

HEALTHCARE INDUSTRY REPORT

Market, Investment & Financing Landscape

India | with global benchmarking context

Prepared by Corporate Finance Team | September 2026

Table of Contents

1. Executive Summary	3
2. Indian Healthcare Industry Overview	5
3. Segment-Wise Healthcare Industry Analysis	10
3.1 Hospitals & Healthcare Delivery	10
3.2 Pharmaceuticals	10
3.3 Diagnostics	10
3.4 Medical Devices & MedTech	10
3.5 Health Insurance	11
3.6 Retail Pharmacy & E-Pharmacy	11
3.7 Biotechnology & Life Sciences	11
3.8 Digital Health, HealthTech & Allied Segments	12
4. Geographic & State-Level Analysis	13
5. Healthcare Investment and Funding Landscape	17
6. IPO & Capital Markets Landscape	24
7. Technology & Future of Healthcare	27
8. Key Investment Themes 2026–2030	33
9. Conclusion	37
10. Appendix — Healthcare Data Book	38

1. Executive Summary

India's healthcare industry is undergoing a structural transformation driven by rising healthcare expenditure, increasing insurance penetration, government-backed financing, digital infrastructure and rapid formalisation of fragmented healthcare delivery. The domestic healthcare market is estimated at **~USD 400–420 billion in 2025**, while healthcare expenditure remains relatively under-penetrated at **3.58% of GDP**, compared with a global average of 6.74%. Government health expenditure has increased to **~1.43–1.48% of GDP**, while out-of-pocket expenditure has declined from **64.2% to 43.4%** over the past decade, signalling a gradual shift toward organised and financed healthcare.

1.1 Key Market Indicators

Metric	Value	Period / Status
Domestic healthcare market size	~USD 400–420 bn	2025, estimate (base case)
Hospital delivery market	USD 193.4 bn → USD 364.6 bn (7.3% CAGR)	2025 actual → 2034 forecast
PM-JAY cumulative coverage	42+ crore cards; 9.64+ crore admissions funded	2018–2025, actual, cumulative
Health insurance gross written premium	₹1,27,417 crore (~USD 15.3 bn)	FY25, actual (IRDAI)
Core diagnostics market (pathology + radiology)	~₹1.1 lakh crore (~USD 13 bn)	2026, estimate
Domestic pharmaceutical market	~USD 60 bn → USD 130 bn target	FY25 actual → FY30 target (Economic Survey/PIB)
Healthcare IPO issuance	11 issues, ₹12,317 crore (incl. Manipal, ₹9,275 cr)	2025 / Aug 2026, actual

Note: figures are drawn from Sections 2, 3, 4 and 8 of this report; source-level detail, definitional caveats and reconciliation of conflicting estimates are set out in each respective section. Where two or more credible sources diverge materially, this report anchors on the more defensible, better-corroborated estimate and treats wider figures as directional context only.

1.2 Investment Landscape

Growth is being accompanied by **formalisation and consolidation**. Diagnostics and retail pharmacy remain highly fragmented, with organised players accounting for only a small share of the overall market. Hospitals are increasingly expanding through specialty formats, hub-and-spoke models and brownfield capacity additions, while pharma is seeing increasing investor interest in **specialty products, biosimilars and CDMO/CRAMS**. Healthcare capital markets are also deepening, with increasing IPO activity and greater differentiation between high-quality and weaker issuers.

1.3 Key Opportunities

- **Hospital & diagnostics expansion:** Capacity deficits and fragmented markets provide a long runway for organised players.

- **Tier-2/3 healthcare:** Significant gaps in organised healthcare infrastructure, particularly in high-demand states, create opportunities for hospital and diagnostics expansion.
- **Pharma & CDMO:** India's manufacturing base, China+1 diversification and specialty-product opportunities support export-oriented investment.
- **Healthcare consolidation:** Fragmented diagnostics and retail pharmacy markets remain attractive for platform-building and consolidation strategies.
- **Digital healthcare:** ABDM and other public digital infrastructure create opportunities in interoperability, analytics and healthcare enablement.

