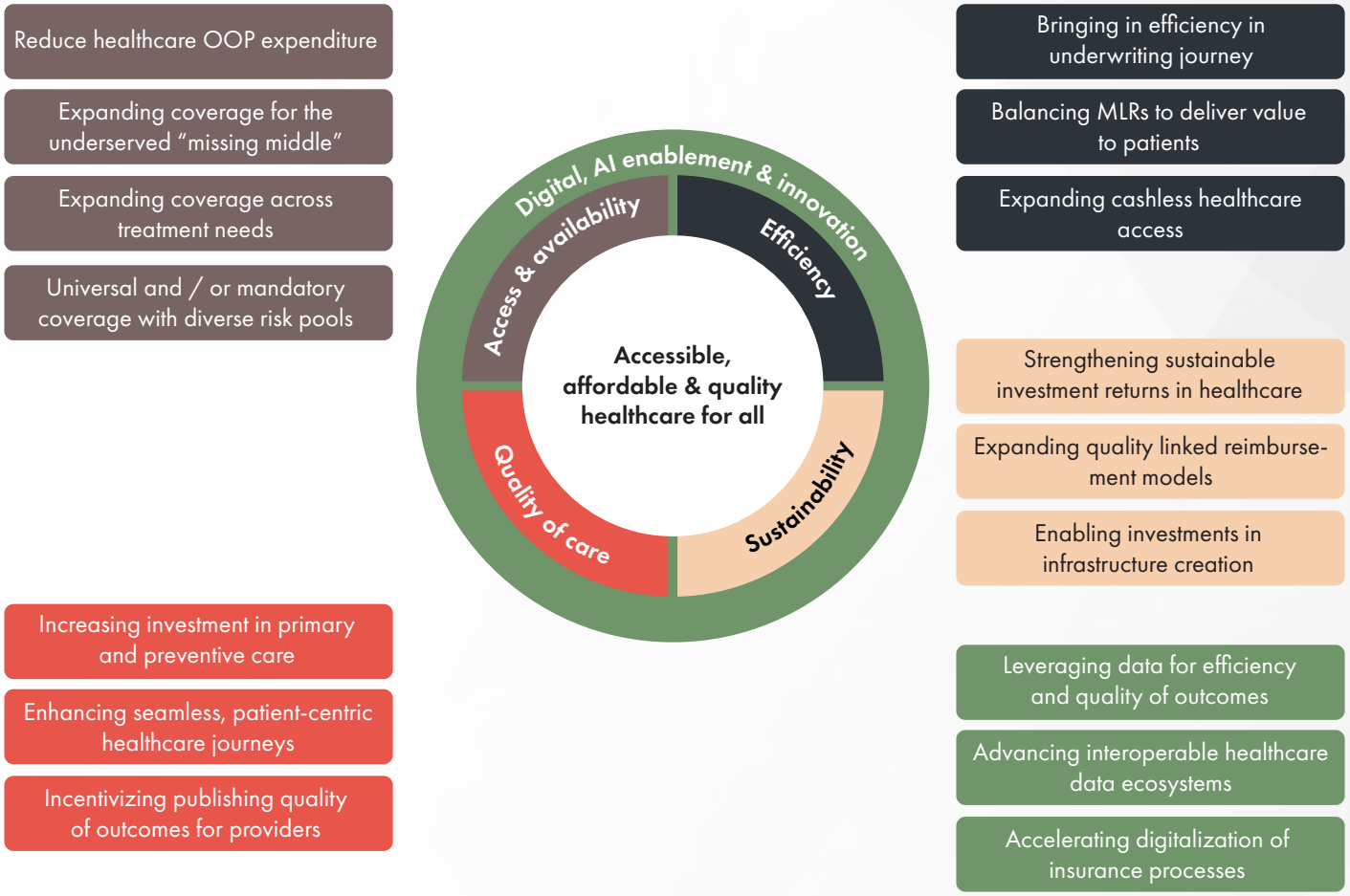
3 OPPORTUNITIES IN INDIAN HEALTH FINANCING

India's healthcare system has developed significant delivery capabilities over the past two decades, supported by innovation in policy, technology, product design, and innovation. However, as the previous section illustrates, the financing architecture supporting this ecosystem remains relatively subscale and fragmented. While insurance coverage and pooled financing mechanisms have expanded in recent years, large segments of the population remain uninsured, and risk pools remain uneven across regions and population groups.

Strengthening health financing therefore represents one of the most powerful levers for transforming the performance of India's healthcare system. Financing mechanisms influence not only how healthcare services are paid for, but also how providers invest in infrastructure, how efficiently care is delivered, and how equitably patients can access treatment.

Exhibit 3.A

Health financing as a game changer for the Indian healthcare ecosystem



Source(s): Praxis analysis

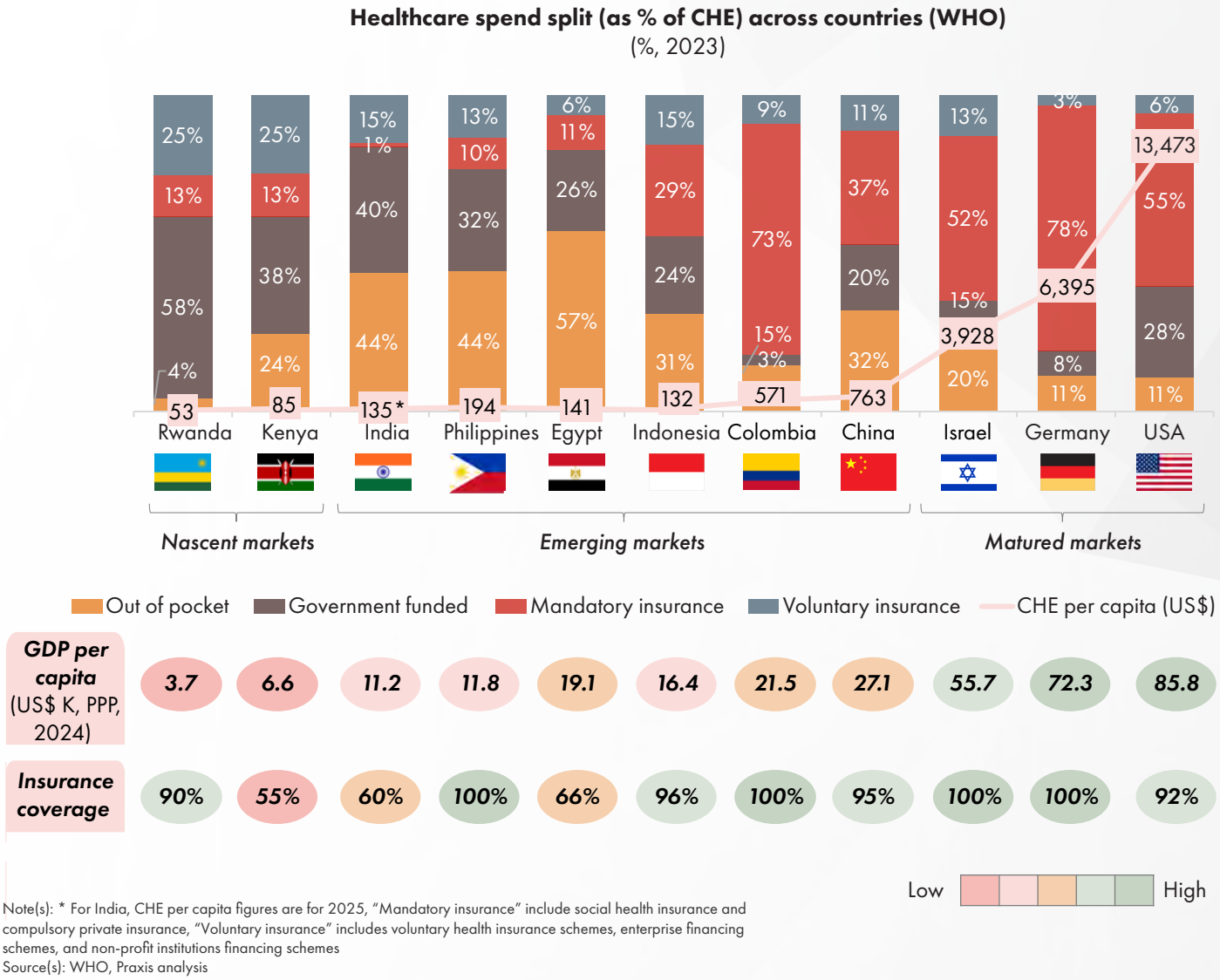
Expanding the depth and structure of healthcare financing has the potential to transform several critical dimensions of the healthcare ecosystem, comprising access and availability, operational efficiency, financial sustainability, quality of care, and digital enablement (Exhibit 3.A). Stronger pooled financing mechanisms can improve access by reducing out-of-pocket expenditure, expanding coverage for underserved populations such as the "missing middle," and broadening insurance coverage across treatment needs. At the same time, more structured insurance mechanisms can enhance operational efficiency within the healthcare system by improving underwriting processes, aligning medical loss ratios, and expanding cashless healthcare access.

Deeper financing pools can also strengthen the long-term sustainability of healthcare delivery by enabling stable investment returns, supporting infrastructure expansion, and encouraging reimbursement models that reward quality outcomes. Alongside these changes, increased investment in primary and preventive care, patient-centric care pathways, and transparent reporting of outcomes can help improve the quality of care delivered across the system. Finally, stronger financing and coordination across stakeholders can accelerate digital and data-driven transformation, enabling interoperable health data ecosystems and more efficient healthcare and insurance processes.

3.1. Access and availability

Exhibit 3.B

Healthcare spending mix across countries by financing source (out-of-pocket, government, mandatory and voluntary insurance)



Note(s): * For India, CHE per capita figures are for 2025, "Mandatory insurance" include social health insurance and compulsory private insurance, "Voluntary insurance" includes voluntary health insurance schemes, enterprise financing schemes, and non-profit institutions financing schemes
Source(s): WHO, Praxis analysis

One of the most significant opportunities in India's healthcare financing landscape lies in strengthening risk pooling across the population. Currently, insurance coverage remains fragmented across government programs, employer-sponsored schemes, and individual retail policies. While programs such as PM-JAY have expanded protection for vulnerable populations, mandatory participation remains largely limited to formal-sector workers through schemes such as Employees' State Insurance (ESIS), leaving large segments outside structured risk pools.

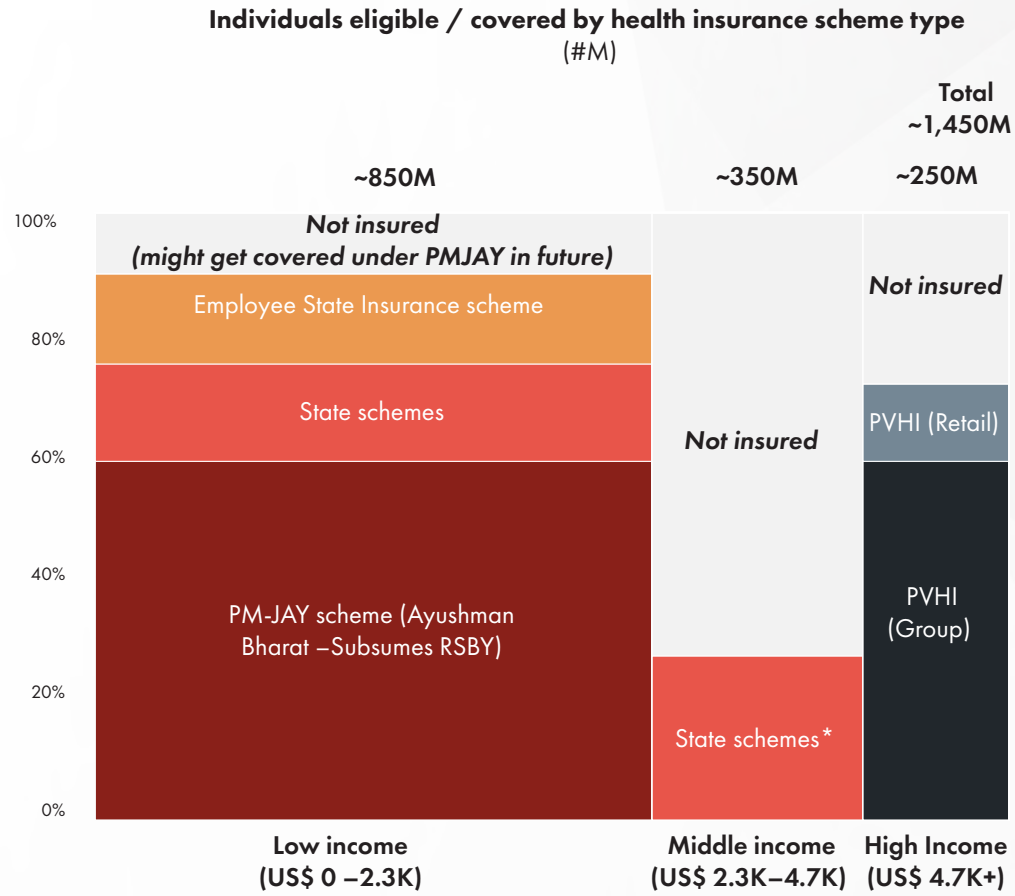
International experience suggests that voluntary insurance alone rarely achieves broad population coverage. In many health systems, voluntary health insurance typically accounts for only ~10–15% of total healthcare financing, while most coverage expansion has been achieved through government-funded programs or mandatory insurance mechanisms (Exhibit 3.B). Countries that have reduced out-of-pocket spending have generally done so by expanding large, pooled financing systems combining public funding with near-universal participation.

India has already taken important steps through government-sponsored coverage programs that have expanded insurance access for lower-income populations. Building on this foundation, there is a significant opportunity to further consolidate financing pools and broaden participation across the wider population.

Moving toward larger and more integrated risk pools, supported by expanded mandatory or semi-mandatory frameworks, would strengthen financial protection for households while providing healthcare providers with more predictable demand and revenue streams. Such expansion would also help reduce reliance on out-of-pocket spending and address the unmet needs of the and "missing middle."

Exhibit 3.C

Distribution of health insurance coverage across income groups and scheme types in India



Note(s): *Also includes a few private schemes., Income is annual income of an individual, Few individuals (~5Cr) might not be a part of low income group; PVHI: Private voluntary health insurance
Source(s): NITI Aayog, IRDAI annual reports, Praxis analysis

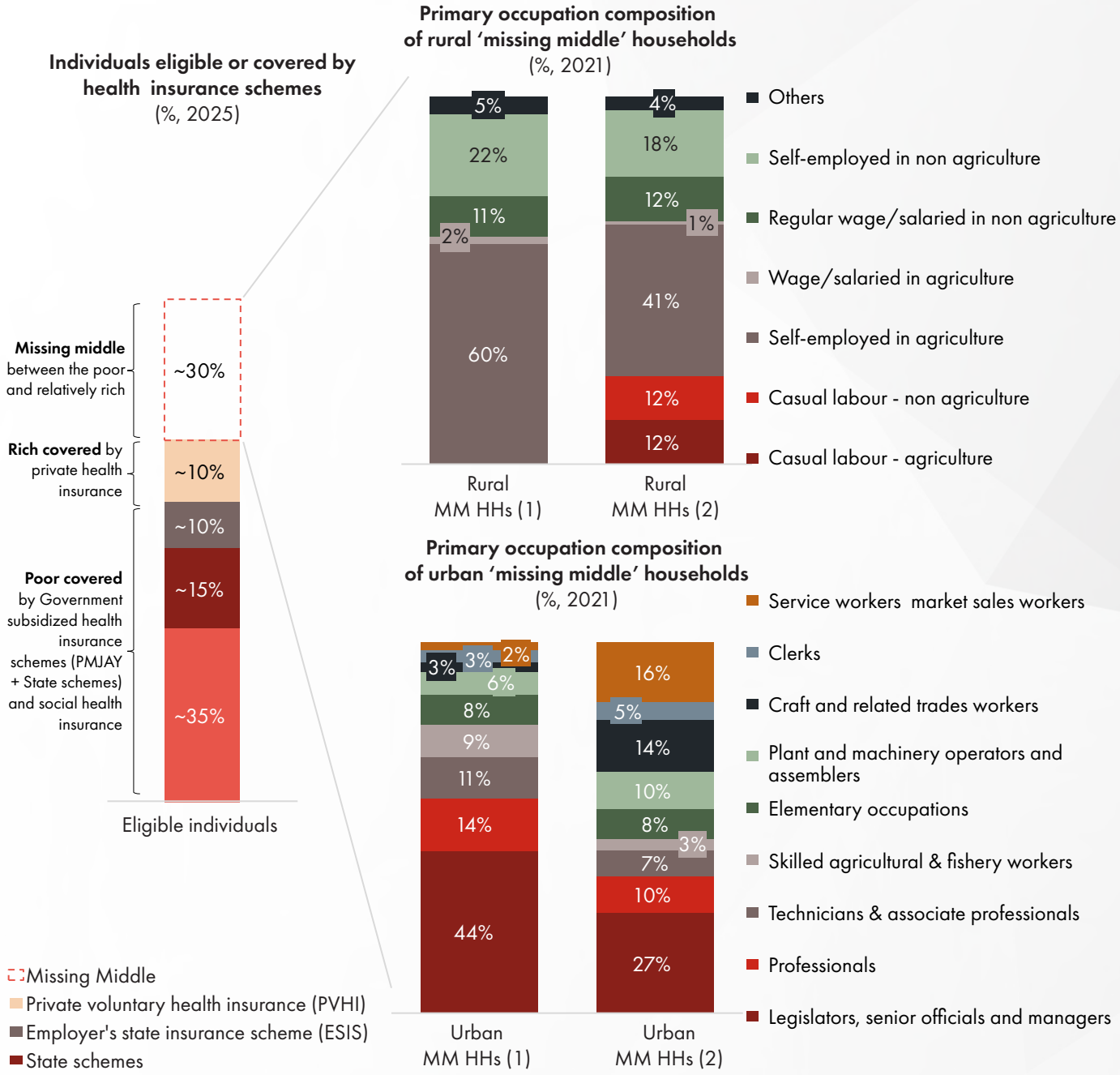
Despite the expansion of government health insurance schemes and employer-sponsored coverage, a substantial share of India's population remains outside formal insurance systems. This gap is most visible in the "missing middle", ~30% individuals that earn too much to qualify for subsidized public schemes but lack stable employer-sponsored coverage or finances to buy private individual insurance (Exhibit 3.C).

As a result, a large segment of the population continues to finance healthcare primarily through out-of-pocket payments. Insurance participation within this group tends to be intermittent, with many households' purchasing coverage only episodically or maintaining policies with limited benefits.

This segment therefore occupies a structurally vulnerable position within the healthcare financing ecosystem: excluded from government protection but not fully integrated into pooled private insurance mechanisms. Addressing this gap represents a major opportunity to deepen insurance coverage while strengthening financial protection for households.

