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# Patients caught in health insurance-hospital face off

**A**nother old turf war is bubbling over once again in the healthcare space, this time between the clinical community and healthcare insurance players. The General Insurance Council (GIC)'s advisory on Admission Criteria for Fever and Infectious Diseases has been a red flag, with clinicians seeing it as an encroachment on their clinical decision making process.

The context to this latest flareup is last year's agitations by health insurance providers moving certain hospital chains from their coverage. Healthcare providers had retaliated by withdrawing cashless facilities for certain health insurance companies. As usual, patients were caught in the middle of this tit for tat.

Since then, there have been attempts to build a consensus and resolve these issues. Meetings convened by the General Insurance Council, which represents more than 30 insurance companies, with key hospital associations, have tried to find common ground. These trust building overtures, steered by the newly formed Health vertical at GI Council and headed by Dr S Prakash, CEO, General Insurance Council (Health Insurance Ecosystem and Strategic Partnerships) resulted in the release of a GIC Advisory on Admission Criteria for fever and infectious diseases (2024-25) based on these consultations.

But hospitals have pushed back once again. Hospital associations like The Association of Healthcare Providers India have rejected the advisory, claiming that even though it is couched as an advisory, it might be used by insurance providers to reject legitimate medical claims. They point out that insurance companies have a vested financial interest and therefore should have no sway over any part of the clinical decision making process.

In a statement clarifying its stance, the GI Council addressed the misconception that referencing clinical guidelines constrains medical autonomy. The statement points out that as India's health insurance sector has expanded rapidly, so has misuse. Between 2019 and 2024, unnecessary hospital admissions (as deemed by GIC) have surged dramatically. GIC's data shows that Rs 94,247.6 crore in total health claims settled in 2024-25, with cashless-only admissions accounting for 66.4 per cent of the volume.

The Council's perspective is that the insurance industry receives hundreds of claims monthly that appear to misuse the privilege of coverage, including admissions for trivial fever, unnecessary investigations, and extended stays that do not align with clinical



At the heart of this tug of war is a system to balance the clinician's judgement of care and insurance's mandate to keep premiums and payouts credible and sustainable

evidence or international best practices.

As per the statement, the advisory was developed to address this crisis-not to restrict legitimate clinical practice, but to combat systematic abuse that inflates premiums for the common man and diverts resources from genuine patient needs.

The GIC advisory is reportedly "derived from and references the clinical guidelines established by The Indian Council of Medical Research (ICMR), The Ministry of Health and Family Welfare (MOHFW) and The National Vector Control Board, and "simply operationalises these government-mandated clinical standards within the health insurance ecosystem."

The GIC press statement also references similar systems globally, pointing out that in the UK, National Institute for Health and Care Excellence (NICE) sets clinical guidelines; NHS coverage follows these standards. In the US, CMS references guidelines from NIH, specialty societies, and state health departments. In Australia, Canada, Germany too, all insurers reference government and statutory health authority guidelines. Is India's healthcare sector evolved enough to be benchmarked to such systems?

The GIC statement stresses that the advisory is not a rule book, and it does not restrict clinical autonomy. It is a framework for appropriate, evidence-based practice. The statement avers that true clinical autonomy is the right to deviate from guidelines when clinically justified-provided that deviation is documented, reasoned, and open to review.

At the heart of this tug of war is a system to balance the clinician's judgement of care and insurance's mandate to keep premiums and payouts credible and sustainable.

Thus the face off continues, with hospital groups reportedly pressing for an Insurance Redressal Forum to resolve such policy disputes more effectively. Until then, patients will be left to wonder if a hospital is advising too early admissions or if their health insurance will suddenly cease to exist. Policy makers need to step in to address these issues and rebuild trust in the healthcare ecosystem.

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## The new growth playbook for hospitals: Integrated care ecosystems

**Rajat Ghai**, Business Head- Enterprise Accounts and Solutions, discusses how enterprise technology, AI-enabled solutions, lifecycle partnerships, and integrated care ecosystems are shaping the next phase of hospital expansion, while helping providers balance clinical excellence, operational efficiency, and financial sustainability

**From an enterprise perspective, what key trends are you seeing among large corporate hospitals today, and how are these ambitious expansion plans influencing the way hospital leaders approach technology and strategic partnerships?**

We are witnessing a change in how hospital leaders approach growth, adopt new technologies, and build strategic partnerships. Most importantly, they matter because they can directly improve the patient experience—making healthcare more accessible, convenient, affordable, and personalised. A key part of this growth story is how the healthcare sector is turning challenges into opportunities. For instance, India currently has just 1.3 hospital beds per 1,000 people, significantly below the global median of 2.9 beds per 1,000 people, highlighting a substantial gap in healthcare capacity. This demand-supply imbalance has attracted strong interest from private equity investors, whose capital is accelerating expansion across the sector. However, this wave of investment is doing more than simply adding beds. It is reshaping the way hospital systems grow. Rather than expanding in a fragmented manner, large hospital chains are increasingly focused on building integrated healthcare ecosystems—bringing together infrastructure, technology, clinical capabilities, and care networks to deliver more connected, accessible, and scalable healthcare.



Across India, corporate hospital chains are collectively planning to add over 18,000 beds in the next three to five years, but the intent behind this expansion is more strategic than before. Hospitals are designing hub-and-spoke networks, where tertiary care centers, secondary facilities, and outreach units operate as interconnected systems rather than standalone entities. This approach enables them to extend quality care from metro cities into Tier 2 in a more consistent and scalable way.

Technology decisions are

no longer made at an individual department or hospital level, instead, they are increasingly treated as enterprise infrastructure investments. Hospital leaders are now focused on ensuring consistency in clinical outcomes across locations, improving asset utilisation, and enabling seamless workflows across a distributed network of facilities. Hospitals are not just looking for equipment providers, they are looking for strategic collaborators who can support them across the lifecycle, from infrastructure planning and technology

roadmap design to deployment, operational optimisation, and long-term scalability.

There is also a clear shift toward sustained engagement. Large hospital chains are increasingly looking for partners who can stay with them through multiple phases of growth, rather than engaging in isolated transactions. This is where a lifecycle-led approach becomes critical, as it allows hospitals to adapt to changing technology requirements over time and scale efficiently.

**Hospitals today are balancing clinical excellence, operational efficiency, and financial sustainability, all at once. How does Wipro GE Healthcare's partnership framework align with the growth objectives of large hospital chains, particularly when it comes to building capability across the full care continuum?**

At Wipro GE Healthcare, we approach this through a partnership approach anchored in three core areas.

The first is Hospital infrastructure and technology planning, where we work closely with hospital teams to define the infrastructure blueprint for hospitals, integrating our expertise in medical technologies and layout planning aligned to both greenfield and brownfield expansion.

The second pillar is Financial Structuring, which helps hospitals optimise lifecycle costs efficiently and ensure long-term performance. The third is

Digital enterprise solutions, which help integrate digital products and analytics to enable visibility and data-driven decision-making across the network.

What is important here is that the partnership is centred on outcomes rather than individual products. Hospitals today are looking to improve clinical quality, increase throughput, optimise resource utilisation, and build scalable systems. Our role is to align with these objectives and co-create solutions that deliver across all three dimensions - clinical, operational, and financial.

**From a digital and enterprise IT standpoint, how do Wipro GE Healthcare's digital and AI-enabled solutions help hospital systems integrate data, improve visibility, and support better decision-making across the organisation?**

As hospital systems expand, one of the biggest challenges they face is not the availability of data, but the fragmentation of data across multiple sites, departments, and systems. This makes it difficult for leaders to get a unified view of operations and make timely, informed decisions.

Digital and AI-enabled solutions play a critical role in addressing this challenge by helping hospitals integrate data, improve visibility, and enable better decision-making across the organisation. At Wipro GE Healthcare, our D3 Strategy - combining smart devices, disease-specific solutions, and digital platforms, is designed to



address exactly this need. It is our pathway towards fulfilling the promise of Healthcare 4.0, which is about creating a more connected, intelligent, and responsive healthcare ecosystem.

A key differentiator in this approach is how AI is embedded seamlessly across our solutions, ensuring that data generated at different points of care can be enhanced, standardised, and made more actionable. In MRI, tools like SONIC DL and AIR RECON DL improve image quality and reduce scan times by up to 50%, enabling higher throughput without compromising diagnostic accuracy. In CT, TrueFidelity delivers crystal-clear reconstructions with lower dose and higher diagnostic confidence. Similarly, in molecular imaging, Precision DL enhances image quality and quantification for more accurate treatment planning. In theranostics, MIM software empowers clinicians with advanced quantification and personalised dosimetry for novel treatments like Lu-177 PSMA and Y-90, shaping the future of targeted therapy.

## Technology decisions are no longer made at an individual department or hospital level, instead, they are increasingly treated as enterprise infrastructure investments. Hospital leaders are now focused on ensuring consistency in clinical outcomes across locations, improving asset utilisation, and enabling seamless workflows across a distributed network of facilities

Enterprise platforms such as Command Center and Tele-ICU empower hospitals with data-driven operational insights, integrated image management, and connected workflows, driving both clinical and operational excellence. Ultimately, digital solutions are enabling hospitals to move toward a more integrated and insight-led healthcare ecosystem, where data is better connected, visibility across operations is improved, and decision-making is more informed and timely.

### From a leadership

### standpoint, how do you build and align cross-functional teams within Wipro GE Healthcare to support large hospital enterprises at scale, while maintaining a true partner-to-partner mindset?

Supporting large hospital enterprises requires a fundamentally different operating model internally. It is not about aligning individual product teams, but about aligning the organisation around the customer's growth priorities. At Wipro GE Healthcare, enterprise engagement brings together multiple functions -

commercial, clinical application, modality, service, digital, and leadership teams, to work as a single unit. The goal is to ensure that all interactions with the customer are consistent, cohesive, and aligned to their long-term objectives.

In practice, this requires clarity on three fronts. First, a deep understanding of the hospital's expansion strategy and priorities. Second, alignment across internal stakeholders on how we can collectively support those priorities. And third, a clear definition of the outcomes we are working toward together.

Equally important is maintaining a trusted advisor mindset. In enterprise healthcare, trust is built when the customer sees that you are invested in their success, not just in closing a transaction. This means listening closely, being transparent about trade-offs, and continuously identifying opportunities to add value. As hospital systems grow in scale and complexity, this kind of cross-functional alignment and partner-to-partner mindset become critical to delivering meaningful and sustained impact.

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Editor, Express Healthcare





## INTERVIEW

# Investing beyond capital: Building healthcare businesses with clinical excellence at the core

**Rakshith Rangarajan**, Equity Fund Manager, Inviga Investment Advisors, speaks to **Viveka Roychowdhury** about the firm's clinician-led investment strategy, why it focuses on the underserved mid-market healthcare segment, and how combining hospital operations with investments in healthtech and innovation aims to create long-term value while improving access and patient outcomes

**India's healthcare sector has attracted considerable PE & VC funding. How is Inviga's investing philosophy different from other such equity investors and platforms?**

India's healthcare sector is well served by capital today, and the depth of institutional interest is a genuine positive for the industry. Inviga's difference is one of vantage point. We are one of the very few clinician-led, thematically focused, mid-market healthcare funds in India, and we run a deliberate two-track strategy: control positions in hospital services that we ourselves operate, alongside active minority positions in high-IP healthcare adjacencies - devices, diagnostics, biotech and supply chain - that connect back into those platforms. Critically, we are operators. Our Sponsor, Dr. B S Ajaikumar, built HCG from roughly Rs 20 crore to Rs 2,000 crore over two decades and remains a practising oncologist. Ramesh Balasubramanian, who leads our hospitals, brings 27 years of senior healthcare leadership - he built the CBCC onco-care franchise from inception to monetisation over a fifteen-year arc and held several leadership positions within the Apollo Hospitals ecosystem. This gives us an inside-out vantage: we can independently manage and optimise healthcare assets,



**We take active minority positions in high-IP, high-growth healthcare adjacencies: devices, diagnostics, biotech, supply chain. The gap we fill is specific. Growth-stage healthcare innovators in India are too large for seed VC and too small for bulge-bracket PE, and even when they raise, they struggle with the thing that actually determines survival - selling into hospitals**

not merely underwrite them. That capability changes what we are willing to own, and it changes what we place at the centre of the enterprise - the clinician. Top clinicians have entrusted their assets and practices to Curis, our hospital platform, because of the reputation and vintage of Inviga's leadership. That is a professional relationship outcome, and it is the paradigm we are altering.

The second differentiator is what the two tracks build together. Our hospital platforms create procurement scale, clinical validation sites, and demand infrastructure that directly strengthen our minority investments; those companies in turn bring technology and IP back into our hospitals. For instance, Forus Health's ophthalmic imaging can be deployed inside Curis, giving Forus a clinical validation site and Curis an advanced diagnostics capability. This is an integrated value creation architecture, available to a fund that operates on both sides of the equation. Holding it together is clinical excellence, which we treat as the primary differentiator in healthcare and our top priority - the mechanism by which the financials work, rather than a compliance layer added after they do. A hospital that delivers reliable outcomes retains clinicians, holds referrals, and keeps patients in their own city. That is what makes a

business model sustainable rather than merely profitable in a given year, and it is what ultimately enhances access in catchments that have been underserved for decades.