1.4 Key Risks

The sector remains exposed to **manpower shortages, regulatory uncertainty, high capital requirements and execution risk**. Pharmaceutical companies face increasing exposure to changes in global trade and US pricing/tariff policies, while e-pharmacy continues to face regulatory uncertainty. For investors and lenders, segment-specific unit economics, leverage, cash-flow visibility and regulatory compliance remain critical to assessing risk.

Overall Outlook

India's healthcare opportunity is increasingly a story of formalisation, consolidation and capacity creation rather than market growth alone. The strongest risk-adjusted opportunities are likely to emerge where **structural demand, fragmented supply, improving financing access and scalable unit economics** converge. Hospitals, organised diagnostics, specialty/CDMO pharma and underserved Tier-2/3 markets therefore remain key areas for capital deployment, subject to disciplined assessment of capital intensity, margins, leverage and execution capability.

Sources: this Executive Summary synthesises sourcing already cited in Sections 2, 3.1–3.8, 4 and 8, including NHSRC/MoHFW National Health Accounts (10th round); IRDAI Annual Report 2024-25; PIB/National Health Authority (PM-JAY, ABDM); Economic Survey 2025-26; World Bank/WHO Global Health Expenditure Database; IMARC Group, Ken Research, MarkNTel Advisors, Nexdigm and TechSci Research; and Business Standard/Capitaline, NSE Indices Factsheet and Simply Wall St.

2. Indian Healthcare Industry Overview

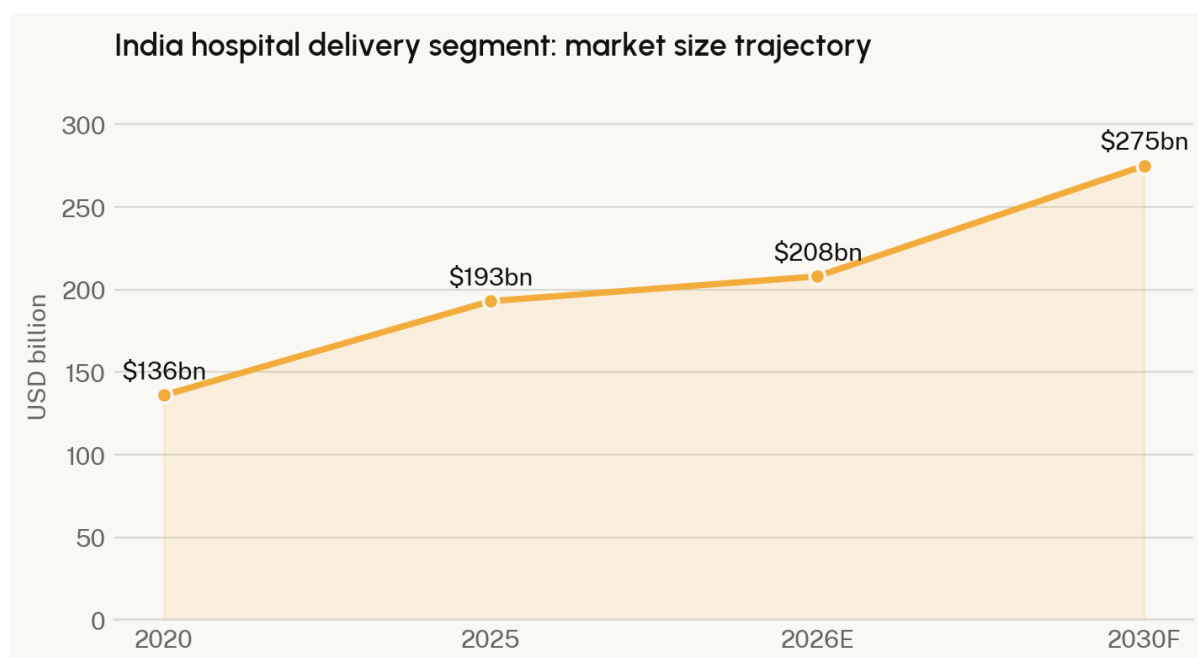
2.1 Evolution of the Indian Healthcare Sector