Exhibit 3.D

Insurance eligibility across income groups and occupational composition of 'missing middle' households in India



Note(s): MM: Missing middle, HH: Households, The analysis of primary occupations in rural and urban settings have been done through two methodologies comprising 35Cr and 27Cr beneficiaries for rural and 11Cr and 13Cr beneficiaries for urban areas
Source(s): Health Insurance for India's Missing Middle (NITI Aayog), MoHFW, News articles, Praxis analysis

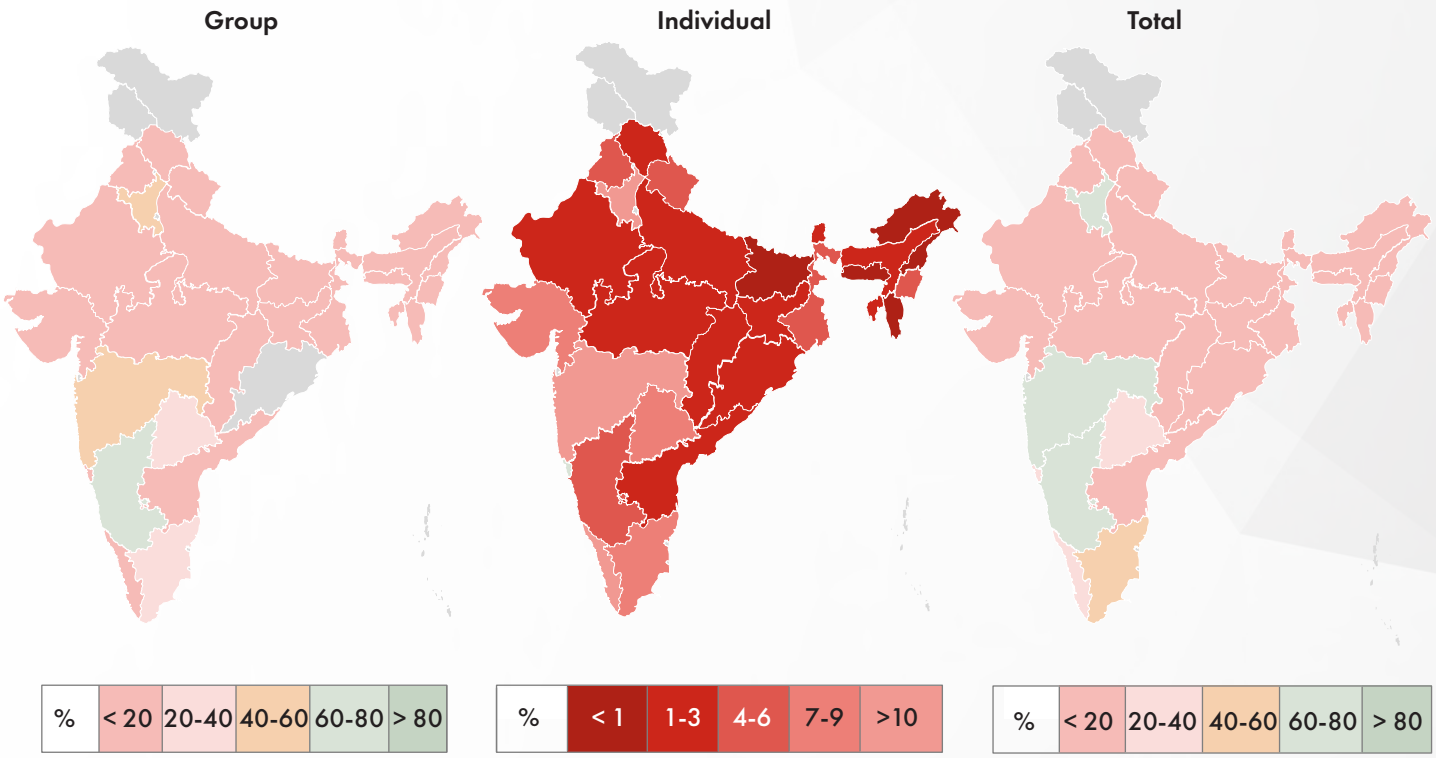
As per NITI Aayog's report on the missing middle, the group spans a diverse group of households across urban and rural India, largely concentrated within informal and self-employed segments of the workforce (Exhibit 3.D). While many in this group have the financial capacity to contribute toward insurance coverage, structural barriers have limited sustained participation in the insurance system. Retail health insurance products are often perceived as complex or expensive, distribution remains concentrated in urban markets, and product design continues to focus primarily on hospitalization rather than broader healthcare needs such as outpatient care. Geographic variation in provider networks and insurance awareness further contributes to uneven adoption across regions.

These characteristics help explain why voluntary insurance uptake alone has struggled to close the coverage gap. Without mechanisms that expand risk pooling such as employer aggregation platforms, targeted incentives, or minimum coverage frameworks, insurance participation tends to remain fragmented and episodic across this segment.

At the same time, the missing middle represents a significant opportunity for expanding pooled healthcare financing. Structured insurance models designed for this segment could substantially expand the risk pool while reducing household exposure to catastrophic health expenditure. Potential approaches include simplified and lower-cost insurance products, micro-contribution models linked to income or digital payment ecosystems, and targeted policy incentives that make coverage more accessible to informal sector workers.

Exhibit 3.E

State-wise distribution of health insurance coverage in India across group, individual, and total private segments



Note(s): Individual and group figures may overlap, Estimated coverage is based on IRDAI reported lives
Source(s): IRDAI Handbook, Praxis analysis

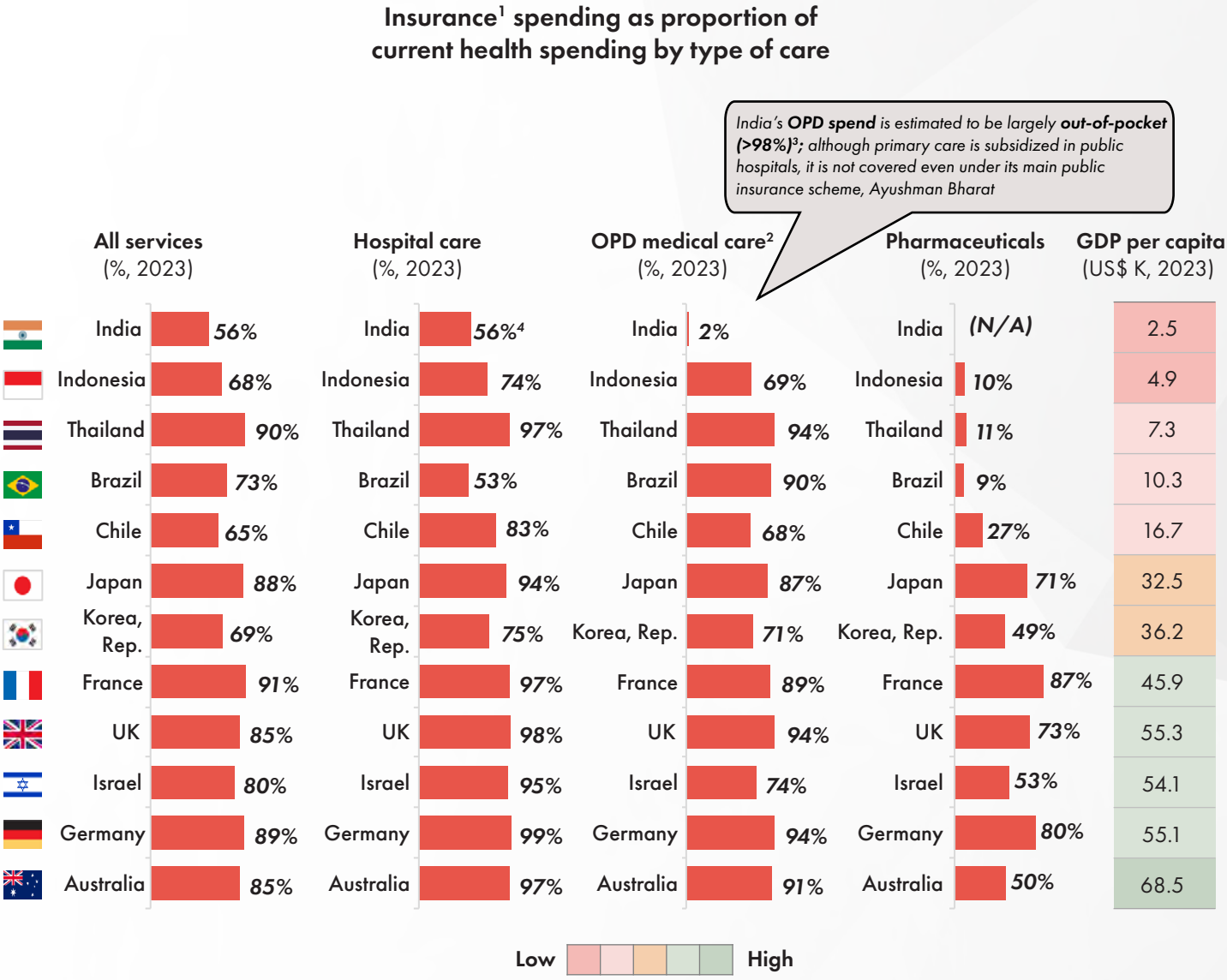
In addition to income-based disparities, health insurance coverage in India also varies widely across states (Exhibit 3.E). Differences in economic development, public health policy implementation, and the maturity of local insurance ecosystems have resulted in uneven insurance coverage across regions.

States such as Karnataka, Maharashtra, Delhi and Haryana generally exhibit higher overall insurance coverage, reflecting stronger healthcare infrastructure, higher formal employment, and more consistent implementation of government insurance schemes. In contrast, states like Uttar Pradesh, Bihar, and parts of northern and central India, continue to exhibit relatively low insurance penetration, leaving a large share of the population dependent on out-of-pocket healthcare spending.

Addressing these geographic disparities represents an important opportunity to strengthen the national healthcare financing architecture. Moving toward greater harmonization of minimum coverage standards and improving portability of benefits across states can help reduce fragmentation. Achieving more universal coverage will therefore require progress across three interlinked dimensions: expanding the breadth of coverage across populations, deepening the scope of services covered, and ensuring greater consistency in how healthcare financing mechanisms operate across states.

Exhibit 3.F

Insurance spending as proportion of current health spending by type of care



Note(s): [1]Calculated by considering % of expenditure financed by govt + compulsory + voluntary schemes using OECD data; [2]outpatient medical care doesn't include dental care & pharmaceuticals; [3]India's OPD insurance coverage is estimated basis enterprise OPD coverage and retail OPD add-on spend; [4]Same as all services given low OPD coverage
Source(s): OECD Health expenditure and financing data, Praxis analysis

International comparisons highlight a structural gap in India's healthcare financing architecture: insurance coverage remains heavily concentrated in inpatient hospital care, while outpatient spending is largely financed out-of-pocket (Exhibit 3.F).

Across OECD and several emerging healthcare systems, insurance mechanisms comprising government schemes, mandatory insurance, and voluntary coverage finance a substantial share of both inpatient and outpatient services. In mature systems, insurance typically covers 70–90% of hospital spending and a similarly large share of outpatient care, reflecting strong risk pooling. Countries such as Germany, France, the United Kingdom, and Japan demonstrate broad insurance participation, ensuring that consultations, diagnostics, and pharmaceuticals are largely funded through pooled mechanisms rather than direct household spending.

In contrast, India shows a markedly different pattern. While insurance covers around 56% of hospital spending, outpatient coverage remains extremely limited at roughly 2% of OPD expenditure. As a result, most outpatient consultations, diagnostics, and routine care are paid directly by households, reducing emphasis on preventive care and increasing reliance on costlier treatment, leading to poorer cost and health outcomes.

This imbalance has significant implications for financial protection and healthcare utilization. Outpatient services form a large share of healthcare interactions and are critical for early detection and long-term management of chronic diseases such as diabetes, hypertension, and cardiovascular conditions. However, as these services are largely excluded from insurance coverage—including under major public schemes like Ayushman Bharat, households continue to bear these costs directly.

Exhibit 3.G

Comparison of healthcare service coverage design by private health insurers across markets

		Emerging markets				*Matured markets*		
Quality enabler	Procedures to add	India	Indonesia	Thailand	Brazil	UK	Germany	USA
OPD consultations	• *Routine GP consult* • *Disease follow-ups*	Mostly add on	Copay	Mostly add on	Copay	Mostly add on	Deductible	Deductible & copay
Primary care	• *Annual check-ups* • *Preventive care*	Mostly add on	Copay	Copay	Copay	Mostly add on	No cost	Copay (No cost for preventive)
Diagnostics testing	• *Basic blood tests* • *Chronic monitoring*	Mostly add on	Copay	Copay	Copay	Mostly add on	Deductible	Deductible & copay
Telemedicine / Virtual consults	• *Virtual consults and e-prescriptions*	Copay	Copay	Copay	Copay	No cost	No cost	Copay
Rehabilitation & physiotherapy	• *Outpatient rehab sessions*	Mostly add on	Mostly add on	Mostly add on	Copay	Mostly add on	Deductible	Deductible & copay
Specialist consultation	• *First specialist visit* • *Referral visit*	Mostly add on	Copay	Mostly add on	Copay	Mostly add on	Deductible	Deductible & copay
Robotic surgery	• *Clinically indicated robotic procedures based on HTA*	Sub-limit[1]	Sub-limit	Copay	Sub-limit	Deductible	Deductible	Deductible & copay
Pharmacy benefits (OPD drugs)	• *Chronic medicines* • *Drug formulary incl. advanced therapies*	N/A	Copay[2]	Copay	Copay	Residents mostly use NHS	Copay	Deductible & copay[2]
Ophthalmology	• *Cataract surgery* • *Diabetic retinopathy*	Mostly add on	Copay	Copay	Copay	Deductible	Deductible	Deductible & copay
Mental health & counselling	• *Psychotherapy* • *Psychiatry consults*	Copay for psychiatry	Copay	Copay	Copay	Deductible	Copay	Deductibl & copay

Mostly covered | Covered as add-on or in high-end plans | Limited / not covered

Note(s): HTA: Health Technology Assessment , OPD: Outpatient department, IPD: Inpatient department, [1]Mostly covers only basic surgery costs, [2]Tightly managed by formularies, mostly require pre-authorization
Source(s): Secondary research, Praxis analysis

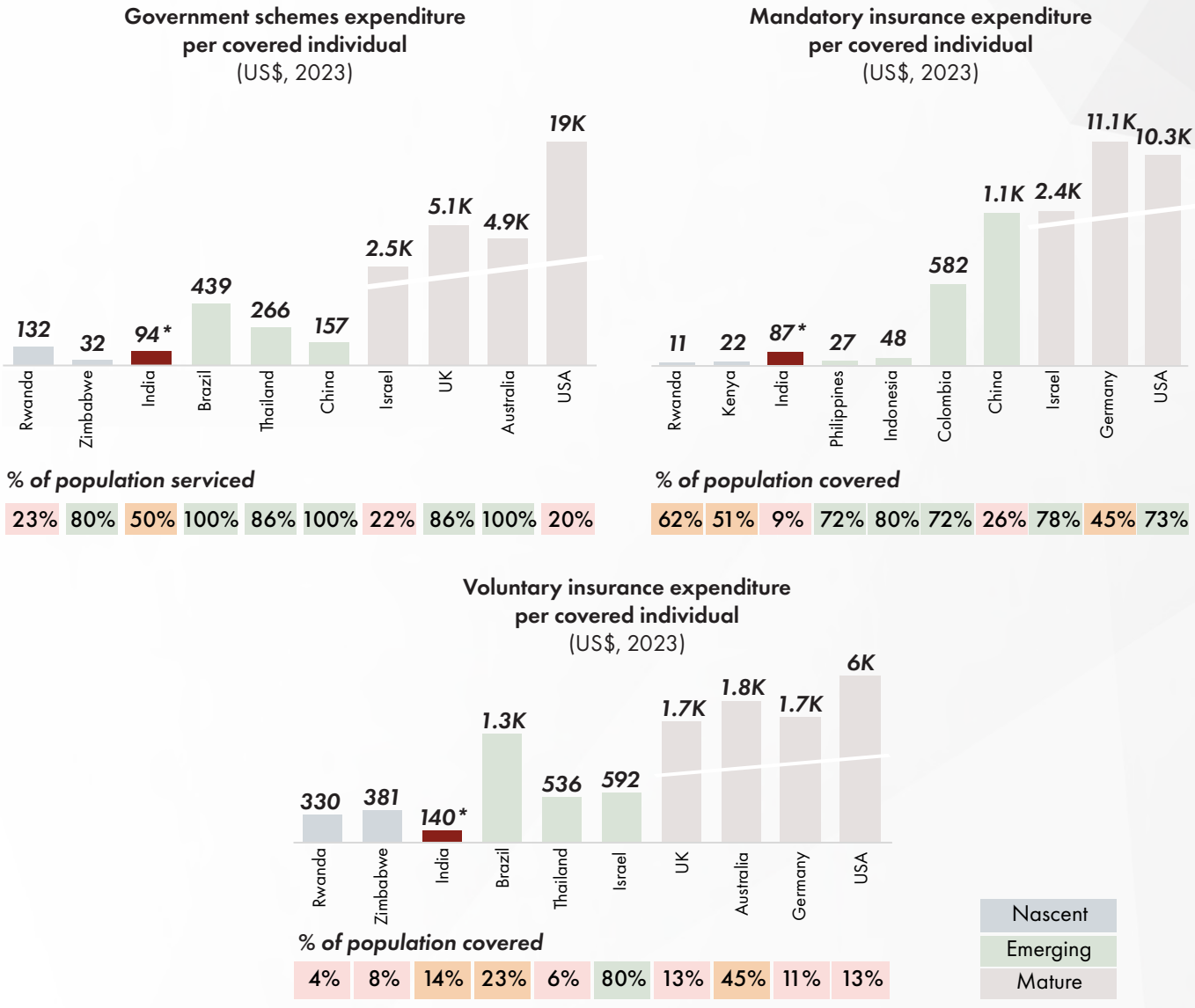
Private health insurance products in India remain largely structured around hospitalization-led coverage models, with most policies designed primarily to reimburse inpatient treatment costs. As a result, several services that form the backbone of routine healthcare, such as outpatient consultations, diagnostic testing, preventive care, and long-term disease monitoring, are either excluded from standard plans or available only through optional add-ons and limited riders (Exhibit 3.G).

International comparisons show that insurance coverage structures in many healthcare systems extend more broadly across the care pathway (Exhibit 3.F). In several mature markets, outpatient services such as general practitioner consultations, diagnostics, rehabilitation, mental health services, and preventive care are covered as part of the standard health benefits available to citizens, through publicly financed universal coverage programs. Even where private insurers offer outpatient or preventive services only as supplemental add-ons, baseline access to primary care, diagnostics, and chronic disease management is often already funded through national health systems.

India's insurance product architecture (esp. voluntary private insurance) therefore remains relatively narrow in scope compared with these systems. The limited integration of outpatient and preventive services into insurance benefits reduces the role that insurers can play in supporting early diagnosis, disease monitoring, and ongoing care management. Expanding private insurance beyond hospitalization therefore represents a key opportunity to align financing with the full continuum of care. Greater inclusion of outpatient services, preventive screenings, chronic disease management, and mental health support in private insurance offerings can improve financial protection while encouraging earlier diagnosis and treatment. Over time, such models can also reduce overall system costs by preventing avoidable hospital admissions and improving long-term health outcomes.

