

EXPRESS HEALTHCARE

INDIA'S FOREMOST HEALTHCARE MAGAZINE SINCE 2000

OCTOBER 2026, ₹50



Erba[®]
Mannheim

TRANSASIA[®]
No.1 Diagnostic Company in India

INTRODUCING

A new Era in **HbA1c** and **Urinalysis** testing begins

Built for Small Labs, Designed for Big Impact

WITH
AI
Integration

APEX UA

Urine Sediment Analyser

APEX Hb

Next-Generation Automated
Glycohemoglobin Analyzer

Integrated
with
Erba CARE Diva[®]



Smarter Urinalysis, Simpler Workflow

- No Centrifuge
- AI Intergration
- Highly Magnified Images with Integrated Reports
- Comprehensive Urine Analysis

Precise & Consistent HbA1c Testing

- Precision: CV <1%
- Quantitative Results with variant
- 96 sec/ Test
- 20 Sample Carousel

TRANSASIA BIO-MEDICALS LTD.

T: (022) 4030 9000
www.transasia.co.in
responses@transasia.co.in

Stay Connected:
X in B Y f



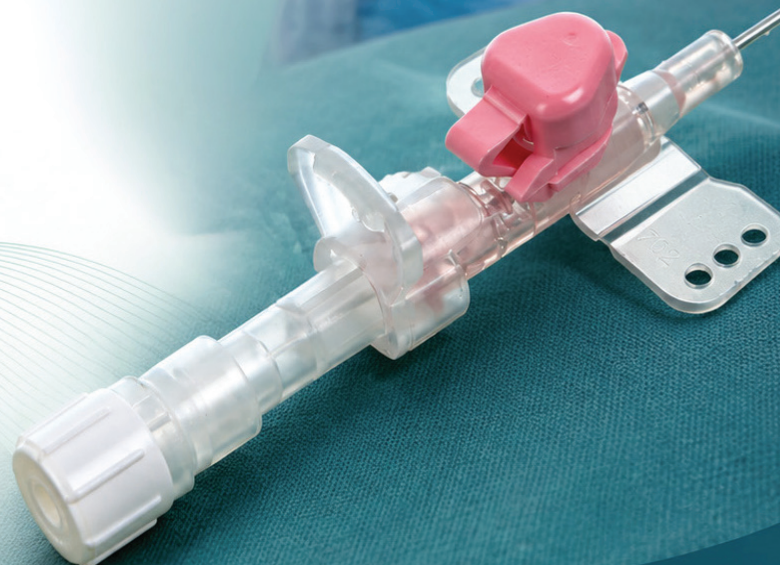
For quick support and
service assistance, Scan Here



POLYSAFETY PRO



User friendly, Self Activating
Safety Mechanism reduces
needle stick injuries



Built Around Safety. Designed Around Care.

- Needle safety guard reduces the risk of needle stick injuries
- Polyurethane catheter provides longer indwelling time

VOL.19 NO.9 PAGES 40

www.expresshealthcare.in



EXPRESS HEALTHCARE

INDIA'S FOREMOST HEALTHCARE MAGAZINE SINCE 2000

OCTOBER. 2026, ₹50



Diagnostics

Aditya Kandoi

Founder & CEO,
Redcliffe Labs

Start-up

Neha Motwani

Founder & CEO,
Luma Fertility

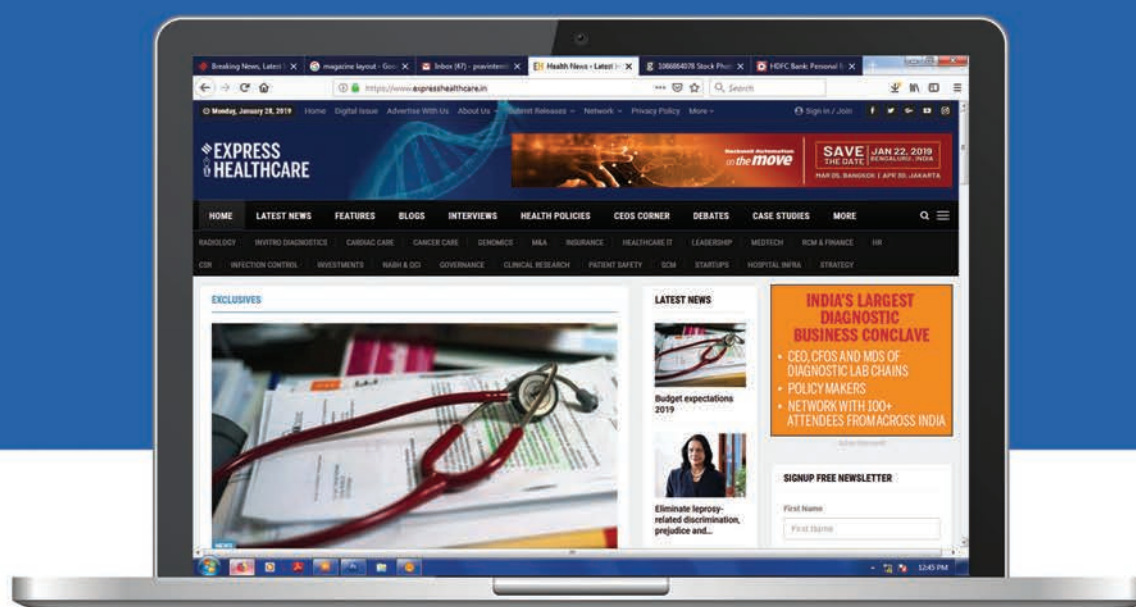
EYE CARE

INDIA'S NEXT GROWTH FRONTIER

India's eye-care sector is expanding beyond major metros but the next phase will depend on how effectively the industry balances scale, access, affordability and clinical quality

JUST 15 MINUTES A DAY.

(And You Can Be On Top Of All Things Healthcare. Daily)



www.expresshealthcare.in

Announcing Our All New Website

Re-Imagined and Redesigned For Your Reading Pleasure.

NEWS AND ANALYSIS

EDITORIAL FEATURES

GUEST BLOGS FROM INDUSTRY LEADERS

EBOOKS AND DOWNLOADABLE CONTENT

BUSINESS VIDEOS AND INTERVIEWS

WEBINARS AND EVENTS

VISIT US ON YOUR MOBILE, TABLET OR PC TO EXPERIENCE THE DIFFERENCE TODAY.

 Facebook
Join us on Facebook

 LinkedIn
Follow us

 Twitter
Join us on Twitter

 Google+
Join us on Google

 RSS
Subscribe our RSS

COVER STORY



LEADERSHIP



P27: INTERVIEW
DR SANDEEP GORE
 DIRECTOR-EMERGENCY MEDICINE,
 FORTIS HOSPITAL MULUND,
 MUMBAI, AND CHAIRMAN,
 EMERGENCY MEDICINE COUNCIL,
 FORTIS HEALTHCARE

Chairman of the Board
 Viveck Goenka

Sr. Vice President-BPD
 Neil Viegas

Vice President-BPD
 Harit Mohanty

Editor
 Viveka Roychowdhury*

Editorial Team
 Lakshmi Priya Nair
 Kalyani Sharma
 Neha Aathavale
 Swati Rana

DESIGN
Art Director
 Pravin Temple

Chief Designer
 Rekha Bisht

Senior Artist
 Rakesh Sharma

Marketing Team
 Rajesh Bhatkal
 Ashish Rampure

Production Co-ordinator
 Dhananjay Nidre

Scheduling & Coordination
 Pushkar Waraliker

CIRCULATION
 Mohan Varadkar

INTERVIEW



P8:
DR CHANDRASHEKHAR THODUPUNURI
 FOUNDER CHAIRMAN,
 RESPLIX AUTISM RESEARCH
 FOUNDATION & INSTITUTE



P9:
RAJDEEP PANWAR
 CHIEF COMMERCIAL
 OFFICER,
 THYROCARE TECHNOLOGIES



P11:
DANIELLA FOSTER
 SENIOR VICE PRESIDENT AND
 GLOBAL HEAD OF PUBLIC
 AFFAIRS, MARKET ACCESS &
 SUSTAINABILITY AT BAYER
 CONSUMER HEALTH



P14:
INTERVIEW
ADITYA KANDOI
 FOUNDER & CEO,
 REDCLIFFE LABS



P25:
INTERVIEW
NEHA MOTWANI
 FOUNDER AND CEO,
 LUMA FERTILITY

DIAGNOSTICS

STARTUP

Express Healthcare®

REDG.WITH RNI NO. MAHENG/2007/22045, POSTAL REGD. NO. MCS/162/2025 -2027, LICENSE TO POST WITHOUT PREPAYMENT LICENSE NO. MR/TECH/

WPP - 367/SOUTH/2025 - 2027, PRINTED AND PUBLISHED BY VAIDEHI THAKAR ON ON BEHALF OF THE INDIAN EXPRESS (P) LIMITED AND PRINTED AT

THE INDIAN EXPRESS PRESS, PLOT NO.EL-208, TTC INDUSTRIAL AREA, MAHAPE, NAVI MUMBAI-400710 AND PUBLISHED AT MAFATLAL CENTRE, 7TH FLOOR,

RAMNATH GOENKA MARG, NARIMAN POINT, MUMBAI 400021.

EDITOR: VIVEKA ROYCHOWDHURY.* (EDITORIAL & ADMINISTRATIVE OFFICES: MAFATLAL CENTRE, 7TH FLOOR, RAMNATH GOENKA MARG, NARIMAN POINT, MUMBAI

400021) * RESPONSIBLE FOR SELECTION OF NEWS UNDER THE PRP ACT. COPYRIGHT © 2017. THE INDIAN EXPRESS (P) LTD. ALL RIGHTS RESERVED THROUGHOUT

THE WORLD. REPRODUCTION IN ANY MANNER, ELECTRONIC OR OTHERWISE, IN WHOLE OR IN PART, WITHOUT PRIOR WRITTEN PERMISSION IS PROHIBITED.

Moving beyond the healthcare pricing blame game

Hospitals and healthtech companies continue to attract funding but the growing discontent with the perceived overpricing of every segment of the healthcare value chain, from medicines, med tech products available in hospitals to hospital bills, will deepen patient distrust.

Over pricing of medical supplies, medicines and inflated hospital bills have been the subject of many social media posts from patients and health activists. The recent spotlight on pricing was most noticeably triggered by Maharashtra FDA chief Tukaram Munde taking to X to flag the differences in institutional purchase prices and the prices paid by patients. (<https://indianexpress.com/article/health-wellness/maharashtra-fda-tukaram-mundhe-hospital-consumables-mrp-nppa-price-control-10880967/>) This was based on a survey conducted by the Maharashtra Food and Drug Administration (FDA), which found wide gaps between procurement prices and printed maximum retail prices (MRPs) of hospital consumables like IV sets, etc. Maharashtra FDA then submitted a proposal to the National Pharmaceutical Pricing Authority (NPPA) seeking price controls on frequently used hospital consumables and medical devices.

Industry associations have urged restraint and policy debate on the issue and referred to recommendations shared during previous discussions on the issue. But this debate has once again pitted hospitals against medical device manufacturers.

Representing hospital managements, the Association of Healthcare Providers of India (AHPI) has called for a balanced and evidence-based approach to discussions around the pricing of medicines and consumables in hospitals, with Dr Girdhar Gyani, Director General, AHPI emphasising that their price should be considered in the context of the complete healthcare delivery ecosystem and the responsibility hospitals undertake for patient safety and clinical outcomes. (<https://www.expresshealthcare.in/news/ahpi-calls-for-holistic-approach-to-pricing-of-medicines-and-consumables-in-hospitals/455400/>)

Taking forward this rationale, Siddhartha Bhattacharya, Secretary General, NATHEALTH, (Healthcare Federation of India), posits that the right question is not only, 'What did the hospital buy the device for?' but also, 'What did it take to make that technology safely, immediately and effectively available to the patient?' NATHEALTH's membership includes a cross-sector group of members across hospitals, medical technology, diagnostics, pharmaceuticals, and healthcare service providers.

As per the NATHEALTH statement, the hospital is not merely a reseller for sophisticated medical devices and consumables. Before a technology reaches the patient, the hospital may undertake clinical evaluation and selection, maintain multiple configurations and emergency inventory, ensure sterile-chain integrity and traceability, provide trained clinical and biomedical teams, manage expiry and obsolescence risks, maintain specialised infrastructure, safe disposal and assume responsibility for quality, safety and outcomes while ensuring compliance to all safety regulations.



The pricing debate has pitted hospitals against medical device manufacturers and valuable time could be lost in this pointless blame game, while patients continue to face the brunt of rising healthcare costs

Similar to AHPI's stance, NATHEALTH therefore calls for an evidence-based and differentiated framework that distinguishes basic consumables from clinically differentiated and high-complexity medical technologies. The policy objective should not simply be to focus on a fixed markup; it should be to determine what constitutes a fair and transparent patient price after recognising the legitimate cost and value involved in making the technology clinically available and integrate it as part of an overall package that is reimbursed either by patient or insurance.

Representing domestic manufacturers of medical devices, the Association of Indian Medical Devices Industry (AiMeD), has called for rationalised trade markups instead of extreme caps, with a workable 2-6x band and pilot-based, evidence-driven policy intervention. In the statement, Rajiv Nath, Forum Coordinator, AiMeD Rajiv Nath, Forum Coordinator, AiMeD, recommends that rationalised markup should be tested through pilots first, as executing a proposed strategy as a pilot is policy making by evidence. Further, the pilots should be uniform and national in design, avoiding state-by-state caps that fragment the market.

Commenting on AHPI's statement that the MRP is determined by the manufacturer and is not independently fixed by hospitals, AiMeD avers that "in practice, MRPs are dictated by hospital buyers, who decide whether a brand will be entertained for business. Ethical manufacturers are compelled to comply with this skewed system if they wish to remain in the market."

Nath of AiMeD asks a counter question: "Why should the onus not shift to hospitals and retailers for ensuring fair pricing? Holding manufacturers solely accountable ignores the structural imbalance. The current system rewards inflated margins, penalises ethical suppliers, and ultimately harms patients. A collaborative pilot on transparent trade-margin caps can demonstrate how responsibility can be shared fairly across the value chain."

Appreciating AHPI's call for a fact-based review of medical product pricing, he points out that AiMeD has already suggested a few categories of devices as pilots for rationalisation and invites AHPI and NATHEALTH to work jointly with AiMeD on these pilots—fact-checking as AHPI desires, identifying products where hospitals seek higher margins as compensation, and agreeing on what is rational versus what is clearly distortion.

As medical inflation continues to rise, pricing seems to be becoming a blame game between hospitals and medical device/medtech manufacturers. The long term reputational damage to the entire sector will include policy makers too, if they do not step in to facilitate a more collaborative approach between the different sections of the healthcare ecosystem and resolve the situation.

VIVEKA ROYCHOWDHURY, Editor
viveka.r@expressindia.com
viveka.roy3@gmail.com



ALLIED
MEDICAL

"People you can Trust"

A NEW STANDARD IN VENTILATION

COMING SOON



Scan here
to **Register**
for the event



From gut microbiome to better health-FMT opens new possibilities

Resplce Autism Research Foundation & Institute has opened its second Faecal Microbiota Transplantation (FMT) Centre in India, in Maharashtra. The institute's first FMT centre, located in Hyderabad, has been operational for the past three years.

Dr Chandrashekhar Thodupunuri, Founder Chairman, Resplce Autism Research Foundation & Institute, spoke to **Express Healthcare** to understand the FMT Centre, the treatment approach, the institute's experience so far and its plans for the future

Can you shed some light on what Resplce Institute is about? How did Resplce Institute's journey start?

Resplce Autism Research Foundation and Institute was founded by me, following a deeply personal experience with my child.

My child had autism along with severe gastrointestinal problems, allergies and steroid-dependent nephrotic syndrome. When conventional treatment options did not provide adequate relief, I explored Faecal Microbiota Transplantation (FMT). Following FMT, there was significant improvement in the gastrointestinal problems, allergies and nephrotic syndrome, along with unexpected improvements in certain neurodevelopmental symptoms.

This experience led me to investigate the science behind the gut microbiome and its potential influence on human health. In 2022, he registered a clinical trial with the ICMR to investigate FMT in autism scientifically.