**What are the specific pain points, gaps in India's healthcare infrastructure that need to be plugged? And what's Inviga's strategy to bridge these gaps?**

The gaps are structural, and capital scarcity is not the primary one. We have often seen cited, statistics to the effect that India has roughly 1.3 hospital beds per 1,000 people against a WHO-recommended benchmark of 3, and the country's public health expenditure remains close to 1.9 per cent of GDP - well below comparable emerging economies. But the more binding constraint is fragmentation. India's top ten hospital operators hold under 15 per cent of the market. The 50-to-300 bed hospitals that serve most of the country are sub-scale individually: they cannot negotiate procurement, fund serious clinical governance, digitise, or professionalise management. Alongside this sits a search-cost barrier that leaves these assets stranded - larger operators face diminishing returns pursuing sub-1,000-bed deals because diligence and integration overheads are disproportionate to the ticket. Growth-stage healthcare innovators face



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the mirror image: too large for seed VC, too small for bulge-bracket PE. This is the missing middle, and it is where most of India's real healthcare capacity and innovation actually sits. Layered on top is a clinical-depth problem in Tier 2 catchments - infrastructure without anchor specialists does not retain patients, and specialists will not stay in a city without a system around them.

Our strategy addresses each directly. We do not build greenfield; it is the slowest and least capital-efficient route to capacity. Through Curis, we acquire and professionalise quality standalone hospitals in high-potential catchments - centralised procurement, digital HIS, specialised clinical protocols, and a governance backbone. The model is deliberately capital-light: assets are acquired substantially via slump sale and long-term lease, real estate is leased, and capital is directed toward revenue-generating equipment and working capital, with deployment averaging around Rs 33 lakh per bed against Rs 50-80 lakh typical for comparable hospitals. Curis today operates across Tamil Nadu and Gujarat, with a meaningful presence in significant Tier 2 cities, and is establishing the first Level III NICU in its Trichy cluster - addressing a genuine neonatal emergency gap in that region. A single 100-bed hospital cannot afford centralised clinical governance; a platform of fifteen can, and each new unit joins an operating system rather than starting from zero. On the innovation side, we act as a quasi-strategic investor to founders in the missing middle, offering demand-side access, supply chain connect, and clinical validation alongside capital - bridging the distance between good Indian technology and the hospitals that should be using it.

**As the primary promoter,**

**how does Dr Ajaikumar's expertise as a veteran oncologist and Executive Chairman of Healthcare Global Enterprises (HCG) shape investing decisions?**

The most consequential influence is thirty-five years of pattern recognition about what makes a healthcare enterprise work, accumulated while building one. Dr Ajaikumar took HCG from roughly Rs 20 crore to Rs 2,000 crore over twenty years, and did so in a manner that dovetailed shareholder value with clinical quality and ethics. Those convictions now sit at the centre of how Inviga underwrites. It is why clinical excellence is our declared first vector of value creation rather than a downstream consideration. It is why we treat the clinician as the enterprise: he has seen first-hand that when the anchor specialist leaves, the referral network, the payer relationships, and the clinical reputation leave with them, and that no term sheet recovers that. And it is why promoter alignment is our most important criterion in a deal. Alternate promoter interests, wavering commitment to the business plan, accounting indiscipline - we have taken a principled view to pursue other opportunities rather than compromise on these, even where the economics were tempting.

Practically, it changes both what we see and what we can offer. Diligence conversations with doctor-promoters are peer conversations - a clinician sitting across from a clinician asks different questions and gets different answers than an analyst working from a data room. We can assess whether a hospital's clinical claims are real, whether its specialist bench is durable or borrowed, and whether its case mix is defensible. It also changes what we can put on the table. For a doctor-promoter in a Tier 2 city, the decision to take a partner is rarely primarily about valuation - it is about

succession, reputation, and whether the institution they spent thirty years building survives them intact. Top clinicians have joined Curis and entrusted their practices to us precisely because of that lineage. The Sponsor also carries substantial skin in the game through a significant personal commitment into the Fund, which ensures that every investment decision is made by someone whose own capital sits alongside our investors'.

**How does Inviga choose companies/hospitals to invest in? Can you give a few examples of existing investments?**

We are looking for a specific combination: a business where our operating vantage is genuinely additive, a promoter or founder whose interests are unambiguously aligned, real IP or clinical depth, and a market that is not crowded or carrying overcapacity risk. Our turn-offs are equally clear - promoter misalignment, alternate promoter interests, heavy greenfield components, low IP quotient, and situations where our strategic contribution is not given credence in rights or economics. We would rather walk away than compromise on any of these, and we have.

Four investments are live. Curis Hospitals, our flagship control platform, is rolling up quality multispecialty assets in underserved Tier 2 catchments across Tamil Nadu and Gujarat, moving towards 400-450 beds today, with the first Level III NICU in its Trichy cluster being established through it. Milann, which we have acquired outright from HCG, is Bangalore's original IVF institution - founded in 1989, over 124,000 families treated, six centres, and an Academy that has trained a significant share of South India's practising fertility specialists. Forus Health is a Bengaluru medical device company whose ophthalmic screening technology has been used to screen over 22

million patients across 85-plus countries, named among TIME Magazine's World's Top 400 HealthTech Companies in 2025, with two global-first products and clinical-grade quality at three-to-four times below incumbent price points. Mynvax, founded by Prof. Raghavan Varadarajan of IISc - a Shanti Swarup Bhatnagar laureate and one of India's foremost biophysicists - and Dr Gautham Nadig, a biotech veteran who has been central to translating the platform's discovery science into clinical-stage programmes, is developing a domestically manufactured influenza vaccine in a country that imports roughly 85 per cent of its flu vaccines. Every rupee has a thesis, and every thesis has a clear clinical advancement driving it.

**What is the horizon/timeline of investing? Does Inviga offer patient capital?**

Inviga Healthcare Fund I is a SEBI-registered Category II AIF with a ten-year term and a five-year commitment period, with provision for extension. Individual holds run roughly four to five years for our minority positions and five to seven years for the hospital platform. So the honest answer on patient capital is more precise than the question usually allows. We are not patient in the sense of having no clock - that discipline matters, and our investors are entitled to it. We are patient in the sense that we decline to force an asset to perform against a timeline it structurally cannot meet. Indian healthcare's chronic failure mode is exactly that mismatch: when a hospital is pushed to demonstrate a turn faster than the institution can bear, the operator defers equipment, under-invests in the clinical bench, and chases volume over case mix. We will not underwrite a deal that requires that trade.

What makes the discipline workable is that our value

creation sequence is real, and each stage is an economic event in its own right rather than a promise deferred to exit. In Curis, capital is deployed in phases - seed the platform, deepen the catchment, season it and demonstrate ROCE, then monetise. A hospital that adds a credible tertiary programme in year two is a materially better institution in year three whether or not anyone sells it. Our deployment pace reflects the same philosophy. We invested a lot of time assembling operating teams, seeding Curis, and building proprietary deal flow before accelerating - and we deliberately commenced external LP fundraising only once the portfolio architecture had taken shape, so that incoming investors had visibility rather than a promise. That is what patience means at Inviga: not an indefinite horizon, but a refusal to let the clock dictate clinical or operational shortcuts. And where an institution's own horizon runs longer than ours, as it usually does, we structure so that its continuity does not depend on our exit. Our exit should be a change of shareholder, not an event the hospital has to survive.

**How does Inviga balance profit with patient outcomes and affordability beyond the metros? What are the metrics that are tracked and how important are patient outcomes?**

We would resist the premise that there is a balance to be struck, because in this asset class the trade-off is largely illusory. A hospital in a Tier 2 city has no captive market - its patients can and do travel to a metro for anything serious. The only thing that keeps them local is the belief that the outcome will be as good, and that belief is built on clinical results. Outcomes are therefore the mechanism of profitability, not a constraint on it, which is why clinical excellence is the first of our six vectors of growth and our stated top priority.

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The same logic runs through the minority portfolio. Forus Health has built a durable global franchise precisely by delivering cutting edge clinical-grade ophthalmic technology at far below incumbent price points - that combination of quality and accessibility is what has carried it into 85-plus countries and 22 million patient screenings. Mynvax's thesis rests on the same principle: India imports roughly 85% of its influenza vaccines at retail prices near Rs 2,000 a shot, and a domestically manufactured vaccine at half that price is both a public health advance and a substantial commercial opportunity. In our portfolio, affordability is a growth engine.

On metrics, we track clinical and financial performance as one dashboard rather than two. Clinically, we hold our platforms to measurable outcomes and value-based health - accreditation standing, clinical success rates that sit in the top quartile of the market, protocol adherence, and case-appropriate quality and safety indicators. Operationally, we track the variables that connect clinical performance to economics: occupancy, ARPOB, EBITDA per bed, ROCE, procurement cost, and capital deployed per bed. We weight clinician retention most heavily of all - physician

attrition is the most reliable leading indicator of value destruction in a Tier 2 hospital, and it typically surfaces in the clinical data well before it appears in the P&L. Access, quality of care, reducing the cost of care, and egalitarianism are the explicit pillars of our impact thesis, and we are candid that formal ESG scoring frameworks will be built out further as the businesses mature. What is not aspirational is the operating rule: no financial target may be met by degrading a clinical one.

## India has many health tech startups as well as clinicians turned entrepreneurs. Does Inviga also invest in such companies and innovative products?

Yes - this is Track Two of our strategy, where we act as a quasi-strategic investor. We take active minority positions in high-IP, high-growth healthcare adjacencies: devices, diagnostics, biotech, supply chain. The gap we fill is specific. Growth-stage healthcare innovators in India are too large for seed VC and too small for bulge-bracket PE, and even when they raise, they struggle with the thing that actually determines survival - selling into hospitals. Healthcare sales in India is nebulous and slow, and search costs are punishing. Our advantage is

that we know the demand side. We can connect a portfolio company into hospital networks, shorten its sales cycle, validate its product clinically within our own platforms, and help it professionalise its supply chain. Forus Health's ophthalmic devices can be deployed inside Curis, giving Forus a clinical validation site and Curis an advanced diagnostics capability at preferential terms. We are one of very few funds in India positioned to offer that, because it requires owning and operating hospitals as well as investing in the companies that sell into them.

What we look for is evidence. We test concepts by wearing the hat of the consumer - would we, as operators of hospitals, actually buy this and keep using it? We want real IP rather than repackaged commodity; genuine clinical or workflow deltas with clinician endorsement; unit economics that survive real procurement cycles; and a regulatory spine that has been built rather than retrofitted. Our two live Track Two positions illustrate the standard. Forus is a fifteen-year IP creator, profitable for six consecutive years, self-funding some of the best R&D we have come across in recent times, with two global-first products and CDSCO SaMD clearances for

its AI platforms. Mynvax is a science-led vaccine platform backed by BIRAC and EU research consortia, now advancing to Indian Phase 1 trials under an ICMR Memorandum of Agreement. Both are Make in India, Make for India and Make for the World propositions with global impact and affordability at their core.

## What is the checklist of healthcare organisations hoping to attract Inviga's interest as an investor?

Five things, in order. First, promoter or founder alignment - non-negotiable, and the reason we have declined more deals than for any other cause. We look for genuine intent to institutionalise. Alternate promoter interests, wavering commitment to the business plan, accounting indiscipline, or related-party dealings will end a conversation regardless of the economics on offer. Second, clinical credibility. In hospitals, that means a real specialist bench and a defensible case mix. In devices and diagnostics, it means IP that a clinician would actually endorse - we are turned off by low IP quotient and by products that cannot survive our own internal validation as operators. Third, an underserved and defensible market: high-growth catchments with genuine unmet need, and an absence

of overcapacity risk.

Fourth, a business we can meaningfully help. Our capital is not the scarce input - our operating vantage is. For control assets, that means situations where centralised procurement, clinical governance, digitisation and professional management can visibly move the needle. For minority positions, it means companies where our hospital network, supply chain connect and clinical relationships create real acceleration, and where that contribution is given credence in rights and economics. A founder who wants only the cheque will find us the wrong partner. Fifth, capital discipline. We are structurally cautious about heavy greenfield components; our preference is for asset-right models where capital goes into revenue-generating equipment and clinical capability rather than land and buildings. Finally, a word on what the checklist is really testing: whether the institution and Inviga can agree on a clear, measurable strategic plan upfront, with defined end-points and honest ratchets for adherence and divergence. Organisations that find that conversation uncomfortable are usually telling us something important.

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## When health becomes a lifestyle investment

Once centred on treating illness, healthcare is increasingly being shaped by consumers choosing to stay well. Services that once prompted Indians to travel overseas are now finding a growing market at home, prompting providers to rethink investments, business models and the next wave of growth across the healthcare ecosystem. **Neha Aathavale** reports

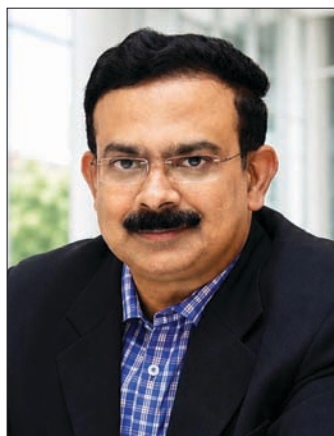
It began with an unexpected search result. Sweat reduction treatments were not the healthcare trend I had set out to explore. Yet, the deeper the search went, the clearer the pattern became. Longevity consultations, executive health memberships, whole-body scans, genomic profiling and continuous glucose monitors for people without diabetes were no longer isolated offerings. They were all catering to a growing appetite for healthcare that extends well beyond the treatment of disease. Individually, each service appears niche. Collectively, they reveal a much larger shift quietly reshaping India's healthcare industry.