Exhibit 3.H

Comparison of health expenditure per covered individual across government, mandatory, and voluntary insurance scheme



Note(s): *India figures are based on 2025 data
Source(s): WHO, Commonwealth fund, Ministries of health across countries, Praxis analysis

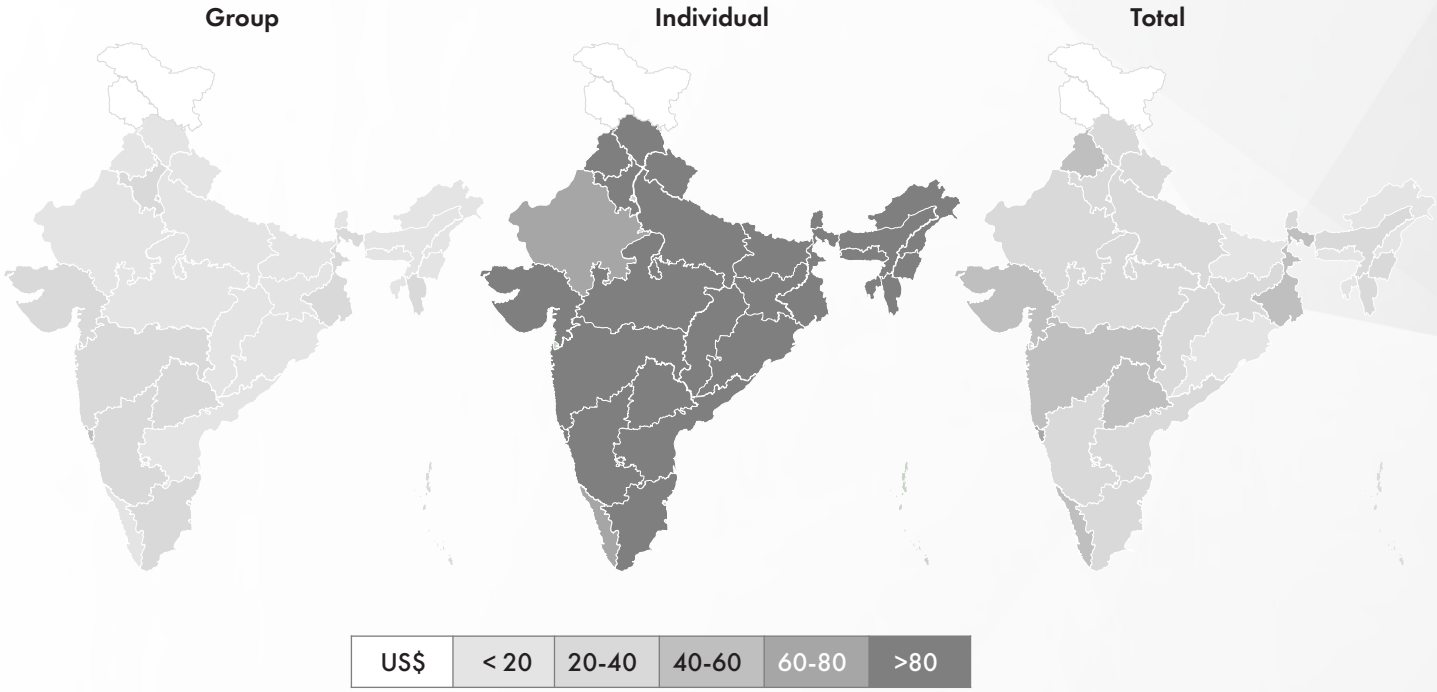
Strengthening healthcare financing requires not only expanding coverage but also increasing the depth of financial protection provided through insurance pools. Across government schemes, mandatory insurance systems, and voluntary insurance, healthcare expenditure per covered individual in India remains significantly lower than in many peer economies. For example, public scheme spending per beneficiary in India is roughly ~US$94 compared with several thousand dollars in mature health systems (Exhibit 3.H).

This gap suggests that while coverage has expanded in recent years, the financial resources allocated per insured individual remain relatively limited. Lower spending per covered person can constrain the breadth of services financed through insurance and may limit the system's ability to support comprehensive care.

Expanding the scale and role of financing pools, across public schemes, mandatory insurance mechanisms, and private voluntary insurance, represents an important opportunity to strengthen the healthcare system. Deeper financing pools can support broader benefit coverage, improve financial protection for households, and provide providers with more predictable funding to invest in infrastructure, workforce capacity, and service expansion.

Exhibit 3.I

State-wise distribution of health insurance premium per insured life across group, individual, and total segments



Note(s): Individual and group figures may overlap
Source(s): IRDAI Handbook, Praxis analysis

As insurance coverage expands, the depth of financing per insured individual becomes an important indicator of system strength. Premiums per insured life provide a proxy for the level of coverage and financial protection that insurance pools can sustain.

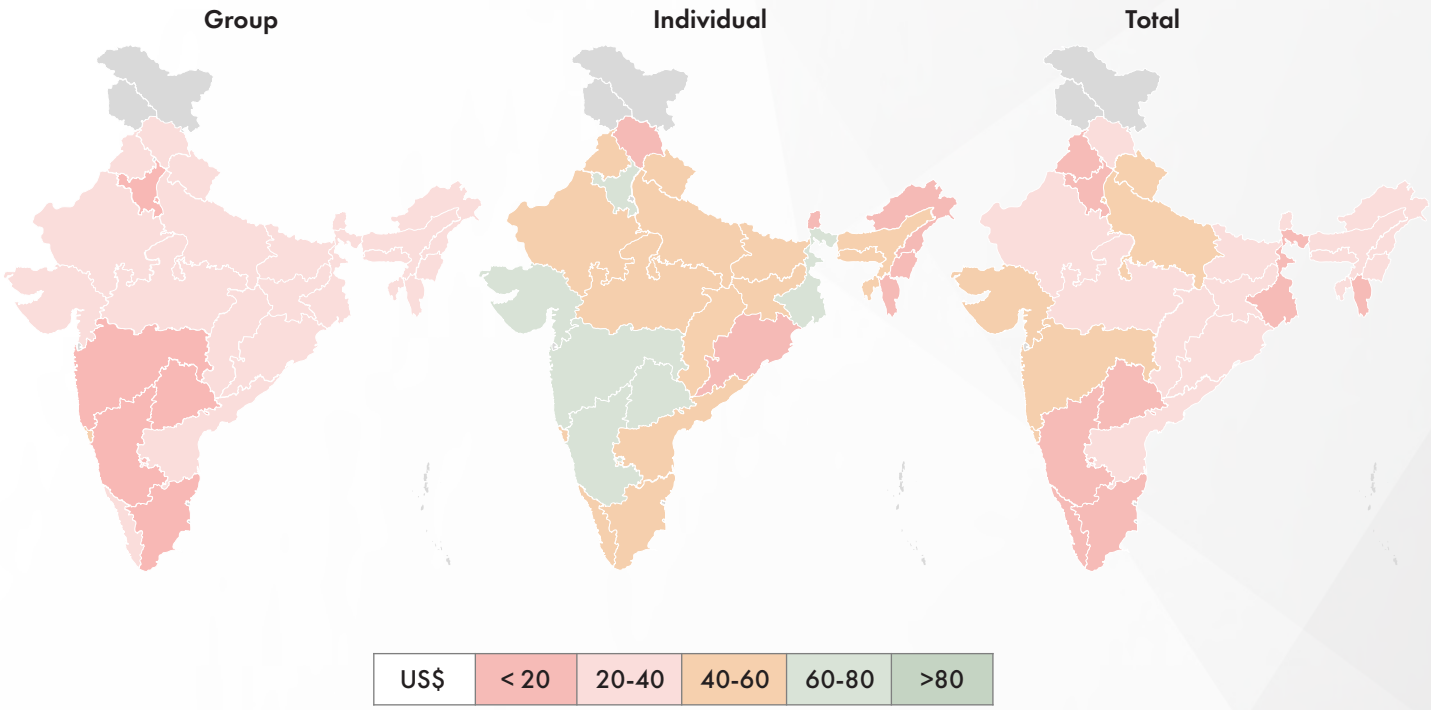
Premium levels vary significantly across states and across insurance segments (Exhibit 3.I). Group insurance policies, typically employer-sponsored, tend to have lower premiums per insured life, reflecting larger and more standardized risk pools. Individual retail policies, by contrast, generally exhibit higher premiums per insured life.

State-level patterns further highlight variation in insurance depth. Economically advanced states such as Maharashtra, Gujarat, Telangana, and Delhi show relatively higher premium levels, while states such as Bihar and Jharkhand exhibit lower premium depth.

This variation underscores an important dimension of India's insurance market. While coverage has expanded, the depth of insurance remains uneven across regions and segments. Strengthening risk pooling and expanding participation across both group and retail segments can help deepen coverage and improve the sustainability of healthcare financing.

Exhibit 3.J

State-wise distribution of expenditure per covered life across group, individual, and total segments



Note(s): Individual and group figures may overlap
Source(s): IRDAI Handbook, Praxis analysis

Healthcare expenditure per covered life provides an important indicator of how effectively insurance pools translate premiums into actual healthcare access. Higher spending per insured individual typically reflects deeper coverage, broader service utilization, and stronger financial protection for policyholders.

Expenditure per covered life varies significantly across both states and insurance segments (Exhibit 3.J). Individual insurance policies generally show higher expenditure per covered life compared with group policies, reflecting higher premiums and more individualized risk pools. Group insurance schemes, while covering larger populations, tend to operate with lower spending per insured individual due to standardized benefits and lower per-person premiums.

State-level patterns also reveal meaningful variation in spending depth. Southern and western states such as Telangana, Maharashtra, Gujarat show relatively higher expenditure per insured individual, reflecting stronger private insurance adoption and more developed healthcare provider ecosystems. In contrast, several northern and eastern states including Himachal Pradesh, Odisha, and parts of the Northeast exhibit lower spending per covered individual, suggesting more limited insurance coverage and lower utilization of insured healthcare services. Across most states, group insurance expenditure remains relatively low and uniform, reflecting standardized employer-sponsored coverage structures and broader risk pools.

The geographic variation across states also highlights differences in insurance maturity, healthcare utilization patterns, and provider ecosystem development. Strengthening healthcare financing will therefore require not only expanding coverage but also deepening financing pools across regions and insurance segments. Greater spending depth per insured life can support broader service coverage, improve healthcare access, and enhance the long-term sustainability of India's health insurance ecosystem.

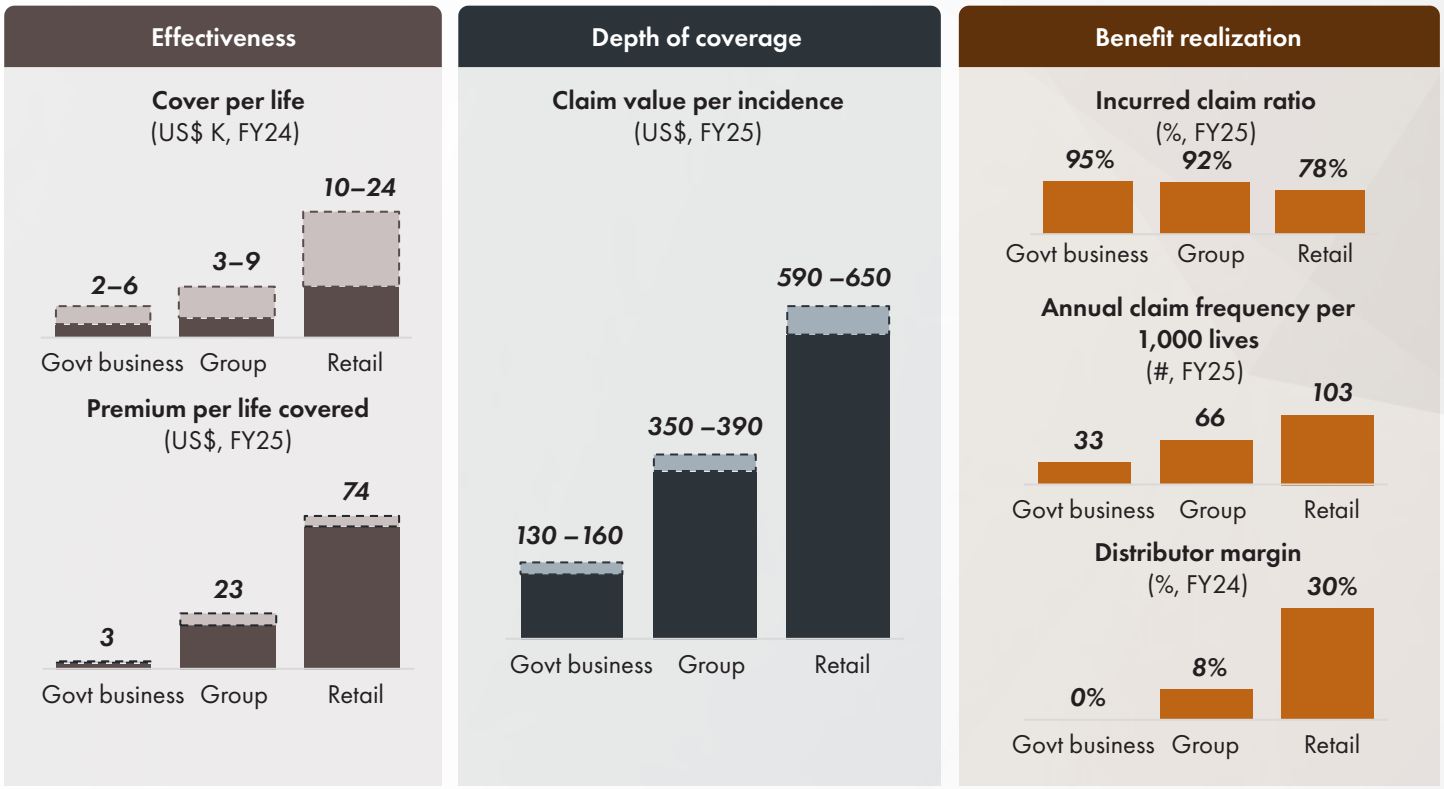
3.2. Efficiency

Health financing systems must not only expand coverage but also ensure that financial resources translate effectively into healthcare access and patient outcomes. In India, the health insurance ecosystem operates through multiple risk pools that differ in size, composition, and claims dynamics. These structural differences influence how efficiently insurance financing translates into healthcare services for patients.

Improving efficiency within the insurance ecosystem is therefore critical to strengthening the overall healthcare financing architecture. This includes ensuring that a greater share of premiums collected is translated into healthcare services, reducing administrative and distribution inefficiencies, and enabling smoother patient access to care through mechanisms such as cashless treatment and streamlined claims processes.

Exhibit 3.K

Comparison of coverage levels, premiums, claim values, and benefit realization across insurance segments



Note(s): Incurred claim ratio has been calculated using net premium and net claims
Source(s): IRDAI annual reports, FICCI-EYP True accountable care Report 2025, Praxis analysis

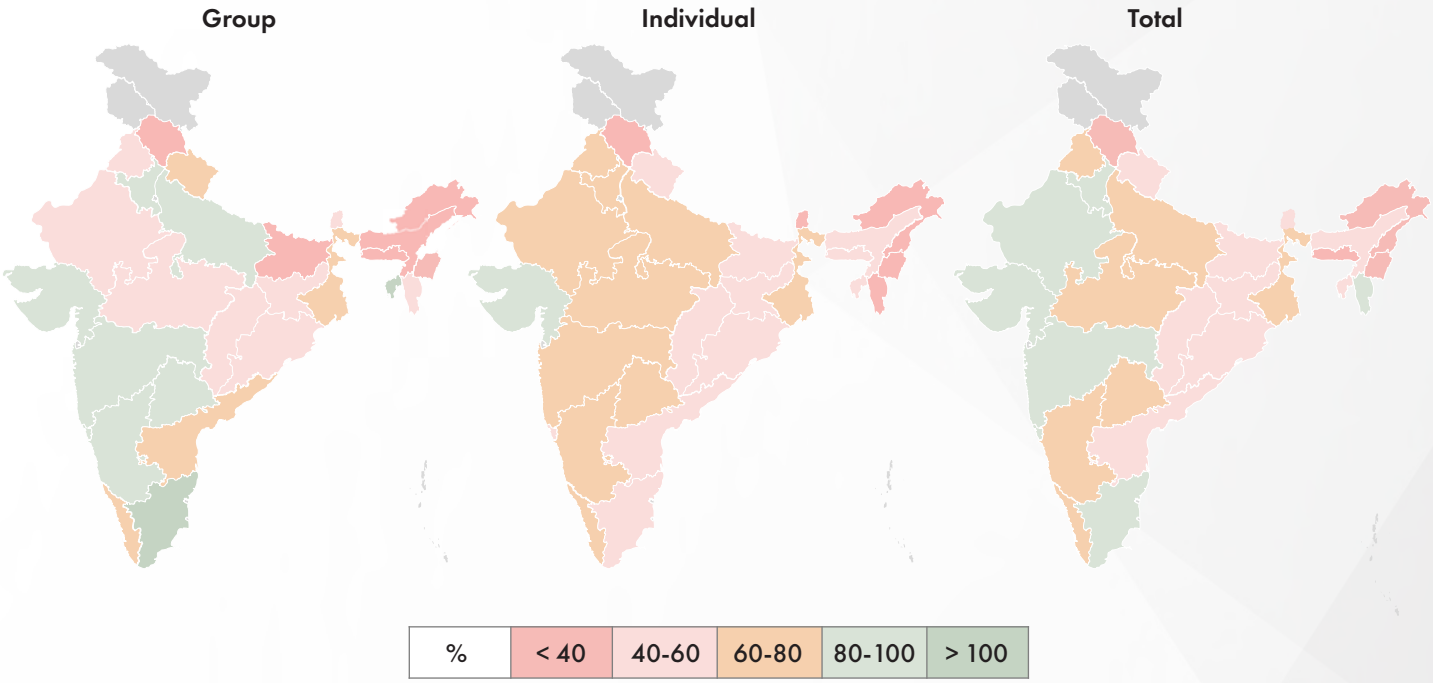
Despite the growth of health insurance coverage across India, the structure and performance of different insurance segments remain uneven in terms of coverage depth, benefit realization, and operational efficiency.

Government insurance programs typically operate with lower premiums per insured life but deliver relatively high claim ratios due to large risk pools and standardized package pricing (Exhibit 3.K). Employer-sponsored group insurance plans demonstrate higher claim frequency and larger claim values per incidence, reflecting broader coverage and higher healthcare utilization among insured populations. Retail insurance products, however, often exhibit lower claim ratios relative to premiums collected. This reflects several structural factors including higher distribution costs, smaller and more fragmented risk pools, and greater administrative overhead associated with underwriting and claims management.