Today, Resplce's vision extends beyond treatment. We are working to understand whether microbiome- and epigenetics-targeted interventions could play a role in autism prevention and preventive healthcare, using multi-omics approaches in collaboration with scientists and researchers.

What is FMT, and how does it work?

FMT stands for faecal microbiota transplantation. It involves transferring a carefully screened and

processed microbiota preparation from a healthy donor to the gastrointestinal tract of another individual.

The gut microbiome interacts extensively with the immune, metabolic, endocrine and nervous systems. Gut microbes and their metabolites can influence immune signalling, neurotransmitter pathways and host biology, including epigenetic mechanisms.

In conditions such as autism, disturbances in the gut microbiome have been reported, although the relationship is complex and still being investigated. Our experience and emerging research suggest that microbiome-based interventions may help address some gastrointestinal and other associated problems.

Importantly, FMT should not currently be presented as a cure for autism. Its potential role in improving specific comorbidities and symptoms requires further rigorous clinical research.

Is FMT an approved form of treatment in India? Is the research still ongoing?

FMT has established clinical use, particularly for recurrent or refractory *Clostridioides difficile* infection, and microbiome-based therapies are also being investigated and used in selected gastrointestinal conditions under appropriate medical supervision.

Research into FMT and microbiome therapeutics is rapidly expanding across several areas, including inflammatory bowel disease,



autism, neurological disorders, cancer and psychiatric conditions. However, the level of evidence varies considerably between these conditions.

At Resplce, we believe promising mechanistic and preliminary clinical findings must be followed by well-designed clinical trials before broader clinical adoption.

Is FMT a relatively new treatment? Many doctors may not be aware of it. How do you plan to educate doctors?

FMT itself is not new. Historical accounts describe the therapeutic use of faecal preparations in traditional Chinese medicine centuries ago. Modern medicine has transformed the concept into a scientifically investigated procedure involving donor screening, microbiological testing and controlled administration.

Awareness among gastroenterologists has increased substantially, but microbiome science remains relatively new across many other medical specialities.

We have launched the "Save

Microbiome, Save Health" campaign to raise awareness among doctors, healthcare professionals, and the public about the importance of the gut microbiome and the emerging science of microbiome-based medicine.

What disorders can potentially be treated using FMT, and how can it benefit patients?

The strongest established indication is recurrent *Clostridioides difficile* infection. FMT and microbiome-based therapies are also being studied extensively in conditions such as inflammatory bowel disease and ulcerative colitis.

There is emerging research in areas including autism, neurological and neurodegenerative disorders, cancer and psychiatric disorders, among others.

However, the evidence is not equally strong for all these conditions. Our objective is to distinguish established indications from promising research areas and generate high-quality clinical evidence wherever the science warrants further investigation.

How many sessions does a person need to be completely treated?

There is no universally established number of FMT sessions that can be described as a "complete treatment," particularly for conditions such as autism where FMT remains investigational.

How do you propose to popularise this treatment so

that patients across the globe can benefit?

Our approach is to let the science lead.

First, we need to educate healthcare professionals and the public about the microbiome.

Second, we need to evaluate existing clinical evidence critically. Third, we need to conduct well-designed clinical trials and publish results transparently in peer-reviewed scientific journals.

If microbiome-based interventions demonstrate safety and efficacy through rigorous research, they can eventually become part of mainstream healthcare.

What are the major challenges you are currently facing?

One major challenge is that FMT is fundamentally different from conventional pharmaceutical products. It involves a complex biological ecosystem rather than a single molecule, making standardisation, quality control, donor screening and scalability challenging.

Limited commercial incentive in some areas of microbiome research can also slow the pace of clinical development.

Our focus is therefore on building scientific evidence, collaborating with researchers, and making microbiome-based approaches accessible to patients who may benefit, while maintaining appropriate safety standards and clinical governance.

(For further details and queries on FMT procedure, doctors can contact on #9821529653)

Increasing health concerns will drive both preventive and curative diagnostics

Rajdeep Panwar, Chief Commercial Officer, Thyrocare Technologies discusses key consumer trends shaping the diagnostics sector, and explains to **Viveka Roychowdhury** why he believes that predictive diagnostics is the next driver for the sector

India's healthcare consumer is showing signs of shifting to preventive healthcare. Do you see Indian consumers doing diagnostic tests even before they feel ill as a form of preventive healthcare?

The trend towards health check-ups has picked up significantly since around 2015. When I started working in the retail pathology segment, health check-ups were about 3-4 per cent of testing. Today, I would say they account for 12-15 per cent of testing across the industry.

Preventive testing is growing at a much faster pace, around 30-40 per cent, compared with 15-20 per cent for the conventional industry. So, the health check-up market is definitely growing.

Certain conditions such as diabetes and thyroid require regular testing. What other areas are seeing increased regular testing, and how are patients managing the cost?

Healthcare access and affordability vary significantly between metros and smaller markets. The industry is still about 80 per cent unorganised, and sometimes pricing pressures result in compromises, particularly in tier 2 and 3 markets.

The organised sector is expanding into these markets. At Thyrocare, we have grown from one lab in 2020 to 42 labs today, helping bring affordable pathology access to smaller markets.

Apart from thyroid and diabetes, hypertension is seeing increased testing. The post-COVID period has also brought greater awareness of cardiac and other health risks.

Preventive healthcare is growing because people want to know what is happening



I still think it is a myth in tier 1 and metro markets that pathology is necessarily expensive. A health check-up can cost about the same as a monthly Netflix subscription. The thinking around preventive healthcare has to develop further, and the organised sector can make it more affordable and accessible

inside their bodies. I still think it is a myth in tier 1 and metro

markets that pathology is necessarily expensive. A

health check-up can cost about the same as a monthly Netflix subscription. The thinking around preventive healthcare has to develop further, and the organised sector can make it more affordable and accessible.

You have opened 40 new labs. Are these new facilities or acquisitions?

These are predominantly Thyrocare-operated labs. We ensured that there is a Thyrocare lab for every 150 kilometers, because we wanted to be present across markets and improve turnaround time while expanding our network. Only a few follow a hybrid model, where we work with an existing diagnostic centre or hospital.

Even in those cases, we manage the quality, equipment, reagents and other aspects of the lab. So most of these are Thyrocare-operated labs rather than existing facilities that have been transitioned to Thyrocare.

What standards do these labs follow? Are they NABL or CAP accredited?

The instrumentation we deploy is what I would call gold-standard instrumentation. A machine in our Muzaffarpur lab, for example, is comparable to the machinery used in the US.

New labs take time to obtain NABL accreditation because documentation is required for six months. Currently, 97 per cent of the testing we do is NABL-accredited.

It is important to understand that NABL is not simply a stamp on a laboratory. It applies to the

quality process and the scope of specific tests. In our case, 97 per cent of testing is done within the NABL-accredited scope, using accredited instrumentation, technicians and processes.

What about staff training to operate and support a NABL-accredited lab?

The technology level is very high, so staff are trained largely in maintaining the instrumentation, running quality controls and calibrating the machines. These are closed systems with multiple checks. The machine will either provide a result or stop if there is an error.

Quality control is conducted every day. If a problem is detected, pathologists intervene and, where required, engineers correct the issue. This supports the reproducibility of the machines and consistency of results.

Patients are increasingly wary of over-testing, particularly because India is price-sensitive and insurance does not cover everything. How can diagnostic companies build trust?

I have also worked with hospital chains and understand the testing required before procedures or treatment. I don't believe we are doing excessive testing in the healthcare industry. In fact, we are probably not testing enough because it is an out-of-pocket expense.

Screening tests do not necessarily diagnose a problem. For example, a lipid profile alone does not tell you whether someone is hypertensive. More extensive testing may be required to

INTERVIEW

understand a patient's condition.

Hospital-based testing is about diagnosing a problem so that treatment can be provided. That requires rigorous testing, sometimes repeatedly, depending on the condition.

How is Thyrocare extending access and advanced diagnostics beyond metro cities?

The top 15 cities may account for more than 30-35 per cent of industry revenue, although that is an assumption rather than a figure backed by a study.

Thyrocare has a different geographic spread. We are a pan-India company and have labs positioned to serve smaller markets. Because we already have a network, we

can deploy larger instruments without depending on that individual lab to generate all the business.

Our average turnaround time across the country is around 13 hours. In the same city where the lab is located, reports can be available within six to eight hours.

What will drive the next phase of growth across tier 1, tier 2 and tier 3 markets?

Both will grow, but for different reasons. In tier 1 and metro markets, more extensive testing and predictive diagnostics will drive growth. For example, people with a family history of cancer may proactively seek predictive genetic testing.

In tier 2 and 3 markets, increasing health concerns, including hypertension and diabetes, will drive both

preventive and curative diagnostics. Curative testing will increasingly move from the unorganised to the organised sector, while preventive diagnostics will also grow. I believe the higher pace of growth will be in tier 2 and 3 markets. Whoever reaches those markets on time will grow more.

Can diagnostic companies go beyond testing to facilitate lifestyle changes, particularly around NCDs?

If we start doing that, we would probably compete with the companies we work with. We already have several health-tech platforms associated with us, and getting into that space ourselves may not help the patient, those companies or us. We will continue

communicating health-related messages based on our data, but we do not immediately have plans to directly get into that model.

What is the next phase of diagnostics in India? What role will AI, ML and genomics play?

I am not sure how AI and ML will change diagnostics because technology has been part of the industry for a long time. Humans have already been replaced by machines in many parts of the testing process. Sample collection, however, will remain human because it requires human interaction.

The next major development, in my view, is predictive diagnostics. Genetics and genomics can help understand the likelihood

of developing certain conditions in the future.

Clinical or whole exome testing can study chromosomes and indicate where an individual may be more prone to certain issues. This has developed significantly in the US and other countries and is beginning to pick up in India, although cost remains a factor.

Non-invasive prenatal testing is one example. It can identify the possibility of conditions such as Down syndrome or other chromosomal abnormalities through a blood test. The cost has also come down significantly. I believe predictive diagnostics is the future of the industry.

viveka.r@expressindia.com
viveka.roy3@gmail.com




EXPRESS HEALTHCARE

SUBSCRIBE NOW!!!

Yes! I Want to
☐ Subscribe
☐ Renew

Tick Terms	NewsStand Price	Subscription Offer	You Save
☐ 1 year { 12 issues }	₹ 600/-	₹ 500/-	₹ 100/-
☐ 2 years { 24 issues }	₹ 1200/-	₹ 990/-	₹ 210/-
☐ 3 years { 36 issues }	₹ 1800/-	₹ 1400/-	₹ 400/-

International Subscription rate for 1 year US \$ 100

Mailing Address:

Name: _____ Subscription No: _____

Company Name: _____ Designation: _____

Address: _____

City: _____ State: _____ Pin: _____

Phone: _____ Fax: _____ Mobile No: _____

E-mail: _____

Payment enclosed Cheque/Demand Draft No.: _____ Dated: _____

For ₹.: _____ Drawn on: _____

For Office Use:

Bp No.: _____ Order No.: _____

Docket No.: _____ Period: _____

Note:
Payment should be made in the name of "The Indian Express (P) Ltd." DOs should be payable at Mumbai.

Please mail to:
Subscription Cell,
Express Healthcare,
Business Publications Division,
The Indian Express (P) Ltd.,
Mafatlal Centre, 7th floor, Ramnath Goenka Marg,
Nariman Point, Mumbai - 400021
Mob.: 9867145028 / 8879199787
E-mail: rajesh.bhajnrik@expressindia.com

Copies will be sent by ordinary post only

Subscribe Online
www.expresshealthcare.in

Email: rajesh.bhajnrik@expressindia.com ■ Contact No.9867145028

Company Name-The Indian Express (P) Ltd, Company Address-Mafatlal Centre,7th Floor,Ramnath Goenka Marg, Nariman Point, Mumbai-400021. Bank Name-HDFC Bank Ltd

● Bank Address-C-5/32, Safdarjung Development Area (SDA), New Delhi-110016.

● Account -00328630000075 ● Swift Code-HDFCINBB ● IFSC -HDFC0000032 Account Type-Current

Integrating self-care into healthcare systems

A new Economist Enterprise research report, *Making self-care work: integrating self-care into health systems*, supported by Bayer, explores how self-care can improve health outcomes, expand access and ease pressure on overstretched health systems. **Daniella Foster**, Senior Vice President and Global Head of Public Affairs, Market Access & Sustainability at Bayer Consumer Health, discusses the report's findings and what it would take to integrate self-care more effectively into formal healthcare systems in an interaction with **Swati Rana**

The report argues that self-care should become more integrated into formal healthcare systems. What would a truly integrated self-care model look like, and where are health systems currently falling short?

Self-care should not sit outside the healthcare system. It should be embedded within it as the first step in a connected healthcare journey—from prevention and the management of minor ailments through treatment. Most health decisions are made at home, not in hospitals or clinics. Globally, of the 8,760 hours in a year, people spend only around 10 hours with healthcare professionals, reinforcing how much of health management happens outside formal healthcare settings.

A truly integrated model empowers people to manage everyday health needs while ensuring they can access professional care when they need it.

For that to work, people need reliable, evidence-based information, affordable access to quality self-care solutions, appropriate safeguards, and clear referral pathways. These elements also need to connect primary care, pharmacies, digital tools, and health literacy. We are already seeing examples of what this can look like. It was highlighted in recent research by Economist Enterprise and supported by Bayer. In Germany, physicians can use “green prescriptions” to formally recommend over-the-counter medicines, while Singapore’s Healthier SG combines digital tools, incentives and community support to encourage prevention and everyday



“Self-care should not sit outside the healthcare system. It should be embedded within it as the first step in a connected healthcare journey”

health management. Indonesia is also advancing integrated self-care through GERMAS, a national movement promoting healthy living, hygiene, and responsible medicine use across schools, workplaces and communities.

The biggest challenge today is that self-care is often recognized in policy but not fully integrated into how healthcare is accessed and delivered. The opportunity now is to move from recognition to practical support: helping people use self-care safely, confidently,

and affordably.

With healthcare systems facing rising costs, workforce shortages and growing patient loads, how much pressure can responsible self-care realistically take off formal healthcare systems?

Self-care cannot replace professional healthcare, and it shouldn't try to. Its value lies in helping health systems use their resources more effectively. When people can manage everyday health needs and recognize when

professional support is required, it frees capacity for the patients who need clinical care most.

Self-care is estimated to generate around US\$144 billion in annual health-system savings and free approximately 2.2 billion hours of physician capacity globally, according to the latest GSCF report. The report also estimates that more effective integration of self-care into prevention and healthcare systems could deliver up to 50% greater health and economic benefits by 2040.

These figures reinforce why prevention and self-care should be viewed not as a cost, but as an investment in stronger and more resilient health systems. The objective is to help people take ownership of their health and well-being, equipping them with information, tools and confidence to play an active role in prevention and treatment.

How can policymakers ensure that self-care complements professional medical care rather than delaying diagnosis or treatment when a patient actually needs clinical intervention?

Responsible self-care is not about replacing healthcare professionals. It is about helping people make better decisions about when and how to engage with them. That means knowing what you can safely manage yourself, recognising warning signs and seeking professional care when further assessment is required.

Pharmacists and other healthcare professionals play an important role in

supporting responsible self-care, offering guidance and referring people into formal care when necessary.

Regulation is equally important. Self-care products must meet appropriate standards for safety, quality and efficacy. As digital health tools and AI become more prominent, credible information, transparency and appropriate safeguards will also be critical.

Self-care is increasingly being positioned as the first point of contact for many health needs. What has changed in consumer behaviour and healthcare systems that makes this shift particularly relevant now?

Ageing populations, the growing burden of chronic disease, workforce shortages and unequal access are placing sustained pressure on healthcare systems.

At the same time, people have unprecedented access to health information and tools in real time, and they increasingly expect to play a more active role in their everyday health.

The question is no longer whether people will play a more active role in their health. They already are. The challenge is ensuring that self-care solutions from consumer health companies are matched by evidence-based guidance, science-based solutions and the right safeguards, so people remain connected to formal care when they need it.

Where do you see the biggest gap today between the potential of self-care and the way health systems actually enable and support it?