The common thread is not the treatments themselves, but the consumer they are designed for. A growing cohort of affluent Indians is willing to spend on healthcare that promises to optimise health, appearance, productivity and healthy ageing, rather than simply treat illness. In response, hospitals, diagnostics providers and MedTech companies are expanding beyond conventional care to build premium, optimisation-focused services that create new, out-of-pocket revenue streams.

What was once viewed as lifestyle spending is steadily emerging as one of healthcare's most compelling business opportunities. The question how different players across the healthcare ecosystem are positioning themselves to capture it.

### Health, now a premium purchase

The shift is beginning to reflect in market numbers. India's health and wellness market is projected to reach \$257.94 billion by 2034, while the diagnostics market is expected to touch \$124.5 billion, driven by growing demand for advanced screening, genomic profiling and bio-



We are witnessing a paradigm shift towards preventive, predictive and personalised healthcare, where individuals are increasingly investing in maintaining health rather than merely managing illness

**Dr Ananth Rao**  
VP & Business Head,  
Fortis Hospitals,  
Bengaluru



Patients seeking health optimisation prefer dedicated, streamlined environments over traditional, crowded clinical setups designed for acute illness

**Dr Madan S. Gaekwad**  
Chief Operating Officer - Ramaiah Memorial Hospital



These evolving needs are reshaping our investment priorities, encouraging hospitals to build care pathways that extend well beyond traditional inpatient care

**Dr Sharan Shivaraj Patil**  
Founder & Chairman - SPARSH Group of Hospitals

marker-based testing. For healthcare providers, the opportunity extends beyond adding another speciality. It is prompting a rethink of business models, with premium preventive care,

subscription-led monitoring and personalised health services creating revenue streams that sit largely outside the price-sensitive and regulated environment of conventional treatment.

Hospitals are among the first to respond to this changing consumer behaviour. Rather than positioning themselves solely as centres for treating illness, they are expanding their role across

the entire continuum of care.

"The healthcare landscape is undergoing a fundamental transformation. Traditionally, hospitals have been viewed primarily as centres for diagnosing and treating disease. Today, however, we are witnessing a paradigm shift towards preventive, predictive and personalised healthcare, where individuals are increasingly investing in maintaining health rather than merely managing illness," says Dr Ananth Rao, Vice President and Business Head, Fortis Hospitals, Bengaluru.

The implications extend beyond introducing executive health programmes or lifestyle clinics. Providers are increasingly investing in precision medicine, genomics, advanced diagnostics, multidisciplinary outpatient care and digital health platforms to create integrated care pathways that keep patients engaged beyond episodic hospital visits. This expanding scope of care is also influencing where hospitals deploy capital and build future capabilities. As Dr Sharan Shivaraj Patil, Founder and Chairman, SPARSH Group of Hospitals, points out, "These evolving needs are reshaping our investment priorities, encouraging hospitals to build care pathways that extend well beyond traditional inpatient care."

From a commercial standpoint, this represents a significant shift in how hospitals generate value. As Rao notes, "From a business perspective, these evolving service lines also represent an opportunity to diversify revenue streams, strengthen patient lifetime value and deepen long-term engagement beyond episodic hospital visits. However, investments must remain firmly anchored in evidence-based medicine, clinical governance and measurable health outcomes rather than consumer trends alone."

## Where hospitals see the next opportunity

The opportunity is also prompting hospitals to move beyond standalone wellness offerings towards structured preventive healthcare verticals. Rather than treating health optimisation as an ancillary service, providers are integrating specialised clinics, diagnostics, nutrition, physiotherapy and digital health into coordinated care models designed around long-term engagement.

For Dr Madan S. Gaekwad, Chief Operating Officer, Ramiah Memorial Hospital, this evolution is being driven by a combination of clinical necessity and changing consumer expectations. "Patients seeking health optimisation prefer dedicated, streamlined environments over traditional, crowded clinical setups designed for acute illness." He adds that dedicated preventive healthcare centres allow hospitals to leverage their clinical expertise while offering evidence-based services with greater credibility than fragmented wellness providers.

The demand itself is becoming increasingly specialised. Executive health programmes continue to remain popular among corporate professionals, but hospitals are also witnessing higher uptake for comprehensive metabolic assessments, preventive oncology, sleep medicine, weight management, cardiac risk evaluation and women's health services. The common denominator is a consumer seeking to preserve functional health and quality of life, rather than simply extending lifespan. Rising lifestyle disorders, corporate wellness initiatives and growing awareness of early diagnosis are further accelerating this shift.

Yet, the implications extend beyond expanding service portfolios. As hospitals create dedicated preventive verticals, they are also positioning themselves differently within an increasingly competitive healthcare market. Preventive care is becoming a point of differentiation, allowing providers to build lifelong relationships with patients instead of limiting interactions to episodes of illness.

## The first touchpoint

If hospitals are expanding the



Recently, people have started to look at diagnostics differently. Most used to visit only when they had symptoms or a doctor recommended it. Now, more are choosing preventive check-ups to understand their health better. This shift means diagnostics now help with early risk detection and long-term wellness, not just finding illness

### Dr Ajay Phadke

Director, Strategic Business Development, Agilus Diagnostics



In the coming years, preventive health care, longevity medicine, and personalisation wellness programs will prove to be an essential sector for hospitals. Even though they might not completely eliminate traditional therapy service, they can surely help with creating loyalty among patients and better clinical outcomes as well as diversifying their income sources

### Dr Sonia Lal Gupta

Joint Managing Director - Metro Group of Hospitals

business of prevention, diagnostics providers are becoming the first point of engagement. The consumer's journey increasingly begins long before a consultation, with health assessments that promise to identify risks, decode biomarkers and provide a clearer picture of future health. In the process, diagnostics is evolving from a service that confirms disease to one that enables informed decision-making.

"Recently, people have started to look at diagnostics differently. Most used to visit only when they had symptoms or a doctor recommended it. Now, more are choosing preventive check-ups to understand their health better. This shift means diagnostics now help with early risk detection and long-term wellness, not just finding illness," says Dr Ajay Phadke, Director, Strategic Business Development, Agilus Diagnostics.

The changing mindset is also influencing how diagnostic services are packaged. Instead of opting for individual investigations, consumers are increasingly choosing comprehensive

health assessments that consider age, lifestyle and family history. Executive health check-ups continue to dominate demand, while metabolic assessments, cardiac risk profiles, thyroid panels and other preventive investigations are witnessing stronger uptake as lifestyle-related diseases continue to rise.

For diagnostic providers, this is translating into measurable business growth. According to Phadke, wellness and preventive services, which accounted for 6 to 12 per cent of revenues for leading diagnostic chains in FY21, now contribute 12 to 25 per cent, registering annual growth of over 25 per cent. More importantly, these programmes are encouraging repeat screenings and sustained customer engagement, making preventive healthcare an increasingly important pillar of diagnostics businesses.

However, Phadke cautions that the growing appetite for advanced screening must continue to be guided by clinical appropriateness. "People are much more

aware of advanced screening options now, but every test should have a clear medical reason. At Agilus Diagnostics, we believe recommendations should depend on a person's age, medical history, lifestyle, risk factors and their doctor's advice."

## Beyond episodic care

For decades, hospitals and diagnostics providers largely operated around episodic interactions, a consultation, a test or a procedure. Lifestyle medicine is gradually changing that equation. Health optimisation relies on regular screenings, annual health assessments, continuous monitoring and periodic consultations, creating opportunities for providers to remain engaged with consumers over a much longer period.

This evolution is encouraging healthcare organisations to move beyond transaction-led care towards relationship-led models. Preventive programmes, executive health memberships and structured follow-up pathways are helping providers build recurring

engagement while creating new revenue streams outside conventional hospitalisation. The emphasis is shifting from one-time interventions to sustained health management, where consumers return not because they are unwell, but because they want to remain well.

Dr Rao, believes this transition is fundamentally changing hospital economics. "From a business perspective, these evolving service lines also represent an opportunity to diversify revenue streams, strengthen patient lifetime value and deepen long-term engagement beyond episodic hospital visits. However, investments must remain firmly anchored in evidence-based medicine, clinical governance and measurable health outcomes rather than consumer trends alone."

A similar trend is playing out in diagnostics. According to Dr Phadke, preventive programmes are encouraging repeat health assessments, strengthening customer retention and making wellness services an increasingly important contributor to diagnostic revenues. The challenge, however, lies in ensuring that growing consumer demand for advanced screening continues to be guided by clinical appropriateness rather than indiscriminate testing

## Healthcare's next chapter

What began as a niche wellness trend is steadily evolving into a strategic business opportunity for healthcare. The challenge now is not whether providers should invest in lifestyle medicine, but how they build clinically robust and commercially sustainable models around it. As Dr Sonia Lal Gupta, Joint Managing Director, Metro Group of Hospitals, puts it, "In the coming years, preventive health care, longevity medicine, and personalisation wellness programs will prove to be an essential sector for hospitals. Even though they might not completely eliminate traditional therapy service, they can surely help with creating loyalty among patients and better clinical outcomes as well as diversifying their income sources."

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# THE CYBERSECURITY IMPERATIVE

As healthcare becomes more connected and data-driven, cybersecurity is emerging as a strategic investment for hospitals. Rising cyber threats, expanding digital infrastructure and growing regulatory expectations are prompting healthcare organisations to strengthen their cyber defences

**By Kalyani Sharma**







Walk into any hospital today and you will find a very different building from the one that stood there a decade ago. Patient records live on screens instead of paper files. Diagnosis happens with the help of AI tools. Infusion pumps and monitors talk to the network. Doctors consult patients over video calls from another city. All of this has made care faster, more accurate and more accessible. But it has also opened many new doors, and hospitals across India are now investing in cybersecurity like never before to make sure those doors stay shut to the wrong people.

It is crucial to understand what is fuelling this spend, where the money should go, and what still needs fixing.

## Why the spend is going up

The simplest explanation is that hospitals have far more to protect than they did a few years ago.

Independent data backs this up. IBM's 2025 Cost of a Data Breach Report found healthcare to be the costliest sector to breach of any industry, a title it has now held for well over a decade, with the average incident taking close to 279 days to even detect. That combination of high cost and slow detection is exactly what is pushing budgets upward.

Bipin Kumar Chaudhary, CIO, Fortis Healthcare, points out that "ransomware attacks on healthcare institutions, growing regulatory expectations around data privacy, and the critical need to ensure uninterrupted patient care are prompting organisations to make cybersecurity a board-level priority." As he puts it, "Investments are increasingly being driven by the need for resilience rather than compliance alone."

That word, resilience, comes up again and again in this conversation, and it points to a deeper change in how attacks are actually unfolding.

Rajnish Gupta, Managing Director, Tenable India, believes the risk itself has changed in nature. "Attack sophistication is the single biggest driver of cybersecurity investments in



Ransomware attacks on healthcare institutions, growing regulatory expectations around data privacy, and the critical need to ensure uninterrupted patient care are prompting organisations to make cybersecurity a board-level priority

## Bipin Kumar Chaudhary

CIO,  
Fortis Healthcare



Attack sophistication is the single biggest driver of cybersecurity investments in healthcare, and AI is steering this shift

## Rajnish Gupta

Managing Director,  
Tenable India



Ransomware attack on a hospital doesn't just impact data- it can disrupt patient care and clinical operations

## Anirban Mukherji

Founder and CEO,  
miniOrange

healthcare, and AI is steering this shift," he says.

What makes healthcare different from any other sector, he adds, is this, "The stakes are higher in the healthcare sector, since it involves human lives. A disrupted radiology system can delay a diagnosis. A manipulated lab result can change a treatment decision."

It is this human dimension, patient safety rather than data alone, that keeps surfacing as the real reason boards are paying attention.

Anirban Mukherji, Founder and CEO, miniOrange, agrees that the human cost is what has changed the conversation in

boardrooms. "A ransomware attack on a hospital doesn't just impact data- it can disrupt patient care and clinical operations," he says.

And the scale of exposure only grows as more devices join the hospital network. Vipin Varma, SVP-Cybersecurity, CitiusTech, brings a number to the table that puts the scale of the challenge in perspective: "A modern intensive care unit (ICU) bed can have 35-40 network-connected medical devices."

When every one of those devices is a potential entry point, the case for higher investment writes itself.

Jivitesh Bansal, VP-Engineering, PB Health, sums up the everyday stakes for clinical teams. "A cyberattack can stall a clinical workflow mid-treatment, push back a surgery, or knock a hospital's systems offline when a patient needs care right now," he says.

Taken together, these views point to one conclusion: healthcare's cybersecurity spend is rising because the sector's risk profile has changed faster than its defences have, and hospitals are now racing to catch up.

## Where the money should go first

With budgets growing, the next

question every hospital is asking is where to spend first. Most experts agree that the basics deserve first claim on the budget, not the newest tool in the market.

This is where hospital and vendor leaders converge almost entirely, even though they are speaking from different chairs.

Surjeet Thakur, Founder and CEO, TrioTree Technologies, keeps it simple: hospitals should focus on "identity and access management, multi-factor authentication, endpoint protection, secure data backup, security monitoring, and vulnerability assessments. These areas should form the core of every cybersecurity budget."

Speaking from inside a hospital rather than a vendor's boardroom, Chaudhary takes a similar view on where to start. "Hospitals should focus on strengthening their foundational cybersecurity capabilities before investing in niche solutions. Priority areas include identity and access management, endpoint detection and response, security monitoring, vulnerability management, data protection and cyber recovery."