These differences contribute to varying levels of benefit realization across insurance segments. Improving efficiency across the system will therefore require addressing structural gaps in distribution, underwriting, and coverage design, while also establishing clearer minimum standards for coverage to ensure that premiums translate more consistently into healthcare access for patients.

Exhibit 3.L

State-wise distribution of medical loss ratios (MLRs) across group, individual, and total segments



Note(s): Individual and group figures may overlap
Source(s): IRDAI Handbook, Praxis analysis

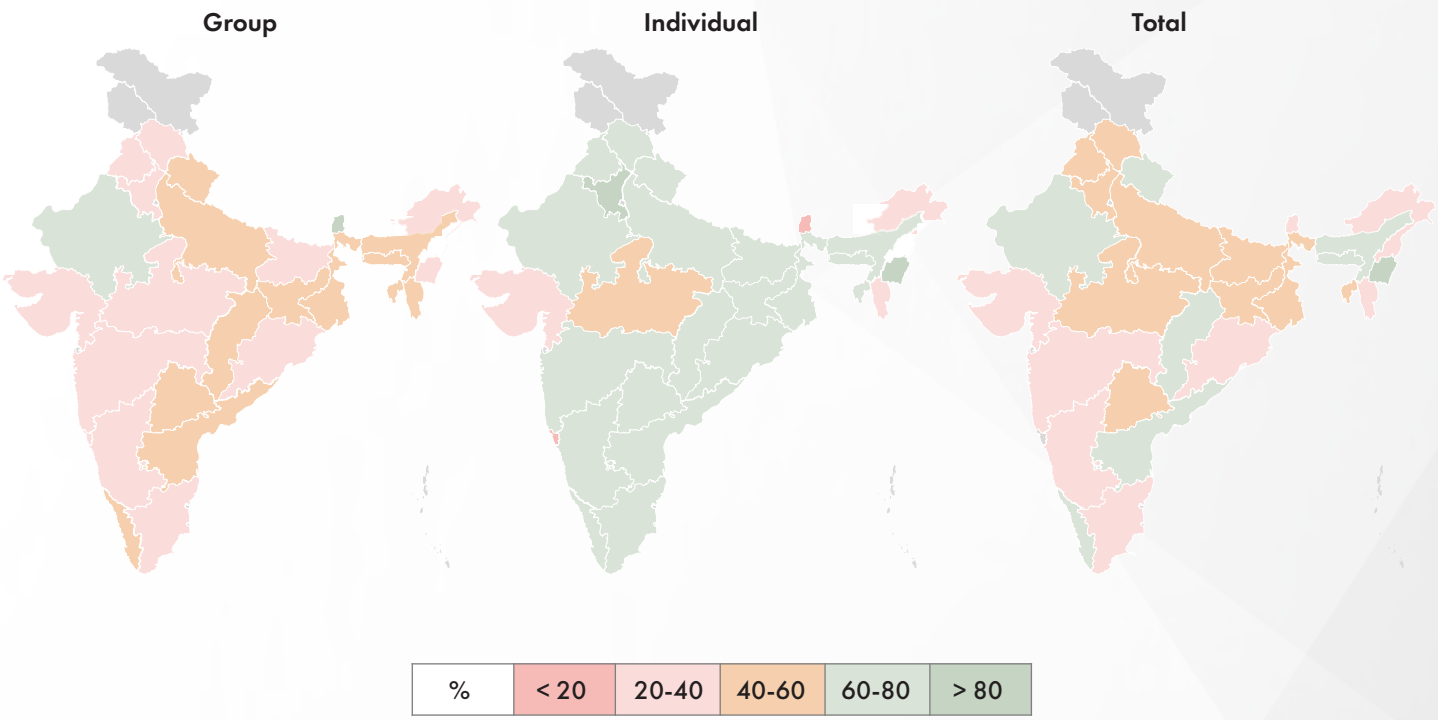
As discussed in the previous section, individual retail insurance policies tend to demonstrate lower claims realization relative to group insurance products. Exhibit 3.L indicates that this structural difference is further amplified by significant geographic variation across states.

MLR distributions vary widely across regions, reflecting differences in insurance market maturity, provider network depth, and healthcare utilization patterns. States with stronger private healthcare ecosystems such as Tamil Nadu, Maharashtra, Gujarat and Rajasthan generally demonstrate higher claims realization. These markets benefit from deeper hospital networks, higher insurance coverage, and greater familiarity with insurance utilization among both providers and patients.

In contrast, states with less developed private healthcare ecosystems or lower insurance awareness such as Himachal Pradesh, Bihar and parts of the North-East often exhibit lower realized MLRs. Limited provider network integration, lower healthcare utilization among insured populations, and weaker claims infrastructure can reduce the extent to which insurance coverage translates into actual care delivery.

Exhibit 3.M

State-wise distribution of cashless penetration across group, individual, and total segments



Note(s): Individual and group figures may overlap
Source(s): IRDAI Handbook, Praxis analysis

Cashless access is a key indicator of operational efficiency in health insurance, as it allows patients to receive treatment without making upfront payments while enabling direct settlement between insurers and providers. The exhibit shows that cashless penetration varies widely across states, indicating uneven integration between insurers, hospitals, and claims administrators across the country.

Interestingly, higher healthcare market maturity does not necessarily translate into higher cashless utilization. For example, large insurance markets such as Maharashtra and Gujarat demonstrate relatively lower cashless penetration, suggesting that reimbursement-based claims remain common even in states with significant insurance activity (Exhibit 3.M). In contrast, several other states demonstrate relatively stronger cashless adoption, reflecting differences in insurer network integration and hospital participation in cashless arrangements.

A further distinction emerges across insurance segments. Employer-sponsored group insurance programs typically drive higher cashless utilization, supported by pre-negotiated hospital networks and standardized corporate policy administration. Individual insurance markets, however, show much greater variability across states, reflecting differences in insurer network breadth, hospital empanelment, and operational claims infrastructure.

3.3. Sustainability

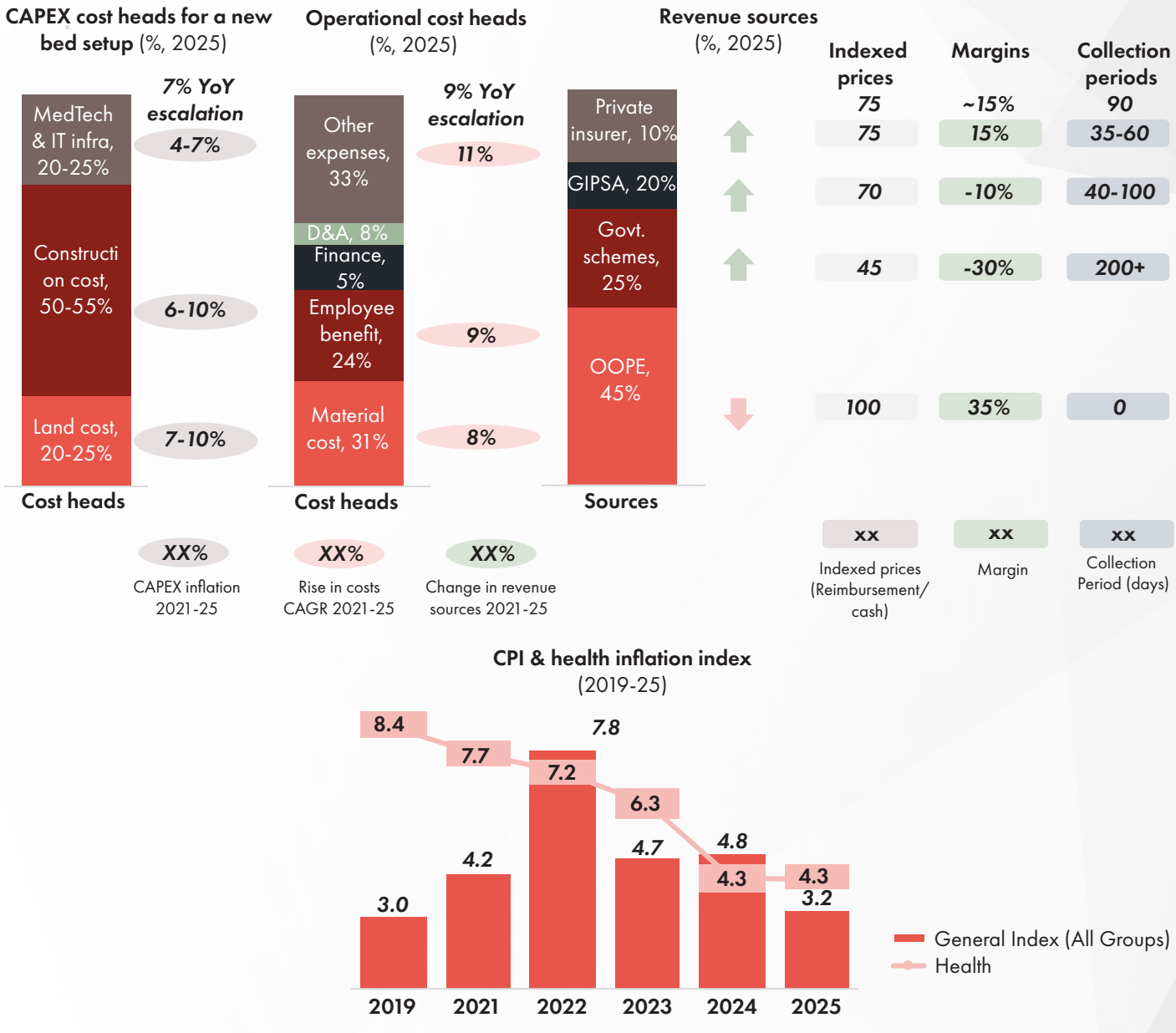
As healthcare coverage expands and utilization rises, the financial sustainability of the healthcare delivery ecosystem becomes increasingly critical. Insurance and government financing mechanisms must not only improve access and financial protection for patients but also ensure that healthcare providers remain economically viable.

Healthcare institutions have been facing ever-increasing inputs costs, with input costs escalation almost being in the 9-10% CAGR domain, owing to rising wages, capex, depreciating INR, and general consumer inflation. Despite this increase in input costs, medical inflation has only hovered around 4% in the recent years, demonstrating that a large share of these cost pressures has been absorbed by hospitals through efficiency and sustainability pressures. Going ahead, it will be critical to ensure control of this input escalation as well as sustainable financing of hospitals for the treatments delivered.

Hospitals operate in a highly capital-intensive environment, requiring sustained investments in infrastructure, medical technology, and skilled workforce capacity. At the same time, a growing share of healthcare revenue is now derived from government programs and insurance payors, many of which operate under standardized reimbursement structures. Maintaining long-term system sustainability will therefore require balancing affordability for patients with reimbursement frameworks that support continued investment in healthcare capacity and quality.

Exhibit 3.N

Hospital cost structure, revenue mix, and healthcare inflation trends



Source(s): MoSPI, Annual reports, Expert conversations, Praxis analysis

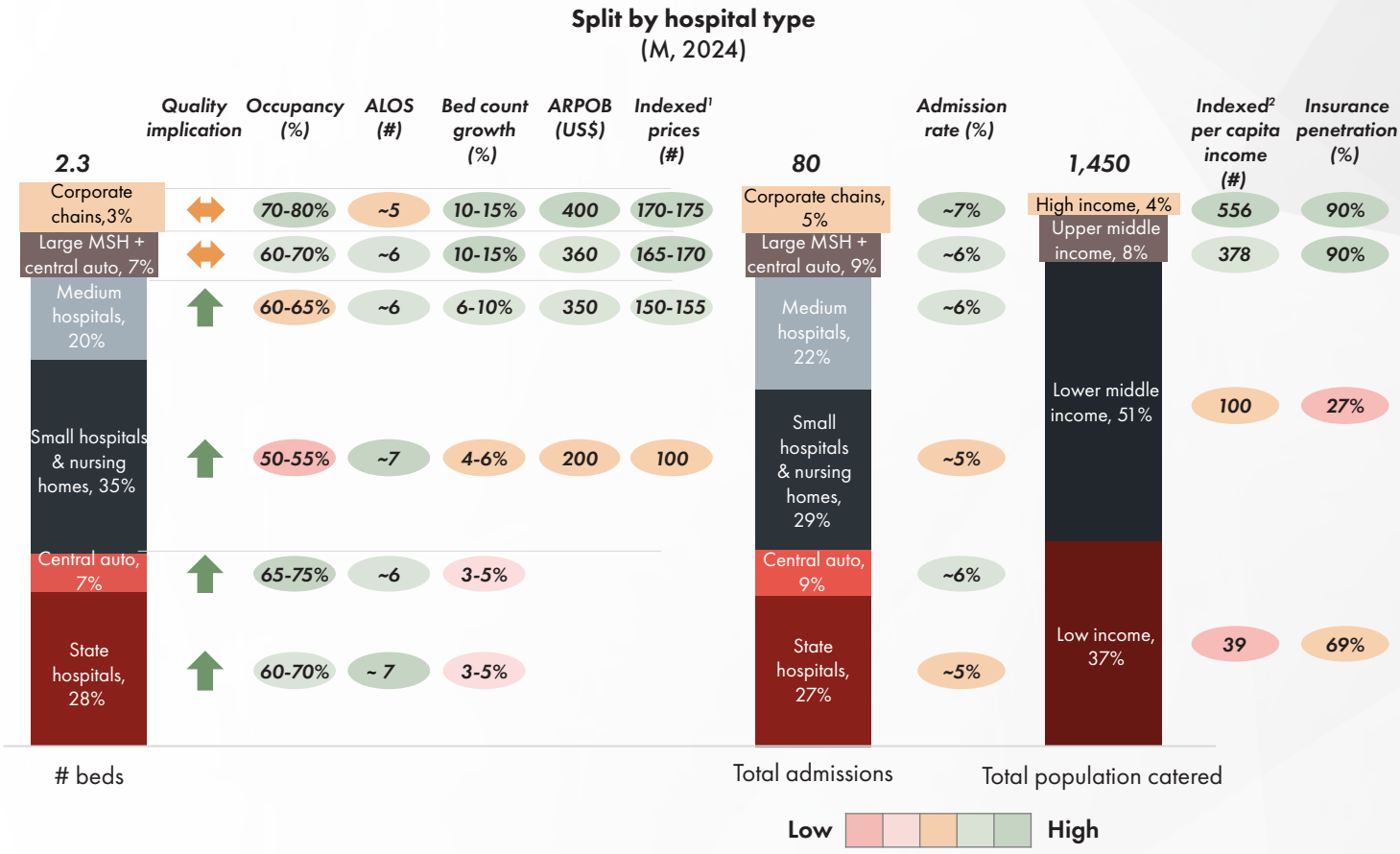
Healthcare financing plays a critical role in shaping the investment capacity and operating stability of healthcare providers. Hospital development is inherently capital-intensive, requiring substantial upfront investment in land, construction, medical equipment, and digital infrastructure (Exhibit 3.N). Expanding insurance-based financing can significantly improve the investment environment for providers by creating more predictable demand, structured reimbursement mechanisms, and stable revenue flows compared with reliance on out-of-pocket payments. Greater insurance penetration can therefore support long-term capital formation and encourage expansion of hospital infrastructure and clinical capabilities.

However, the current structure of insurance financing also presents operational challenges for providers. Reimbursement tariffs under government programs and several insurance contracts are often tightly negotiated and revised infrequently, while payment cycles can extend over several months. This creates pressure on provider margins, particularly in an environment where operating costs, including workforce expenses, medical consumables, and technology investments, continue to rise.

Strengthening the provider financing environment will therefore require improvements in how insurance systems interact with healthcare delivery. More predictable tariff revision mechanisms, faster claims settlement cycles, and reimbursement structures that better reflect cost inflation can help ensure that providers remain financially viable while continuing to invest in quality, capacity expansion, and advanced clinical services. Over time, a more balanced financing framework can align insurer sustainability with provider investment incentives, enabling the healthcare system to expand without compromising quality of care.

Exhibit 3.O

Performance metrics and patient mix across hospital types in India



Note(s): [1]indexed against average price for small hospitals & nursing homes; [2]indexed against average per capita income for lower middle income group; auto: autonomous
Source(s): Praxis analysis

Patient demand patterns increasingly reflect a preference for providers that offer advanced clinical capabilities and comprehensive care pathways. Corporate and multi-specialty hospitals, which typically provide a broader range of specialized services and clinical infrastructure, are therefore seeing relatively stronger occupancy and utilization levels despite operating at higher price points. The corporate hospital chains operate at occupancy levels of ~70–80% compared with ~50–55% in smaller hospitals, while also maintaining higher revenue per occupied bed. (Exhibit 3.O)

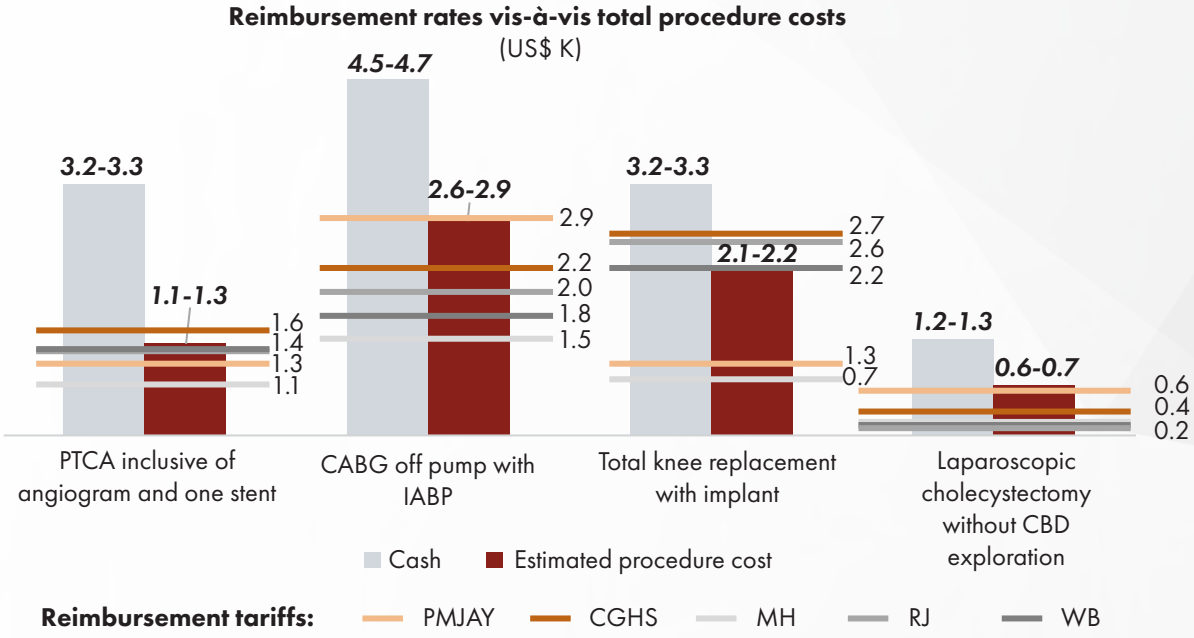
This pattern suggests that patients are willing to prioritize quality of care over cost when making treatment decisions. As a result, demand increasingly concentrates in providers that demonstrate stronger clinical capabilities and care outcomes, while smaller and lower-capability hospitals operate at comparatively lower utilization levels. While also comparing occupancy, it is critical to note that the

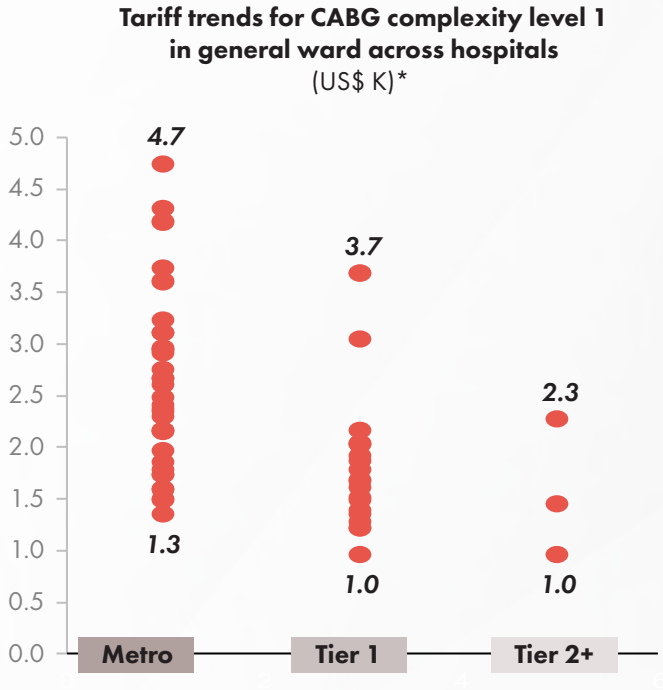
cost of care at some of these organized hospitals is not more than 2x of the standalone unorganized providers, despite the patient population coming to these centres being 3-5x wealthier. All these observations would demonstrate the trend that patients are increasingly preferring quality rather than compromising for lower cost with lower quality, irrespective of financial background. The implication of this is that health financiers and insurers should benchmark against organized providers, focus on quality over lower cost, as well as demand quality of outcomes from the unorganized providers.