New research by Economist Enterprise and supported by

INTERVIEW

Bayer states that WHO guidance has already informed self-care policies and frameworks in more than 50 countries, showing that the policy conversation has moved forward. But self-care happens in homes, pharmacies, communities, workplaces, digital platforms and formal healthcare, so responsibility is naturally spread across different parts of the system.

As a result, self-care can remain fragmented, placing greater responsibility for information, financing, and care management on individuals.

We need to move from simply recognizing self-care in health policy to embedding it across health systems, with clearer responsibilities, stronger coordination and defined pathways linking prevention, self-care, referral and follow-up.

Affordability and access remain major barriers. What policy and industry interventions are needed to ensure that self-care does not widen existing health inequalities?

Self-care can expand access to healthcare, but only if affordability and equity are built into how it is implemented. Governments need to consider which evidence-based self-care interventions should be publicly funded, subsidized, reimbursed or included within universal health coverage benefit packages. Depending on the health system, public

procurement, appropriate pricing policies or integration into primary-care services can also help improve access.

Affordability matters, but access is about more than price. Health literacy, language, culture, trust and digital access all influence whether people can use self-care safely and effectively. Systems therefore also need clear guidance, community-based support, and non-digital routes to care where required.

Industry has a role in contributing quality, science-based solutions and supporting health literacy, while governments and other stakeholders need to create the policy and financing environment that makes responsible self-care accessible. The goal should be to use self-care to close gaps in healthcare access, rather than create new ones.

Clear referral pathways are identified as an important requirement. What should the connection between consumers, pharmacies, self-care products and healthcare professionals look like in practice?

From the consumer's perspective, it should feel like one connected healthcare journey. A person may begin by seeking trusted information or using an appropriate self-care solution. They should understand what it is intended for, how to use it safely, and when symptoms indicate that they need additional support. Pharmacists can provide an

important point of guidance and, where necessary, help connect that person with a doctor or another healthcare professional.

The level of support should depend on the intervention. Some forms of self-care can be safely managed independently when the right information is available. Others may require pharmacist consultation, while certain symptoms or conditions require professional care from the outset.

We already see models that reflect this principle. In Australia, some non-prescription medicines are available through general retail, while others are pharmacy-only or require pharmacist consultation. The principle is simple: greater access should be matched with the right level of support and a clear route back into professional care.

From Bayer Consumer Health's perspective, what role should the industry play beyond developing products—in areas such as health literacy, prevention, responsible self-care and collaboration with governments?

At Bayer, we believe our role extends beyond the products we bring to market. If we want people to be the CEOs of their own health, they need access to science-based solutions—and the knowledge and confidence to make informed decisions. Trust starts with science: products must meet the standards of safety,

efficacy, and quality that people deserve. But trust also depends on understandable, actionable information, which is why we invest in health literacy and education, including initiatives such as The Truth, Undressed.

Technology creates another opportunity. As AI and digital tools become an increasingly important part of healthcare, we can use them to make credible information more personalized and relevant, while ensuring those tools are grounded in high-quality, evidence-based data. But industry cannot build this ecosystem alone. Governments, healthcare professionals, industry and other stakeholders must work together to strengthen health literacy, responsible self-care and access. In Indonesia, for example, we are strengthening local manufacturing capabilities to produce UNIMMAP-standard prenatal supplements containing 15 essential vitamins and minerals for pregnant women, supporting the government's priority to improve maternal and child health.

Our role is to bring science, innovation, and evidence to those partnerships, helping ensure people have the confidence to make informed decisions about their health.

Looking ahead five years, what policy or system-level change would you most like to see to make self-care a recognised and effective component of healthcare—

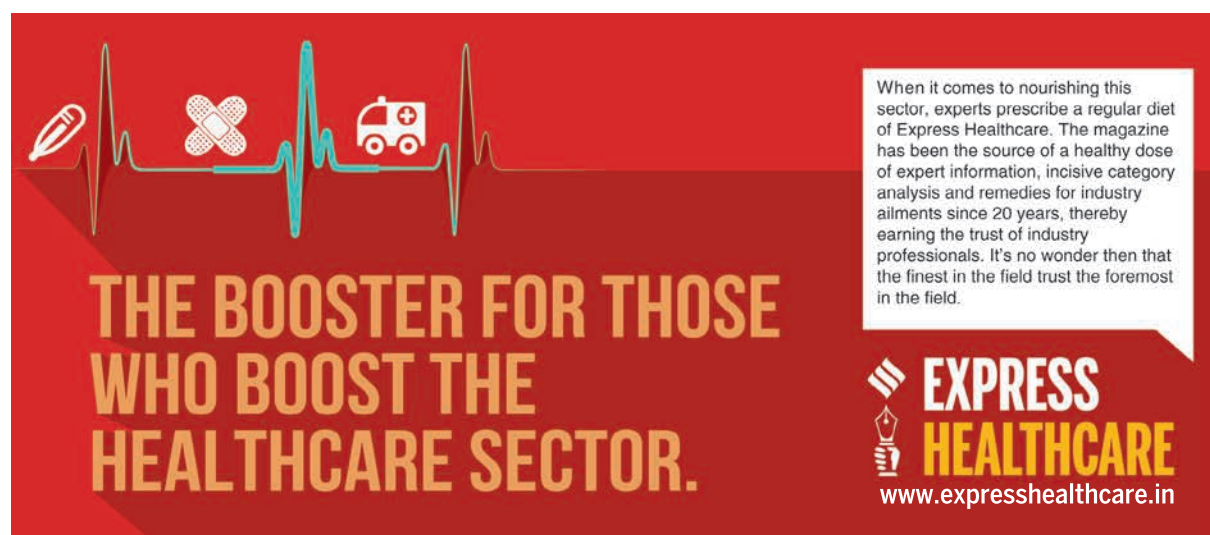
and what would success look like?

Over the next five years, I would like to see self-care move from policy recognition to seamless integration with healthcare systems. That means clearer policy frameworks, appropriate regulation and financing, stronger health literacy, defined referral pathways and better measurement of outcomes, safety, equity and continuity of care. It also means recognising prevention and self-care as part of the broader investment needed to build healthier populations and more resilient health systems.

The 2027 UN High-Level Meeting on Universal Health Coverage will be an important opportunity to advance this conversation and consider how self-care can contribute to sustainable progress towards universal health coverage.

To me success would mean people can easily access trusted information, affordable, science-based solutions, and understand what they can safely manage themselves, and when to seek professional care. For health systems, it would mean greater capacity to focus on chronic conditions and on the patients who need clinical care most. The goal is to make self-care a recognised trusted and supported part of healthcare—not something that sits separately from it.

swati.rana@expressindia.com
Swatirana.express@gmail.com



When it comes to nourishing this sector, experts prescribe a regular diet of Express Healthcare. The magazine has been the source of a healthy dose of expert information, incisive category analysis and remedies for industry ailments since 20 years, thereby earning the trust of industry professionals. It's no wonder then that the finest in the field trust the foremost in the field.

EXPRESS HEALTHCARE
www.expresshealthcare.in



Progress with purpose: Polymed's path to sustainability

Dhruv Baid, Senior Manager, Corporate Strategy, Poly Medicure, outlines Polymed's sustainability initiatives, from renewable energy and product life-cycle assessments to cleaner mobility and greener logistics

At Polymed, we believe that sustainable growth is fundamental to creating long-term value for our stakeholders while making a meaningful contribution to society and the environment. For us, sustainability is not a stand-alone initiative, it is an integral part of how we conduct our business and pursue responsible growth. As we expand our global footprint and strengthen our position as a leading medtech company, we remain committed to ensuring that this growth is environmentally responsible, socially inclusive and underpinned by strong ethical governance.

Our sustainability approach is centred on balancing business performance with our responsibility towards our people, communities and the planet. Over the past year, Polymed has continued to make meaningful progress towards its 2030 ESG goals, with a strong focus on reducing our environmental footprint, improving resource efficiency through operational improvements and embedding sustainability considerations across our operations and products.

One of the key areas of progress has been Polymed's transition towards renewable energy. We have continued to invest in solar power generation, through the form of PPA (Power Purchase Agreement) as well as direct capital deployment, reducing our dependence on conventional sources of electricity and consequently contributing to a reduction in Scope 2 emissions. Our solar power generation has grown 2.39 times compared with the baseline, marking an important milestone in our renewable energy journey. As we move forward, we remain committed to scaling up renewable energy adoption and identifying further opportunities to reduce the carbon inten-



Sustainability at Polymed extends beyond our operations to the products we develop. Understanding the environmental impact of products across their life cycle is an important part of building a more sustainable medtech ecosystem

sity of our operations.

Sustainability at Polymed extends beyond our operations to the products we develop. Understanding the environmental impact of products across their life cycle is an important part of building a more sustainable medtech ecosystem. During the year, we completed a Life Cycle Assessment (LCA) of Poly Flush (Prefilled Saline Syringe) in accordance with ISO 14040/44. The assessment was complemented by an independent critical review and verification process in accordance with ISO 14071, strengthening the credibility and robustness of the assessment.

This initiative represents an important step towards incorporating life cycle thinking into product development and decision-making. With over 120 million Saline Prefilled Syringes manufactured annually, Polymed is the first and only company globally to have completed a critical reviewed LCA for this product. Polymed is also progressing with LCAs for two additional products, which will provide deeper insights into their environmental footprints and help identify opportunities for improvement across their respective life cycles.

Looking ahead, Polymed is evaluating multiple opportunities to further reduce emissions. The company is assessing investments in electric vehicles (EVs) as part of its efforts to progressively reduce emissions associated with mobility and transportation. As investment in public infrastructure increases, Polymed will add long range heavy vehicles to its fleet, with a concrete plan to phase out older vehicles. However, in the meantime, Polymed will be adding shorter range vehicles as part of its last mile fleet network with the first vehicle delivery expected later this financial year.

Polymed is also exploring

modifications to its HVAC systems, with the objective of transitioning towards refrigeration gases with lower emissions and reduced environmental impact. These initiatives demonstrate the company's approach of continuously evaluating both established and emerging technologies to make its operations more sustainable.

Sustainability also extends to the movement of products across markets. Through Zemba, Polymed, as the first and only Indian member company, has formalised an agreement with shipping company Hapag-Lloyd for the adoption of e-fuels. The programme is scheduled to commence in 2027 and is expected to support efforts to reduce emissions across logistics operations while advancing more environmentally responsible transportation practices.

Polymed recognises that sustainability is not a destination but a continuous journey; one that requires ambition, innovation and collective action. From renewable energy and product life-cycle assessments to cleaner mobility, lower-emission technologies and more responsible logistics, the company is progressively integrating sustainability into the way it operates and creates value. Sustainability is no longer optional. Around the world, tightening regulations, stricter tender requirements and rising public expectations are reshaping how governments, businesses and consumers choose their partners, and they are choosing organisations that can show real, measurable progress.

As Polymed moves forward, it will continue to invest in technologies, processes and partnerships that enable it to operate more responsibly and create lasting value for its stakeholders, communities and the planet.

DIAGNOSTICS

INTERVIEW

Our simple endeavor is to enable people to test periodically and preventively

Aditya Kandoi, Founder & CEO, Redcliffe Labs, explains to **Viveka Roychowdhury** the company's shift from illness care to preventive health, helping consumers understand their reports and creating personalised plans covering lifestyle, diet, movement, and sleep; strategies to achieve the company's FY27 revenue target of Rs 600+ crore, and plans to IPO in FY30, when revenue is projected to exceed Rs 1,200 crore

How do organisations like Redcliffe Labs look at the opportunities emerging in healthcare? How do you maintain quality as you scale up?

These are some of the best times for healthcare. Its prominence has never been greater. Earlier, we thought about healthcare only when illness affected us or our families. COVID provided a tailwind to diagnostics, but that prominence was getting lost over the last two to three years.

Over the last year, we have seen a mindset shift. People are becoming more aspirational and want to plan ahead rather than address health issues later.

India is also grappling with an epidemic of non-communicable diseases (NCDs). There is a chronic patient in almost every family, whether diabetic, pre-diabetic, or dealing with cardiovascular, cancer, or lipid-related issues. A recent ICMR study said that 80 percent of Indians are dyslipidemic, which is an early signal of poor metabolic health.

Lifestyle is a major contributor. Eating habits have shifted from home food towards outside food, while quick commerce and e-commerce are changing consumption patterns. Rising incomes and prosperity are also contributing to what I would call a poor health syndrome.

This is the problem we wanted to address when we



AI has made access to health information easier for the common consumer. But health tech needs medical guardrails. We use AI within medical guardrails so that the output is vetted and does not hallucinate

started Redcliffe Labs. We did not want to focus only on illness because acute and terminal illnesses, surgeries, and hospital-based diagnostics are already relatively well served in India. Healthcare is also affordable and accessible.

We wanted to shift the conversation from illness care to healthcare. If we do not, the epidemic will become so visible that we may not have enough beds to treat people. Around 500 million Indians are either chronic or near-chronic, although that figure is understated because there is no single uniform study assessing the risk.

Our simple endeavour is to enable people to test periodically and preventively. Our business strategy is built around four As: affordability, accessibility, awareness and actionability.

Affordability is critical. If tests remain expensive, people will wait until a problem arises. As a direct-to-consumer player, we can pass on the margin benefit from not having channel costs and from operating at volume. Today, we are able to offer tests at almost 40–50 per cent lower prices than traditional players.

The second is accessibility. People do not want to visit a centre at six or seven in the morning for a fasting test and stand in a queue. They want convenience and doorstep services. Technology has enabled us to operate at scale. Home collections account for close to 60 per cent of what we

do, compared with 10–20 per cent for traditional players. We have more than 1,200 phlebotomists covering around 3,000 pincodes across India.

The third is awareness. Even educated consumers often do not know which tests they should take, why they should take them or what the results mean. We have invested in awareness from day one. More than 20 million people visit our website organically for content explained in simple, vernacular language.

The fourth, and one that diagnostic companies rarely discuss, is actionability. A diagnostic company's relationship with a consumer often ends when the report is delivered. For us, that is the starting point.

A report should provide more than highlighted parameters. Individual parameters cannot tell you whether you are healthy, ill, or borderline; they need to be assessed together and in the context of the appropriate panel. We believe someone should help consumers understand their reports and create a personalised plan covering lifestyle, diet, movement, and sleep.

This approach has helped us scale rapidly. In five years, we have crossed Rs 500 crore in ARR as of August'26 and ~1.3 crore people. We conduct about 100,000 tests a day.

Healthcare is also moving towards preventive and continuous care. Consumers are increasingly tracking

longitudinal data on apps and looking at how their markers change over time. Our app and reports show these trends and explain what the consumer should do next. We also offer consultation and expert guidance, including diet plans, free of cost.

Another trend is the movement beyond metros and tier-1 cities. Preventive testing is increasingly reaching tier-2 and smaller cities. We are seeing growth rates of around 18–20 per cent in tier-2 and above, compared with an overall market growth of around 12–13 per cent.

What is the role of health tech in a diagnostic company like Redcliffe Labs?

AI has made access to health information easier for the common consumer. But health tech needs medical guardrails. We use AI within medical guardrails so that the output

is vetted and does not hallucinate.

We call this Health AI Companion. Consumers can ask questions and receive responses based on our database, within medical guardrails vetted by doctors. We have doctors with expertise in AI who have helped build our LLM models, bringing medical and technology expertise together.

Can this be personalised for each patient?

Yes, it is personalised. Earlier health-tech applications were largely rule-based. Today, AI-based solutions consume large amounts of data and use generative AI to produce explanations and recommendations.

But healthcare is sensitive. AI could incorrectly tell someone they are diabetic and even recommend medication. That is where the risk lies. A

company like us, which is a medical company but technology-led, can build guardrails to prevent such outcomes.

It is also important that the system can say it cannot provide an answer rather than generate a wrong one. That is where healthcare-focused AI has an advantage over a general AI model providing health information directly to consumers.

What are the expansion plans for FY2027?

We ended FY26 at ₹420 crore in net revenue (standalone diagnostics) and anticipate touching close to Rs 600 crore in FY27. We are growing at more than 30 per cent organically this year, compared with industry growth of around 12–14 per cent. Our CAGR over the last four years has been 40 per cent.