Beyond the fundamentals, one area keeps getting overlooked: what happens after an attack has already happened.

Praveer Kochhar, CPO and Co-Founder, KOGO AI, brings the conversation to a subject hospitals often overlook until it is too late: recovery. "The real cost of an attack on a hospital isn't just the breach, it's the hours of clinical downtime while systems are rebuilt. Most hospitals also fall for what we call the backup mirage: "backup successful" shows up green on a dashboard, but that's not the same as restorable under fire. Nobody finds out the difference until they're mid-incident and the restore fails. A hospital that hasn't rehearsed its recovery is betting patient care on a document it's never opened under pressure."

With AI now sitting inside clinical and administrative workflows, a newer line item is also demanding budget of its own.

For Varma, the newest priority on the list is AI itself. "The first priority should be AI

security. As hospitals increasingly adopt AI to improve operational efficiency, clinical decision-making, and administrative workflows, organisations must ensure that AI applications are developed, deployed, and governed securely."

Bansal puts it just as plainly: "Hospitals have to prioritise core cybersecurity fundamentals over shiny new tools."

The pattern across all five views is hard to miss: get identity, backup and recovery right before chasing anything more advanced.

### How AI, cloud and connected devices are changing the game

Every expert agreed that AI, cloud computing and connected medical devices have changed what cybersecurity means in a hospital setting, and not always for the simple reason of adding new tools to defend.

The interesting part is that the same technologies reshaping patient care are also reshaping the threat itself, on both sides of the fight.

Sachhin Gajjaer, Founder and CEO, Sattrix describes it as a battle being fought with the same weapons on both sides. "AI is a double-edged force: attackers now use it to craft convincing phishing, deepfakes, and faster-mutating malware, while defenders lean on it for anomaly detection and automated response," he says, summing up the moment with a line of his own: "AI to AI is the new cyber mantra for any critical and sensitive organisation."

That double-edged nature is not just about tools attacking tools. It is also changing the basic question a security team has to ask.

Kochhar frames the shift in a different way. Where security teams once asked whether a system could be hacked, they must now ask something new. "The security question changes from 'can someone read this data' to 'can someone get an autonomous system to act on their behalf,'" he says.

Part of what makes this harder to govern is how quickly AI tools are now being built and adopted inside hospitals, often



## AI to AI is the new cyber mantra for any critical and sensitive organisation

### Sachhin Gajjaer

Founder and CEO,  
Sattrix



## AI application development has become significantly faster and less expensive, enabling business users and citizen developers to build AI agents and applications within days

### Vipin Varma

SVP-Cybersecurity,  
CitiusTech



## Hospitals have to prioritise core cybersecurity fundamentals over shiny new tools

### Jivitesh Bansal

VP-Engineering,  
PB Health

outside the IT department's usual purview.

Varma also sees AI reshaping the job of the security team from the ground up, since "AI application development has become significantly faster and less expensive, enabling business users and citizen developers to build AI agents and applications within days using low-code or no-code platforms and vibe coding."

For clinical staff on the ground, though, the shift is felt in much simpler terms.

Dr Ashish Chandra, Chief Operating Officer, ISIC Multi-speciality Hospital, sums up the everyday reality for clinical

teams well. "AI can help identify unusual activity and detect threats faster, but cybercriminals can also use AI to create more advanced attacks," he says, adding that hospitals now "need a security approach that protects not just computers and networks, but the entire digital healthcare ecosystem."

### The gaps that remain, even with higher spending

Bigger budgets do not automatically mean fewer weak spots, and every expert flagged at least one gap that money alone cannot close. This is perhaps the most important message for hospital leadership, since it means the

size of the cheque is not, by itself, the answer.

Gupta believes the mismatch between spend and outcome comes down to pace. "The strategies aren't keeping pace with the technological change," he says, pointing out that "every new piece of connected equipment a hospital brings in creates a new blind spot that most traditional tools weren't built to see."

That pace problem shows up most starkly in how long a breach can go unnoticed.

Gajjaer's list of gaps includes an uncomfortable but familiar one: response time. "The sector still averages 8+ months to identify a breach," he notes, and

many hospitals "have bought tools but lack the 24/7 monitoring, tuned alerting, and trained analysts to act on them."

Not every gap is technical, though. Some of it comes down to how cybersecurity is treated inside the organisation.

Mukherji points to a gap in mindset rather than technology. "Many organisations continue to view cybersecurity as a technology problem rather than an organisational responsibility," he says. "Security must be integrated into governance, operations, procurement and clinical workflows."

A newer and quieter version of that same mindset gap has arrived with AI itself.

Varma highlights a newer and quieter risk that has crept in alongside AI adoption. "Individual clinicians, administrators, and business users are increasingly deploying AI tools independently, often without centralised oversight," he says. As he warns, "Even seemingly simple tools such as AI-powered transcription services may transmit protected healthcare information to external platforms" if left ungoverned.

On the regulatory side, awareness itself is a gap. Gupta also flags a compliance blind spot that hasn't had the same attention as the technical one. "Familiarity with the DPDP Act and its newly notified Rules sits only at roughly 28 per cent among Indian healthcare organisations," he says. "DPDP isn't just about avoiding penalties; it's about handling patient data with the care it actually demands."

And underneath every one of these gaps sits a much more basic problem.

Bansal points to something more basic than any tool: visibility. "You can't secure what you don't know you have, and this is one of those unglamorous problems that doesn't get the attention it deserves until something goes wrong," he says.

### What smaller hospitals can do with a smaller budget

Not every hospital has a large IT team or a large security budget, and the good news from every expert is that strong cybersecurity does not have to



cost a fortune.

This is arguably the most reassuring theme to come out of this conversation, since it means smaller hospitals are not locked out of good security simply because they cannot match a large network's spend.

"Cybersecurity does not require higher expenditure; what is important is that appropriate measures are taken," says Thakur, who recommends that mid-size hospitals start with "multi-factor authentication, data backup, endpoint protection, software updates, and educational programmes for employees."

A hospital administrator hears this slightly differently, but arrives at the same starting point. Dr Chandra echoes the same idea from a hospital administrator's chair. "Smaller hospitals do not necessarily need expensive technology to improve cybersecurity," he says. "They should first identify their most critical systems and protect them with basic measures such as strong passwords, multi-factor authentication, regular data backups and timely software updates."

Before spending anything at all, though, clarity on what actually needs protecting comes first.

Mukherji suggests starting with clarity rather than a shopping list. "Smaller hospitals don't necessarily need the largest budgets- they need the right priorities," he says, recommending "a realistic risk assessment to identify the systems and data that are most critical to patient care" as the first step.

Once priorities are clear, smaller hospitals also have a shortcut available that larger networks often build in-house. Gajjaer points to outside help as a smart shortcut for smaller teams. "Mid-sized and smaller hospitals get the most protection per dollar by focusing on fundamentals rather than expensive tooling," he says, and can lean on "managed detection-and-response and co-managed SOC & compliance providers" to get round-the-clock coverage without building a large team from scratch.

None of this, however, should be mistaken for smaller hospi-



Investments in the area of cybersecurity in healthcare will become an integral element of the digital health planning process in India instead of being simply another IT expense that organisations incur

**Surjeet Thakur**  
Founder and CEO,  
TrioTree Technologies



The real cost of an attack on a hospital isn't just the breach, it's the hours of clinical downtime while systems are rebuilt

**Praveer Kochhar**  
CPO and Co-Founder,  
KOGO AI



Cybersecurity spending in healthcare is likely to become a core part of strategic and operational planning rather than a separate IT expense

**Dr Ashish Chandra**  
Chief Operating Officer,  
ISIC Multispeciality Hospital

tals facing a smaller threat.

Kochhar reminds smaller hospitals not to underestimate the threat they face. "Smaller hospitals do not mean they will only face smaller attacks," he says, even if their budgets will naturally look different from a large hospital network's.

Bansal points out that strong security does not have to mean a large spend. "The good news is that some of the highest-impact measures aren't expensive: multi-factor authentication, backups that get tested regularly (not just scheduled and forgotten), patching internet-facing systems promptly, and basic staff awareness training," he says.

## What the next three to five years look like

Every expert sees cybersecurity moving from an IT line item to a permanent part of how hospitals plan and grow, and the outlook, despite the challenges, is a positive one.

What stands out is how similar the direction of travel sounds, whether the view comes from inside a hospital or from a security vendor.

Chaudhary sees this shift already underway. As he puts it, "cybersecurity is evolving from a technology requirement to a patient safety and business resilience imperative," and he expects hospitals to invest more in "AI-driven threat detection,

Zero Trust architectures, cloud security, medical device security and automated cyber recovery capabilities."

Regulation is expected to keep pushing in the same direction. Thakur expects regulation and scale to work together to keep budgets climbing. In his words, "investments in the area of cybersecurity in healthcare will become an integral element of the digital health planning process in India instead of being simply another IT expense that organisations incur."

Dr Chandra agrees the mindset will shift from a compliance checkbox to something more central, saying "cybersecurity spending in healthcare is

likely to become a core part of strategic and operational planning rather than a separate IT expense."

Some go further still, predicting that the very idea of cybersecurity as a separate function will start to fade.

Bansal takes the long view. "My sense is that cybersecurity stops being a 'function' over the next few years and just becomes part of how healthcare technology is built, full stop," he says, expecting more investment to flow into "AI-powered threat detection, zero trust architectures, identity-centric security, and automated response."

And as AI itself becomes part of the hospital's everyday toolkit, securing it is expected to become a budget line of its own.

Varma offers a striking way to think about where budgets are headed. "An increasingly common observation is that the cost of securing an AI application can exceed the cost of building it," he says, expecting cybersecurity's share of the technology budget to keep climbing over the next few years.

And Kochhar leaves hospitals with a simple choice to make now rather than later. "The hospitals that make this shift will stop finding out about their weak points during an actual incident," he says.

## The bottom line

The message from every corner of the industry is remarkably consistent. Digitisation has made healthcare better for patients, and it has also made cybersecurity a permanent part of running a hospital, not a one-time project. The hospitals that treat it as a shared responsibility across technology, people and leadership, and that build in resilience rather than chase compliance alone, are the ones best placed to keep patient care running no matter what comes their way. For an industry built around protecting life, protecting the systems that make modern care possible is simply the next natural step.

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# Dark data: The untapped opportunity in lifesciences

**Raghuveer Hanumanth**, Head of Business Consulting, Global Life Sciences & Healthcare, EPAM India, explains why unlocking "dark data" has become critical for AI readiness in life sciences and how better data governance can help organisations translate untapped information into faster innovation, stronger compliance and improved patient outcomes

Lifesciences organisations have actively started investing in artificial intelligence (AI), advanced analytics, real-world evidence platforms and precision medicine initiatives. Yet many of these efforts are constrained by a less visible challenge. Valuable enterprise data, including clinical records, laboratory results, manufacturing data, regulatory documents, imaging files and more, often remains dark data. These are information bits that have been collected and stored over time but remain unclassified, disconnected across systems and difficult to govern. As a result, much of this data stays inaccessible to AI models and decision-makers, limiting its potential to drive better business outcomes.

As per the research findings of the Institute for Health Metrics, roughly 70–80 per cent of patient information within Electronic Health Records resides in unstructured notes, leaving significant clinical and operational insights inaccessible to analytical systems. By harnessing dark data through

AI and advanced analytics, cloud-native architectures and validated pipelines, organisations can accelerate discovery, improve compliance and deliver meaningful patient outcomes.

## Dark data is becoming an AI readiness issue

The next generation of AI in life sciences is moving beyond content generation toward scientific and operational decision support. Organisations are building assistants that help scientists review prior research, support regulatory submissions, accelerate investigations and answer complex questions across decades of enterprise knowledge.

These use cases depend less on model sophistication than on knowledge availability.

If historical clinical evidence, CMC (Chemistry, Manufacturing and Controls) documentation, validation records, deviation investigations or regulatory correspondence remain fragmented across repositories, AI cannot retrieve or reason over them with confidence. The challenge is tuning



decades of institutional knowledge into a form that AI can trust and use.

## Metadata analytics for dark data optimisation

Metadata analytics is the process of analysing 'data about data'. It is essential to data management, as it provides context and meaning to data sets, making it easier to search, organise and interpret. Businesses and organisations can gain valuable insights into their data by analysing metadata, including patterns, trends and relationships between different data sets. It involves using advanced software tools and ML (machine learning) algorithms to extract meaningful information, such as file names, dates and attributes. This in-

formation can be used to improve search functionality, optimise storage, enhance data security and ensure compliance with regulatory requirements.

When it comes to dark data, metadata can help identify where they are located, what they contain, what's their age, who owns them and how to utilise them best. For example, you have a large dataset containing clinical trial information. By applying metadata tags, you can create a searchable database to find the files you need quickly.

## Moving from data management to knowledge activation

Unlocking dark data requires more than consolidating storage systems. It demands a strategic approach to data governance and interoperability. Organisations must focus on making data discoverable, contextualised and reusable. Enterprise data catalogs and FAIR (Findable, Accessible, Interoperable and Reusable) data principles provide the foundation for turning fragmented in-

formation assets into enterprise knowledge. The objective is not simply better data management. It is the creation of a connected information ecosystem where researchers, clinicians and AI systems can identify relevant insights when and where they are needed.