However, current reimbursement structures do not always adequately differentiate between providers based on quality or outcomes. As patient volumes gravitate toward higher-quality hospitals, the financing framework must evolve to better align incentives across the system. Linking reimbursement more closely to provider quality and outcomes would ensure that payment structures reward higher standards of care while encouraging quality improvements across the broader provider ecosystem.

Exhibit 3.P

Comparison of reimbursement rates versus procedure costs and tariff variation across hospital tiers





Note(s): CABG: Coronary Artery Bypass Grafting; IABP: Intra-Aortic Balloon Pump; CBD: Common bile duct; *As per analysis of rates across ~90 hospitals across 15 cities and potential for harmonization using illustrative methodology
Source(s): FICCI, EY-P report (2025), Praxis analysis

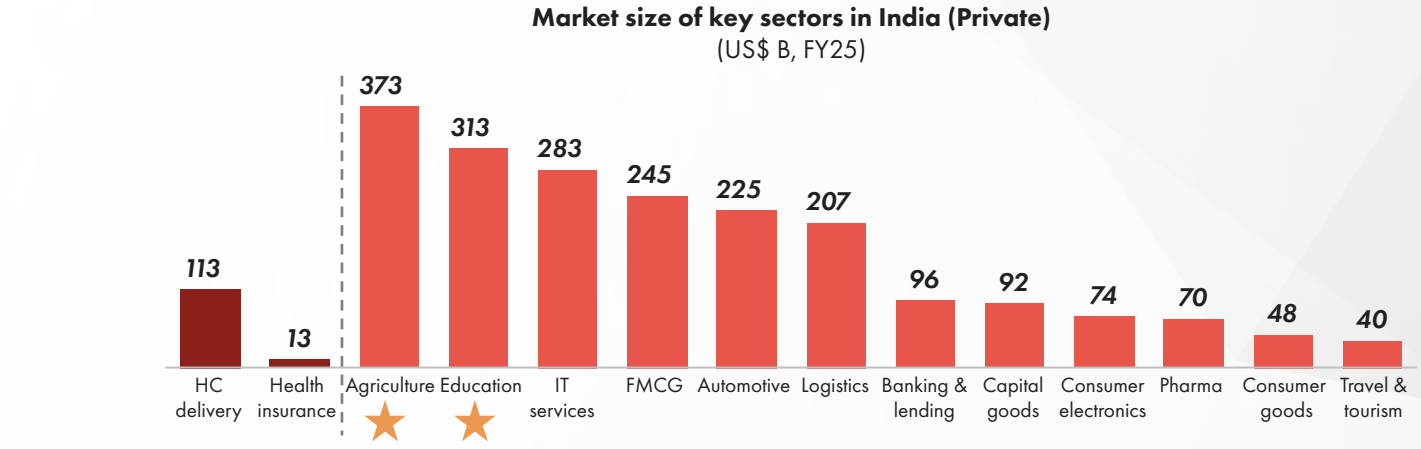
While patients increasingly gravitate toward higher-quality providers, reimbursement structures across the healthcare financing ecosystem remain fragmented. Tariffs across public insurance schemes and payer programs often vary significantly across procedures and geographies (Exhibit 3.P), and in several cases do not adequately reflect the underlying cost structures required to deliver high-quality care. This creates a disconnect between the level of clinical capability required and the reimbursement available to providers.

In addition, tariff dispersion across hospitals for similar procedures indicates limited consistency in how care is valued across different markets and provider tiers. Such variability can weaken incentives for providers to invest in clinical quality, infrastructure, and advanced capabilities, particularly when reimbursement does not sufficiently differentiate between higher and lower-quality providers.

As India's healthcare ecosystem matures, a more structured and transparent tariff framework will be critical. Aligning reimbursement more closely with quality standards, outcomes, and provider capability can help ensure that payment systems reward better care, encourage adherence to accreditation and quality benchmarks, and support the long-term sustainability of high-quality healthcare delivery.

Exhibit 3.Q

Comparison of market size and investment returns across key sectors in India



Investment economics for top 3-5 listed players:

ROCE	13-15%	4-7%	15-18%	15-20%	20-25%	26-30%	15-19%	15-20%	5-8%	20-24%	17-20%	21-28%	17-21%	15-18%
Debt interest	8-11%	8-10%	7-9%	7-10%	7-10%	7-9%	7-9%	7-9%	8-13%	8-10%	8-11%	7-11%	7-9%	5-8%
Returns on equity	9-17%	7-9%	16-21%	18-22%	20-25%	28-32%	14-18%	15-19%	9-15%	10-15%	12-16%	15-17%	12-15%	11-15%

Priority sectors as per RBI

Favorability: Low — High

Note(s): HC – Healthcare delivery
Source(s): Company annual reports, Industry reports, Praxis analysis

While demand for healthcare services continues to grow and patients increasingly seek higher-quality providers, the financial structure of the sector does not yet fully support large-scale investment. Healthcare delivery and health insurance continue to operate at relatively modest scale within the broader economy, while also exhibiting constrained return profiles, not matching its true potential, with healthcare providers typically generating return on capital employed of around 13-15% and health insurers reporting returns of about 4-7% (Exhibit 3.Q). At the same time, borrowing costs remain broadly comparable to other industries, limiting the financial flexibility required to support capital-intensive healthcare infrastructure expansion.

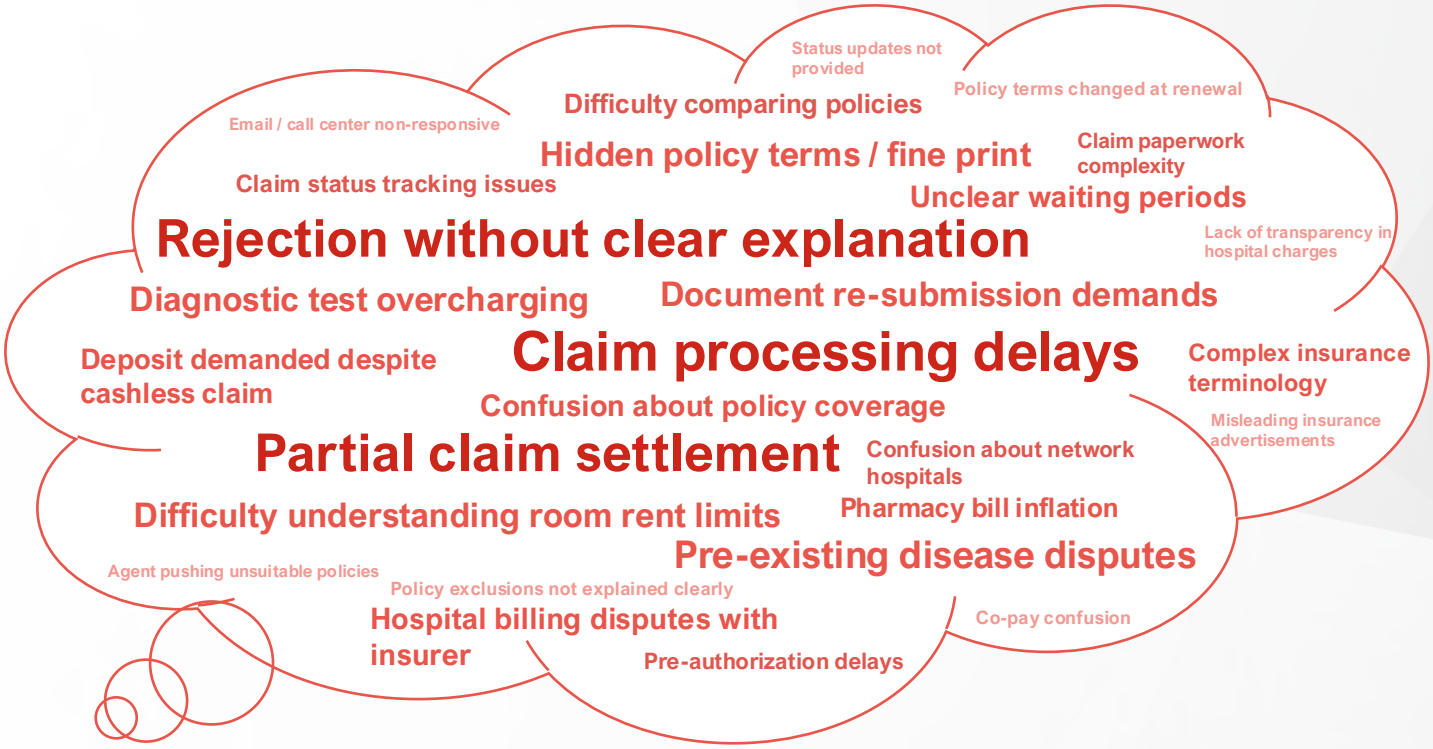
In sectors like agriculture and education, policy prioritization and enabling financing mechanisms have played an important role in improving investment economics and accelerating capacity creation. Enabling similar support could help strengthen the investment environment for healthcare as well. As India's healthcare system evolves toward greater coverage, quality, and scale, strengthening the investment attractiveness of healthcare delivery and health insurance will be critical. Measures such as improving reimbursement structures, expanding insurance coverage, and considering priority sector or preferential lending status for healthcare infrastructure and services could help lower the cost of capital and unlock greater private investment into the sector.

3.4. Quality of care

While strengthening financing structures and reimbursement frameworks is critical to improving the sustainability of the healthcare ecosystem, patient experience ultimately determines whether health insurance delivers meaningful access to care. Despite growing insurance coverage, patients in India continue to face significant friction across the insurance journey, from policy purchase and pre-authorization to claims settlement and post-treatment reconciliation.

Exhibit 3.R

Common patient-reported issues during health insurance claims processing in India



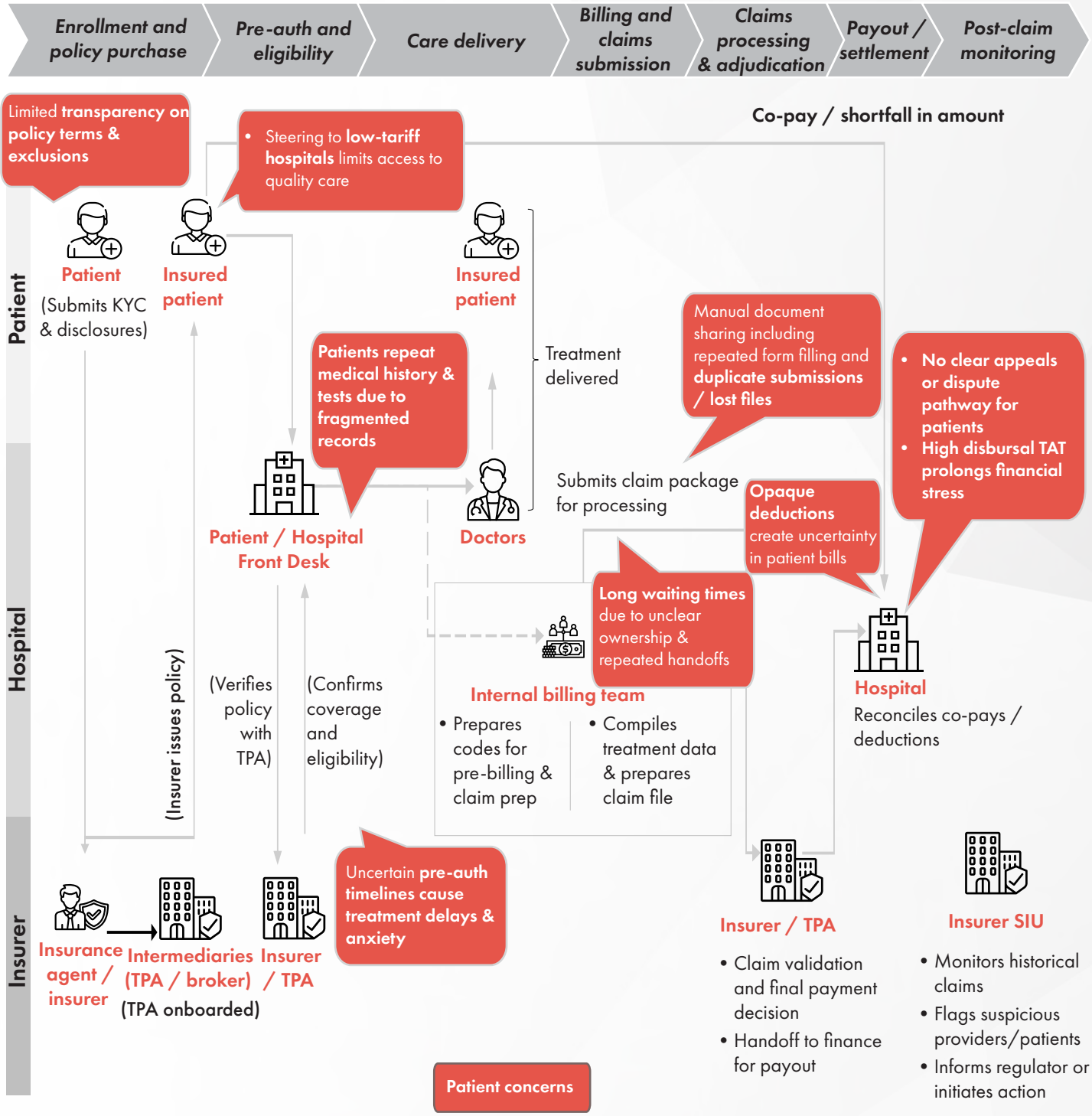
Sources(s): News articles, Secondary research, Praxis analysis

Patients in India continue to face significant friction across the health insurance journey, particularly during the claims process. Issues such as claim rejections without clear explanation, delays in claim processing, and partial claim settlements emerge as some of the most frequently reported concerns by patients navigating the system (Exhibit 3.R). These challenges not only create financial stress during medical episodes but also undermine trust in insurance coverage at a time when patients are most vulnerable.

Addressing these issues will be essential to improving patient trust and strengthening the role of health insurance in India's healthcare ecosystem. Greater transparency, simpler policy design, and more efficient claims management processes can help ensure that insurance functions as a reliable mechanism for financial protection during healthcare events.

Exhibit 3.S

Health insurance claims journey highlighting patient-level concerns across the process



Note(s): SIU: Special Investigative Unit
Sources(s): Primary conversations, News articles, Secondary research, Praxis analysis

Patient concerns arise across multiple touchpoints in the insurance lifecycle, including policy purchase, pre-authorization, care delivery, claims submission, and post-claim monitoring (Exhibit 3.S). Limited transparency around policy terms and fragmented documentation often lead to confusion and delays in approvals.

During claims, manual processes, repeated submissions, and unclear ownership across stakeholders result in long timelines and opaque deductions. Patients are also sometimes required to pay deposits despite cashless claims, increasing financial uncertainty.

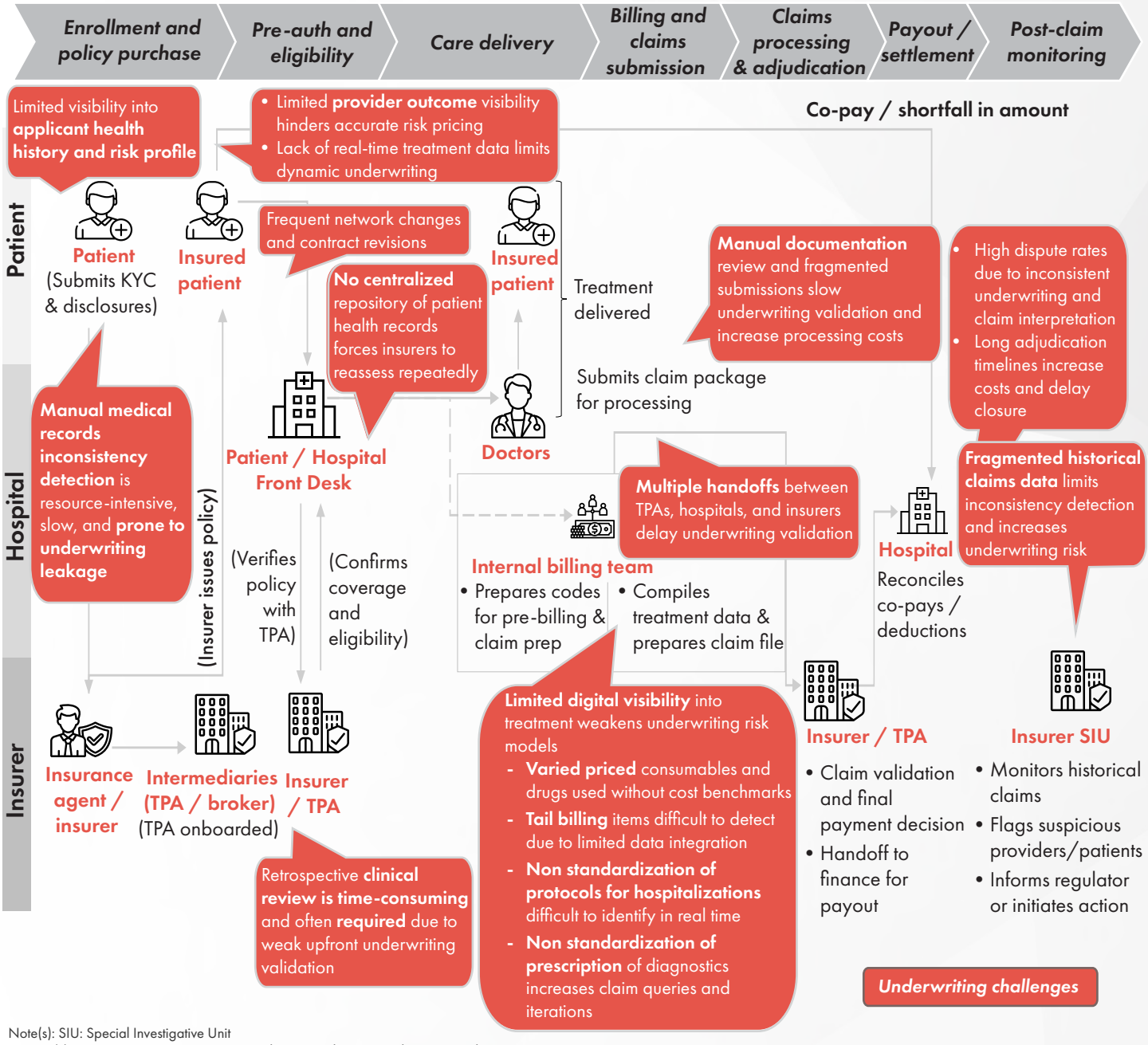
Strengthening coordination and leveraging technology to streamline processes, enable real-time verification, and improve transparency can significantly enhance patient experience and operational efficiency.