Beyond geographic expansion, we are going deeper into capabilities. Integrated diagnostics is a major opportunity. Pathology players have built large networks but have not necessarily built radiology alongside them. Consumers do not want to visit multiple locations when a doctor prescribes both scans and blood tests.

We are therefore building integrated healthcare infrastructure. We have partnered with and acquired businesses in Rajasthan, Bengaluru and Pune, retaining key professionals, including radiologists. These partnerships allow us to add radiology capabilities alongside our existing strength in home collection and pathology.

We anticipate another 10 per cent growth from inorganic expansion this year,

thus taking us to ₹600 crore (in addition to the organic growth anticipated in FY27).

When do you plan to IPO, as the next step in your scale-up journey?

We measure scale through the people we serve and the number of tests we conduct. An IPO is also a financial milestone for our investors, who backed us at an early stage. We believe the company can grow at 26–30 per cent over the next three years. By FY30, we expect the topline to reach Rs 1,200 crore-plus. We believe that would be an appropriate scale for becoming a publicly traded company, provided there are no major macroeconomic changes. With the current landscape, we believe FY30 is a good time to go public.

viveka.r@expressindia.com
viveka.roy3@gmail.com

CONTRIBUTOR'S CHECKLIST

- *Express Healthcare* accepts editorial material for the regular columns and from pre-approved contributors/columnists.
- *Express Healthcare* has a strict non-tolerance policy towards plagiarism and will blacklist all authors found to have used/referred to previously published material in any form, without giving due credit in the industry-accepted format.
- As per our organisation's guidelines, we need to keep on record a signed and dated declaration from the author that the article is authored by him/her/them, that it is his/her/their original work, and that all references have been quoted in full where necessary or due acknowledgement has been given. The declaration also needs to state that the article has not been published before and there exist no impediment to our publication. Without this declaration we cannot proceed.
- If the article/column is not an original piece of work, the author/s will bear the onus of taking permission for re-publishing in *Express Healthcare*. The final decision to carry such republished articles rests with the Editor.
- *Express Healthcare*'s prime audience is senior management and professionals in the hospital industry. Editorial material addressing this audience would be given preference.
- The articles should cover technology and policy trends and business related discussions.
- Articles by columnists should talk about concepts or trends without being too company or product specific.
- Article length for regular columns: Between



- 1300 - 1500 words. These should be accompanied by diagrams, illustrations, tables and photographs, wherever relevant.
- We welcome information on new products and services introduced by your organisation for our Products sections. Related photographs and brochures must accompany the information.
- Besides the regular columns, each issue will have a special focus on a specific topic of relevance to the Indian market. You may write to the Editor for more details of the schedule.
- In e-mail communications, avoid large document attachments (above 1MB) as far as possible.

- Articles may be edited for brevity, style, relevance.
- Do specify name, designation, company name, department and e-mail address for feedback, in the article.
- We encourage authors to send a short profile of professional achievements and a recent photograph, preferably in colour, high resolution with a good contrast.

Email your contribution to:
viveka.r@expressindia.com
viveka.roy3@gmail.com
Editor, *Express Healthcare*

Molecular Diagnostics in India: From Metro Monopoly to Indigenous Automation

How automation, decentralisation and indigenous manufacturing are redefining access to precision molecular testing **Pramod Ahire**, Group Marketing Head – Immunology, Transasia Bio-Medicals Ltd

Molecular diagnostics in India has moved far beyond its origins as a specialised capability concentrated within premier academic and reference laboratories. What was once largely an elite, infrastructure-intensive diagnostic discipline is increasingly becoming an integral part of clinical decision-making across a much broader healthcare ecosystem.

The transformation is being driven by three powerful forces: automation, decentralisation and indigenous manufacturing.

Together, these developments are changing not only how molecular tests are performed, but also where they can be performed, who can perform them and how economically they can be deployed.

The larger shift is from centralised, manual molecular testing towards automated, sample-to-answer platforms capable of serving Tier-2, Tier-3 and rural healthcare ecosystems.



The old model: sophisticated science, limited access

Before 2020, molecular diagnostics in India faced several structural constraints.

More than 85% of molecular testing capacity was concentrated in premier institutes and metropolitan reference chains, including institutions such as AIIMS, Tata Memorial Centre and NIV Pune. This concentration reflected the complexity of molecular workflows and the infrastructure required to operate them.

Traditional molecular testing could require three-room physical segregation with negative airflow to minimise amplicon contamination. Nucleic acid extraction was often manual and labour-intensive, relying on silica spin-column extraction workflows.

The economics were equally challenging. Heavy dependence on imported closed platforms

made routine applications such as HIV, HBV and HCV viral-load monitoring, as well as oncology panels, financially inaccessible to a large section of patients.

At the same time, early point-of-care molecular systems often had narrow menus, focusing predominantly on single-target qualitative screening, such as initial MTB detection, without the broader multiplexed resistance profiling increasingly required in modern clinical practice.

The result was a significant access gap: India possessed advanced molecular science, but molecular testing remained disproportionately concentrated in sophisticated laboratories and major urban centres.

COVID-19 created the infrastructure for the next phase

The COVID-19 pandemic fundamentally accelerated India's mo-

lecular diagnostics ecosystem.

The rapid expansion of RT-PCR testing created a much larger installed base of molecular infrastructure, laboratories and trained personnel. According to the source material, RT-PCR capacity expanded to more than 3,500 accredited facilities during the pandemic.

That expansion created something more important than temporary testing capacity: a foundation for decentralised molecular diagnostics.

The market could now begin addressing a different question.

Instead of asking how to bring samples from smaller centres to a handful of specialised molecular laboratories, the industry could ask:

How can molecular testing itself be taken closer to the patient?

This is where automation and sample-to-answer technolo-

gies become strategically important.

Sample-to-answer: simplifying the molecular workflow

One of the most important technological shifts is the emergence of integrated sample-to-answer cartridge platforms.

Conventional molecular testing involves multiple sequential stages, each requiring infrastructure, trained personnel and quality controls. Modern cartridge-based systems increasingly integrate these steps within a closed workflow.

A single cartridge can combine:

- Automated sample lysis
- Magnetic-bead-based nucleic acid extraction
- Lyophilized reagent reconstitution
- Real-time molecular amplification and detection
- Multi-channel fluorescence detection

Advanced systems can employ multiple detection channels, including FAM, HEX, ROX and Cy5, enabling multiplexed detection within a single testing workflow.

The source material identifies integrated platforms capable of delivering this automated workflow in under 140 minutes, with walkaway simplicity. This is more than an incremental technology improvement; it changes the operational economics of molecular diagnostics.

Reducing manual intervention can reduce workflow complexity, dependence on specialised technical manpower and opportunities for handling-related variability. This makes molecular testing more practical for a much wider range of laboratories.

In the next phase of molecular diagnostics, workflow simplicity will be as important as analytical sophistication.

Cold-chain independence: solving an overlooked challenge

Decentralisation also requires solving a less visible but critical problem: reagent logistics.

Sophisticated molecular technology cannot scale effectively into diverse geographies if its reagents depend on complex and uninterrupted cold-chain infrastructure.

Lyophilisation is helping address this challenge.

The use of lyoprotectant matrices such as Trehalose and Ficoll can enable PCR reagents to remain stable at room temperature within sealed cartridges. This can reduce dependence on cold-chain infrastructure and help overcome supply-chain vulnerabilities, particularly in tropical and geographically distributed healthcare environments.

From a technology perspective, this is a chemistry innovation.

From a market perspective, it is an access innovation.

A molecular platform that can operate with greater logistical flexibility has a fundamentally different scalability profile.

Policy is accelerating the molecular diagnostics market

Technology adoption does not happen in isolation. India's public-health priorities are creating strong structural demand for molecular testing.

Under the National Tuberculosis Elimination Programme (NTEP), Universal Drug Susceptibility Testing promotes up-front molecular testing for presumptive TB cases, including simultaneous detection of Mycobacterium tuberculosis and Rifampicin resistance through the rpoB target.

The National Viral Hepatitis Control Programme (NVHCP) is driving the use of quantitative viral-load monitoring for Hepatitis B and Hepatitis C.

At the infrastructure level, PM-ABHIM is supporting the development of Integrated Public Health Laboratories across districts, creating further demand for compact and automated molecular platforms.

These initiatives demonstrate an important evolution in the role of molecular diagnostics.

It is no longer restricted to specialised clinical applications. Molecular testing is increasingly becoming part of large-scale disease-management and public-health strategies.

The next frontier: AMR and syndromic testing

The next wave of molecular diagnostics is likely to be defined by increasingly sophisticated applications in antimicrobial resistance (AMR) and acute-care diagnostics.

Binary qualitative testing can answer whether a pathogen is present. The next generation of multiplex molecular diagnostics can potentially answer a more clinically meaningful question:

Which pathogen is present, and what resistance markers does it carry?

Syndromic panels for conditions such as sepsis and pneumonia can combine pathogen identification with detection of critical resistance markers.

The technical landscape includes markers such as:

- blaNDM
- blaKPC
- blaOXA-48
- mcr-1

Molecular testing is also ex-

panding into second-line TB drug resistance, including markers associated with resistance to Fluoroquinolones and Bedaquiline.

The commercial implication is significant.

As molecular menus become broader and more clinically actionable, the value proposition shifts from simply selling a test to enabling faster clinical decision-making.

Oncology: Bringing actionable mutation testing closer to the patient

Oncology represents another major frontier.

Today, certain actionable mutation analyses can involve centralised testing pathways and relatively long turnaround times. The next generation of molecular platforms has the potential to bring selected mutation testing closer to routine diagnostic workflows.

The source material identifies EGFR Exon 19 deletion, L858R and T790M among actionable driver mutations that could be addressed through rapid molecular platforms.

Technologies such as ARMS (Amplification Refractory Mutation System) and PNA/LNA blocker chemistry can support targeted mutation detection on rapid, multi-channel cartridge platforms, potentially reducing dependence on longer 10–14 day NGS workflows for selected applications.

This does not mean molecular platforms will replace NGS

across oncology.

Rather, it points towards a more differentiated diagnostic ecosystem in which rapid targeted molecular testing and comprehensive genomic profiling can serve complementary clinical needs.

From imported technology to indigenous precision engineering

Perhaps the most important transformation is taking place at the manufacturing level.

India's molecular diagnostics market has historically depended substantially on imported technologies, platforms and components. The emergence of indigenous manufacturing is creating the possibility of a more locally responsive molecular diagnostics ecosystem.

The Medical Device PLI scheme and GeM procurement preferences are supporting domestic manufacturing capabilities, including precision-moulded cartridges, automated optics and locally produced master mixes.

This is where Make in India becomes more than a manufacturing slogan.

Indigenous molecular diagnostics can potentially provide greater control over product development, localisation, supply chains and cost structures while allowing technologies to be designed around the specific requirements of Indian healthcare.

The competitive advantage will increasingly belong to organisations that can bring to-

gether molecular biology, reagent chemistry, microfluidics, optics, automation and manufacturing at scale.

The Erba Transasia perspective: Building for India's diagnostic reality

For companies operating in this space, the opportunity is not simply to introduce another molecular analyser.

It is to build technology that addresses the realities of India's diagnostic market: diverse geographies, variable infrastructure, manpower constraints, cost sensitivity and the growing need for faster clinical answers.

This is the direction being pursued by Transasia Bio-Medicals, which is scaling indigenous molecular diagnostics by combining ambient-stable, cold-chain-free reagents with automated sample-to-result platforms.

By bringing together automated microfluidics and domestic manufacturing, the objective is to move precision molecular testing beyond its traditional metropolitan footprint and towards a more accessible nationwide model.

The significance of this approach lies in the combination.

- Automation addresses complexity
- Ambient stability addresses logistics
- Indigenous manufacturing addresses scalability and supply resilience
- Decentralisation addresses access.

Together, these elements can

fundamentally alter the economics and reach of molecular diagnostics.

The next chapter is about access

India's molecular diagnostics journey is entering a new phase.

● The first phase established the science.

● The second expanded infrastructure, particularly during COVID-19.

● The next phase is about scale.

Scale will require molecular diagnostics to become simpler without compromising sophistication, decentralised without compromising quality, and more affordable without compromising performance.

The technology already points in that direction: sample-to-answer cartridges, automated extraction, multiplex real-time detection, lyophilized reagents, ambient-stable chemistry, targeted molecular oncology, syndromic AMR panels and indigenous manufacturing.

The larger transformation is therefore not merely about developing better molecular tests.

It is about building a diagnostic ecosystem in which precision molecular testing can travel beyond the laboratory walls of India's largest cities and become part of routine healthcare delivery across the country.

That is the real promise of the next generation of molecular diagnostics: not just more advanced testing, but more accessible precision.



THE AID FOR THOSE WHO AID THE HEALTHCARE SECTOR.

When it comes to nourishing this sector, experts prescribe a regular diet of Express Healthcare. The magazine has been the source of a healthy dose of expert information, incisive category analysis and remedies for industry ailments since 20 years, thereby earning the trust of industry professionals. It's no wonder then that the finest in the field trust the foremost in the field.



EXPRESS
HEALTHCARE

www.expresshealthcare.in



EYE CARE

INDIA'S NEXT GROWTH FRONTIER

India's eye-care sector is expanding beyond major metros but the next phase will depend on how effectively the industry balances scale, access, affordability and clinical quality

By Kalyani Sharma



India's eye-care market is broadening beyond cataract as retina, glaucoma, refractive care and paediatric ophthalmology gain ground. Organised networks are expanding into smaller cities, technology is changing diagnosis and treatment, and the next phase of growth will depend on taking specialised care closer to patients without compromising clinical quality, affordability or outcomes.

For decades, cataract surgery has been the volume anchor of India's eye-care ecosystem. That role is unlikely to change in the near term. But the market around it is changing steadily.

An ageing population, the growing burden of diabetes, increased screen exposure, rising awareness and greater acceptance of preventive eye examinations are bringing more patients into the system. At the same time, patients are increasingly seeking care for conditions that require longer-term monitoring rather than a single procedure.

The result is a market that is becoming more specialised, more organised and increasingly technology-enabled.

Badrinarayan Srikanth, Group CEO, Maxivision Super Speciality Eye Hospitals, sees the sector at a significant stage of transition.

He mentioned, "India's eye-care market is at a decisive growth stage, driven by rising life expectancy, greater screen exposure, increasing incidence of diabetes, and stronger awareness around preventive health. Cataract care remains significant, but demand is widening across retina, glaucoma, cornea, refractive correction and paediatric ophthalmology."

The widening demand is important because it changes the way providers have to think about the market. Cataract can often be addressed through a defined surgical pathway. Conditions such as glaucoma, diabetic retinopathy and retinal disorders require continuing engagement, monitoring and, in many cases, repeated interventions.



India's eye-care market is at a decisive growth stage, driven by rising life expectancy, greater screen exposure, increasing incidence of diabetes, and stronger awareness around preventive health

Badrinarayan Srikanth,

Group CEO, Maxivision Super Speciality Eye Hospitals



New technologies, tools and workflows are making many eye procedures less invasive and more precise

Dr Cyres K Mehta

Cataract & Refractive Surgeon, International Eye Centre, Mumbai



Tier 2/3 is where the real unmet need sits, since metro markets are approaching saturation relative to their population base

Dr Rishi Raj Borah

Country Director, Orbis India



Digital tools and AI-based screening are perhaps the most exciting shift for accessibility

Dr Prashaant Chaudhry,

Senior Consultant & Head-Ophthalmology, Aakash Healthcare Super Speciality Hospital

Dr Cyres K Mehta, Cataract & Refractive Surgeon, International Eye Centre, Mumbai, points to the change in patient behaviour as another factor behind the market's evolution.

According to him, "India's eye-care market has come a long way. Earlier, patients often visited an ophthalmologist only when they had a problem, such as irritation or blurred vision. Today, awareness about eye health is growing. Patients are more regular with eye check-ups and are more aware of the need for early diagnosis."

This shift towards earlier engagement could prove important for both clinical outcomes and the economics of eye care. Earlier diagnosis creates opportunities for intervention before vision loss becomes advanced, while regular monitoring can help manage chronic conditions over longer periods.

The market is also moving away from a fragmented model towards more structured delivery networks. Organised providers, backed by capital and professional management, are increasingly looking at ophthalmology as a scalable healthcare category.