## A future outlook

The next phase of digital transformation in life sciences will not be defined solely by new technologies. It will be determined by how effectively organisations leverage the information they already possess. CIOs (Chief Information Officers), CDOs (Chief Data Officers) and digital leaders across the life sciences ecosystem should not treat dark data as a technical debt issue. It is a strategic asset hiding in plain sight that can accelerate discovery, strengthen regulatory readiness and amplify the impact of AI investments. By reframing dark data as a catalyst, life sciences organisations can unlock unprecedented value, ensuring that innovation is efficient, compliant, patient-centric and scalable.

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## INTERVIEW

# Health and education: Two sides of the same development story

**Jaison C Mathew**, Chief Executive Officer, Christel House India, speaks to **Kalyani Sharma** about why improving child survival alone is no longer enough, the growing impact of nutrition, mental health and preventive healthcare on learning outcomes, and why schools should play a larger role in identifying health challenges early

**India's health indicators have improved markedly over the past two decades, but are we overlooking a different crisis, one where children are surviving but not necessarily developing to their full potential? What are you seeing on the ground that national data may not fully capture?**

India has made significant progress in improving child-mortality numbers and expanding access to healthcare, and that deserves recognition. The next challenge, however, is ensuring that children are not only surviving but also developing to their full potential.

What we see at Christel House India is that many children from underserved communities arrive at school physically present but carrying barriers that are far less visible. Hunger may no longer be severe enough to keep them out of school, but poor nutrition still affects concentration and cognitive development. Untreated vision or hearing issues can quietly impact learning for years. Many children are also coping with family instability, financial stress, or emotional trauma that makes it difficult to engage fully in the classroom. We had a student who was struggling to concentrate in class and was frequently falling ill. Our nursing staff discovered that he was anaemic. After receiving the right nutritional and medical support, he began attending regularly and participating more



**For children growing up in underserved communities, nutrition, physical health, mental well-being, and access to healthcare are deeply interconnected, with each influencing the others**

actively in class.

These are challenges that are not always reflected in research indicators, but they have a profound influence on a child's ability to learn and, ultimately, build a different future. This is why we view education and child development as inseparable. Alongside academics, our model integrates nutrition, healthcare, counselling, and social-emotional support because a child who is hungry, unwell, or emotionally distressed cannot fully benefit from even the best classroom instruction.

For children from underserved communities, survival is the starting point. Real progress is measured by whether they are healthy, confident, and supported enough to translate education into long-term opportunity.

**In your experience, which health-related issues most commonly disrupt a child's educational journey—nutrition, chronic illness, mental health concerns, access to care, or something else? How have these challenges evolved over the years?**

It is rarely one health-related issue alone. For children growing up in underserved communities, nutrition, physical health, mental well-being, and access to healthcare are deeply interconnected, with each influencing the others.

Many children join us carrying multiple burdens at once. They may be

malnourished, living with untreated health conditions, experiencing stress at home due to financial insecurity, or lacking access to timely medical care. Any one of these can affect school attendance, concentration, confidence, and ultimately a child's ability to learn. Together, they can significantly disrupt a student's educational journey.

Over the years, we have also seen the nature of these challenges evolve. While undernutrition and untreated illnesses remain concerns, there is growing evidence of the impact that chronic stress, anxiety, and emotional well-being have on children's ability to participate fully in school. These are not always visible in the way a fever or an infection is, but they influence how children engage with learning every day.

Combining nutritious meals, preventive healthcare, counselling, and social-emotional support at a school level, as we do, is important. This is because meaningful learning is only possible when a child's physical and emotional needs are being met. Addressing one without the others rarely delivers lasting outcomes.

**Schools are rarely viewed as part of the healthcare ecosystem. Yet they are often the first institutions to spot signs of malnutrition, emotional distress, or untreated illness. Do you think India**

### **is underutilising schools as a platform for preventive healthcare?**

Schools often become the first place where signs of health-related challenges begin to surface, since children spend a large part of their formative years there. Teachers and school staff see children almost every day. They notice when a student is frequently absent, struggling to concentrate, becoming withdrawn, or showing changes in behaviour. Those observations can provide an early indication that something beyond academics may be affecting the child.

This creates a significant opportunity for schools to play a stronger role in preventive healthcare, particularly for children from underserved communities who may have limited access to regular medical care. Schools cannot replace healthcare providers, but they can become an important point for early identification, timely referrals, and ongoing support before relatively minor issues begin to affect a child's education.

We have seen the value of integrating health into the school experience. Regular health screenings, vision and hearing assessments, dental care, counselling, and access to healthcare professionals help us identify concerns early and intervene before they become larger barriers to learning. Because these services are part of the school ecosystem, children receive support in an environment that is familiar and accessible to them. In one instance, a student who had been consistently falling behind academically was found, through a routine vision screening, to have severe eyesight issues. After receiving corrective glasses, the student's classroom participation improved significantly, demonstrating how early identification of a relatively simple health concern can have a meaningful impact on learning.

Ultimately, health and

education should not be viewed as separate conversations. When schools are equipped to recognise these challenges early and work alongside families and healthcare providers to address them, they become not only places of learning, but also important partners in supporting children's overall development.

### **Mental health among children and adolescents has become a growing concern globally. How visible is this challenge among students from economically vulnerable communities, and are existing support systems adequate to address it?**

Among children from economically vulnerable communities, mental health is closely linked to the realities they live with every day. These could be financial insecurities at home, unstable family environments, exposure to violence, uncertainty about the future, or the pressure to contribute to household income.

Some students become withdrawn or anxious, while others struggle with concentration, attendance, confidence, or behaviour in the classroom. Without the right support, these signs are sometimes mistaken for a lack of interest or discipline, when they may actually reflect emotional distress.

Although awareness of mental health has improved considerably today, access to support remains uneven. Many families are unfamiliar with mental health services, continue to carry a stigma about it, or face practical barriers in accessing them. Schools often have limited counselling resources despite being the institutions that interact with children most consistently.

This is one reason why we have made emotional well-being an important pillar in our educational approach. Our counsellors and social workers work closely with students, while social-emotional learning is

embedded into everyday school life. Equally important, we engage families because a child's well-being is shaped both inside and outside the classroom.

When children feel emotionally safe and supported, they are better able to participate in school, build healthy relationships, and develop the confidence needed to pursue opportunities beyond education.

### **Policy makers often discuss health and education as separate sectors competing for resources. From your perspective, what are the costs of treating them as independent priorities rather than interconnected investments in human capital?**

Health and education are often discussed as separate sectors, but for the children we work with, they are inseparable parts of the same journey. A child who is hungry, frequently unwell, or experiencing emotional distress cannot fully benefit from even the best classroom instruction. Equally, good health on its own cannot unlock opportunity without access to quality education.

Poverty, poor nutrition, limited access to healthcare, financial stress, and interrupted education reinforce one another. Addressing only one of these challenges means the others continue to hold a child back.

That understanding has shaped our approach. Alongside academics, we invest in healthcare, nutrition, counselling, family engagement, career guidance, and support beyond Grade 12 because we have seen that lasting educational outcomes depend on much more than what happens inside the classroom. These interventions are not separate programmes. Together, they create the conditions that allow children to learn, remain engaged, complete higher education, and transition successfully

into employment. The outcomes reinforce this approach. At Christel House India, we have consistently recorded an approximate 98 per cent attendance rate and a 97 per cent student retention rate. Also, about 99 per cent of our graduates are either pursuing higher education or employed.

When we think about investing in human capital, this is what it means. Health enables learning. Education expands opportunity. And when put together, they create the foundation for economic mobility, stronger communities, and a more productive workforce.

As India works towards the vision of *Viksit Bharat*, I believe we need to see these sectors not as competing priorities, but as complementary investments. The greatest returns will come when every child, particularly those from underserved communities, has both the health and the educational support needed to realise their full potential.

### **As India shifts its focus from reducing mortality to improving quality of life and long-term outcomes, what policy interventions would have the greatest impact on ensuring that children not only stay healthy but are also able to learn, thrive, and break cycles of poverty?**

As a country, we have made significant progress in improving child survival and expanding access to education. The next stage of that journey is ensuring that every child has the opportunity not only to survive, but to thrive and realise their full potential.

To achieve that, I believe we should continue strengthening the systems that support the whole child. Good nutrition, access to preventive healthcare, mental health support, and quality education should work together rather than as separate interventions. When these foundations are in place, children are far better positioned to learn, stay

engaged in school, and build the confidence and resilience needed for the future.

For children from underserved communities, another important priority is supporting them through the transitions where many are at greatest risk of falling behind. Securing admission to college is a significant milestone, but for many first-generation learners, the challenges do not end there. Navigating higher education, managing financial pressures, adapting to unfamiliar environments, and preparing for employment often require continued guidance if educational gains are to translate into long-term mobility. Our own experience at Christel House India has reinforced the importance of this long-term approach. We continue supporting students from early childhood through young adulthood with career guidance, employability skills training, socio-emotional support, mentoring, internships, job placements, and scholarships for higher education. As a result, 100 per cent of our students transition into tertiary education before taking their next steps towards employment.

While supporting children with healthcare, nutrition, counselling, family engagement, and career guidance during their school years is important, continuing that support through higher education and into employment has an equally significant role to play in helping them build sustainable futures.

Investing in children from underserved communities is one of the most meaningful investments we can make to grow as a nation. When we equip them with the health, education, and sustained support they need to succeed, we are not only transforming individual lives but also strengthening the country's future human capital and long-term economic growth.

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## Mental health insurance in India: From policy wording to patient access

**Yuvveer Bagai**, Director, Zenre and Designated Partner, YB Advisors LLP, highlights the need to make mental health insurance more accessible by translating policy provisions into meaningful patient care

Mental health remains one of the most neglected areas of Indian healthcare. Psychiatry and psychology are still too often treated as peripheral departments in hospitals and clinics — under-prioritised, under-funded and under-integrated into mainstream care. The neglect is not because the need is small; it is because stigma continues to shape how society, institutions and even insurance systems view mental illness.

It is considered normal for a person to say they have fever and are seeing a physician, or that they have back pain and are visiting an orthopaedic specialist. But when someone says they feel low, anxious, depressed or emotionally overwhelmed, and that they are consulting a psychologist or psychiatrist, the response is often hesitation, discomfort or judgement. This social taboo delays treatment, deepens suffering and prevents people from seeking timely care.

The brain is an organ like any other organ. Just as the heart, liver, kidneys or lungs can malfunction, the brain and mind too can suffer from illness, imbalance, trauma, stress and dysfunction. Depression is not weakness. Anxiety is not drama. Addiction is not moral failure. Mental illness is a medical and human reality, and it deserves the same dignity, urgency and financial protection as physical illness.

India's mental health burden is substantial. The India State-Level Disease Burden Initiative estimated that in 2017, around 197.3 million Indians were living with mental disorders, including approxi-



mately 45.7 million with depressive disorders and 44.9 million with anxiety disorders.<sup>[1]</sup> The National Mental Health Survey 2015-16 found that the current prevalence of mental morbidity among adults was 10.6 per cent, and that nearly 15 per cent of adults required active mental health intervention. The same survey reported a treatment gap ranging from 70 per cent to 92 per cent across different mental disorders.<sup>[2]</sup>

These numbers point to a difficult truth: a very large number of Indians need mental healthcare, but most do not receive it adequately or in

time.

The urgency is even greater when viewed against India's demographic scale. India's population is estimated at about 1.46 billion in 2025.<sup>[3]</sup> A large part of this population is young, exposed to academic stress, workplace pressure, digital overload, financial uncertainty, relationship challenges and lifestyle disruption. Mental health is therefore not only a healthcare issue. It is also a question of family wellbeing, workplace productivity, educational performance and national resilience.

The legal position is clear.

Section 21<sup>(4)</sup> of the Mental Healthcare Act, 2017 requires every insurer to make provision for medical insurance for the treatment of mental illness on the same basis as treatment for physical illness.<sup>[4]</sup> In 2026, the Government of India also clarified in Parliament that policies covering OPD treatment for physical illness must cover mental illness on the same basis.<sup>[5]</sup>

This principle of parity is important. Mental health coverage should not be a cosmetic clause in a policy document. It should not be a rider, top-up, add-on or symbolic inclusion. It should form part of the base structure of every health insurance policy. If a policy offers Rs 10 lakh of health cover, mental illness should be meaningfully covered within that framework, not pushed into restrictive sub-limits, unclear exclusions or delayed approvals.

India also has a larger insurance protection gap. In FY 2024-25, India's overall insurance penetration stood at 3.7 per cent of GDP, with life insurance at 2.7 per cent and non-life insurance at only 1 per cent. Insurance density was about USD 97, far below the global average of about USD 943.<sup>[6]</sup> During the same year, India's insurance sector issued 41.84 crore policies, collected premiums of approximately Rs 11.93 lakh crore and paid claims of around Rs 8.36 lakh crore.<sup>[7]</sup>

Health insurance has grown, but coverage is still uneven. IRDAI's Annual Report 2024-25 records that general and health insurers covered 58 crore lives under 2.65 crore health insurance policies. Of these lives, 42.3 per cent were

covered under government-sponsored schemes, 47.4 per cent under group business and only about 10.3 per cent under individual policies.<sup>[6]</sup> In a country of nearly 146 crore people, this shows both progress and a large gap in meaningful individual protection.

The gap is especially relevant for mental healthcare because most treatment is outpatient-based. Mental healthcare is not primarily an admission-based specialty; it is a continuity-based specialty. A person with depression may need repeated psychiatric consultations, therapy sessions and medication review. A child with developmental concerns may need psychological assessment and early intervention. A person with anxiety may need counselling and follow-up. A patient recovering from addiction may need relapse-prevention support. An elderly person may need cognitive assessment and caregiver counselling.