3.5. Digital, AI enablement & innovation

Many of the operational challenges across the insurance journey stem from fragmented processes, limited data visibility, and heavy reliance on manual documentation and verification. As the healthcare ecosystem continues to scale, improving efficiency, transparency, and underwriting accuracy will require stronger digital infrastructure across insurers, providers, and intermediaries.

Exhibit 3.T

Health insurance claims process flow and operational challenges across stakeholders



Note(s): SIU: Special Investigative Unit
Sources(s): Primary conversations, News articles, Secondary research, Praxis analysis

Insurers often have restricted visibility into patient medical histories, treatment records, and provider outcomes, which makes it difficult to perform accurate underwriting and real-time risk assessment (Exhibit 3.T). In the absence of integrated digital records, underwriting and claims validation processes rely heavily on manual documentation review and retrospective clinical verification. This not only increases administrative costs but also prolongs claims adjudication timelines and raises the likelihood of disputes between providers and insurers.

Expanding digital infrastructure across the healthcare ecosystem, including standardized health records, interoperable data platforms, and AI-enabled analytics tools, can significantly improve underwriting accuracy, enable faster claims validation, and strengthen fraud detection mechanisms. Over time, greater digital integration will be critical to building a more efficient and transparent healthcare insurance ecosystem.

04

GLOBAL CASE STUDIES: **WHAT CAN WE LEARN FROM OTHER MARKETS?**

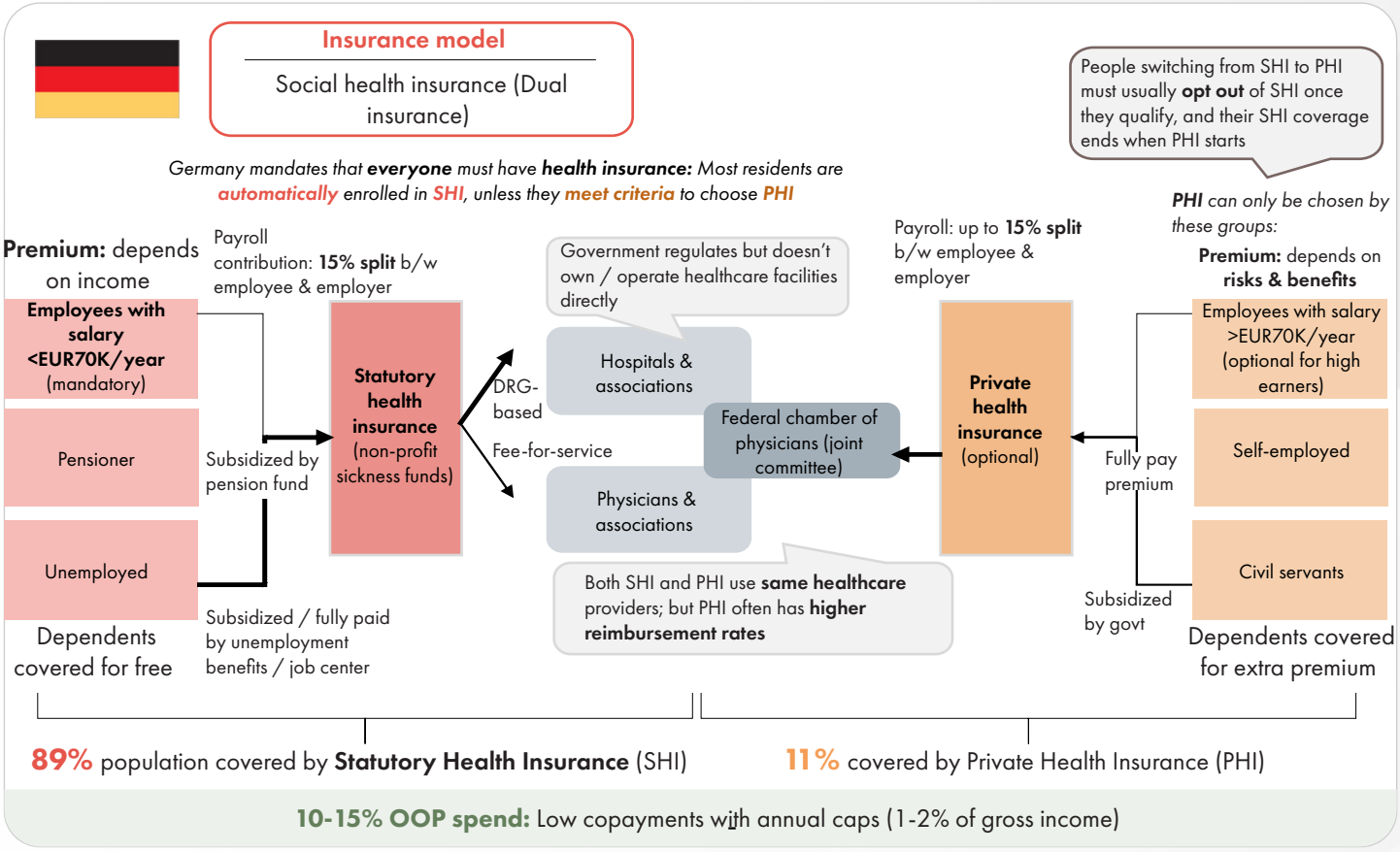
4 GLOBAL CASE STUDIES: WHAT CAN WE LEARN FROM OTHER MARKETS?

Many of the challenges observed in India's healthcare ecosystem, ranging from fragmented data systems to operational inefficiencies, have also been encountered by healthcare systems globally. Several countries have successfully addressed these challenges through targeted policy reforms, innovative payment models, and stronger digital health infrastructure, helping improve care quality, patient experience, and system efficiency. These global experiences offer valuable insights into how healthcare financing frameworks can evolve to better align incentives, streamline operational processes, and enable more effective coordination between providers and insurers.

4.1. Germany

Exhibit 4.A

Structure of Germany's health insurance system



What has worked

- Self-reported inability to access medical care due to cost, distance or waiting times is 0.3% (i.e., **unmet need is low**)
- **Low disparities** across income groups because basic access is not income-linked; also, cross-subsidization within SHI
- **Reference pricing** for drugs: insurers pay up to set maximum
- **Standardized state-wide** procedure codes and costs (DRG* basis) calculated from 300+ hospitals

Lessons for India

- **Mandatory insurance:** Universal mandate with **public-private synergy,** not competition; India could mandate a contributory 'Ayushman Bharat Plus' -a paid, income-linked scheme for the non-poor; private insurance can continue to be optional
- **Cross-subsidy:** Income-based contributions ensure **cross-subsidization** from rich to poor
- **Regulation:** Strong regulation prevents **cream-skimming** of applicants and ensures solidarity

Note(s): *Diagnostic Related Group system pays hospitals a fixed amount per case, based on diagnosis and procedures creating incentives to increase efficiency and shorten unnecessary stays
Source(s): Commonwealth fund, Economist, Insurance Germany, Praxis analysis

Lessons framework: Access & availability | Quality of care | Efficiency | Sustainability

Germany operates a dual health insurance system, achieving near-universal coverage through a complementary arrangement of statutory health insurance (SHI) and private health insurance (PHI). Germany mandates that all residents maintain health insurance coverage, achieved through a compulsory policy where SHI covers 89% of the population - primarily employees earning below the annual income threshold, pensioners, unemployed on benefits, and students; PHI (covering 11% population) is not universally accessible but reserved for specific population segments - high earners above the threshold, self-employed individuals, and civil servants. A critical structural feature is that SHI and PHI function as mutually exclusive primary insurance systems. Individuals cannot simultaneously maintain both full statutory and full private coverage, except during brief transition periods.

SHI is financed through income-linked payroll contributions shared by employers and employees, while PHI operates through risk-based premiums. Most retirees remain in or transition to SHI, with contributions calculated as a percentage of their pension income. Those receiving unemployment benefit or basic income support are automatically enrolled in SHI, with contributions fully covered by the Federal Employment Agency or local job centres. Unlike the income-linked solidarity model of SHI, PHI premiums are individually calculated based on risk factors (age, health status, etc.). Those earning above the compulsory insurance threshold may opt out of SHI and choose PHI as their primary. Self-employed individuals have unrestricted access to PHI regardless of income, representing a classic target group for private coverage. Civil servants receive state allowance covering 50-80% of medical costs, typically purchasing PHI "residual cost" policies for the remaining expenses rather than enrolling in full SHI.

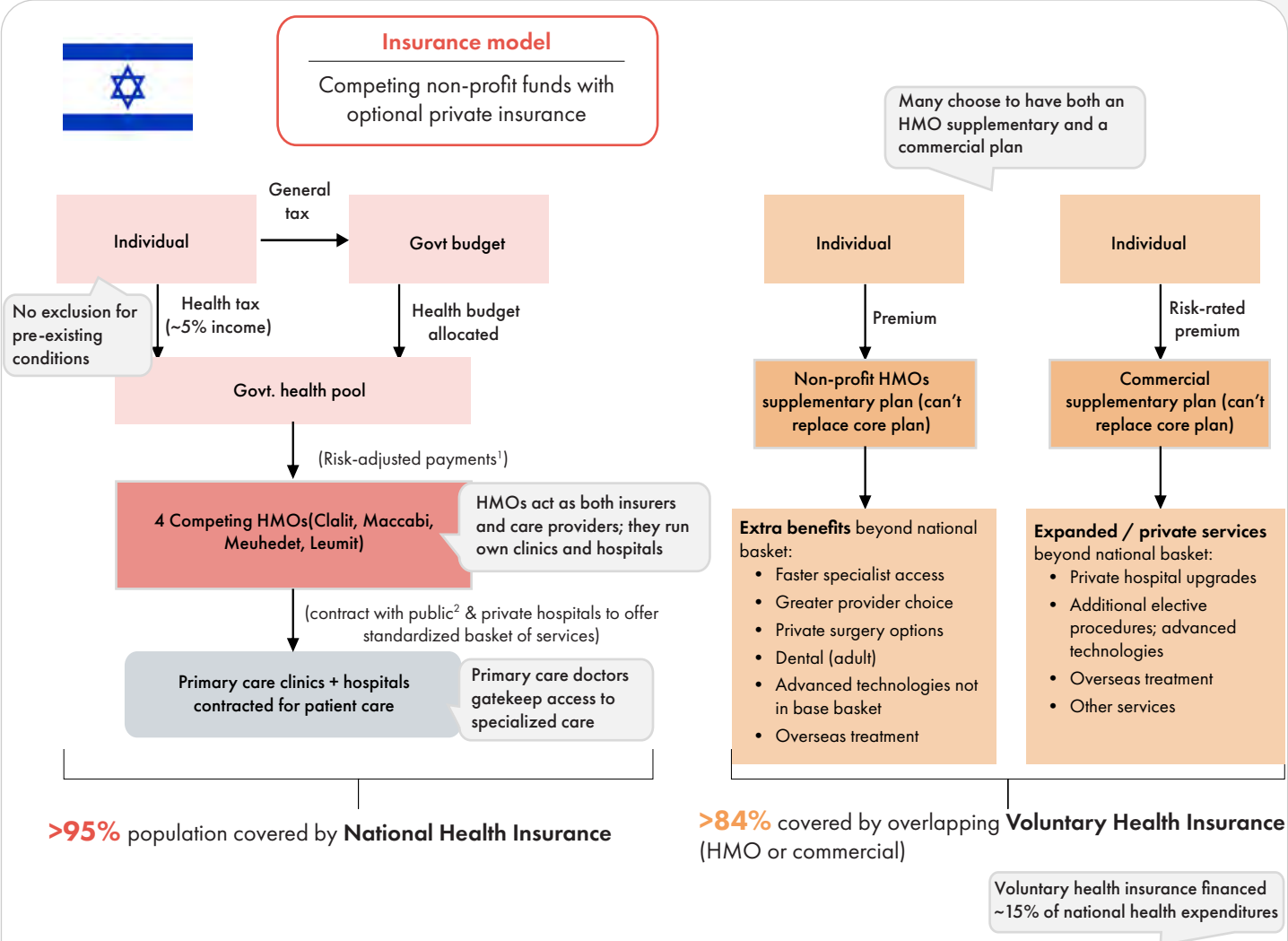
Importantly, both SHI and PHI utilize the same provider ecosystem and standardized reimbursement frameworks, with hospital payments largely determined through diagnosis-related group (DRG) mechanisms. The DRG system functions as the sole pricing, billing, and budgeting mechanism for all acute care hospitals, accounting for ~80% of total hospital reimbursement. This makes Germany unique internationally- DRGs are not merely a partial payment tool but the dominant revenue source for hospitals. Standardized payment systems and strong regulation ensure consistency in care delivery, while the presence of private insurance allows additional flexibility and supplementary coverage options.

For India, Germany's experience highlights the potential for public and private insurance to operate in a complementary manner rather than as competing systems. India could mandate a contributory 'Ayushman Bharat Plus' a paid, income-linked scheme for the non-poor; private insurance can continue to be optional. Mandatory coverage with income-based contributions, and strong regulatory oversight can help expand coverage while maintaining financial sustainability and provider participation.

4.2. Israel

Exhibit 4.B

Structure of Israel's health insurance system



~20% OOP spend: National basket is limited, leading to high private sector health financing in addition to OOP

What has worked

- Managed **competition** among health funds incentivizes quality and efficiency
- Transparent annual process for **expanding health basket;** regular HTA and new tech added only via committee
- **Capitation-based** budgets incentivize prevention and efficiency
- Israel shows excellent outcomes with moderate spending; e.g., lowest preventable mortality (134/100K) - 2nd best in OECD after Switzerland

Lessons for India

- **Regulated competition: VHI supplements** without undermining universal public coverage; India could enable regulated non-profit health insurers (similar to Israel's HMOs) to deliver standardized coverage under government oversight
- **Transparency in processes:** Transparent process for expanding coverage builds trust

Note(s): HMO: Health Maintenance Organization; HTA: Health Technology Assessment; [1]The government pays the HMO based on the number and characteristics of its members; [2]public hospitals in Israel are those owned by govt / HMOs;

Lessons framework: Access & availability | Quality of care | Efficiency | Sustainability

Israel operates one of the world's most efficient healthcare systems, combining universal public insurance with regulated competition among four non-profit health funds (HMOs: Clalit ~54%, Maccabi ~25%, Meuhedet ~13%, Leumit ~8%) under the National Health Insurance Law (1995), which mandates automatic enrollment for all ~9.8 million residents regardless of age, pre-existing conditions, or income. These funds serve as both insurers and care coordinators, providing a standardized national "health basket" of benefits (medications, treatments, preventive services) funded primarily through an earmarked progressive health tax (~5% of income, split between employees and employers, collected by the National Insurance Institute) plus general government revenues. Payments to funds use risk-adjusted capitation formulas accounting for age, sex, geography, and morbidity to prevent adverse selection and promote fairness. Members can switch funds twice yearly, fostering competition on service quality and innovation while open enrollment ensures equity.

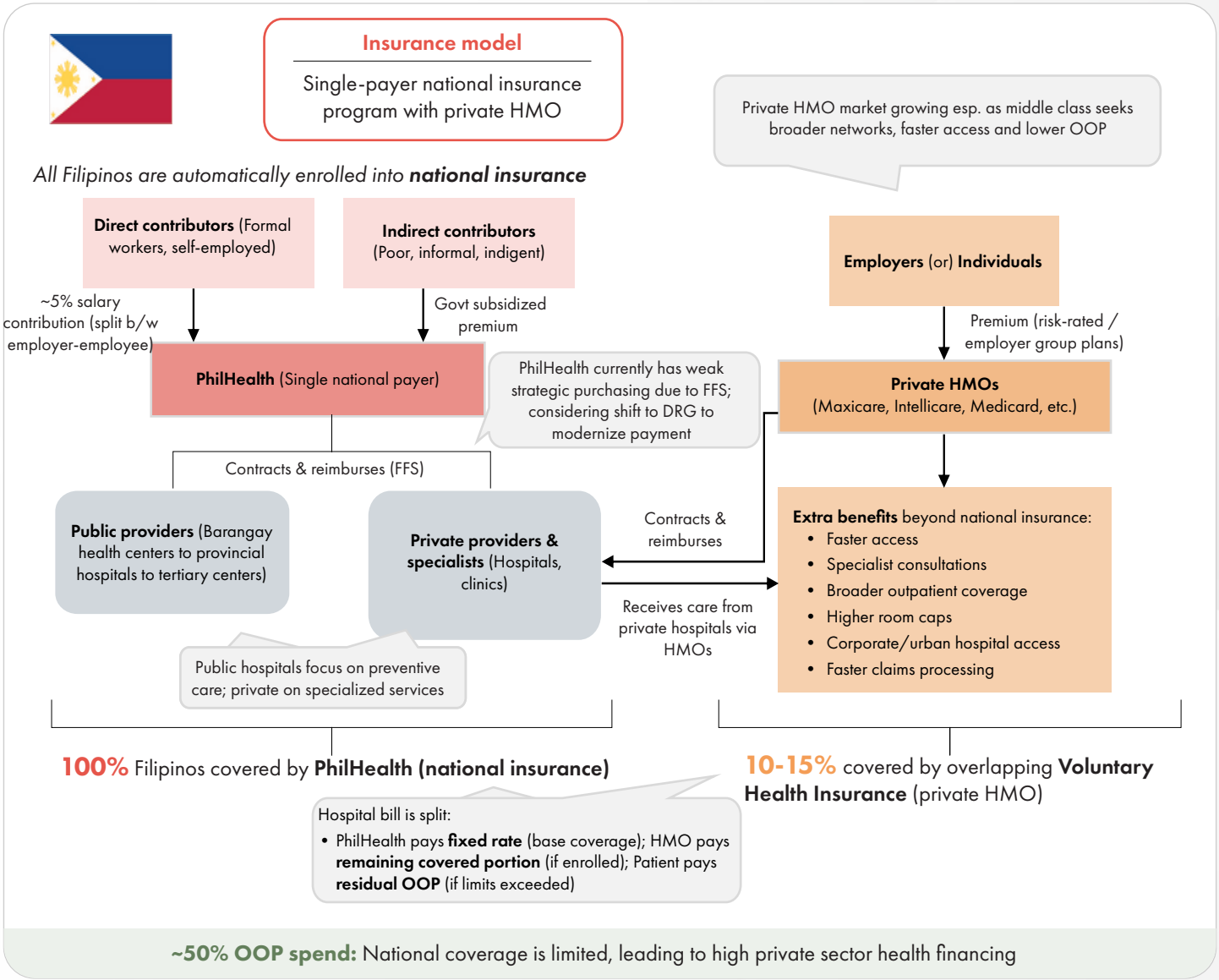
This system has enabled Israel to deliver strong health outcomes with relatively moderate healthcare spending, while maintaining universal coverage for over 95% of the population (Exhibit 4.B). The health basket- updated annually via a public committee reviewing hundreds of technologies/drugs against clinical, economic criteria- is identical across funds, with transparent processes building public trust; supplementary voluntary insurance (held by ~80% of citizens) covers extras like private rooms or faster specialist access. Both HMOs and private insurers reimburse the same providers: office-based primary/specialist physicians (many HMO-employed/contracted) operate clinics across funds' networks, while hospitals handle inpatient care via negotiated contracts or DRG-like payments, with HMOs owning/renting facilities for integrated delivery. Low co-pays and out-of-pocket spending (~20% of total health expenditure) support accessibility.