Dr Rishi Raj Borah, Country Director, Orbis India, describes this transition as a broadening of the specialty mix.

He said, "India's eye-care sector is moving from a volume-driven, cataract-centric model to a more diversified specialty ecosystem. Cataract will remain the largest procedural category given the size of the ageing population. Demand is becoming increasingly diverse, with growing attention to glaucoma and retinal disorders, diabetic retinopathy, corneal disease, paediatric ophthalmology, and refractive errors, pushing demand into sub-specialties once treated as niche."

The next market is outside the metros

While metropolitan markets continue to account for a substantial share of organised eye

care, the next phase of expansion is increasingly being linked to Tier 2, Tier 3 and district markets.

The opportunity is straightforward. Large sections of India's population still do not have convenient access to specialised ophthalmic services. But taking a metropolitan model and replicating it in a smaller city is not necessarily straightforward.

Dr Prashaant Chaudhry, Senior Consultant & Head-Ophthalmology, Aakash Healthcare Super Speciality Hospital sees a clear mismatch between the supply of specialised care and the geography of demand.

He believes that that's where the real headroom is. "Metro markets are getting saturated and competitive, while Tier 2 and Tier 3 cities have enormous unmet need, often with a single overworked ophthalmologist serving an entire district."

The challenge is not simply identifying demand. Smaller markets have different economics, workforce constraints and referral patterns. Specialist availability can be limited, while equipment and infrastructure costs remain substantial.

Dr Vikas Jain, Group COO, ASG Hospital, puts the strategic importance of smaller markets quite directly.

He stresses, "The next decade of organised eye care will be won in Tier 2, Tier 3 and district markets, not by adding another flagship centre in a metro."

For organised providers, this changes the expansion equation. Instead of concentrating investment in large urban hospitals, networks have to consider a combination of full-service centres, satellite facilities, diagnostic-led units and referral arrangements.

Dr Neeraj Sanduja, Director, Viaan Eye & Retina Centre, Gurugram, points to the scale of unmet demand while also underlining the need for a different operating model. He said, "Tier 2 and Tier 3 cities represent a significant opportunity for organised eye



Scale without a clinical operating system is just like adding more buildings. Consistency is the hard part

Dr Vikas Jain,
Group COO, ASG Hospital



Beyond cataract, medical retina is likely to remain one of the most important growth areas, particularly because of the increasing burden of diabetes and diabetic eye disease

Dr Neeraj Sanduja
Director, Viaan Eye & Retina Centre, Gurugram



India needs greater public awareness around eye donation, stronger donor-registration and retrieval systems, better coordination among hospitals and eye banks, and wider access to corneal-transplant expertise and technology

Dr Ayan Mohanta
Senior Consultant, Cataract & Refractive Services, Disha Eye Hospitals, Kolkata

care because a considerable amount of unmet demand exists outside the major metros. Patients in these markets increasingly seek reliable diagnosis, modern surgical options and access to specialists closer to home."

That demand, however, cannot be converted into sustainable growth simply by adding physical capacity. The clinical ecosystem around a centre matters just as much.

In many smaller markets,

patients may still travel to larger cities when they need a subspecialist. Building confidence in local services therefore requires reliable diagnostics, experienced doctors, trained technicians, referral pathways and predictable clinical standards.

Making the economics work

The Tier 2 and Tier 3 opportunity comes with a difficult business equation. Equipment

costs do not necessarily fall with the size of the market, while the ability of patients to pay may be lower.

This is particularly relevant for advanced retinal, glaucoma and corneal services that need sophisticated diagnostics and specialist expertise.

As Dr Borah explains, "Tier 2/3 is where the real unmet need sits, since metro markets are approaching saturation relative to their population base. What holds back <

expansion is not demand but economics: specialty-grade equipment, trained technicians and resident specialists are expensive to sustain against smaller-market volumes and price points."

The workforce question is especially important. A hospital can invest in infrastructure relatively quickly, but building a dependable clinical team takes considerably longer.

Dr Chaudhry points to the practical difficulties involved in attracting specialists outside large urban centres. "The opportunity is real, but so are the constraints. Setting up a quality eye centre needs skilled manpower, and specialists are understandably reluctant to relocate away from urban infrastructure, schools and social life for their families."

This is where hub-and-spoke models, tele-ophthalmology and centralised specialist support can become relevant. The smaller centre does not necessarily have to replicate every capability of a tertiary eye hospital. Instead, it can become part of a network in which diagnosis, routine procedures and follow-up are delivered locally, while complex cases are referred to higher-level centres.

The same principle can also help providers manage capital more efficiently.

"Setting up a centre alone is not enough. It needs experienced doctors, trained staff and the right diagnostic support to serve patients well. Cost and awareness are equally important." Srikanth's observation highlights a broader point. Expansion is meaningful only when the infrastructure around the centre is strong enough to translate investment into patient access.

Awareness also remains an important factor. In some markets, patients continue to delay consultations or travel to metros because they are not aware that specialised services are available closer to home.

Beyond cataract

Cataract will continue to dominate volumes, but the growth

story around it is becoming considerably broader.

The rising prevalence of diabetes is particularly important. Diabetic retinopathy and other retinal conditions require regular screening and long-term management. Age-related conditions will also become increasingly relevant as life expectancy rises.

Srikanth identifies several areas where demand is likely to build. "Beyond cataract, retina care is likely to see substantial growth, led by the rising prevalence of diabetes, age-related retinal conditions and greater access to advanced imaging. Refractive surgery will also expand as younger, digitally active patients increasingly seek freedom from spectacles."

The shift is visible across both medical and surgical ophthalmology. Refractive services are benefiting from greater awareness and changing expectations among younger patients, while glaucoma and retinal care are being driven by demographic and disease trends.

Dr Ayan Mohanta, Senior Consultant, Cataract & Refractive Services, Disha Eye Hospitals, Kolkata, sees several segments developing simultaneously.

He mentions, "We see strong growth potential in refractive surgery, myopia management, retinal care, glaucoma and corneal care. Myopia and other eye conditions are becoming more common. Awareness about eye health is also increasing."

For providers, this diversification has implications beyond the number of procedures performed. Several of these segments require patients to remain within the system for years.

Cataract will remain the volume backbone. The strongest incremental growth will come from five segments

- Medical and surgical retina, led by diabetic retinopathy and age-related macular degeneration. India already has a very large diabetic population, a meaningful share already has some



The biggest gap in the ecosystem today is that the patients actually come to us when they become symptomatic

Dr Priyanka Jawahar

Consultant, Ophthalmology, SIMS Hospital, Chennai



The eye-care ecosystem in India is still tilted toward cataract and refractive surgery volumes, while the preventive, lifestyle-linked care, screen strain, diabetic eye disease and early degeneration have been largely ignored

Dr Mandeep Singh Basu

Director, Dr Basu Eye Care Centre



Clinical standards should be the same irrespective of whether the patient is being treated in an urban setting or in a smaller town

Deepshikha Sharma

CEO, Sharp Sight Eye Hospitals

retinopathy, and vision-threatening disease is still under-screened. Intravitreal injections, lasers and vitrectomy will grow wherever screening reaches primary and secondary care.

- Glaucoma-It is still the quiet epidemic. Most patients are diagnosed late because the disease is asymptomatic and comprehensive screening is not yet routine. As OCT, visual fields and better public awareness enter more centres, both

medical management and surgery will rise.

- Refractive surgery and premium vision correction. LASIK, ICL and related procedures are moving beyond metros as disposable incomes rise and younger patients refuse to accept glasses as the only answer. This segment is quality- and technology-sensitive; it rewards centres that invest in diagnostics and treatment modalities.

- Paediatric ophthalmology,

squint and ROP. School screening, myopia control and neonatal retina programmes will create sustained demand. This is clinically intensive and workforce-constrained, which is why organised networks that train their own fellows have an advantage.

- Oculoplasty, cornea and ocular surface. Smaller in volume than retina or cataract, but rising with trauma, infection, cosmetic demand and better referral from general

ophthalmology.

Source: Dr Vikas Jain, Group COO, ASG Hospital

That transition is already changing the capabilities that organised eye-care networks need to build. Retina specialists, glaucoma services, paediatric ophthalmology, corneal expertise and refractive platforms are becoming increasingly relevant to a comprehensive network.

Chronic care changes the model

The growth of non-cataract services is also changing the relationship between the provider and the patient.

A cataract patient may undergo a procedure and complete the immediate treatment pathway. A patient with glaucoma or diabetic eye disease may need regular examinations, imaging, medication, injections or other interventions over several years.

Dr Sanduja explains why medical retina is likely to become particularly important. "Beyond cataract, medical retina is likely to remain one of the most important growth areas, particularly because of the increasing burden of diabetes and diabetic eye disease. These conditions often require long-term monitoring and, in some cases, repeated treatment, making it important to build reliable follow-up systems rather than focus only on individual procedures."

This makes continuity of care a commercial as well as a clinical consideration. Providers that can maintain patients within an integrated care pathway may be better placed to manage chronic disease.

For paediatric ophthalmology, the opportunity is different. Early diagnosis can influence visual development and long-term quality of life, making screening and intervention particularly important.

Dr Priyanka Jawahar, Consultant, Ophthalmology, SIMS Hospital, Chennai, highlights the importance of retina within this changing disease burden.

"More than cataract, I feel like retina is particularly very important because it has had its importance for quite a few years as of now because of the increase in diabetes."

The broader market is therefore moving towards a combination of surgical care, chronic disease management and preventive services.

Dr Mandeep Singh Basu, Director, Dr Basu Eye Care Centre, sees several areas gaining attention as the disease profile changes. "Cataract will remain the volume drive of the eye, which comes with ageing, as it is a disorder, but I expect the fastest growth in a few adjacent areas: diabetic retinopathy and medical retina, given India's diabetes burden; glaucoma management, as awareness and screening improve; paediatric eye care and myopia control, driven by rising screen time in children; and dry eye and ocular surface disease, which has exploded post-pandemic due to digital device use."

The significance of these segments extends beyond market size. They also create a stronger case for preventive screening, regular follow-up and patient education.

Technology moves from the operating room to the care pathway

Technology has become one of the defining features of the new eye-care market.

The changes are visible in diagnostics, imaging, surgical systems, medical records, tele-ophthalmology and increasingly in AI-assisted screening. But the impact is not simply about adding sophisticated equipment to hospitals.

Dr Mehta says technology is already changing the patient experience.

"New technologies, tools and workflows are making many eye procedures less invasive and more precise. They can also support faster recovery and better patient experiences. As awareness increases, patients are becoming more comfortable with new treatment options and are placing greater

trust in technology-led eye care."

The economics of technology are equally important. If diagnostic tools can identify disease earlier, they can potentially reduce the number of patients who reach hospitals only after significant deterioration. If tele-ophthalmology can connect specialists to peripheral centres, it can also reduce the need for patients to travel for every consultation.

Dr Jain summarises the broader impact succinctly. "Technology is changing both the cost curve and the care pathway."

This makes technology relevant not just to clinical teams but also to hospital operators and investors. The question increasingly is how technology can improve utilisation, reduce delays and extend specialist capacity.

Dr Sanduja describes how this is happening across multiple stages of care. "Better diagnostics, including OCT, wide-field imaging and improved biometry, are helping clinicians detect disease earlier and make more informed treatment decisions."

The increasing use of digital systems could also support more distributed models of care. A patient can undergo initial screening locally, have images reviewed remotely and be referred to a specialist when required.

AI and the accessibility question

Artificial intelligence is adding another layer to this transition, particularly in retinal imaging and screening.

For a country with a large disease burden and uneven distribution of ophthalmologists, AI-assisted screening could help increase the number of people assessed without requiring a specialist to examine every patient at the first stage.

Dr Chaudhry sees this as one of the more significant technology-led changes. "Digital tools and AI-based screening are perhaps the most exciting shift for accessibility, since they allow non-specialists at a

primary level to screen large populations and flag only genuine cases for specialist referral."

This model could be particularly relevant to diabetes-linked eye disease, where large populations need regular screening.

Deepshikha Sharma, CEO, Sharp Sight Eye Hospitals, points to the speed at which AI can support image assessment. "Technology is allowing us to be more efficient. Through the use of AI, retinal scans can be analysed within seconds and any indications of diabetic retinopathy, glaucoma or macular disease may be pointed out."

The technology, however, does not eliminate the need for ophthalmologists. Instead, it changes where specialist time is spent. Screening and triage can potentially become more efficient, allowing specialists to focus on diagnosis, treatment and complex cases.

That distinction will be important as providers assess technology investments. Equipment and software have value when they solve a defined clinical or operational problem. Technology on its own is not a substitute for trained manpower or clinical judgement.

Quality has to scale with the network

As organised providers expand, one of the industry's biggest challenges will be ensuring that growth does not create variation in clinical outcomes.

A multi-centre network can offer wider access, but every additional centre also creates another point at which standards have to be maintained.

Dr Borah stresses the need to build quality into the operating model itself. "The key to maintaining quality as eye-care networks expand is to build consistency into the system from the outset."

That consistency has several components: standardised clinical pathways, appropriate protocols, outcome measurement, infection control, equipment maintenance and contin-

uing training.

Dr Jawahar brings the workforce dimension into the discussion. "The advances in surgical technology have actually helped us to give that precision and sometimes we can actually use it as a screening tool where we are not available, as in the previous question about the Tier 2 and Tier 3 cities where we are not possible."

Technology can extend the reach of a specialist, but it cannot fully replace specialist expertise. As networks grow, therefore, training and referral systems become increasingly important.

Sharma makes the principle of consistency explicit. "Growth can never come at the cost of clinical standards. Clinical standards should be the same irrespective of whether the patient is being treated in an urban setting or in a smaller town."

For hospitals, that means expansion has to be accompanied by investment in people and processes. It also means building mechanisms that allow complex cases to move to centres with the appropriate subspecialty expertise rather than expecting every facility to provide every service.

The workforce challenge

Specialist manpower is already one of the constraints affecting expansion beyond major cities.

Training ophthalmologists takes years, while developing allied clinical teams requires sustained investment. Technicians, optometrists, nurses and other support staff are equally important to the functioning of modern eye-care centres.

Dr Sanduja argues that networks need to build this capacity alongside physical expansion. "The most important principle is that clinical quality must be built into the system, rather than depend entirely on the expertise of individual doctors. As networks expand, standardised clinical pathways, appropriate surgical protocols, infection-control

practices and regular outcome audits become essential."

This also changes the role of larger organised providers. Beyond building centres, they have an opportunity to develop fellowships, continuing education and career pathways that can support specialist retention.

Dr Mehta points to the need to build a stronger talent pipeline. "The key will be trust, transparency and consistency. Standardised processes and strong clinical training will be important as networks grow. We also need to encourage more young people to consider careers in ophthalmology and allied health-care."

The requirement is particularly acute outside the metros. A network can centralise certain functions, but local clinical teams still need enough expertise to provide safe and reliable care.

Corneal transplantation and the eye-bank ecosystem

While market expansion often focuses on procedures, hospitals and investment, another important part of the eye-care ecosystem is the availability of donor tissue.

India continues to face a gap between the number of people who could benefit from corneal transplantation and the availability of suitable donated corneas. Improving the system requires action across awareness, registration, retrieval, preservation, allocation and surgical capability.

Dr Mohanta highlights the need for greater coordination. "India needs greater public awareness around eye donation, stronger donor-registration and retrieval systems, better coordination among hospitals and eye banks, and wider access to corneal-transplant expertise and technology."

The challenge is therefore not restricted to increasing the number of donations. The ecosystem has to ensure that donated tissue can move efficiently through the system and

reach patients who need it.

Dr Basu also stresses the importance of building a consistent care pathway. “As eye-care networks expand, consistency must be driven by protocols that are standard and integrative – combining Ayurvedic care like Netra Tarpana and lifestyle-based prevention with modern diagnostics and surgery, so that every centre follows one evidence-based pathway and not a diluted version.”

For the wider sector, the eye-bank system represents an area where hospitals, public-health institutions, specialists and other stakeholders can work together to address an access gap that cannot be solved by hospital expansion alone.

Dr Mohanta adds that the ecosystem needs to connect donated tissue with patients more efficiently. “A more integrated ecosystem can help bridge the gap between donated tissue and patients in need.”