India's healthcare sector has moved through three broad phases. Until the early 1990s, delivery was overwhelmingly public, built around district hospitals and primary health centres under the Ministry of Health & Family Welfare, with private care limited to small nursing homes and solo practices. Post-liberalisation (1991 onward), corporate hospital chains — Apollo, Fortis, Max, Manipal — entered urban tertiary care, backed by rising disposable incomes and NRI capital, and private delivery began to outpace public capacity addition. The third phase, from roughly 2015 onward, has been shaped by three forces simultaneously: public health financing reform (Ayushman Bharat-PMJAY, 2018), private capital formalisation (PE/VC entry into hospitals, diagnostics and pharma), and digital disruption (telemedicine, e-pharmacy, health-tech platforms, accelerated by COVID-19).

Implication. The sector today is a hybrid system — a public backbone focused on primary care and catastrophic-cost protection, layered under a private, increasingly organised and consolidating delivery and financing ecosystem. This duality shapes almost every segment discussed in Section 3.

2.2 Market Size and Growth

Fact. An Indian Healthcare Market: Large, Growing and Increasingly Private-Led India's healthcare market is estimated at ~USD 400–420 billion in 2025 and is expected to expand significantly over the coming years, supported by rising healthcare consumption, increasing private-sector participation, infrastructure expansion and growing health awareness.



Source: IMARC Group, India Hospital Market Report. Figures are analyst estimates and forecasts, not government-audited data.

Implication. Overall market-size figures should be used directionally rather than as precise benchmarks in any valuation or financing context; the segment-level estimates in Section 3 are more reliable building blocks for financial analysis.