Very little of this care is inpatient. Most of it takes place in OPD settings, clinics, counselling rooms, digital consultations and structured follow-up programmes.

Therefore, a policy that claims to cover mental illness but largely restricts coverage to hospitalisation is structurally inadequate. Mental health insurance must include psychiatric consultations, psychology sessions, counselling, psychotherapy, psychometric assessments, neuropsychological testing, digital follow-ups, rehabilitation support and clinically required diagnostics.

Diagnostics also deserve serious attention. In physical healthcare, diagnostic investi-

gations are accepted as a part of the treatment. Blood tests, ECGs, scans and imaging are not treated as luxuries. Mental healthcare should be viewed similarly. Psychological assessments, developmental evaluations, cognitive testing, addiction assessments, sleep assessments and brain-health diagnostics should be covered where clinically indicated. Early diagnosis reduces suffering, improves outcomes and may reduce long-term costs for families, employers and insurers.

Daycare mental health services should also be included where relevant. Many interventions do not require overnight admission but may involve structured therapy programmes, supervised assessments, neuromodulation support or short-duration clinical procedures. Insurance frameworks must evolve beyond the old binary of OPD versus hospitalisation.

The private sector is central to this reform. Much of Indian healthcare is private-sector driven, and this is particularly true for mental healthcare. Patients often seek help from individual psychiatrists, psychologists, counsellors, mental wellness centres and specialised outpatient clinics. If insurance networks are limited mainly to large hospitals, access will remain narrow.

Private mental health clinics and centres must be able to empanel with TPAs, insurers and government schemes through a seamless, transparent and digital process. Empanelment should be based on clear eligibility standards, qualified professionals, ethical documentation, privacy safeguards and defined timelines — not opaque paperwork or discretionary approvals.

Government schemes such as Ayushman Bharat, CGHS, DGHS and similar programmes should also recognise the role of private mental health providers. Ayushman Bharat PM-JAY provides eligible families with health cover of up to Rs 5 lakh per family per year for secondary and tertiary care hospitalisation. Recent government data

## Mental health insurance must include psychiatric consultations, psychology sessions, counselling, psychotherapy, psychometric assessments, neuropsychological testing, digital follow-ups, rehabilitation support and clinically required diagnostics

records more than 44 crore Ayushman cards, over 12 crore hospitalisations and more than 36,000 empanelled hospitals under the scheme.<sup>[8]</sup> Mental healthcare must be integrated more meaningfully into such frameworks, including OPD-linked models where appropriate.

Fair pricing and timely payments are equally important. Mental healthcare is manpower-intensive and cost-intensive. A quality centre requires trained psychiatrists, clinical psychologists, counsellors, therapists, assessment tools, digital systems, privacy infrastructure, crisis protocols, continuous training and, in some cases, expensive technology such as neuro-modulation or brain-mapping systems. Margins are often limited because the service depends heavily on professional time and clinical quality.

If reimbursement rates are unviable or payments are delayed for months, good providers will avoid empanelment. The private sector can complement the government sector only if it is treated as a genuine partner. Claims and bills should be processed through time-bound, digital and transparent systems, with minimal administrative friction.

For patients, the claims experience is the real test of insurance. In FY 2024–25, general and health insurers settled 3.26 crore health insurance claims and paid Rs 94,248 crore, with 69 per cent of claims settled through TPAs and 58 per cent settled through cashless mode.<sup>[6]</sup> Mental health claims need similar efficiency, sensitivity and transparency.

A person in psychological

distress should not be made to wait endlessly for approval. Patients dealing with depression, panic, trauma, addiction withdrawal, suicidal thoughts, grief or severe anxiety are already vulnerable. Insurance processes must not add to their distress through repeated paperwork, insensitive questioning, arbitrary deductions or avoidable denials.

Cashless OPD and daycare mental health services should be enabled wherever policies provide such benefits. Reimbursement should also be simple. Since consultations and therapy usually do not involve consumables, disposables or complex hospital billing, eligible consultation and therapy fees should not be reduced through arbitrary deductions.

There is also a need for separate reporting of mental health claims. IRDAI and insurers should publish data on the number of mental health claims filed, approved and rejected; average claim amount; settlement time; mode of settlement; and reasons for denial. Without this transparency, it is impossible to know whether mental health insurance is genuinely helping patients or merely existing in policy wording.

Confidentiality must be non-negotiable. Patients should not fear that seeking psychiatric or psychological care will affect employment, insurance renewal, portability, social standing or future insurability. Mental health data must be handled with particular sensitivity and shared only where necessary for legitimate claim processing.

Employers too have a role to play. Group health policies should include mental health OPD, counselling, therapy,

psychiatrist consultations and employee assistance programmes. Workplace stress, burnout, anxiety and depression are no longer peripheral issues; they directly affect productivity, retention and organisational culture.

Mental health insurance must also reach beyond metros. Tier-2, tier-3 and rural India need access through tele-psychiatry, online counselling, digital follow-ups, community screening and empanelment of smaller qualified centres. Digital mental health services should be recognised for insurance claims when delivered by qualified professionals with proper documentation.

India now needs a practical Mental Health Insurance Charter. Such a charter should include mandatory mental health coverage in all health policies; OPD coverage for psychiatry, psychology and counselling; coverage for diagnostics, assessments and daycare services; recognition of digital consultations; no discriminatory sub-limits, waiting periods or premium loading; time-bound cashless approvals and reimbursements; separate mental health claims data; seamless digital empanelment for private providers; fair pricing under government schemes; confidentiality safeguards; and quality standards to prevent misuse.

Insurance must be commercially sustainable, but it cannot become inaccessible. Expanding mental health insurance should not mean unregulated billing. It should mean responsible, measurable, ethical and accessible care.

The success of mental health insurance in India

should not be measured by whether policy documents mention mental illness. It should be measured by whether a person in distress can walk into a clinic, speak to a qualified professional, receive timely care and have the claim processed without stigma, delay or denial.

India has already taken the first legal step through the Mental Healthcare Act, 2017. The next step is implementation with sincerity.

Mental health, psychiatry and psychology can no longer remain neglected departments in Indian healthcare. The brain is an organ. The mind deserves care. Mental illness deserves treatment. And treatment deserves insurance coverage.

Mental health insurance must move from policy wording to patient access.

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## Truevis Technologies: Advancing India's radiology and radiation oncology ecosystem through innovation and accessibility

Through integrated technologies, local manufacturing, and a growing presence in Tier-II and Tier-III cities, the company is supporting hospitals in building future-ready diagnostic and oncology infrastructure

### Building the next generation of healthcare infrastructure

India's healthcare system is undergoing a significant transformation, driven by increasing investments in advanced diagnostics, precision cancer care, and the need to improve access to quality healthcare beyond metropolitan cities. As demand for sophisticated radiology and radiation oncology technologies continues to rise, the focus is gradually shifting from merely supplying medical equipment to building integrated healthcare ecosystems that support the entire continuum of diagnosis, treatment, and clinical excellence.

Truevis Technologies Pvt. Ltd. is at the forefront of this transformation. With a vision to become one of India's leading advanced medical technology companies, Truevis is building a comprehensive ecosystem spanning diagnostic imaging, radiation oncology, manufacturing, technology partnerships, clinical applications, engineering services, installation, commissioning, and lifecycle support. The company's long-term objective is to enable healthcare providers to deliver world-class diagnostic imaging and precision cancer care across India.

### Strengthening India's radiology and radiation oncology ecosystem

Truevis offers one of India's comprehensive portfolios of advanced radiology and radiation oncology solutions, including Computed Tomography (CT), Magnetic Resonance Imaging



(MRI), Positron Emission Tomography-Computed Tomography (PET-CT), Digital Subtraction Angiography (DSA), and Linear Accelerators (LINACs). Together, these technologies support the complete patient journey from early disease detection and diagnosis to image-guided intervention, treatment planning, and precision cancer therapy.

Radiology forms the foundation of modern healthcare by enabling early diagnosis, screening, treatment planning, and disease monitoring. Complementing this, radiation oncology has become indispensable in cancer management, delivering highly precise, targeted treatments that improve clinical outcomes while minimising damage to surrounding healthy tissues. By integrating both specialties under one platform, Truevis is helping healthcare providers strengthen diagnostic capabilities while expanding access to compre-

hensive cancer care.

As India's disease burden continues to evolve, the demand for integrated diagnostic and oncology solutions is expected to grow significantly, making advanced radiology and radiation oncology technologies central to the future of healthcare delivery.

### Expanding access to advanced radiology and cancer care

One of the biggest challenges facing India's healthcare system is the uneven distribution of advanced healthcare infrastructure. While metropolitan cities have relatively better access to sophisticated imaging and oncology technologies, patients in Tier-II and Tier-III cities often travel long distances for specialised diagnostic investigations and cancer treatment.

Recognising this gap, Truevis has strategically prioritised expanding advanced radiology

and radiation oncology infrastructure into emerging healthcare markets. The company has successfully completed its initial installations across India, marking an important milestone in its growth journey. Building on this momentum, Truevis is targeting more than 100 installations during the current year, with a strong emphasis on strengthening healthcare delivery across Tier-II and Tier-III cities.

This expansion reflects the company's commitment to making advanced healthcare technologies more accessible while supporting hospitals in enhancing their diagnostic and oncology capabilities closer to where patients live.

### More than equipment: Delivering end-to-end healthcare solutions

Truevis believes that successful deployment of advanced medical technology extends far beyond equipment installation.

Hospitals increasingly require partners who can support every stage of the equipment lifecycle from site planning and project execution to installation, commissioning, clinical application training, preventive maintenance, software upgrades, and technical support.

Accordingly, the company has developed multidisciplinary teams comprising engineers, application specialists, service professionals, and project management experts who work closely with healthcare providers to ensure high equipment uptime, efficient clinical workflows, and long-term operational reliability.

This integrated approach enables hospitals to maximise the value of their investments while improving operational efficiency and delivering better patient outcomes.

### Supporting India's Make in India vision

As part of its long-term growth strategy, Truevis is strengthening domestic manufacturing and system integration capabilities through its operations at the Andhra Pradesh MedTech Zone (AMTZ), Visakhapatnam. By localising assembly and integrating advanced radiology and radiation oncology systems within India, the company aims to reduce import dependence, improve supply chain resilience, shorten deployment timelines, and contribute to the country's growing MedTech manufacturing ecosystem.

Complementing these efforts are strategic global technology collaborations that en-

able Truevis to bring internationally proven healthcare technologies to Indian providers while adapting them to local clinical requirements and service expectations.

### Advancing cancer care through clinical collaboration

Truevis Technologies believes that innovation in radiation oncology extends beyond technology, it requires continuous collaboration with clinicians, researchers, and healthcare institutions. As part of this commitment, the company actively participates in leading scientific conferences and educational platforms that advance evidence-based cancer care.

Most recently, Truevis participated in the Best of ASTRO India 2025, held on 1-2 August 2026 in New Delhi, one of In-

dia's premier scientific meetings dedicated to radiation oncology. The conference brought together renowned radiation oncologists, medical physicists, healthcare leaders, and industry partners to discuss the latest advances in precision radiotherapy, clinical research, and cancer care.

The event witnessed participation from more than 20 industry organisations and over 200 radiation oncology professionals, providing an important platform for scientific exchange and technology collaboration. As part of the scientific program, Truevis Technologies, in association with Shinva Medical, conducted a dedicated symposium titled "Empowering Cancer Care with Advanced Radiation Oncology Solutions," highlighting innovations in modern ra-

diotherapy and precision oncology while engaging with leading clinicians from across the country.

Through such engagements, Truevis continues to strengthen its relationships with the clinical community, contributing not only through technology but also by supporting education, knowledge sharing, and the advancement of oncology practice in India.

### Creating long-term value for healthcare providers

The future of healthcare technology lies not only in innovation but also in creating dependable partnerships with healthcare institutions. Truevis is therefore focused on building long-term relationships by combining advanced technology, engineering excellence, clinical expertise, re-

sponsive after-sales support, and continuous customer engagement.

By delivering comprehensive solutions rather than standalone products, the company enables hospitals to improve operational efficiency, maximise equipment utilisation, strengthen diagnostic and treatment capabilities, and enhance patient care across both radiology and radiation oncology.

### Looking ahead

India's demand for advanced radiology and radiation oncology infrastructure is expected to grow significantly over the coming decade. This presents an unprecedented opportunity for companies capable of delivering world-class technologies supported by localised manufacturing, reliable serv-

ice, strong clinical partnerships, and continuous innovation.

With its integrated business model, expanding installation footprint, focus on Tier-II and Tier-III markets, commitment to the Make in India initiative, and ambition to achieve 100+ installations this year, Truevis Technologies is steadily positioning itself as a trusted partner in India's healthcare transformation.

As the company continues to expand its presence across the country, its vision remains clear to make advanced radiology and precision cancer care solutions more accessible, affordable, and sustainable, enabling healthcare providers to deliver better clinical outcomes and improving the lives of millions of patients across India.



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## Bridging the gap in pain awareness and treatment accessibility

**Dr Aanchal Sharma**, Pain Physician, Principal Consultant and Head of Department, Department of Pain Medicine, BLK MAX Hospital, New Delhi, explains how advances in pain medicine and minimally invasive interventions are changing the way persistent pain is diagnosed and managed, helping improve patients' quality of life

Ask someone living with chronic pain why they did not seek treatment earlier, and the answer is rarely straightforward.