From treatment to prevention

The next phase of India's eye-care market will also depend on whether the system can move further upstream.

Today, many patients continue to seek care only after symptoms appear. That can be particularly problematic for conditions such as glaucoma and diabetic retinopathy, where early disease may be difficult for patients to recognise themselves.

Dr Jawahar identifies this as a major weakness. “The biggest gap in the ecosystem today is that the patients actually come to us when they become symptomatic.”

This places greater emphasis on screening programmes, primary-level awareness and referral systems. It also creates an opportunity for hospitals and technology companies to develop models that bring eye-health assessment closer to communities.

Dr Basu points to a similar gap in the current structure of care. “The eye-care ecosystem in India is still tilted toward

Technology has become one of the defining features of the new eye-care market. The changes are visible in diagnostics, imaging, surgical systems, medical records, tele-ophthalmology and increasingly in AI-assisted screening. But the impact is not simply about adding sophisticated equipment to hospitals

cataract and refractive surgery volumes, while the preventive, lifestyle-linked care, screen strain, diabetic eye disease and early degeneration have been largely ignored.”

The opportunity is to build prevention and early diagnosis into the routine eye-care pathway rather than treating them as separate initiatives.

That could mean stronger diabetes screening partnerships, school-based vision programmes, community screening, workplace eye-health initiatives and technology-enabled referrals.

Building a connected ecosystem

The industry therefore faces a challenge that is larger than expansion. The opportunity lies in connecting different parts of the system so that patients can move from screening to diagnosis, treatment and follow-up without unnecessary gaps.

Srikanth sees this as an integrated care opportunity. “The strongest opportunity is therefore to build integrated eye-care ecosystems that combine community screening, diagnostics, specialist consultation, surgery and long-term follow-up.”

This model also offers a potential answer to the Tier 2 and Tier 3 challenge. Instead of expecting smaller centres to replicate every capability available in a metropolitan tertiary hospital, networks can connect local facilities to specialist hubs.

Sharma similarly underlines the importance of

the support system around smaller centres. “At Sharp Sight Eye Hospitals, our experience has reinforced that expanding access is not just about opening centres, but about building the right clinical support systems around Tier 2 and Tier 3 cities.”

The same principle applies to technology. Digital records, remote consultation and image-based screening can help connect smaller facilities to specialist teams, but they need to be integrated into a functioning clinical pathway.

The role of partnerships will become increasingly important here. Hospitals, technology providers, eye banks, public-health organisations, insurers and financing companies can each address different parts of the access challenge.

The investment opportunity

For investors and hospital operators, the changing market presents several areas of opportunity. These include organised networks, diagnostic centres, day-care surgery, retina and glaucoma services, refractive care, paediatric ophthalmology and technology-enabled screening.

But the investment case cannot be based only on the number of centres that can be added.

Dr Chaudhry identifies the importance of building capacity where the disease burden is concentrated. “For hospitals and investors, I see genuine opportunity in building scalable, tech-enabled

screening networks that feed into specialist centres, in expanding insurance and financing products for chronic eye care, and in training the next generation of ophthalmologists specifically for underserved geographies rather than only urban practice.”

That approach would broaden the market beyond traditional hospital expansion. It would also address some of the structural barriers that have limited access to specialised eye care.

For organised providers, affordability will remain a critical consideration. Advanced diagnostics and procedures can improve outcomes, but their value will be limited if large sections of the population cannot access them.

The next phase of eye care

India's eye-care market is entering a phase in which scale, technology and specialisation will increasingly converge.

Cataract will remain central to the sector, but it will sit alongside a growing portfolio of retinal, glaucoma, corneal, paediatric and refractive services. Chronic eye diseases will bring patients into longer care pathways, while screening and early diagnosis could become more important in preventing avoidable vision loss.

The expansion opportunity is significant, but the industry's ability to capture it will depend on how effectively it addresses access, workforce, affordability and quality.

Dr Jain captures the operational challenge succinctly.

“Scale without a clinical operating system is just like adding more buildings. Consistency is the hard part.”

That consistency will matter even more as providers move beyond the largest cities. A successful network will need to make its clinical standards portable across locations while allowing care to remain responsive to local needs.

For patients, the real measure of expansion will ultimately be whether specialised care becomes available earlier, closer to home and at a cost they can afford.

Dr Mohanta points to the broader opportunity in strengthening the system around patients. “The key gaps remain access, affordability, awareness, early diagnosis and availability of specialised care, particularly beyond major cities. The opportunity lies in strengthening healthcare infrastructure, expanding technology-enabled care, building clinical capabilities and creating stronger partnerships between hospitals, technology providers and other healthcare stakeholders.”

Way forward

The direction of travel is clear. The next chapter of Indian eye care is unlikely to be defined by cataract volumes alone. It will be shaped by how effectively the sector builds a wider, more connected and more accessible ecosystem around the changing needs of the country's population.

For hospitals, investors and technology companies, that creates room for growth. For the healthcare system, it creates a larger responsibility: ensuring that growth in capacity translates into timely diagnosis, appropriate treatment and consistent outcomes across geographies.

The opportunity, ultimately, is not simply to build more eye-care centres. It is to build a system in which a patient, wherever they enter it, can reach the right care at the right time.

*journokalyani@gmail.com
kalyani.sharma@expressindia.com*

INTERVIEW

Building a more transparent fertility care model

Neha Motwani, Founder and CEO, Luma Fertility, in an interview with **Kalyani Sharma**, discusses the operational challenges of scaling fertility services, the need for greater transparency in IVF outcomes, fertility preservation, affordability and the role of technology in improving patient experience

Luma Fertility's first centre reached break-even within its first year. What were the key operational and business decisions that helped achieve this?

At the outset, it is important to understand what we were trying to differentiate because fertility is a very competitive segment. There are more than 200 centres just in Mumbai, so the question was: why create one more centre?

I come from an entrepreneurial background. I had created a fitness marketplace platform called Fitternity, which was acquired by Cult.fit, and I had no plans of creating an IVF centre. But my personal journey led me to it.

Between 2020 and 2023, I went through multiple rounds of IUI, IVF and other treatments. It was a very frustrating experience. I kept asking myself, "Everything that I'm seeing is optimised for the doctor and the clinic, but who is thinking about the patient?"

Why was nobody thinking about the woman going through this? Why was the journey so non-empowering, non-empathetic and non-transparent? Eventually, my husband told me, "Just build it or stop complaining."

I said, how can I build it? I am not a doctor. But then the idea was to create something that combines clinical excellence, which is obviously critical because patients come here with a clinical outcome in mind, with a significantly better patient experience.

I attribute our break-even and scale to bridging a gap that existed in the market. During my research, I met more than 200 women



As women, we are perhaps the first or second generation in our families to become financially independent. I believe biological independence is the next step

because I wanted to understand whether I was the only person who felt this way. Many women described feeling like they were being treated like cattle. They felt that nobody was really holding their hand through the journey.

So, what we tried to do was create a place that combines

clinical excellence and good infrastructure with care and comfort. There is a care navigator who acts as a single point of contact through the journey. There is an app and there is transparency around the process.

We believe India is moving towards what I would call healthcare 2.0. Just because

hospitals and healthcare centres have traditionally operated in a particular way does not mean they have to continue doing so. We asked ourselves, what does fertility care 2.0 or IVF 2.0 look like?

The challenge going forward will be to replicate the same level of patient-centricity and empathy across multiple centres as we expand.

What differentiates Luma from other fertility providers?

I think clinical excellence is a given. Clinically, we are at par, if not better, with the best centres out there.

Beyond the clinical side, I would highlight three things. First, every patient who walks in is treated with empathy and support. The care navigator and the entire care ecosystem are centred around the patient.

We have identified 55 friction points in the fertility journey and have built solutions around each of them. For example, if a patient needs an injection administered during the treatment cycle, we can send nursing staff to her home or office so that she does not have to disrupt her schedule and come to the centre.

The second is convenience. We have looked at the entire patient journey and identified convenience as an area that has traditionally been overlooked. The clinic does not feel like a conventional clinic. It feels more like a wellness centre. Our charges are transparent, and we are open seven days a week, from 8 am to 8 pm.

The idea is to meet the patient where she is, rather

than always asking her to come to where we are.

The third is how we integrate holistic care. You are not just treating somebody's ovaries or uterus. You are treating the whole person. When you are preparing somebody for pregnancy, you cannot ignore psychological wellbeing.

A person may have good AMH levels and good fertility parameters, but if she is not psychologically prepared for the journey, how is she going to go through it? So we focus on psychological counselling and nutrition as part of the overall approach.

Another area I care deeply about is fertility preservation. I regret not freezing my eggs at 27 because I did not know that it was an option. I never wanted to have children at that point, but I changed my mind at 34. I wished I had known about egg freezing earlier.

That is one reason our egg-freezing programme is an important part of what we do. It is an outcome-based programme targeting 12 eggs. It allows women to understand where they are in their fertility timeline and what options are available to them, without feeling judged.

We are also taking fertility awareness programmes into corporates. Again, the idea is to reach women where they are, rather than waiting for them to find us.

You are targeting 30 per cent quarter-on-quarter growth going forward. What will be the key drivers of this growth?

One of the biggest drivers will be expansion into more locations. We are currently in

Bandra in Mumbai and will gradually look at national expansion.

The second driver will be our increased focus on fertility preservation. Even though we may be doing a significant volume of egg-freezing cycles, we believe we are only scratching the surface.

In the US, one in three cycles are egg-freezing cycles, whereas in India it is less than one per cent. There is significant scope for women to preserve their fertility and for couples to consider embryo freezing, particularly as people are getting married at 30 and beyond.

Awareness is still very low. Often, what prompts someone to consider egg freezing is hearing the experience of someone they know or look up to.

Ameera Shah, who is an investor and board member, is an example. She has spoken publicly about her own egg-freezing journey and having children later. Recently, around 60 women attended an event to hear her speak about that experience.

One point she made really stayed with me: you may not want children today, but you can change your mind. You are allowed to change your mind. She had her first child at 41 and twins at 44, and she said she would not have been able to do that without having preserved her fertility.

As women, we are perhaps the first or second generation in our families to become financially independent. I

believe biological independence is the next step.

After several IVF cycles, I was told that I might need an egg donor. I was shocked because I did not even know that was an option. That experience made me feel that women need to know that these choices exist. Ultimately, it is their decision.

Today, around 30 per cent of IVF cycles are donor cycles. Awareness around fertility preservation and reproductive options therefore needs to improve.

Is cost also a major barrier to the uptake of fertility preservation and IVF?

Absolutely. Cost is definitely a factor. These are treatments that require financial planning.

But there are ways to address it. The cost can be broken down and paid through EMIs. Corporates can also contribute. If women are building careers and contributing to an organisation, companies could consider fertility benefits, including funding a portion of an egg-freezing programme.

In the US, fertility benefits are an important factor in decisions around changing jobs. If an employee can receive a funded IVF or egg-freezing cycle, that becomes a meaningful benefit. I see this gradually coming into India as well. We work with corporates that fund IVF and egg-freezing cycles for their employees.

At Luma, we have also

tried to simplify the way egg freezing is discussed. Instead of telling women that they may need multiple cycles without giving them a clear objective, we looked at the numbers and created a programme targeting 12 eggs.

We have structured the programme at Rs 3 lakh, including two years of freezing, with EMI options. The idea is to create an integrated model and pricing structure that makes the treatment more financially manageable.

What parameters should fertility providers be tracking to give patients and the industry a more meaningful picture of outcomes?

The industry needs to track success rates and, more importantly, live birth rates, rather than simply reporting a success-rate number.

India does not currently have a standardised registry like the US or UK, where clinics report their numerator and denominator. There are also different definitions of what constitutes success. Is it beta-hCG? A heartbeat?

Pregnancy? Live birth? Is it based on embryo transfer or another parameter? There are many variables. In the absence of a standardised reporting framework, every IVF provider should ideally break down its success rates and track outcomes through to live birth rather than

stopping at pregnancy rates.

At Luma, we are also planning to publish our live-birth outcomes. Transparency needs to include failed IVF cycles as well. You cannot only report successful outcomes. Patients need to see the complete picture.

We try to break down our success rates across different stages and provide a transparent view of outcomes.

But there is another dimension that is often overlooked: the patient experience. Nobody is really measuring that.

A patient does not want to be treated like a file. She wants to be treated like a human being. Are we measuring waiting times, convenience, empathy, transparency and clarity? I think there needs to be much greater focus on these parameters as well.

What needs to change for the fertility sector to scale without compromising clinical standards?

The last two decades have been about improving success rates. The next phase needs to focus on scaling that clinical quality while maintaining standards across centres.

As fertility providers expand, standardisation, transparent outcome reporting and consistent clinical protocols will become increasingly important. Technology will also have a role to play in making care more consistent and easier to navigate.

Where do you see technology genuinely changing clinical decision-making in IVF, and where should its role remain limited?

Technology can play a significant role in scaling care and managing clinical pathways. But ultimately, AI and technology should be evaluated based on what they can do for the patient.

Today, we have apps for almost everything in our lives. Fertility is a particularly time-sensitive journey. Patients have to take injections and medicines at specific times, often linked to their menstrual cycle.

So why shouldn't there be a patient-facing app for this journey?

At Luma, our patient-facing app tells patients where they are in their treatment journey and what is going to happen next. Their reports are available in one place, so they do not have to carry physical files.

The app also creates a calendar for injections, medicines and reminders. On the backend, there is a technology platform that helps doctors navigate the patient journey.

The objective is not to replace clinical judgement, but to use technology to make a complex, time-sensitive treatment journey easier for both patients and doctors.

Kalyani.sharma@expressindia.com
journokalyani@gmail.com



When it comes to nourishing this sector, experts prescribe a regular diet of Express Healthcare. The magazine has been the source of a healthy dose of expert information, incisive category analysis and remedies for industry ailments since 20 years, thereby earning the trust of industry professionals. It's no wonder then that the finest in the field trust the foremost in the field.

EXPRESS HEALTHCARE
www.expresshealthcare.in



VOL. 11, ISSUE 14
EXPRESS HEALTHCARE
INDIA'S FOREMOST HEALTHCARE MAGAZINE SINCE 2006
FEBRUARY 2026
Start-ups
Aditya Vuchi
General Practice, Urology

THE HOMEWARD SHIFT IN CANCER CARE

Advances in Cancer treatment have improved survival, but only if the need for supportive care is recognised. India is embracing a paradigm shift toward home-based oncology services.

LEADERSHIP

INTERVIEW

From first response to system ownership

Dr Sandeep Gore, Director-Emergency Medicine, Fortis Hospital Mulund, Mumbai, and Chairman, Emergency Medicine Council, Fortis Healthcare, speaks to **Kalyani Sharma** about the evolution of emergency medicine in India, the need for trained manpower and stronger pre-hospital care, and how technology can help build a more responsive emergency care system

You have seen emergency medicine evolve considerably during your career. How has your own journey evolved from treating individual emergencies to building a system?

I trained in emergency medicine at Christian Medical College (CMC), Vellore, which has a very high volume of emergencies. That is where I developed my core skills, including intubation and ventilation, inserting lines and intercostal drains, and stabilising polytrauma patients.

After CMC, I joined Jahangir Hospital, Pune, as a consultant with independent clinical decision-making authority. That was my first opportunity to apply these skills independently. One of the early experiences that gave me confidence was a prolonged CPR case where the patient achieved return of spontaneous circulation and eventually walked out of the hospital. We were also among the first teams to reach and rescue patients during the German Bakery blast in Pune.

A resuscitation case we handled was later reported in the media, and that's what brought me to Fortis's attention. I joined Fortis in 2011.

We had several prolonged CPR cases at Fortis, including patients who were revived after 40-45 minutes of CPR without neurological deficits. Saving a patient and seeing that person walk out of the hospital on their own legs seven or eight days later gives you a gratification that is difficult to find elsewhere.

That was the individual



excellence part of my journey. But we realised that this level of care had to be available around the clock. Emergency medicine cannot depend on one individual being present 24 hours a day. The same standard of care must be delivered irrespective of the time.

So, we built an emergency medicine team, developed protocols and invested extensively in training doctors and nurses. We also started tracking outcomes.