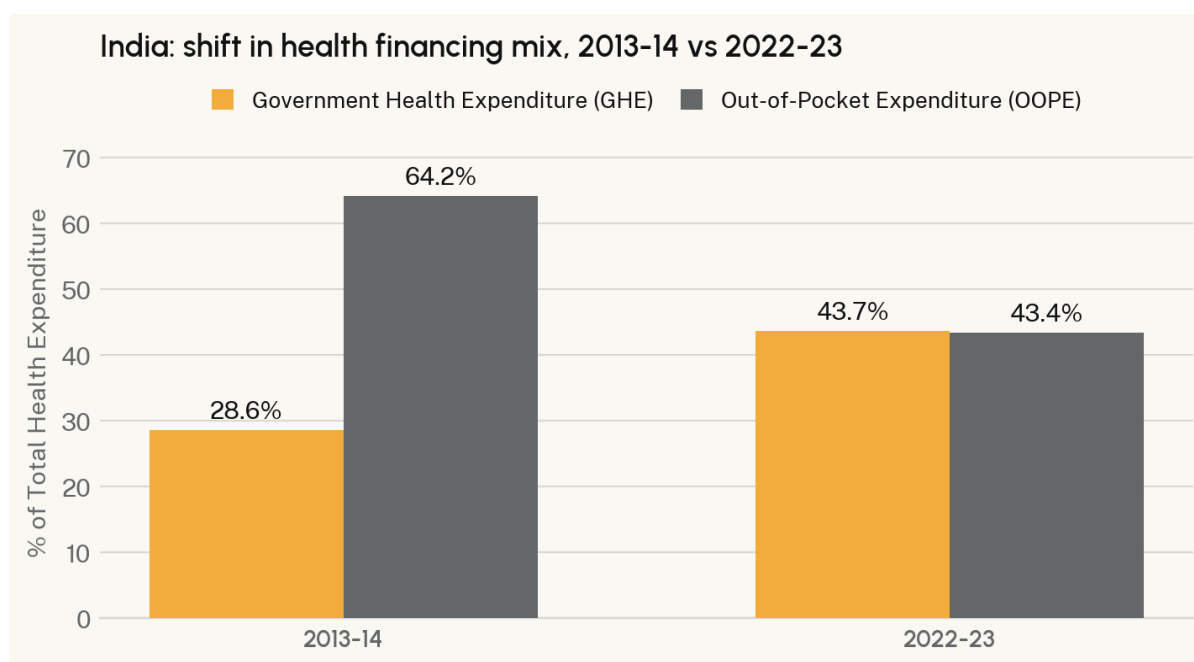
2.3 Healthcare Expenditure

India's National Health Accounts (NHA) — the government's official, internationally comparable expenditure series (System of Health Accounts, 2011 framework), published by the National Health Systems Resource Centre under the Ministry of Health & Family Welfare — released its 10th round covering 2022-23. Key figures:

Metric	2013-14	2021-22*	2022-23 (latest)
GHE, % of GDP	1.15%	1.84%	1.43% (1.48% revised base)
GHE, % of Total Health Expenditure	28.6%	48.0%	43.7%
OOPE, % of Total Health Expenditure	64.2%	39.4%	43.4%
Social Security Expenditure, % of THE	6.0%	8.7%	9.9%
GHE per capita	₹1,042	₹3,169	₹2,786

*2021-22 figures were elevated by one-time COVID-19 emergency response spending (ECRP-I/II, national vaccination programme) and should be read as a pandemic-period anomaly, not a new trend level. Source: National Health Accounts Estimates for India, NHSRC / MoHFW (10th round), PIB releases.

Analysis. Excluding the pandemic-distorted 2021-22 reading, the decadal trend is structural: GHE's share of GDP has risen from 1.15% to 1.43–1.48%, and its share of total health spending has grown by roughly 15 percentage points, driven by Ayushman Bharat–PMJAY and expanded primary care spending (₹0.5 lakh crore to ₹1.4 lakh crore over the decade). Correspondingly, OOPE's share of THE has fallen by roughly 21 percentage points over the decade.



Implication. The convergence of GHE and OOPE is the single most important structural financing shift in Indian healthcare over the past decade — a direct enabler of the hospital and diagnostics segment economics discussed in Section 3.

2.4 Public vs. Private Healthcare

Fact. Private hospitals account for 59% of India's hospital market by value, and private providers dominate outpatient and diagnostic volumes nationally, while the public system carries a disproportionate share of primary care, rural inpatient care and — since 2018 — secondary/tertiary care funded indirectly through Ayushman Bharat-PMJAY (over 42 crore health cards issued and more than 9.64 crore hospital admissions funded as of 2025).

Analysis. Government financing increasingly flows through private delivery infrastructure via PM-JAY empanelment, blurring the traditional public/private boundary and creating a quasi-public payer base for private hospital chains, particularly in Tier-2/3 markets.

Implication. Government scheme reimbursement (PM-JAY tariffs) is becoming a material, if lower-margin, revenue stream for private hospitals — a factor examined in the payer-mix and margin analysis in (Section 3.1)

2.5 Healthcare Penetration

India's healthcare infrastructure and workforce metrics remain well below global benchmarks on a per-capita basis, notwithstanding large absolute numbers:

Indicator	India	Global benchmark	Gap
Hospital beds per 1,000 population	~1.3–1.9*	WHO minimum: 2.0	Shortfall of 0.7–1.6 beds/1,000
Doctor-to-population ratio (registered)	1:811	WHO benchmark: 1:1,000	Nominally ahead — see caveat
Nursing workforce	~3.9 million	34.5 workers/10,000 by 2030	~650,000 additional nurses needed
Non-life (incl. health) insurance penetration	1.0% of GDP	Global average: ~3–4% of GDP	Materially underpenetrated

**Bed-density estimates vary by source depending on registered vs. functional bed counts; all sources agree India sits below the WHO benchmark. Sources: Rubix Data Sciences, IBEF, World Bank, WHO Global Health Observatory, IRDAI Annual Report 2024-25.*

Analysis. The doctor-to-population ratio requires a caveat: it is based on registered practitioners, which includes doctors who have emigrated, retired, or moved into non-clinical roles. Actively practising physician density is materially lower than the headline 1:811 figure suggests. To meet WHO thresholds, India requires an estimated additional 2.4 million hospital beds, ~160,000 doctors and ~650,000 nurses.