Some thought the pain would eventually go away. Others blamed it on age, work pressure, or a busy lifestyle. Many simply got used to it. That may sound surprising, but it happens more often than we realise. Pain has a habit of quietly becoming part of a person's routine. A missed walk here. A restless night there. A decision to skip an outing because the discomfort feels a little worse than usual.

The problem is that pain often enters people's lives gradually, making it easier to ignore until it starts affecting daily life in a meaningful way. When pain becomes "Normal"

One of the reasons pain management remains challenging is that people frequently underestimate persistent pain. A stiff back after a long day is one thing. Pain that keeps returning for months is another. Yet many individuals continue to treat the two as if they are the same.



By the time medical advice is sought, the impact is often visible. Work becomes harder. Sleep suffers. Everyday activities that once felt effortless begin to require planning and adjustment. For employers, this can translate into lost productivity. For individuals, it can mean years spent adapting to a prob-

lem instead of addressing it. Knowing help exists doesn't always mean complete knowledge about it. Awareness is important, but it is only part of the picture. Due to lack of complete awareness, people are reluctant to get the treatment. As per general understanding, treatment of pain means either taking long

term pain killers or some kind of surgery done. Some just continue doing home physiotherapy for months without getting any significant pain relief. But with the development of the new field called "Pain Medicine" the approach to taking care of pain has changed. A Pain Medicine doctor specialises in diagnosis and treatment of the pain which has been bothering you for a very long time. The pain physician helps you identify the cause of your pain. It is done through detailed history, examination followed by some blood test and radiological test like X ray, CT scan or MRI if needed. After identifying the cause of pain, a plan is made which works best for the patient.

This plan included various minimally invasive pain and spine intervention (MIPSI) which targets on the cause of the pain. Once cause has been taken care of, pain automatically disappears. These procedures are done under image guidance which is either X ray machine or Ultrasound and hence safe for the patients. The discharge is

done on the same day of the procedure. Looking ahead there is no single answer to the challenge, but progress is happening.

Teleconsultations are helping reduce geographical barriers. Healthcare providers are increasingly working across specialties. More importantly, conversations around pain are changing. With the advancement in medical field, there are technologies which can accurately diagnose the cause of patient's pain and with the MIPSIs, the treatment is targeted to remove that cause.

### That shift matters.

Pain may be common, but living with untreated pain should not be. The goal should be simple: help people recognise pain earlier; access care more easily, and receive the support they need before pain begins to define their everyday lives. Consulting a "Pain Physician" at an early stage in the disease process, can help not only getting rid of the pain completely but also on overall quality of life, independence, and well-being.



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## How women are reshaping leadership in healthcare

**Dr S Narayani**, Business Head-Maharashtra, Fortis Hospitals Maharashtra, explains how stronger mentorship, equitable workplace policies and inclusive organisational cultures are essential to bridge the leadership gap and build more diverse, resilient healthcare organisations

When people ask me about my journey in healthcare, they often expect me to talk about clinical milestones or professional achievements. Healthcare has never lacked talented women. They are leading patient care, advancing research, teaching the next generation of doctors and driving innovation every day. Yet when it comes to senior leadership, their representation remains disproportionately low. As the sector evolves, understanding why this gap persists deserves greater attention.

India's healthcare sector has seen encouraging growth in the number of women entering the profession. Women today account for nearly 29 per cent of registered doctors in the country and represent a significant share of the segment's workforce. However, their presence becomes noticeably smaller at senior leadership levels. According to the International Center for Research on Women (ICRW),

women occupy around 18 per cent of leadership positions in healthcare organisations.

This shows that the conversation has moved beyond simply encouraging more women to enter healthcare. The bigger challenge today is ensuring they have the same opportunities to grow into leadership roles. There is no shortage of talented women across medical colleges, residency programmes and hospitals. Yet many find that as they progress in their careers, opportunities for mentorship, sponsorship and leadership become harder to access. The ICRW's 2024 report, based on consultations with nineteen healthcare organisations in India, highlights that factors such as organisational culture, limited mentoring and professional development opportunities, and unconscious bias can all influence career progression.

Today, the sector is grappling with increasingly complex challenges such as growing burden of



non-communicable diseases (NCDs), rapid digital transformation, workforce shortages, and rapidly evolving patient expectations. Addressing these challenges calls for building leadership teams that bring different perspectives to the table, experiences and ways of thinking. Studies from around the world have consistently shown that organisations with more diverse leadership often see stronger collaboration, deeper

employee engagement and more balanced decision-making. In healthcare, since leadership decisions can directly influence patient outcomes and the resilience of the organisation, the value of diverse perspectives becomes crucial.

Throughout my career, I have seen that the most effective leaders are those who create an environment where people feel heard, invest in developing young minds, and never lose sight of the patient at the centre of every decision. These qualities are by no means exclusive to women, but they are strengths I have often seen in women who have progressed into leadership roles despite the challenges along the way. They bring perspectives that encourage collaboration, strengthen teams and help organisations think beyond immediate priorities.

Creating more women leaders does not happen by chance. It requires organisations to consciously build an environment where talent can thrive.

At Fortis Healthcare, we have seen the value of fostering a culture that emphasises equal opportunity, mentorship and merit-based growth. Transparent promotion processes, structured mentoring and sponsorship, support during career transitions and regular reviews of workplace equity all play an important role. More importantly, diversity and inclusion need to be embedded in an organisation's culture rather than treated as stand-alone initiatives.

Healthcare has always been built on the collective expertise of its people. As the sector continues to evolve, creating opportunities for more women to contribute at the highest levels is not simply about representation. It is about strengthening leadership with a broader range of perspectives, experiences and ideas. Ultimately, that benefits healthcare organisations, the professionals who work within them and, most importantly, the patients they serve.

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## Enhancing healthcare worker safety: The economics of closed vacuum blood collection

Blood collection methods directly influence healthcare worker safety, diagnostic quality, and hospital efficiency. Hindustan Syringes & Medical Devices (HMD) supports safer phlebotomy with its VAKU-8 closed vacuum blood collection system, designed to minimise occupational risks while improving patient comfort

### The hidden cost of every extra step

Blood collection is often perceived as routine, yet the traditional syringe-based method carries avoidable risks. Each manual transfer of blood into tubes exposes healthcare workers to needle-stick injuries (NSIs), splashes, aerosols, and contaminated surfaces. These incidents not only endanger staff but also increase hospital costs through repeat testing, delays, and waste disposal.

### Occupational hazards of syringe phlebotomy

Open syringe techniques introduce multiple points of exposure:

- Needle-stick injuries during recapping, transfer, or disposal
- Blood splashes and aerosol generation during manual transfer
- Sharps disposal errors from extra handling steps
- Repeat venipuncture due to hemolysed or inadequate samples

Closed vacuum blood collection systems eliminate manual transfer. Blood flows directly from vein to tube through a sealed pathway, reducing exposure risks and pre-analytical errors. Pre-calibrated tubes ensure standardised volumes, improving specimen quality and lowering rejection rates. This reduces repeat venipuncture, enhancing both patient comfort and staff efficiency

Each added step is another opportunity for exposure, with NSIs remaining among the most reported occupational incidents worldwide.

### Closed vacuum systems: Safety by design

Closed vacuum blood collection systems eliminate manual transfer. Blood flows directly from vein to tube through a sealed pathway, reducing exposure risks and pre-analytical

errors. Pre-calibrated tubes ensure standardised volumes, improving specimen quality and lowering rejection rates. This reduces repeat venipuncture, enhancing both patient comfort and staff efficiency.

### Beyond purchase price: The economics of safety

While syringes may appear cheaper upfront, hidden costs tell another story:

- NSI management: An NSI

generates costs even when no infection is transmitted like medical assessment, HIV/HBV/HCV testing, prophylaxis, counselling, and staff absence

- Rejected samples: repeat kits, venipuncture, staff time, reprocessing, and diagnostic delays
- Productivity loss: extra minutes per collection accumulate into longer queues and reduced throughput

Closed vacuum systems reduce these burdens. Standardised tubes support automation, faster processing, and fewer errors. The real metric is not device price but the total cost per accurate, reportable result.

### Safety that pays for itself

Closed vacuum blood collection is more than a safety upgrade, it is a strategic investment in healthcare worker protection, diagnostic reliability, and institutional productivity. Hindustan Syringes & Medical Devices (HMD), a leading Indian manufacturer, offers VAKU-8 tubes with colour-coded closures for hematology and chemistry applications, paired with precision-engineered single-use needles designed for smooth venipuncture and minimal patient discomfort.

By adopting closed systems, hospitals can safeguard staff, improve patient outcomes, and realize long-term economic gains. In phlebotomy, safety truly pays for itself.



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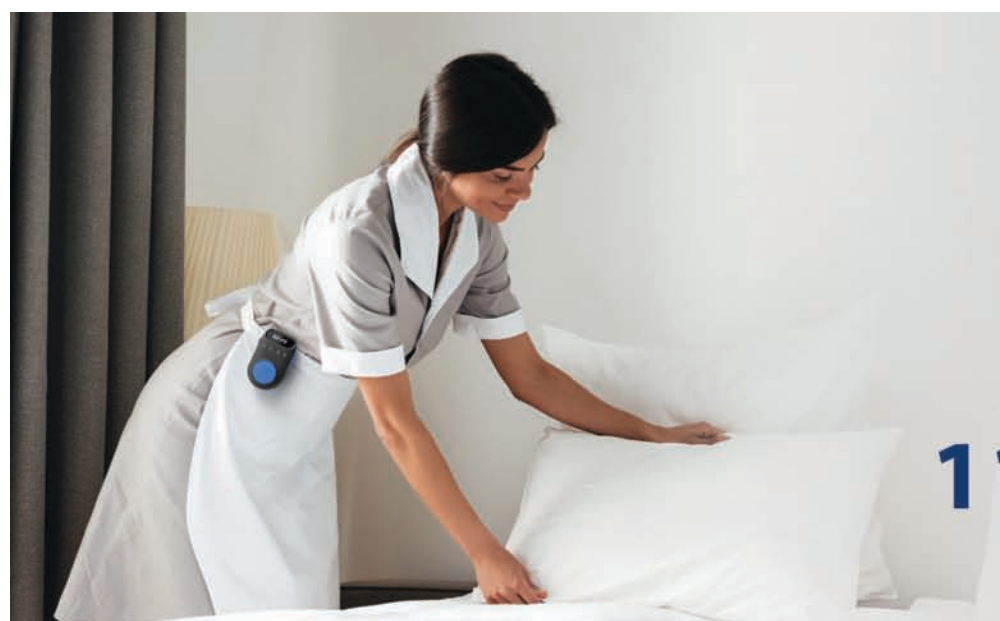
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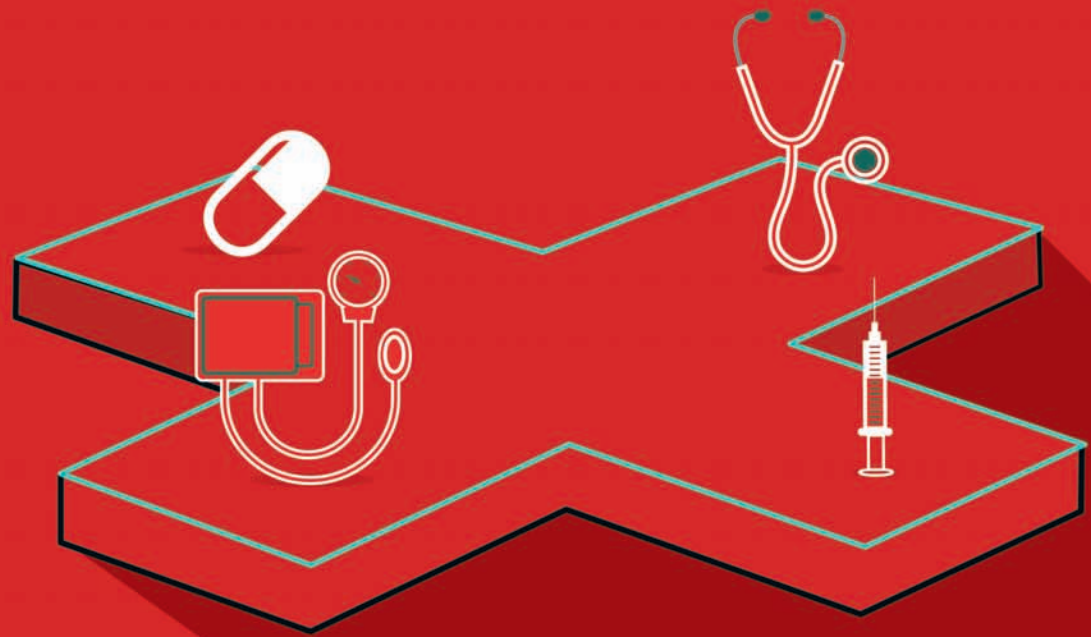
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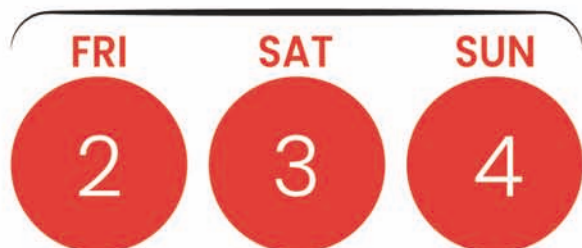
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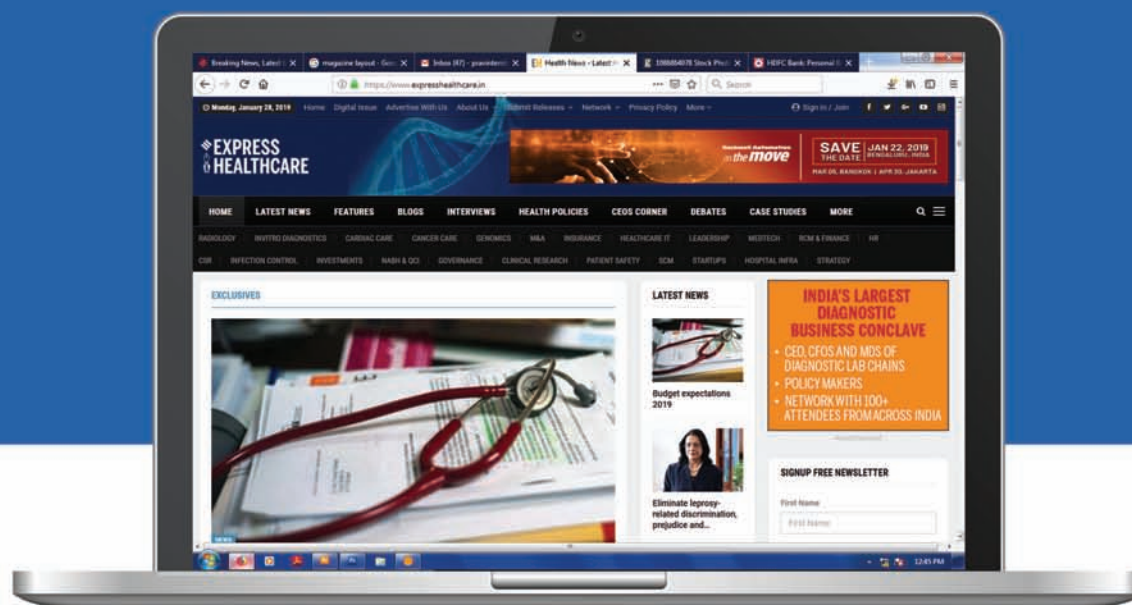
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# OEM manufacturing partner-Life Sciences