For India, Israel illustrates how regulated competition among insurers can improve system efficiency without compromising universal coverage; India could enable regulated non-profit health insurers (similar to Israel's HMOs) to deliver standardized coverage under government oversight. Establishing standardized benefit packages, risk-adjusted payments, and clear governance mechanisms could help strengthen coordination between insurers and providers while improving service quality.

4.3. Philippines

Exhibit 4.C

Structure of Philippines health insurance system



~50% OOP spend: National coverage is limited, leading to high private sector health financing

What has worked

- **Automatic** PhilHealth **enrollment** achieved universal coverage on paper by 2019
- **Private HMOs complement** PhilHealth; no substitution of public coverage
- **Government subsidies** for informal sector increased access for low-income groups

Lessons for India

- **Mandatory insurance: Automatic enrollment** achieves universal coverage administratively; however, coverage ≠ access as Philippines has shown implementation gaps
- **Financing public healthcare:** Payment reform is critical; outdated rates undermine system sustainability
  - **Govt subsidies** are essential for informal sector; Expand AB-PMJAY enrollment to informal workers

Note(s): HMO: Health Maintenance Organization; DRG: Diagnosis Related Group; Barangay: Small territorial and administrative district forming the most local level of government
Source(s): PhilHealth documents, Health Affairs journal, Praxis analysis

Lessons framework: Access & availability | Quality of care | Efficiency | Sustainability

The Philippines has pursued universal health coverage through a national single-payer insurance system led by the Philippine Health Insurance Corporation (PhilHealth), supported by government subsidies and mandatory enrolment. Under the Universal Health Care Act, all citizens are automatically enrolled in PhilHealth regardless of employment status, age, or pre-existing conditions. Direct contributors (formal sector workers, self-employed) pay progressive premiums shared equally with employers, while indirect contributors (informal/low-income, indigents, seniors) receive full government subsidies via national / local government budgets; PhilHealth provides a standardized benefits package including inpatient, outpatient consultations, maternity, benefits for catastrophic illnesses (e.g., cancer, dialysis), and primary care gateways. Private health maintenance organizations (HMOs) offer supplementary coverage to 10-15% population, largely via employer-sponsored plans, topping up PhilHealth after its payments with broader networks and extras like private rooms.

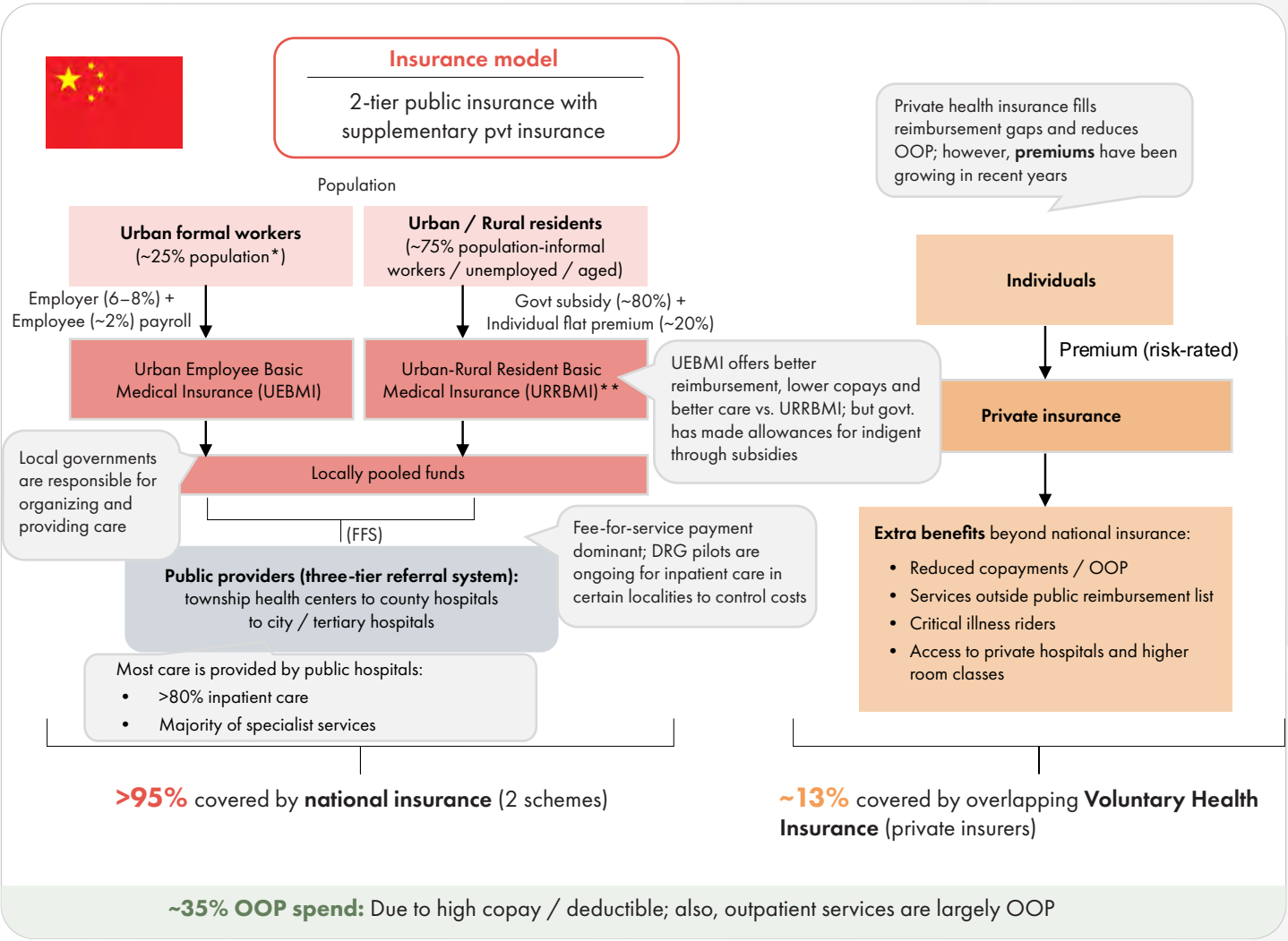
Through this approach, the Philippines has achieved universal enrolment in the national insurance program, with 100% of the population covered by PhilHealth (Exhibit 4.C). Despite universal enrollment successes, key challenges persist: outdated reimbursement rates cover only ~50-60% of actual costs (majority of claims exceeded reimbursements), causing provider losses, delayed payments, de-accreditation, and cost-shifting to patients via informal charges, exacerbating high OOP and catastrophic spending.

For India, the Philippines highlights the importance of automatic enrolment mechanisms and targeted subsidies for informal and low-income populations. Expanding contributory coverage alongside government-funded schemes could help strengthen financial protection while leveraging private insurers to provide complementary services. The Philippines is also a lesson against inadequate reimbursements eroding financial protection, thus emphasizing robust payment mechanisms, provider incentives, and private complementarity.

4.4. China

Exhibit 4.D

Structure of China's health insurance system



What has worked

- Strong political commitment enabled **rapid UHC expansion** with govt funding
- **Integration** of urban-rural schemes (URRBMI) **reduced fragmentation and inequity**
- **Zero-markup drug policy** reduced drug expenses in pilot hospitals; prior to reform, public hospitals were allowed to add a 15% markup to drugs they sold, which encouraged over-prescribing and inflated drug costs
- Supplementary PHI promotes **preventive care** without undermining public coverage

Lessons for India

- **Financing public healthcare:** Tiered public insurance (employer + government subsidies) achieves rapid UHC; government **health subsidies critical** for covering informal and rural populations
- **Primary care focus:** China revived village clinics and township health centers as first-contact points, integrated with insurance. India must strengthen **Ayushman Bharat PHCs** to reduce hospital bypassing and enable preventive care

Note(s): *Non-employed dependents are not included in UEMBI; **Urban-Rural Resident Basic Medical Insurance (URRBMI) were originally 2 separate schemes; there are plans to integrate all schemes because the benefits under the 2 schemes are different
Source(s): Commonwealth fund, WHO, Praxis analysis

Lessons framework: Access & availability | Quality of care | Efficiency | Sustainability

China has achieved near-universal coverage (>95% of ~1.41 billion population) through a tiered public insurance system launched via 2009 reforms, featuring 2 main schemes: Urban Employee Basic Medical Insurance (UEBMI) for urban formal workers / retirees (mandatory payroll contributions); Urban-Rural Resident Basic Medical Insurance (URRBMI, merging separate schemes for urban informal workers & rural residents) for ~1.06B others (individual premium + heavy government subsidies especially for rural/poor); and supplementary critical illness insurance for catastrophes. Benefits emphasize inpatient coverage, with lower outpatient / primary coverage; funds are county / municipal-pooled with central subsidies, but integration remains incomplete. In recent years, reforms have sought to integrate these schemes to reduce fragmentation and improve equity. Private commercial health insurance supplements ~13% middle / high-income via top-up plans covering gaps/extras.

Large-scale public investment and coordinated policy reforms have helped rapidly expand access to healthcare services, while ongoing reforms aim to control costs and strengthen primary care (Exhibit 4.D). China's experience underscores the importance of strong government commitment and sustained public financing in achieving universal health coverage. For India, targeted subsidies for informal populations and strengthened primary care systems could help expand coverage while improving care coordination and cost control.

4.5. Brazil

Exhibit 4.E

Structure of Brazil health insurance system

Insurance model

Tax-funded public health system

Tax-deductible private insurance costs incentivize middle-class uptake; With private plan, citizen can:
- Use SUS (free public option)
- Use private network (faster, paid by insurer)

*All residents are enrolled into **national insurance***

Population

Auto-enrolled

SUS – Sistema Único de Saúde (Tax-funded, no premiums)

SUS funds (pooled taxes across 3 govt levels)

tax

***Ministry of health** (at each level)*

Federal govt	*Sets policy, national guidelines, drug list*
State govt	*Sets policy, national guidelines, drug list*
Municipal govt	*Contracts with providers & delivers service*

(FFS[1])

Public providers Primary care (via Family health strategy) to secondary care (polyclinics) to tertiary centers

Private hospitals (contracted by SUS)

Many **private** hospitals deliver SUS-funded care (i.e., SUS pays negotiated rates); however, in-patient care is driven by public hospitals

Community participation in public health is ensured through health councils composed of local community members

Individuals

Premium (risk-rated)

Private insurance

Private health plans offer care via **own facilities oraccredited facilities** Alternatively, private insurance can **reimburse** enrollees for purchased health care services

Extra benefits beyond SUS:
- Faster access
- Avoid SUS waiting times
- Greater provider choice
- Private hospital amenities

Family Health Strategy (FHS)[2]: Community-based primary care teams which cover ~60% of population with a preventive focus

100% covered by **national insurance** (Sistema Único de Saúde- SUS)

~25% covered by overlapping **Voluntary Health Insurance** (private insurers)

~26% OOP spend: Due to gaps in coverage (e.g., medicines are not fully covered

What has worked

- Higher FHS coverage consistently linked to **lower child mortality** and reduced inequalities; targeted vulnerable populations
- Constitutional right to health; universal entitlement with **no application process**
- **Free medicines** for chronic diseases; comprehensive vaccination program

However, only ~9% of retail pharmaceuticals are covered by SUS (i.e., most drug costs are OOP)

Lessons for India

- **Automatic enrollment:** Constitutional guarantee ensures universal entitlement; no eligibility criteria
- **Primary care focus:** Strong primary care foundation critical; FHS model reduced child mortality; strengthen Ayushman Bharat PHC network with community workers
- **Financing public healthcare:** Without adequate funding, universal system underperforms

Brazil's constitutional amendment 95 (2016) introduced a strict 20-year ceiling on public expenditure growth[3] which has threatened the sustainability of SUS

Lessons framework: Access & availability | Quality of care | Efficiency | Sustainability

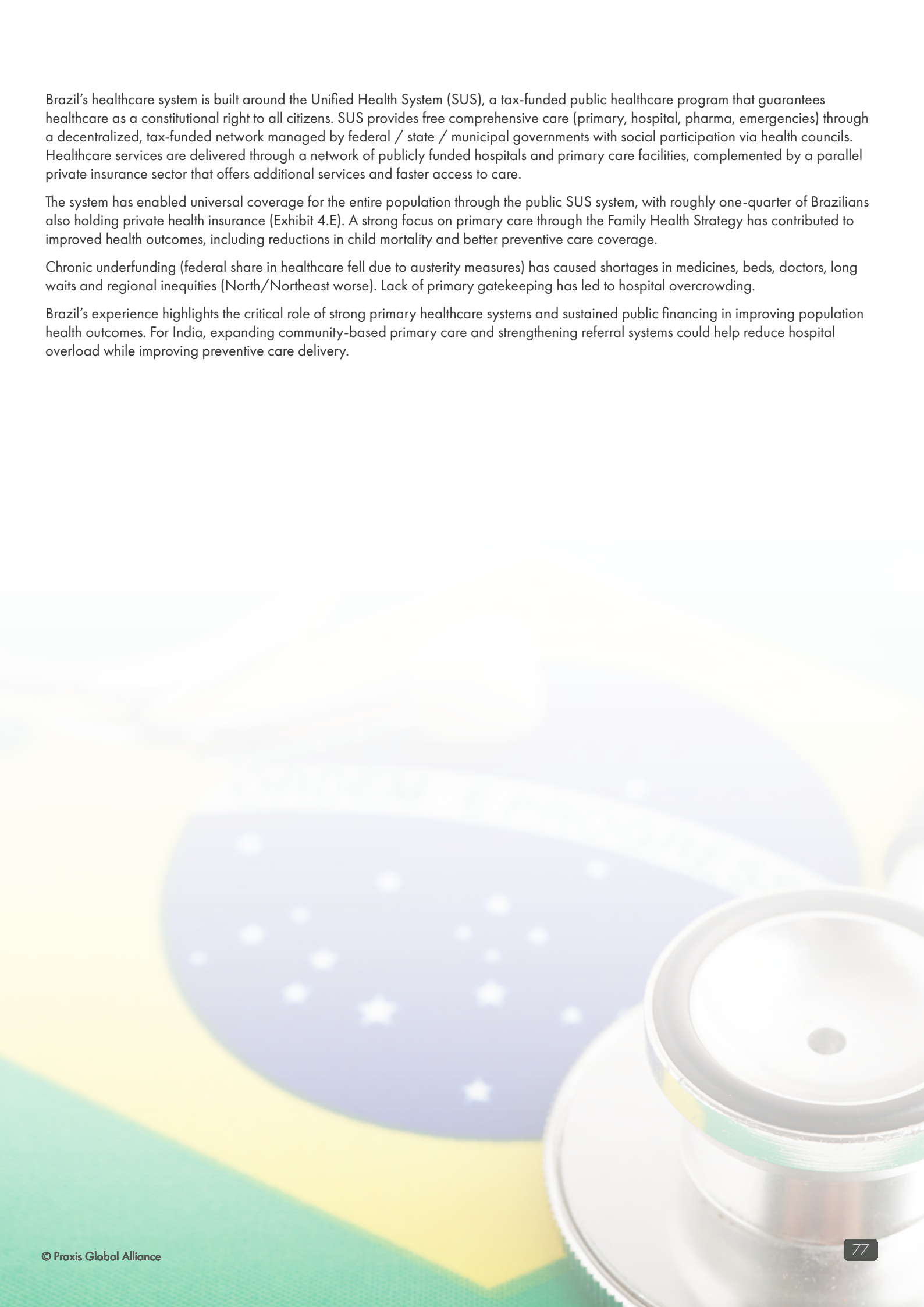
Note(s): [1]Fee for service based on SUS procedure list which are below actual costs; [2]Family health strategy: Team consists of 1 doctor, 1 nurse, 1 nurse assistant & <12 community health workers. The teams cover 2,000 to 4,000 individuals in households across a geographic area; [3]Adjusting spending only for inflation, not for population growth or demand;
Source(s): OECD, Commonwealth fund, Praxis analysis

Brazil's healthcare system is built around the Unified Health System (SUS), a tax-funded public healthcare program that guarantees healthcare as a constitutional right to all citizens. SUS provides free comprehensive care (primary, hospital, pharma, emergencies) through a decentralized, tax-funded network managed by federal / state / municipal governments with social participation via health councils. Healthcare services are delivered through a network of publicly funded hospitals and primary care facilities, complemented by a parallel private insurance sector that offers additional services and faster access to care.

The system has enabled universal coverage for the entire population through the public SUS system, with roughly one-quarter of Brazilians also holding private health insurance (Exhibit 4.E). A strong focus on primary care through the Family Health Strategy has contributed to improved health outcomes, including reductions in child mortality and better preventive care coverage.

Chronic underfunding (federal share in healthcare fell due to austerity measures) has caused shortages in medicines, beds, doctors, long waits and regional inequities (North/Northeast worse). Lack of primary gatekeeping has led to hospital overcrowding.

Brazil's experience highlights the critical role of strong primary healthcare systems and sustained public financing in improving population health outcomes. For India, expanding community-based primary care and strengthening referral systems could help reduce hospital overload while improving preventive care delivery.