Implication. The infrastructure and workforce deficit is the foundational investment thesis for hospital capacity expansion (Section 3.1), healthcare staffing platforms (Section 3.9), and medical education/skilling.

2.6 Key Growth Drivers

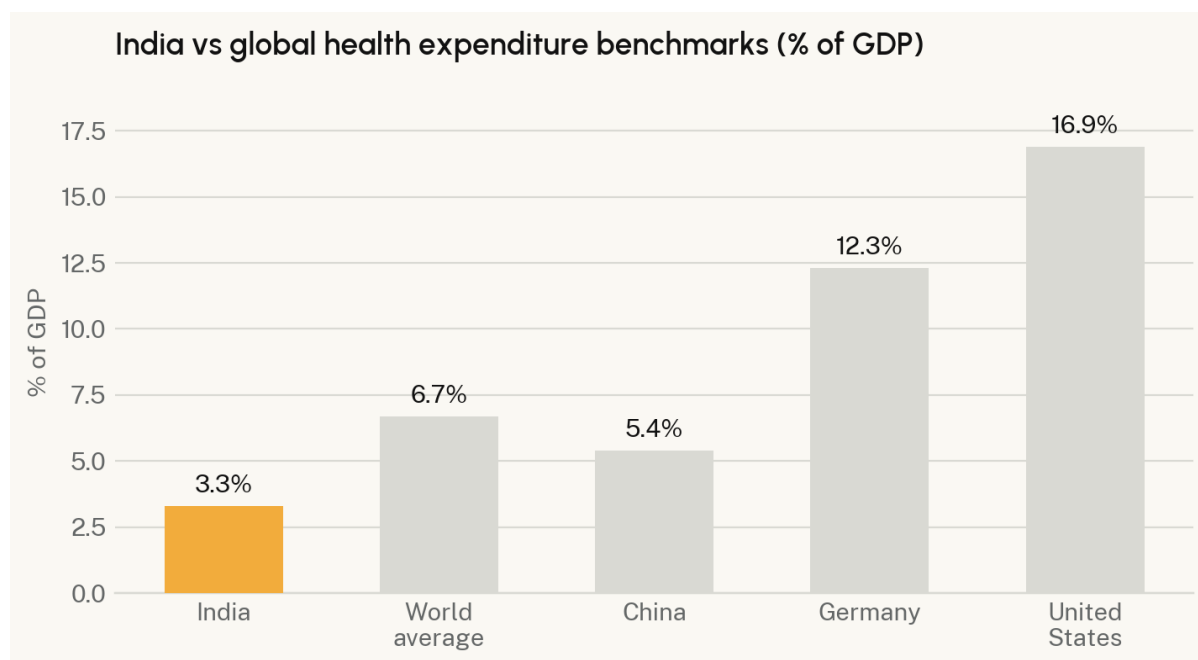
- Demographic transition — India's elderly population (60+) is projected to reach 158.7 million (11.1% of population) by 2025, rising toward 340 million (19.1%) by 2050 (UN Population Division).
- NCD burden — non-communicable diseases now account for 62% of India's total disease burden (DALYs); diabetes prevalence is projected to rise from 40.9 million to 69.9 million cases.