For example, in acute heart attack cases, revascularisation has to happen within the recommended time frame. Over the last year, in more than 90 per cent of our relevant cases, we achieved door-to-balloon times within 90 minutes. Our emergency department also recorded no heart attack deaths in

calendar year 2025.

Emergency medicine is not a one-man show. If I perform CPR and the patient survives, it is a collective effort involving doctors, nurses and the entire team. Building a self-sustaining system is therefore very important.

Today, we have 18 doctors in our emergency department, including some of our former students who are now consultants. When you train people, they carry forward the approach and mindset they have learnt.

When you entered emergency medicine, emergency departments in India were very different from what they are today. What was the turning point that helped establish emergency medicine as a specialty in its own right?

I found emergency medicine exciting because you are working at the border between life and death. At that time, however, there was no established concept of emergency medicine as a specialty in India. I learnt that the first emergency medicine department had been established at CMC Vellore and decided to train there.

The importance of emergency medicine is clear because any delay in evaluation, diagnosis or treatment can increase mortality and morbidity. The major change came when emergency medicine received specialty status in 2009. But the emergency medicine movement began well before that; it has always been a movement for the people, by the people, of the people.

Earlier, in many places, the emergency department was essentially a transit point, with junior doctors assessing patients and directing them elsewhere. Once emergency medicine became an established specialty, trained clinicians began taking ownership of the patient and ensuring that time-bound care happened.

That ownership culture has been the game changer.

Take a STEMI patient; when someone comes in with chest pain, it's our job to do the ECG and relevant tests, diagnose, stabilise, involve the cardiologist early, and ensure timely revascularisation.

Emergency medicine is increasingly being recognised as a resuscitation-based specialty dealing with some of the most decisive moments in a patient's care.

What are the biggest gaps that India needs to address now?

The biggest challenge is skilled manpower.

You can build an emergency department and equip it with high-end technology, but equipment alone cannot deliver outcomes. You need doctors and nurses who are trained to use that infrastructure effectively.

Infrastructure can be built relatively quickly if resources are available. Building a highly competent emergency medicine workforce takes years. There is no shortcut to developing clinical judgement, resuscitation skills and the ability to make decisions under time pressure.

I've personally discussed the emergency medicine demand-supply gap with NITI Aayog, focusing on the need to expand training capacity and create more emergency medicine programmes.

The other major challenge is pre-hospital care.

Suppose someone develops a heart attack on the 40th floor of a building. Ideally, a trained emergency response team should reach that patient quickly. But in cities such as Mumbai, traffic can make this extremely difficult. In many Western countries, ambulances have dedicated lanes and can reach patients within defined response times.

India needs to strengthen the entire chain, from pre-hospital care to the hospital emergency department.

You describe the modern emergency department as a

command centre. What does that mean in practice?

The modern emergency department is no longer simply the first point of contact. It is the most decisive point of contact.

Take a patient with a heart attack. We also track the outcome. How quickly are we diagnosing these patients? How many are being revascularised within the recommended time? That is what quality means.

The same applies to stroke. In stroke, time is brain. Every minute of delay can result in the loss of millions of neurons. When a patient presents with suspected stroke, we immediately activate the imaging pathway so that appropriate treatment can be initiated quickly.

Another example is breathing difficulty. The cause could be asthma, anxiety, pulmonary embolism or several other conditions. Point-of-care ultrasound (POCUS) can help us rapidly identify certain conditions and guide further investigation. In polytrauma, we need to control bleeding, stabilise the airway and circulation, identify serious injuries and activate appropriate teams. If there is significant blood loss, a massive transfusion protocol needs to be activated.

POCUS is increasingly becoming a visual extension of the stethoscope. We can put the probe on the chest, heart or abdomen and rapidly assess what may be happening.

It is an adjunct to clinical judgement, not a replacement for it. Its value is also that it can help us see changes in real time. That is what I mean by the new-age emergency department.

How can emergency medicine reach rural and district-level healthcare facilities?

Emergency medicine cannot be limited to large tertiary hospitals. It must extend from the village to the district hospital and then to the tertiary centre.

At the village level, a primary healthcare doctor should be able to manage common emergencies and stabilise patients before transfer. Rural and district hospitals need competent emergency teams so that more patients can be treated locally instead of being referred unnecessarily.

The principle should be - refer less, resolve more.

For example, a snakebite occurring in a village should ideally be treated there rather than automatically transferring the patient to a distant tertiary centre. Similarly, a patient with acute gastroenteritis who primarily requires fluids should not necessarily need a tertiary hospital.

The demand-supply gap is stark; India likely has only 10-15 per cent of the emergency medicine workforce it needs. We need to expand training capacity and create more programmes, with path-breaking measures to close this gap faster than the current pace allows.

India needs an integrated emergency care system comprising pre-hospital care, rural emergency care, district hospital emergency care and tertiary emergency care. This requires both infrastructure and trained manpower.

Where can technology help bridge these gaps?

Artificial intelligence has a significant role to play, particularly in situations where there are grey areas and a senior clinician may not immediately be available.

A junior doctor may be uncertain about a particular decision. An AI-based system, working under appropriate clinical supervision, could support decision-making using established algorithms and clinical information.

Telemedicine is another important area. It can allow doctors in smaller centres to access expert opinion. Data tracking is equally important.

Technology can help through AI, telemedicine, POCUS, simulation-based

training and data systems. We also need district-level emergency command centres, similar to existing 24x7 toxicology helplines, where doctors in smaller centres can share an ECG or clinical parameters with an experienced emergency physician for real-time guidance.

Can India develop emergency care models suited to its own scale and disease burden?

Yes. India has its own challenges and opportunities.

But the Indian context is different from the Western context. Our emergency departments are often crowded and do not operate in a controlled environment.

At the same time, India has a major advantage: patient volume and clinical diversity.

We follow guidelines from organisations such as the American Heart Association and the European Society of Cardiology, but we also need to track what happens when those guidelines are applied in the Indian setting.

Our biggest opportunity is data. Every day, Indian EDs resuscitate large numbers of patients, but few of these experiences are documented and published. It's not that the work isn't happening; it's that we're not capturing and sharing enough of it.

India already contributes through research, simulation-based training, POCUS and advanced capabilities like ECPR. With our patient volume and diverse disease burden, systematically documenting outcomes could position India as a major contributor to global emergency medicine learning.

You are also a high-altitude mountaineer. Has that experience influenced how you practise emergency medicine? And what gives you the greatest satisfaction today?

High-altitude mountaineering and emergency medicine are both passions of mine, and the

parallels between them run deep.

I have climbed to around 6,153 metres in Ladakh and have been part of several Himalayan expeditions.

Before climbing a mountain, you have to understand the challenge in front of you. You study the route, terrain and weather, assess your fitness, select the right equipment and develop backup plans.

The same mindset applies to emergency medicine.

If I need a skill, say, advanced resuscitation, I have to prepare for it and prove I can perform it. You can't just say you know how to insert a line or intubate a patient. You have to develop the skill and demonstrate it.

There is also a fear factor in both situations. When you are climbing at 6,000 or 7,000 metres, you are aware of the risks. In emergency medicine, you are also dealing with life-and-death situations. You have to manage that fear and still make an objective decision.

I have fallen into a crevasse and was pulled out by two colleagues. You have moments where you have to decide whether to continue or turn back. That mindset has stayed with me.

In emergency medicine, you have to make decisions in limited time, explain the situation to the family, involve them in the decision-making process and execute the plan.

The greatest satisfaction today comes when doctors whom I have trained save a patient's life. Recently, one of our doctors told me about a patient who arrived with an unrecordable blood pressure. She stabilised the patient and achieved a good outcome. When someone you have trained is able to independently manage such a situation, it gives you a different kind of satisfaction. I call it vicarious joy.

I can relate this to mountaineering as well. My 13-year-old son recently climbed two mountains, including Kedarkantha and Kuari Pass. When he summited, I felt the same

kind of happiness that I would have felt from my own summit.

What gives me optimism is the interest among young doctors, their willingness to learn and the resuscitation capabilities I've seen across the country give me real hope for the field.

Almost every hospital has a success story involving its emergency medicine team.

That gives me a very optimistic view of the future. I believe the next 10-15 years of modern medicine will see emergency medicine play an increasingly important role.

You have been involved in building and standardising emergency care across the Fortis network. Based on this experience, what should be the priorities for Emergency Medicine in India over the next few years?

The future of Emergency Medicine is not about creating a few excellent Emergency Departments it is about creating systems of excellence. Across our network, we have standardised pathways for STEMI, stroke, sepsis and trauma, created outcome-based dashboards, strengthened resuscitation and POCUS capabilities, and used clinical governance to continuously improve care.

India now needs the same approach at scale: stronger pre-hospital care, standardised Emergency Departments, trained emergency physicians and nurses, regional networks for time-critical emergencies, and national quality benchmarks.

Most importantly, we must move from measuring infrastructure and volumes to measuring outcomes time to treatment, survival and quality of care.

My vision is simple: wherever an emergency occurs in India, the patient should receive the right care, at the right place, at the right time.

Kalyani.sharma@expressindia.com
journokalyani@gmail.com

India has built the healthcare network. Now it must build the last mile

Dr Huzaifa Khorakiwala, Trustee and CEO, Wockhardt Foundation, looks at why India's next healthcare challenge is improving last-mile access, connecting existing infrastructure and ensuring continuity of care for underserved communities

The Indian healthcare story in the last decade has been one of phenomenal growth. The nation has expanded its healthcare capacities considerably, improved its primary and preventive care systems, enhanced the level of financial coverage, improved diagnostic facilities, and has entered into the world of digital health which can connect patients with the providers and medical record systems across borders. But, despite these developments, there is still the problem of the serious discrepancy between the health care available and the health care accessible. So the challenge now is not just to provide more health facilities, but to make the existing facilities easier to access and use.

What's the real meaning of the last mile?

For a family living in a remote village, a health centre may exist on paper but still be difficult to reach because of distance, transport, work commitments or the absence of someone who can accompany an elderly patient. A teleconsultation may connect a patient to a specialist, but the patient may still need a diagnostic test, medicines or a physical examination. A government scheme may provide financial protection, but a family may not know where to go, which facility is empanelled or how to complete the process. Healthcare access is therefore not a single point. It is a chain. If even one link is weak, the patient journey can break. India has already built many of those links. The next step is to connect them better.

The measure of last-mile healthcare should therefore shift from people reached to care successfully completed.

Community health workers can become the missing navigation layer

India already has one of its strongest last-mile assets in its community health workforce. ASHA workers and other frontline workers have demonstrated that healthcare becomes more effective when there is a trusted person between the system and the household. During the pandemic and in chronic disease programmes, community workers helped maintain treatment and follow-up for patients who could not routinely travel to facilities. WHO has documented examples in India where ASHA workers supported doorstep delivery of medicines and helped achieve continuity of hypertension care despite transport constraints.

This model can be expanded

The frontline worker of the future should not be viewed only as someone responsible for awareness or mobilisation. With appropriate training and digital support, that worker can become a health navigator: helping families understand available services, scheduling appointments, tracking referrals, reminding patients about follow-ups and identifying when a condition requires escalation. Technology can make this role considerably more effective without replacing the human relationship that makes it work.

Digital health must meet people where connectivity and confidence meet

India has shown that digital health can work at remarkable scale. eSanjeevani has brought specialist consultations closer to underserved communities,



while the Ayushman Bharat Digital Mission is building a more connected and portable health ecosystem. The next step is to make these systems easier to use for people who may not be digitally confident.

Digital healthcare should therefore be built around assisted access. Community health workers, local health centres, pharmacies and outreach clinics can help patients create digital health identities, access records, book teleconsultations and navigate referrals. The goal is simple: technology should remove a journey, not create another one.

Diagnostics and medicines are as important as doctors

Healthcare access is not only about having doctors and hospitals nearby. A patient's care can still be disrupted if essential diagnostics are unavailable, medicines are out of stock or reports do not move with the patient between facilities. The last-mile agenda must therefore strengthen diagnostics, medicines and logistics alongside clinical care. Mobile diagnostic services, decentralised sample collection, hub-and-spoke laborato-

ries and reliable medicine supplies can reduce repeated travel and treatment delays. The guiding question should be simple, "What can be taken to the patient, rather than what must the patient travel to find?"

Referral systems need to close the loop

A referral should not end with a patient being handed a piece of paper. A stronger system would track the entire journey, with every referral linked to a destination, timeline and follow-up. Digital tools can help monitor whether patients reach the next facility, while community health workers can support those who need help completing the journey. The goal should be a coordinated patient pathway, with public institutions, private providers, civil society and technology platforms connecting their strengths rather than working in isolation.

The next frontier is continuity, especially for chronic disease

India's growing burden of hypertension, diabetes, cardiovascular disease and cancer requires care that continues beyond a single consultation or health camp. For many patients, especially in remote communities, the journey involves screening, diagnosis, medication, monitoring and periodic specialist care over years. A practical answer is a hybrid care model that combines community-level screening and follow-up, primary care closer to home, teleconsultation for specialist advice and physical referral when needed. India does not need a specialist in every village. It needs a system that ensures every village can reliably reach

the right specialist when required.

Last-mile healthcare should also be designed around dignity

Accessibility is not only about geography. An elderly person may struggle with multiple counters and long queues. A person with disability may need physical accessibility. A woman may require a female health worker or greater privacy.

A migrant worker may need services that remain accessible outside the home state. Someone with limited literacy may need information in a local language and through channels beyond written instructions. These are not peripheral considerations. They determine whether a healthcare service is actually used. The next phase of healthcare design must therefore ask a more human question and that is "Can a person navigate the system without needing privilege, familiarity or a personal network?"

Measure the distance between the patient and the outcome

India's next healthcare priority should be to measure not just infrastructure created, but care actually completed from referrals and diagnostics to continuous medicines and follow-up. Hospitals, specialists and digital platforms remain essential, but so are community health workers, mobile clinics and local diagnostics that connect patients to them. The next breakthrough will not simply be another facility or technology; it will be ensuring that every patient can reach the right care, at the right time, wherever they live.

What the BRICS New Delhi Declaration means for the next phase of healthcare

Dr Vikram Thaploo, CEO, Apollo TeleHealth, outlines how telehealth, connected care and responsible use of AI can help translate this digital foundation into more coordinated and accessible healthcare

Healthcare access can no longer be seen just in terms of the existence of a doctor or hospital near where a patient lives. The bigger challenge lies in ensuring that people find the right medical expert and receive timely treatment despite the absence of that expert in their vicinity. Technology has increasingly been playing a role in bridging that gap by connecting patients with doctors over geographical distances.

The BRICS New Delhi Declaration makes this development clear.

It was adopted officially at the 18th BRICS Summit and urges the members to work together in the fields of people-oriented digital healthcare systems and the principles of the BRICS Compendium on Digital Health Architecture for Continuum of Care which includes access to healthcare in remote areas.

For India, this is particularly relevant. The country has built significant digital health foundations, but the next challenge is to connect these capabilities into a more continuous care ecosystem. Telemedicine should not be viewed simply as a video consultation. Its greater value lies in connecting patients, clinicians, diagnostic services and specialists across different points of care.

Throughout the country, practices in telehealth are showing how it is possible to make specialised medical expertise available beyond hospital walls. Tele-radiology, tele-cardiology, tele-ICU, tele-consultations, and connected disease management programs can provide useful remote medical services in small towns and socially deprived areas. What is required



The next phase of India's digital health journey should focus on scalable, interoperable and clinically meaningful solutions. Telemedicine can extend reach, connected care can strengthen continuity, and AI can augment the capabilities of healthcare professionals

now is to combine remote healthcare services into a single continuum instead of treating each digital patient intervention as a separate service.

A patient may begin care at a primary facility, require diagnostic evaluation, need specialist advice and then require regular monitoring. If these interactions remain disconnected, technology can create more digital touchpoints without necessarily improving the patient journey. Interoperable systems, digital health records and secure information ex-

change can instead allow relevant clinical information to move with the patient.

While AI can play an important role in enhancing this ecosystem, its role ought to be confined to the enhancement of clinical capabilities and not the replacement of human judgment in the matters pertaining to medicine. AI can be of use in huge data analysis, identifying many patterns, assisting in the risk assessment process, helping in the process of clinical decision-making, and allowing intervention at a much earlier stage.