05

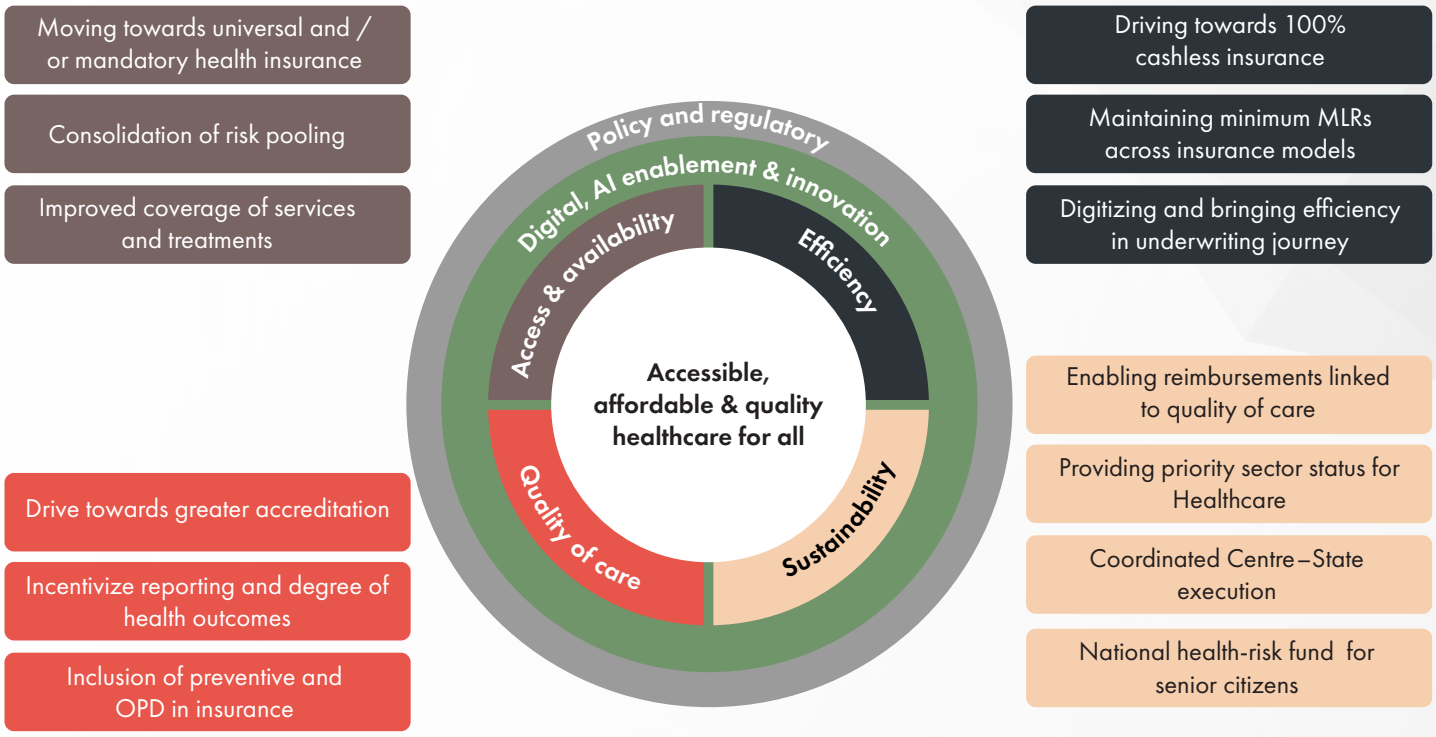
FUTURE ROADMAP: **RECOMMENDATIONS FOR BRIGHTER FUTURE**

5 FUTURE ROADMAP: RECOMMENDATIONS FOR BRIGHTER FUTURE

India's healthcare system now requires a coordinated shift from fragmented expansion toward a more integrated model that can deliver care at scale while maintaining affordability and quality. Achieving this transition will depend on strengthening four critical dimensions of the healthcare ecosystem: expanding access and availability of services, improving operational efficiency across financing and delivery, ensuring long-term financial sustainability, and raising the overall quality of care delivered to patients. These priorities must be supported by key ecosystem enablers, strong policy and regulatory frameworks, along with digital, AI-driven enablement and innovation, which together can accelerate coordination, transparency, and scalability across the health system.

Exhibit 5.A

A "win-win" framework to create a symbiotic payor provider patient ecosystem supported by the government



Source(s): Praxis analysis

5.1. Key recommendations

Strengthening India's healthcare system will require a combination of near-term operational improvements and longer-term structural adjustments across the healthcare ecosystem. In the immediate term, progress can be achieved by improving the functioning of existing mechanisms that connect patients, insurers, and providers. Enhancing coordination across stakeholders, reducing friction in claims and care delivery processes, and addressing key gaps in insurance coverage can improve the efficiency with which healthcare financing translates into patient access. Expanding the scope of insurance coverage to better reflect common patterns of healthcare utilization, while improving transparency and consumer awareness, can further strengthen confidence and participation in insurance systems.

Exhibit 5.B

Key recommendations for immediate and near term

Recommendations for immediate term (1-2 years)

1	Accelerate **ABDM-driven integration** through a **timeline-based adoption plan** • Enables near-100% cashless utilization, improves customer experience, and unlocks interoperable payer–provider coordination	●
2	**Extend insurance to non-hospital care, starting with high-value products** based on utilization data • Covers primary care, diagnostics, drugs, robotic surgery, advanced procedures, and new technologies to close critical care-coverage gaps	◕
3	Staff **appropriately licensed and experienced medical professionals** for claims and admissions review • Ensures decisions reflecting sound clinical judgment	◑
4	**Publish** independently validated **outcomes for hospitals and public-sector care costs** • Enables transparent benchmarking and a unified, publicly reported quality index; Can be enabled via greater accreditation	◑
5	**Launch sustained nationwide IEC campaigns and strengthen grievance redressal systems** • Builds consumer trust, normalizes insurance uptake, and deepens the risk pool	◔
6	**Simplify practitioner mobility and establish single-window healthcare licensing** • Reduces regulatory friction and accelerates infrastructure and workforce expansion	◔

Recommendations for near term (3-5 years)

7	**Mandating basic health insurance** for the uninsured and/or enabling universal risk pooling through **health savings accounts, tax savings, non-profit insurers, and other innovative distribution models** • Expands coverage, reduces OOP and insures the missing middle	●
8	**National health-risk fund** to co-finance care for seniors (70+ years) and the growing NCD burden • Protects vulnerable segments, stabilizes premiums	◕
9	Eliminate premium caps and curb excessive premium growth, **mandate 80% minimum MLRs across policy types** • Aligns pricing with cost and quality	◕
10	Establish **tiered accreditation and link to empanelment** • Incentivizes quality improvement and drives system-wide standardization across providers	◑
11	**Strengthen cooperative Centre–State execution** with sequenced reform rollout • Ensures consistent implementation of national priorities while enabling state-level innovation	◑
12	**Provide priority sector lending status for healthcare infrastructure and services** • Expands access to affordable credit for healthcare & insurance providers	◑

Impact

Low ○ ◔ ◑ ◕ ● High

Regulators *Payors* *Providers*

Note(s): IEC: Information, Education and Communication
Source(s): Praxis analysis

Over the immediate term, these improvements can be complemented by measures that reinforce the structural foundations of healthcare financing and service delivery. Expanding the depth of pooled financing can help reduce reliance on out-of-pocket spending while providing more stable funding for healthcare providers. Greater alignment between reimbursement mechanisms, provider standards, and quality outcomes can also help ensure that system expansion is accompanied by improvements in care quality. Sustained coordination across national and state institutions, together with continued investment in healthcare infrastructure and workforce capacity, will be important to support the near-term evolution of India's healthcare system.

5.2. Stakeholder alignment - Roles across government, payors and providers

Achieving meaningful improvements in healthcare access, financing depth, and quality outcomes requires coordinated action across all stakeholders in the healthcare ecosystem. Regulators, payors, and providers each play distinct but interdependent roles in shaping how healthcare services are financed, delivered, and monitored. Progress in any one area is unlikely to translate into system-wide impact unless supported by complementary actions across the others. Aligning incentives and responsibilities across these stakeholders therefore becomes critical to ensuring that reforms translate into tangible improvements in patient access, affordability, and quality of care.

5.2.1 Regulator

Government institutions play a foundational role in shaping the structure and stability of the healthcare ecosystem. Through policy design, regulatory oversight, and system-level coordination, regulators establish the enabling environment within which insurers and providers operate. Their role extends beyond rule-setting to building the institutional and digital infrastructure that allows healthcare financing and service delivery to function efficiently and transparently.

Exhibit 5.C

Role of regulator

Primary role

Design the digital backbone, institutionalize sustainable financing, and enforce quality and governance standards to stabilize and integrate the health system

Access & availability	Efficiency	Sustainability	Quality of care
(2) **Mandate inclusion of OPD, diagnostics, chronic drugs, robotic surgery, rehabilitation, and preventive care** within standardized minimum benefit packages (5) Launch **nationwide awareness campaigns and strengthen grievance redressal** to build customer trust and increase insurance uptake (7) Shift from voluntary insurance to broad-based **mandatory risk pooling** to deepen **pooled financing and reduce household OOPE** a. Mandate or incentivize **basic health insurance** for uncovered groups, including **compulsory employer coverage** in the formal as well as informal sector b. Enable **tax-advantaged Health Savings Accounts (HSAs)** with insurance as catastrophic cover c. Provide **tax incentives for OPD and preventive coverage** d. Aggregate MSME & gig workers **into collective risk pools** e. Explore **hybrid models with minimum buy-in and targeted government support** for low-income segments	(1) Issue phased compliance mandates for **ABHA linkage, EHR integration, interoperable health data as well as claims, and 100% digital pre-authorization** and discharge workflows (1) Establish an **ABDM-integrated fraud registry, standardized digital audit trails, and monitoring of claims, underwriting, and billing** (3) Require insurers to staff claims review with **appropriately licensed as well as experienced medical professionals** to ensure decisions reflect sound clinical judgment (9) **Eliminate premium caps** and **mandate minimum MLR ratios (~80%)** across policy types	(6) **Simplify practitioner mobility and introduce single-window healthcare licensing** to accelerate infrastructure and workforce expansion (8) **Co-finance elderly (70+) and high-NCD cohorts** to stabilize premiums and prevent adverse selection from destabilizing private insurance markets (11) **Set national digital and quality standards** while enabling structured state-level innovation to **strengthen Centre–State reform alignment** (12) Grant **priority sector lending status to healthcare infrastructure and services** to expand access to affordable credit for hospitals and healthcare providers	(4) Transition to **outcome-based accountability** and benchmarking providers through a **Unified Public Quality** Index tied to outcome-linked payments along with creating frameworks for **public sector hospitals for publishing of costs** (10) Create tiers of accreditation and link **accreditation tiers, empanelment, and reimbursement rates** to independently validated outcome metrics (e.g., mortality, infection rates, ALOS)

Note(s): ABHA: Ayushman Bharat Health Account, EHR: Electronic Health Records, NCD: Non-Communicable Diseases, MLR: Medical Loss Ratio, ALOS: Average Length of Stay
Source(s): Praxis analysis

In India's evolving healthcare landscape, regulators are uniquely positioned to strengthen the system's long-term foundations. This includes enabling interoperable digital health infrastructure, expanding pooled healthcare financing mechanisms, and ensuring that governance frameworks promote accountability and quality. By aligning financing structures, regulatory standards, and quality benchmarks, regulators can help create a healthcare ecosystem in which access expands alongside improvements in efficiency, financial sustainability, and care outcomes.

5.2.2 Payor

Health insurers play a critical role in translating pooled financing into accessible healthcare services. Through product design, pricing structures, and reimbursement mechanisms, payors influence how healthcare is utilized, how providers are compensated, and how financial risk is distributed across the system. As insurance coverage expands, the role of insurers increasingly extends beyond claims reimbursement toward shaping care delivery models and encouraging more preventive, coordinated healthcare pathways.

Exhibit 5.D

Role of payor

Primary role

Expand and stabilize risk pools, redesign products for preventive care, and enforce operational and clinical discipline to enable sustainable Universal Health Coverage

Access & availability	Efficiency	Sustainability	Quality of care
(2) Extend insurance beyond hospitalization to include **OPD, diagnostics, drugs, preventive care, and select advanced procedures** to close key coverage gaps (5) Participate in **national health insurance awareness efforts and strengthen customer grievance redressal systems** to build trust and improve policyholder experience (7) Integrate the "missing middle" into broader insurance pools through **contributory, MSME aggregated and platform-based group coverage models** to deepen cross-subsidization and reduce adverse selection (7) Develop **standardized, simplified insurance products aligned with minimum benefit packages** to improve consumer protection and uptake	(1) Use ABDM datasets to **track disease trends, utilization patterns, and regional capacity gaps,** and link funding allocations to epidemiological evidence rather than historical budgets; **Digitize the patient journey and claims addressal process** tied to integrated EHR data; Improve actuarial and product innovation through utilization of health records (1) **Digitize the full claims lifecycle to achieve near-100% cashless processing** through interoperable pre-authorization, adjudication, and real-time settlement workflows (3) Ensure that **claims and utilization reviews are led by appropriately licensed and clinically experienced professionals** to support medically sound decision-making	(8) Implement a **robust risk-adjustment framework to ensure insurers compete with efficiency** and quality rather than selecting healthier populations (9) **Align pricing and cost structures to meet 80% minimum MLR,** ensuring premium spend translates into measurable patient care value (11) Collaborate with **Centre and State authorities to align insurance products and provider networks** with national schemes and state priorities (12) Leverage priority sector lending to **scale healthcare and insurance services** through improved access to affordable financing	(4) Link provider **reimbursement to independently validated clinical outcomes and quality benchmarks** to align incentives around measurable performance and efficiency (10) **Drive simplified / automated empanelment of accredited hospitals** through tiered accreditation frameworks to **incentivize quality improvement and drive system-wide standardization** across providers and network of hospitals along with reimbursement rates

Source(s): Praxis analysis

In this context, payors have an opportunity to strengthen the efficiency and depth of healthcare financing. By improving risk pooling, expanding coverage across the continuum of care, and leveraging data-driven insights to guide utilization and pricing, insurers can support more sustainable healthcare financing models. At the same time, aligning reimbursement frameworks with measurable care outcomes can help encourage greater accountability and value creation across the healthcare ecosystem.

5.2.3 Provider

Healthcare providers remain the operational backbone of the healthcare system, translating financing and policy frameworks into actual patient care. Their role extends beyond the provision of clinical services to include the development of healthcare infrastructure, adoption of advanced medical technologies, and implementation of operational practices that shape efficiency and quality across the system.

Exhibit 5.E

Role of provider

Primary role

Deliver high-quality, outcome-driven care at scale while strengthening transparency, capacity, and operational efficiency

Access & availability	Efficiency	Sustainability	Quality of care
(2) Develop standardized OPD, diagnostics, and preventive care pathways **aligned with insurer coverage frameworks; Invest and build scale in advanced treatment modalities** (incl robotic surgery) that enables cost efficient insurer underwriting (5) Participate in **health insurance awareness efforts and strengthen patient grievance redressal systems** to build trust and improve patient experience (7) **Expand provider capacity and operational readiness** to handle higher patient volumes at lower treatment costs expected under universal health coverage (UHC)	(1) **Adopt full ABDM integration, interoperable EHR systems, and digital documentation** to enable seamless claims processing and care continuity (1) **Digitize the patient journey through a seamless and unified experience** leveraging integrated EHRs, ABHAs, and AADHAR IDs; Simplify admission and claims documentation; Create systems to **share and leverage health records between providers** (2) **Improve cost efficiency** through lean operations, technology adoption, and **process automation to absorb medical inflation without compromising quality**	(11) **Scale healthcare infrastructure through state-contingent models** – hospital-first in dense markets and primary-care-first in Tier 2/3 regions – to address regional access gaps (12) **Leverage priority sector lending to finance infrastructure expansion and capacity creation**, particularly in underserved regions	(4) Institutionalize robust internal quality governance with **measurable as well as standardized KPIs (infection rates, mortality, readmissions, patient experience) and publish independently validated clinical outcomes** to strengthen accountability and differentiate high-quality care; **Public sector hospitals to create frameworks for public disclosures of cost of care** (10) **Adopt recognized accreditation standards** to strengthen quality assurance, improve clinical governance, and enhance eligibility for insurer empanelment

Source(s): Praxis analysis

Strengthening provider capacity therefore requires a dual focus on expansion and operational excellence. Investments in infrastructure, technology adoption, and specialized clinical capabilities will be essential to meet rising demand, particularly for chronic disease management and advanced medical services. At the same time, greater transparency in clinical outcomes, stronger quality governance, and improved operational efficiency will help ensure that healthcare expansion is accompanied by consistent improvements in patient care and system performance.

5.3. Road ahead

India now has the opportunity to convert healthcare reform into a broader national health dividend. The objective is not simply expanding healthcare spending, but building a coordinated ecosystem where financing, care delivery, and digital infrastructure work together at scale.

A clear pathway is emerging. Digitizing the core through ABDM will create the digital backbone for interoperability and efficient claims and care coordination. On this foundation, expanding the risk pool through broader insurance participation will deepen healthcare financing and reduce reliance on out-of-pocket spending. Together, these shifts will align incentives across payors, providers, and patients while enabling sustainable expansion of healthcare capacity.

If executed effectively, this transformation will deliver tangible national returns: reducing out-of-pocket expenditure from ~50% to below 25%, expanding coverage toward universal risk protection, and enabling the healthcare ecosystem to grow to US$700–1,000 billion. Infrastructure expansion will also create 3-4 million jobs, while strengthening India's position as the "World's Hospital," combining global cost leadership with improving quality.

Viewed through this lens, health is national infrastructure, not a cost centre, and securing this dividend will be central to India's journey toward Viksit Bharat 2047.

About NATHEALTH

NATHEALTH was created with the vision to "Be the credible and unified voice in improving access and quality of healthcare". Leading healthcare service providers, medical technology providers (devices & equipment), diagnostic service providers, health insurance companies, health education institutions, healthcare publishers, and other stakeholders have come together to build it as a common platform to power the next wave of progress in Indian healthcare. NATHEALTH is an inclusive institution that has representation of small & medium hospitals and nursing homes. It is committed to working on its mission to encourage innovation, help bridge the skill and capacity gap, help shape policy & regulations, and enable the environment to fund long-term growth. NATHEALTH aims to help build a better and healthier future for both rural and urban India.

Website: www.nathealthindia.org

General Secretariat

Siddhartha Bhattacharya
Secretary General, NATHEALTH

Anwesha Pandey
Assistant Secretary General

Vrinda Chaturvedi
Director

Sachin Sharma
Director

Jayyaa Siingh
Additional Director – Government Affairs

Shambhavi Yadav
Executive Assistant – Operations Executive

Jyotsana Saluja
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Aryaman Tandon

Managing Partner & Co-founder

E: aryaman.tandon@praxisga.com

For media queries, please contact

Shivam Bajaj

Associate Manager - PR & Events

E: pr@praxisga.com

M: +91 935 453 3135

www.praxisga.com

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