- Rising formal financing — convergence of GHE and OOPe, the September 2025 GST exemption on individual health insurance premiums, and IRDAI's "Insurance for All by 2047" agenda.
- Government infrastructure push — PLI schemes for pharmaceuticals and medical devices have catalysed over ₹33,500 crore of committed industrial investment across 78 approved projects (as of late 2024).
- Urbanisation and rising incomes — continued urban migration and income growth are expanding demand for organised, higher-acuity private care in metros and increasingly Tier-2/3 cities (Section 4).

2.7 Key Industry Trends

- Financing formalisation — the master trend underpinning almost every segment's growth economics (Section 2.3).
- Consolidation — private equity and strategic capital are actively consolidating hospitals, diagnostics and retail pharmacy (Sections 6, 7).
- Digital health acceleration — telemedicine, e-pharmacy and AI-enabled diagnostics growing at an estimated 24–25% CAGR, 2025–2030 (Section 3.7, Section 9).
- Tier-2/3 expansion — organised healthcare delivery extending beyond the traditional eight metro markets (Section 4).
- Medical value travel — India's medical tourism market, valued at USD 8.71 billion in 2025, is projected to reach USD 16.2 billion by 2030 (13% CAGR).

2.8 India vs. Global Benchmarks



Source: World Bank current health expenditure database. Figures for China, Germany, the United States and world average are latest available World Bank/OECD estimates and are approximate; cross-country comparisons should be read directionally given differing reporting years and methodologies.

Fact. India's current health expenditure has averaged 3.58% of GDP over 2000–2022 against a world average of 6.74% — roughly half the global norm — and far below the US (~17%) and Germany (~12%).

Analysis. This gap is not purely a function of income level — India's health spending is low even after adjusting for per-capita GDP relative to peer emerging markets. It reflects historically low public allocation combined with a large informal/unorganised care segment.

Implication. As GHE continues its structural climb and insurance penetration converges toward global norms, India's health expenditure-to-GDP ratio has substantial structural headroom to expand — a multi-decade tailwind for organised healthcare delivery, financing and technology segments covered in the remainder of this report.

Section 2 — Summary Implications for the Report

1. Financing formalisation (GHE up, OOPE down) is the single most important structural shift and directly underwrites private hospital, diagnostics and insurance growth (Sections 3.1, 3.5, 6).
2. Infrastructure and workforce shortfalls versus WHO benchmarks establish the core capacity-expansion investment case (Sections 3.1, 3.4, 3.9, 10).
3. Residual OOPE concentrated in outpatient/pharma creates a distinct financing gap that retail pharmacy, diagnostics and digital health business models are positioned to address (Sections 3.6, 3.7).
4. Low expenditure-to-GDP ratio versus global peers implies long-run structural headroom for the sector as a whole — a theme revisited in the Key Investment Themes (Section 10).

Sources: National Health Accounts Estimates for India (NHSRC/MoHFW, 10th round, 2022-23); PIB press releases (2024–2026); World Bank Open Data; WHO Global Health Observatory and Global Health Expenditure Database; IRDAI Annual Report 2024-25; IBEF Healthcare Industry Report; MarkNTel Advisors, Nexdigm and IMARC Group market research; UN Population Division (2024); ORF; Ayushman Bharat–PMJAY official data.

3. Segment-Wise Healthcare Industry Analysis

3.1 Hospitals & Healthcare Delivery

Market Overview

India's hospital market is estimated at USD 193.4 billion in 2025, rising to USD 207.5 billion in 2026 and projected to reach USD 364.6 billion by 2034 (IMARC Group, 7.3% CAGR 2026–2034). Alternative estimates range from USD 104.7 billion (Expert Market Research, narrower services-only definition) to USD 197.3 billion (TechSci Research, 10.6% CAGR 2025–30). This report anchors on the IMARC estimate for consistency with the overall market-sizing convention established in Section 2.

3.2 Pharmaceuticals

Market Overview

India's domestic pharmaceutical market is currently valued at approximately USD 55–60 billion and is expected to more than double to around USD 120–130 billion by 2030.