India has also moved towards creating the governance architecture required for responsible health AI. In 2026, the Ministry of Health and Family Welfare launched the Strategy for Artificial Intelligence in Healthcare for India, or SAHI, and the Benchmarking Open Data Platform for Health AI, or BODH. These initiatives emphasise safe, ethical, evidence-based and inclusive adoption, alongside validation, data stewardship and monitoring.

This is critical because healthcare AI cannot be as-

sessed only by technological performance. Solutions must work across diverse populations and clinical settings, protect patient privacy and remain subject to appropriate clinical oversight. Trust will be as important as innovation.

The opportunity for BRICS is therefore not simply to exchange digital tools, but to share implementation experience, standards, evidence and models that can make technology meaningful at scale. Countries across the grouping face common challenges around specialist availability, chronic disease, rural access and health-system resilience. Collaboration can help translate successful digital health approaches into models suited to different healthcare contexts.

The next phase of India's digital health journey should focus on scalable, interoperable and clinically meaningful solutions. Telemedicine can extend reach, connected care can strengthen continuity, and AI can augment the capabilities of healthcare professionals. Together, these technologies can help move healthcare from episodic access towards more proactive and coordinated care.

Final thoughts

Ultimately, the success of digital health should not be measured by the number of platforms or algorithms deployed. It should be measured by whether patients receive care sooner, clinicians have better information to make decisions, follow-up becomes more consistent and quality healthcare becomes accessible irrespective of where a person lives. The BRICS New Delhi Declaration provides an important platform for advancing that vision at scale.



IFB

**WASHES FROM
11 KG TO 130 KG**

Bulk laundry solutions for total peace of mind
———— **COMMERCIAL LAUNDRY SOLUTIONS** ————



-  Impeccable hygiene
-  Water savings
-  Manpower savings
-  Quick turnaround
-  Higher productivity



COMMERCIAL LAUNDRY RANGE		COMMERCIAL DISHWASHING RANGE		24x7 SERVICE ACROSS INDIA	COMMERCIAL ESSENTIALS
 Washer Extractor	 Tumble Dryer	BIS CERTIFIED  Made in Italy		 IFB CARE Always at your service. Anytime. Anywhere. 24x7	
 Flat Work Ironer	 Finishing Equipments	 Undercounter Glass Washer	 Undercounter Dishwasher		
		 Hood Type Dish Cum Bottlewasher	 Rack Conveyor Dishwasher	Nationwide Service Network 110+ trained engineers across India	 Scan here to visit our website
				Spare Parts Always Available Inventory maintained at all major towns	
				AMC & CAMC Options Flexible maintenance packages for peace of mind	

☎ 080 45845678 / +91 95139 91116 ✉ query_industrial@ifbglobal.com 🌐 www.ifbappliances.com



Ami Polymer
Enabling Healthcare

PRECISION SILICONE COMPONENTS FOR RESPIRATORY CARE

Ami Polymer develops customized silicone components for CPAP, BiPAP and APAP devices, supporting medical device manufacturers with precision-engineered solutions for critical respiratory applications. From mask cushions and water chamber seals to tubing connectors and other custom components, our silicone solutions are designed to deliver dependable performance, flexibility and sealing integrity.

CUSTOMIZED TO YOUR REQUIREMENTS

From concept to component, Ami Polymer works with CPAP device manufacturers to develop tailor-made silicone solutions aligned with specific design and application requirements.

CPAP / BiPAP / APAP



www.amipolymer.com
media@amipolymer.com



**EXPRESS
HEALTHCARE**



Note:
Payment should be made in the name of
"The Indian Express (P) Ltd."
DDs should be payable at Mumbai.

Please mail to:
Subscription Cell,
Express Healthcare,
Business Publications Division,
The Indian Express (P) Ltd.,
Mafatlal Centre, 7th floor, Ramnath Goenka Marg,
Nariman Point, Mumbai - 400021
Mob.: 9867145028 / 8879199787
E-mail: rajesh.bhajnrik@expressindia.com

Copies will be sent by ordinary post only

Subscribe Online

www.expresshealthcare.in

SUBSCRIBE NOW!!!

Yes! I Want to ☐ **Subscribe** ☐ **Renew**

Tick Terms	NewsStand Price	Subscription Offer	You Save
☐ 1 year { 12 issues }	₹ 600/-	₹ 500/-	₹ 100/-
☐ 2 years { 24 issues }	₹ 1200/-	₹ 990/-	₹ 210/-
☐ 3 years { 36 issues }	₹ 1800/-	₹ 1400/-	₹ 400/-

International Subscription rate for 1 year US \$ 100

Mailing Address:

Name: _____ **Subscription No:** _____

Company Name: _____ **Designation:** _____

Address: _____

City: _____ **State:** _____ **Pin:** _____

Phone: _____ **Fax:** _____ **Mobile No:** _____

E-mail: _____

Payment enclosed Cheque/Demand Draft No.: _____ **Dated:** _____

For ₹.: _____ **Drawn on:** _____

For Office Use: _____

Bp No.: _____ **Order No.:** _____

Docket No.: _____ **Period.:** _____

Email: rajesh.bhajnrik@expressindia.com ■ Contact No.9867145028

Company Name-The Indian Express (P) Ltd, Company Address-Mafatlal Centre,7th Floor,Ramnath Goenka Marg, Nariman Point, Mumbai-400021. Bank Name-HDFC Bank Ltd

● Bank Address-C-5/32, Safdarjung Development Area (SDA), New Delhi-110016.

● Account -00328630000075 ● Swift Code-HDFCINBB ● IFSC -HDFC0000032 Account Type-Current

Neusoft Medical Systems | **TRUEVIS**

GLOBAL IMAGING TECHNOLOGY

Advanced Imaging Solutions
Powered by Innovation. Driven by Excellence.



PET/CT

Precision in
Molecular Imaging



MRI

Exceptional Clarity.
Unparalleled Comfort.



CT

Speed. Accuracy.
Confidence.



DSA

Real-time Precision.
Better Outcomes.



www.truevistech.com



contact@truevistech.com



Manufacturing Excellence
at AMTZ, Visakhapatnam

Make In India, For The India & World

World-class manufacturing facility
delivering advanced imaging solutions
from India to the world.



Advanced
Manufacturing
Excellence



AMTZ,
Visakhapatnam



Global Standards.
Indian Strength.



Innovating Today.
Transforming
Tomorrow.



www.truevistech.com



contact@truevistech.com



www.medicalfair-india.com

India's No.1 Trade Fair For Hospitals, Health Centres and Clinics

**Connect, Witness &
Lead the Future of
Healthcare**

13-15 March 2027

Hall 4 & 5, Bharat Mandapam
(Pragati Maidan) New Delhi

20-22 August 2027

Hall 2 & 3, Bombay Exhibition Center
Goregaon (E), Mumbai



Special Features



AiMed - Make In India Pavilion



Clin Lab / IVD Pavilion & Conference



Future for Health Digital Health Start-up
Pavilion & Conference



Dedicated Platform for
Raw Materials, Components, Machinery, Services
& MedTech Manufacturing Solutions
MMI Pavilion & Conference



International Conferences



MT India Healthcare Awards

Show Highlights 2027



15,500 m²
Exhibit Area



500+
Exhibiting Brands
from 14+ Countries



18,000+
Visitors from
30+ Countries



450+
Delegates



4
International
Conferences

For more information, please contact: Adarsh Verma, Director - Projects | VermaA@md-india.com | 91-124-4544 507

An initiative by



Supported by



Media Partner



Building the Infrastructure Behind Medical Imaging

Truevis Technologies and Neusoft Medical Systems strengthen India's medical imaging service ecosystem with a strategic spare-parts and service hub in Chennai

As India's healthcare infrastructure continues to expand and the adoption of advanced diagnostic technologies accelerates, the availability of reliable service support is becoming increasingly important. For hospitals and diagnostic centres, the performance of sophisticated imaging equipment depends not only on the technology itself, but also on the timely availability of technical support, maintenance services and critical spare parts.

Recognising this need, Truevis Technologies Pvt. Ltd., in collaboration with Neusoft Medical Systems, has established a strategic service and spare-parts hub in Chennai to strengthen the management and distribution of medical imaging spare parts, components and accessories across India.

The Truevis - Neusoft Mega Hub in Chennai is designed to support hospitals, diagnostic centres and healthcare institutions operating advanced medical imaging systems, including CT, MRI, PET/CT and other diagnostic technologies.

Strengthening the Service Infrastructure

The initiative represents an important step in building a more responsive and organised support infrastructure for medical imaging across the country.

As healthcare providers increasingly deploy advanced imaging systems, dependable access to technical support and critical components becomes essential to maintaining operational continuity. The Chennai Mega Hub has been established to address this requirement by bringing essential inventory closer to the Indian market and creating a more structured distribution network.

The facility builds on Truevis' existing India-wide support network and



complements its established facility in Visakhapatnam, creating a stronger and more connected infrastructure for customers across the country.

The Chennai facility will serve as a central point for receiving, managing and distributing medical imaging spare parts and accessories, based on demand from customer locations.

Connecting Global Sourcing with Pan-India Distribution

At the heart of the initiative is an integrated supply-chain model that connects international sourcing with centralised inventory management and pan-India distribution.

Parts, tubes and accessories sourced from China can be consolidated and brought into India through the Free Trade Warehousing Zone (FTWZ) ecosystem, enabling structured customs processing, inventory management and onward distribution from Chennai.

Through this model, components can be dispatched to hospitals, diagnostic centres and healthcare institutions as required.

The streamlined flow from global sourcing to the Chennai Mega Hub, followed by inventory management and nationwide distribution is designed to make the availability of critical components more predictable and efficient.

For service teams, this creates a centralised mechanism through which required components can be received,

managed and moved to customer locations based on demand.

Moving Beyond Equipment Supply

The establishment of the Mega Hub also reflects a broader shift in the medical imaging industry from simply supplying equipment to building the complete service infrastructure required to support that equipment throughout its operational lifecycle.

For healthcare providers, the value of sophisticated medical imaging technology ultimately depends not only on the performance of the equipment, but also on the availability of timely and dependable support.

A critical component that is unavailable when required can have implications for service timelines and equipment availability. By positioning inventory closer to the Indian market and creating a structured distribution network, the Chennai Mega Hub is intended to strengthen the supply-chain infrastructure supporting advanced imaging systems.

Demand-Driven Inventory Management

A key element of the Chennai facility will be demand-driven inventory management.

The Mega Hub will monitor consumption patterns and requirements to maintain appropriate stock levels and enable timely replenishment. This approach is intended to improve inventory visibility, strengthen

supply-chain readiness and reduce the risk of critical parts becoming unavailable when required.

The facility will also support structured processes for returned and defective components, integrating forward distribution with reverse logistics.

This creates a more organised flow of components across the lifecycle from sourcing and inbound movement to inventory management, customer dispatch, returns and handling of defective parts.

A Connected National Support Network

The Chennai Mega Hub complements the existing facility in Visakhapatnam and strengthens the broader service infrastructure supporting Truevis and Neusoft's medical imaging ecosystem in India.

Chennai's strategic position as a major logistics and business gateway further strengthens its role in connecting the Mega Hub with customer locations across the country.

The facility will enable inbound shipments, inventory management and outbound distribution to be coordinated through a structured logistics framework, supporting service teams in accessing and moving components where they are needed.

This connectivity is particularly important as advanced imaging technologies become increasingly widespread across India and healthcare institutions place greater emphasis on equipment availability, service responsiveness and lifecycle support.

Supporting Continuity of Advanced Imaging Services

The initiative comes at a time when advanced diagnostic technologies are becoming increasingly important to clinical decision-making and healthcare delivery across India.

As the installed base of sophisticated imaging equipment grows, the supporting ecosystem around these technologies becomes equally important. Reliable access to components, structured logistics, technical support and maintenance services can play a critical role in ensuring that healthcare institutions are able to operate their imaging infrastructure effectively.

Building the Infrastructure Behind Healthcare Technology

The Chennai Mega Hub represents more than an additional inventory location. It is part of a broader effort by Truevis Technologies and Neusoft Medical Systems to strengthen the infrastructure that supports medical imaging technology across India.

By combining international sourcing, centralised inventory management, demand-driven distribution, reverse logistics and an established national support network, the initiative is designed to create a more connected and responsive spare-parts ecosystem.

For hospitals, diagnostic centres and healthcare institutions, the objective is straightforward: ensuring that the infrastructure supporting advanced imaging technology is equipped to respond when and where it is needed.

As India's healthcare infrastructure continues to expand and advanced diagnostic technologies become increasingly important to clinical decision-making, dependable service support will remain a critical priority.

Through the Chennai Mega Hub, Truevis Technologies and Neusoft Medical Systems are investing in the infrastructure behind medical imaging technology, working towards a more connected, organised and responsive spare-parts ecosystem for healthcare institutions across India.

INS partners with Poly Medicure to advance clinical excellence through PACE

The partnership brings together the clinical expertise and professional network of INS with Polymed's commitment to clinical education and capability development through PACE

The Infusion Nursing Society (INS) and Poly Medicure Ltd. (Polymed) have signed a Memorandum of Understanding (MoU) to strengthen clinical knowledge and capability building among healthcare professionals through the Polymed Academy of Clinical Excellence (PACE).

As part of the collaboration, Poly Medicure will serve as the Knowledge Partner for INS through PACE, supporting access to clinical education, training and knowledge-sharing initiatives for INS members.

The partnership brings together the clinical expertise

The partnership brings together the clinical expertise and professional network of INS with Polymed's commitment to clinical education and capability development through PACE. The collaboration aims to foster continuous learning, promote knowledge exchange and contribute to advancing standards of infusion nursing and patient care.

and professional network of INS with Polymed's commitment to clinical education and capability development through PACE. The collaboration aims to foster continuous learning, promote knowledge exchange and contribute to advancing standards of infusion nursing and patient care.

Commenting on the partnership, Col Binu Sharma, CEO, Infusion Nursing Society, said: "We are delighted to partner with Poly Medicure and PACE in our shared commitment towards strengthening clinical knowledge and advancing infusion nursing practice. This collaboration will provide

a valuable platform for learning, knowledge exchange and professional development for our members.

Indranil Mukherjee, CEO - India & APAC, Poly Medicure, said: "We are pleased to collaborate with the Infusion Nursing Society as its Knowledge Partner through PACE. At

Polymed, we believe that advancing healthcare is not only about innovation in products and technology, but also about building clinical knowledge, skills and confidence among healthcare professionals. This partnership is an important step in our journey to create meaningful platforms for continuous learning and knowledge exchange, and to contribute to the advancement of infusion care and, ultimately, better patient outcomes."

The MoU will reinforce the shared commitment of both organisations to clinical excellence, continuous learning and better healthcare outcomes.

EXPRESS
HEALTHCARE
www.expresshealthcare.in



THE AID FOR THOSE WHO AID THE HEALTHCARE SECTOR.

When it comes to nourishing this sector, experts prescribe a regular diet of Express Healthcare. The magazine has been the source of a healthy dose of expert information, incisive category analysis and remedies for industry ailments since 20 years, thereby earning the trust of industry professionals. It's no wonder then that the finest in the field trust the foremost in the field.

Canon

***Aquilion** Start*

Quality care for all



Start with High-End Technology



ERBIS ENGINEERING COMPANY LIMITED

39 Second Main Road, Raja Annamalaipuram, Chennai - 600 028. Tel: 044 42961400 Mail ID : info@erbismedical.com

ERBIS ENGINEERING COMPANY LIMITED is an official distributor of Canon Medical Systems Corporation



"Affordable Diagnostics Systems. Africa & Worldwide"

DRIVING IMPACT IN AFRICA & BEYOND – OUR NEW MILESTONE AT

WHX NAIROBI 2026

(Formerly – Medic East Africa)

16th – 18th September, 2026

**Kenyatta International Convention Centre (KICC),
Nairobi, Kenya**

**WHX – World Health Expo, Nairobi is East Africa's
premier B2B healthcare and medical trade exhibition.**



Website : phantomhealthcare.com | Email : biz@phantomhealthcare.com
Mobile: +91-9899963601, +91-8384037073 | Phone: +91 129 4312423