**Atharwa Mishra**, Executive Domestic Marketing, Ami Polymer, talks about how specialised OEM manufacturing is enabling faster, compliant and scalable production of IV bags and fluid systems

Your next IV bag doesn't need its own factory. It needs the right partner. Ami Polymer engineers and manufactures sterile fluid-containment systems for medical device companies — so your team can focus on the clinic, not the cleanroom.

cessing a decade ago. Here's what that partnership looks like with Ami Polymer.

**Spec → Product: Built to your spec, not a catalogue**  
No two devices share identical fluid-path requirements. Every bag is engineered backward



FIG. 01 — DUAL-PORT SINGLE-USE FLUID BAG, GAMMA-STERILIZED

|                              |                      |                              |                          |
|------------------------------|----------------------|------------------------------|--------------------------|
| 25+ YEARS IN POLYMER SCIENCE | 3.5L SQ.FT. FACILITY | VII/VIII ISO CLEANROOM CLASS | 13485 ISO QUALITY SYSTEM |
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You've designed the device. Regulatory pathway is mapped. Clinical need is validated. Then comes the question that quietly derails timelines: who actually manufactures the fluid-contact components — sterile, compliant, and at scale?

Building an in-house cleanroom line for IV bags or single-use fluid systems means years of capital investment and validation before a single unit ships. That's exactly why OEM partnerships have become the default strategy across infusion, dialysis, and diagnostics — the same shift biopharma made with single-use biopro-

cessing a decade ago. Here's what that partnership looks like with Ami Polymer.

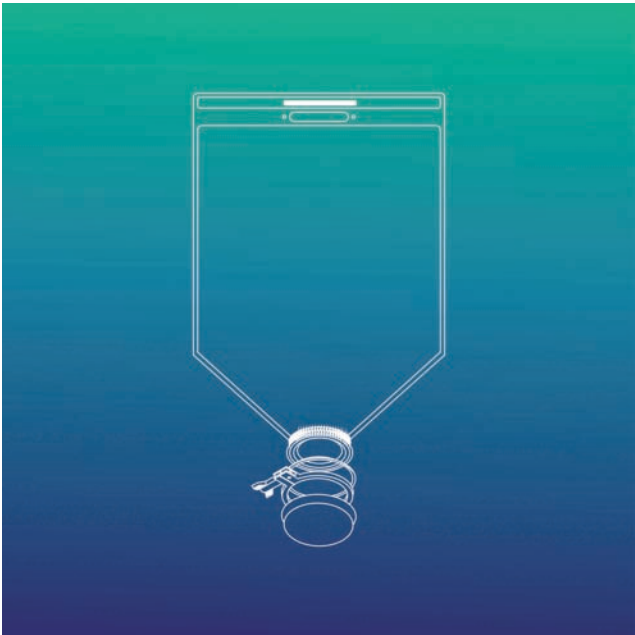
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from your clinical use-case:

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- Film selection — matched to your fluid chemistry and shelf-life
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**Engineered, not adapted: Every port earns its place**

- Multi-line inlet/outlet for aseptic transfer
- Reinforced port welds, 100 per cent integrity-tested
- Compatible with standard



lower capital risk are outweighing the perceived control of owning the factory — and that's exactly the intersection Ami Polymer occupies: polymer science, cleanroom manufacturing, and regulatory-grade quality, delivered as a partnership rather than a five-year internal project.

**Bring us your specification. We'll show you the partnership**  
If your team is evaluating an OEM manufacturing partner for IV bags, single-use fluid systems, or custom polymer components, we'd like to understand your requirement and walk you through what working with Ami Polymer looks like in practice.

| PROPERTY               | LEGACY PVC                            | AMI POLYMER FILMS                  |
|------------------------|---------------------------------------|------------------------------------|
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| Chemical compatibility | Limited with solvents/lipids          | Broad — biologics, buffers, APIs   |
| Regulatory standing    | Facing tightening restrictions        | USP <87>, <88>, <661.1>, ISO 10993 |
| Environmental profile  | Chlorine, phthalate content           | Chlorine-free, recyclable options  |

SUS connectors & hardware

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When you outsource manufacturing, the compliance risk transfers to your supplier's discipline. Every bag ships with a Certificate of Analysis and Sterility Report, fully traceable from raw material batch to gamma sterilisation record — produced under ISO 13485 and cGMP-aligned systems.

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From low-volume R&D and pilot batches to full commercial-scale runs, Ami Polymer's 3,50,000 sq. ft. facility absorbs the scale-up — so you're not

forecasting and funding your own cleanroom expansion years in advance.

**PVC vs Non-PVC — the material decision behind every bag**  
Legacy IV bags still run on PVC with plasticizers like DEHP — a growing liability as regulators push toward phthalate-free alternatives.

**The bigger picture: Why device companies are choosing partners over factories**  
Across infusion therapy, dialysis, biologics, and diagnostics, manufacturers are increasingly choosing specialised polymer partners over vertical integration. Speed to market and

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Author- Atharwa Mishra  
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# Addressing the triad of modern diagnostics: Automation, manpower shortages, and quality standardisation in Indian laboratories

**Shobhit Jain**, Senior Manager - Product Management - Clinical Chemistry and Urinalysis, Sysmex India Pvt Ltd, discusses how automation can help diagnostic laboratories address rising testing volumes, workforce shortages, and the need for consistent quality standards, with a focus on modernising routine urinalysis workflows

The landscape of clinical diagnostics in India is undergoing a profound transformation. As healthcare access expands, diagnostic laboratories face an unprecedented surge in sample volumes. This spike intersects critically with two persistent systemic challenges: an acute shortage of skilled medical laboratory technicians and the pressing need for stringent quality standardisation across fragmented tier-1, tier-2, and rural networks.

While automation has successfully streamlined high-volume chemistry and hematology testing, urinalysis has traditionally lagged behind. In this demanding environment, routine tests like urinalysis are highly vulnerable. Traditionally considered a baseline, labor-intensive procedure, urinalysis has long been prone to operator subjectivity, delayed turnaround times (TAT), and standard operating

procedure deviations. Manual microscopy requires continuous technical focus—a luxury in understaffed laboratories where technicians must multitask across disciplines. Variations in manual sediment interpretation between different operators can lead to inconsistent diagnostic reporting, which directly compromises clinical decisions and patient care.

To bridge these operational gaps and mitigate human error, the paradigm must shift toward intelligent, end-to-end automa-



tion. Modernising urinalysis workflows changes the traditional process into a reliable science by eliminating manual steps—from processing native sample to the final classification of formed elements and providing additional clinical values beyond routine urinalysis.

A prime example of this paradigm shift is the Sysmex UN-Series Automated Urinalysis Solution. By leveraging advanced technologies like fluorescence flow cytometry (FFC) in their particle analyzers,

these scalable platforms provide precise counts and morphological evaluations of cellular elements.

Coupled with automated urine chemistry and walkaway digital imaging devices, the system minimises the need for manual sediment microscopy through rule-based, intelligent auto-validation. By automatically sorting out normal samples, it reduces technical hands-on time and frees up the constrained workforce to focus exclusively on highly complex pathological cases.

Ultimately, tackling the triad of diagnostics in Indian laboratories requires adopting these cross-cutting, error-reducing technologies. Automating routine workflows like urinalysis allows diagnostic centers to withstand severe manpower shortages, achieve true standardisation, and maintain the highest levels of quality and patient safety.

**Modernising urinalysis workflows changes the traditional process into a reliable science by eliminating manual steps—from processing native sample to the final classification of formed elements and providing additional clinical values beyond routine urinalysis**

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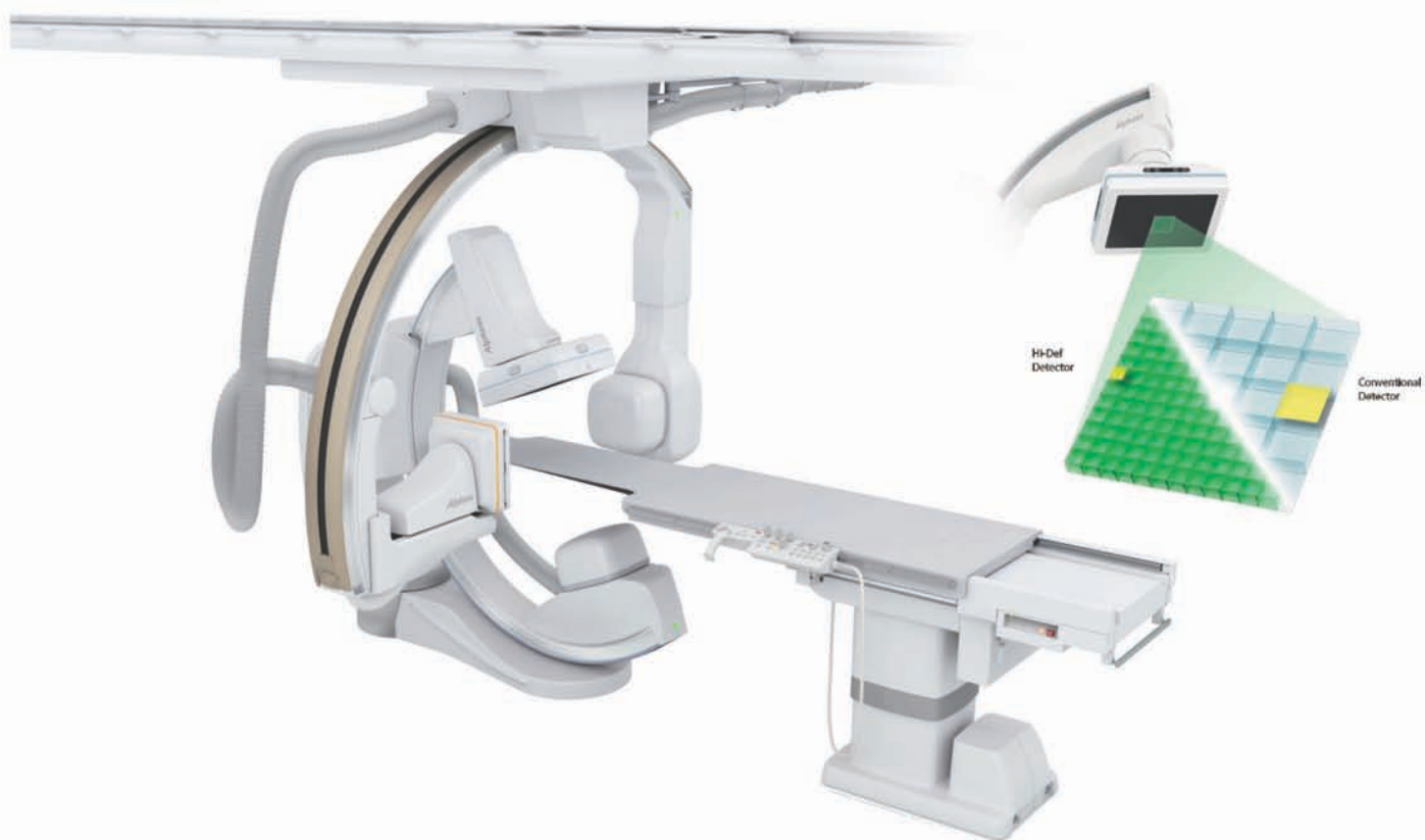
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