Market Indicator	Current	2030 Outlook
Domestic Pharmaceutical Market	~USD 55–60 Bn	~USD 120–130 Bn
Implied Growth	—	~15%+ CAGR*

3.3 Diagnostics

Market Overview

India's diagnostics market is estimated at approximately USD 11–13 billion in 2025–26 and is expected to grow at ~11–12% annually, potentially reaching USD 24–29 billion by 2030–34.

Market Indicator	Current	Growth Outlook
Diagnostics Market	~USD 11–13 Bn	~USD 24–29 Bn
Expected CAGR	—	~11–12%
Market Characteristic	Fragmented	Formalisation & consolidation

3.4 Medical Devices & MedTech

Market Overview

India's medical devices market is estimated at ~USD 12–15 billion in FY2026 and is expected to grow at approximately 12–15% annually. Despite being one of Asia's largest markets, India remains heavily dependent on imports, creating significant headroom for domestic manufacturing.

3.5 Health Insurance

Market Structure and Penetration

India's health insurance industry generated ~₹1.27 lakh crore (\$15.3 billion) in gross written premium in FY25, making health insurance the largest non-life insurance segment. With ~58 crore lives covered, the market continues to expand alongside rising healthcare utilisation and insurance penetration.

Market Indicator	FY25
Health Insurance Premium	₹1.27 lakh Cr (~\$15.3 Bn)
YoY Premium Growth	9.2%
Share of Non-Life Premium	41.4%
Lives Covered	~58 Cr
Private Insurers' Share	~63%

3.6 Retail Pharmacy & E-Pharmacy

Market Structure

India's retail pharmacy market is estimated at ~USD 27–30 billion in 2025 and is growing at approximately 9–10% annually. Despite its scale, the market remains highly fragmented, with independent chemists accounting for the vast majority of pharmacy outlets

E-Pharmacy — Market and Business Models

Online pharmacy specifically is estimated at \$3.71 billion (2025), rising to \$14.08 billion by 2034 (15.98% CAGR) per IMARC — materially faster growth than organised offline retail, though off a small base. Business models bifurcate into inventory-led platforms (Tata 1mg, PharmEasy, Netmeds), which hold stock and fulfil directly, and hybrid omni-channel models (Apollo 24|7, MedPlus online) that route orders through an existing owned-store network. A newer entrant category — quick-commerce platforms (Blinkit, Zepto) offering 10-minute medicine delivery — has drawn scrutiny from medical bodies over prescription-verification standards, per multiple December 2025 media reports questioning the adequacy of teleconsultation before dispensing.

3.7 Biotechnology & Life Sciences

Market Overview — Bioeconomy vs. Biopharma

Fact. India's bioeconomy — a broad government accounting concept spanning Bio Medical, Bio Industrial, Bio Agriculture, and Bio Services — has grown roughly 20-fold from \$10 billion (2014) to \$195 billion (2025), a ~18% CAGR, per BIRAC's India Bioeconomy Report 2026, and contributes approximately 4–5% of GDP. The government's stated target is \$300 billion by 2030, split (per official projections) into BioMedical ~\$128bn, BioIndustrial ~\$121bn, BioServices ~\$42.4bn, and BioAgriculture ~\$39.3bn.

3.8 Digital Health, HealthTech & Allied Segments

1. Public digital infrastructure (ABDM, 65 crore health IDs) dwarfs the private commercial digital-health and HealthTech markets in scale, meaning the more durable private-sector opportunity is building on top of this infrastructure rather than around it.
2. Home healthcare is the largest allied/emerging segment by current market size, directly linked to the hospital capacity constraints identified in Section 3.1, and the most investable of the segments covered here given the clearer services-led revenue model.
3. HealthTech capital-market conditions have tightened sharply into early 2026; financing and valuation work for consumer-facing digital-health platforms should reflect this reset rather than extrapolate from the larger funding rounds of 2021–2023.

Sources: Mordor Intelligence; VynZ Research; Grand View Research; CMI (Custom Market Insights); IMARC Group; Nexdigm; Chambers and Partners (Digital Healthcare 2026 guide); PIB/National Health Authority (ABDM disclosures); Coherent Market Insights (medical tourism, elder care); Inc42 Datalabs; Tracxn (HealthTech funding data); GrowthJockey; eHealth Magazine; healthbuzz; Bain & Company (HealthTech VC allocation estimate, as cited).

For a Detailed Information and Research on the above sections Please use the Links below



3.1 Hospitals & Healthcare delivery



3.2 Pharmaceuticals



3.3 Diagnostics



3.4 Medical devices & medtech



3.5 Health Insurance



3.6 Retail pharmacy & E-pharmacy



3.7 Biotechnology & Life sciences



3.8 Digital health, healthtech & allied segments

4. Geographic & State-Level Analysis

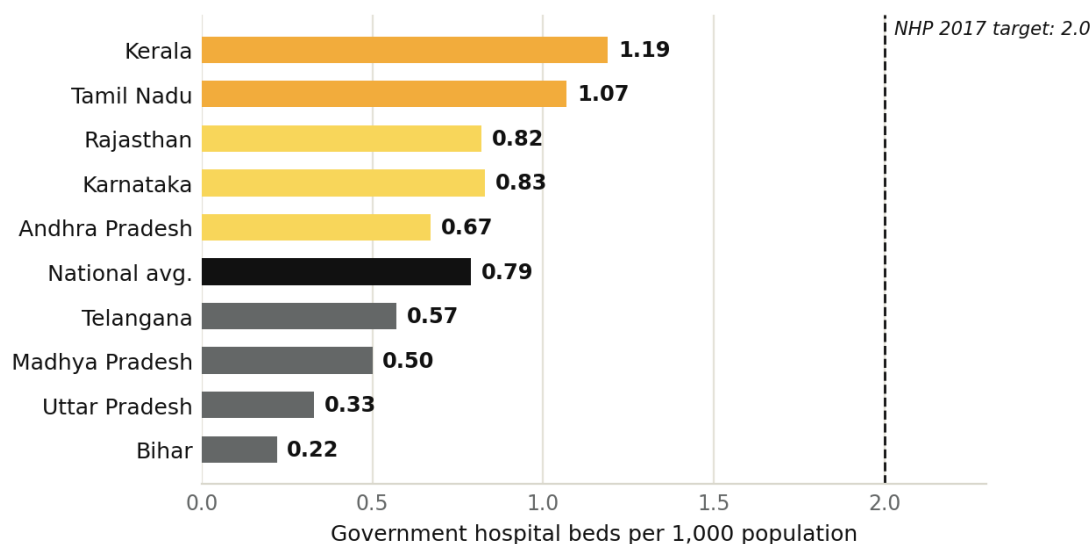
India's healthcare industry is not one national market but a set of structurally different regional markets. This section examines that variation directly, rather than repeating the segment-level geography already noted in Sections 3.1–3.8 (e.g. Dr Lal PathLabs' Delhi NCR base, Metropolis' Western concentration, Vijaya's Andhra Pradesh/Telangana stronghold, South India's API/CDMO clustering) — the focus here is what the state-level pattern means for capital allocation and policy risk across the industry as a whole.

4.1 Regional Healthcare Landscape

Fact. India's government hospital-bed density averages 0.79 beds per 1,000 population — against a National Health Policy 2017 target of 2.0 and a global average of 2.7. Including private capacity, Knight Frank/Berkadia estimate the all-India ratio at 1.3 beds per 1,000, implying a shortfall of approximately 2.4 million beds nationally. The state-level range is far wider than the national average suggests: government bed density spans from 1.19 (Kerala) and 1.07 (Tamil Nadu) down to 0.33 (Uttar Pradesh) and 0.22 (Bihar) — a 5.4x gap between the best- and worst-served large states. Private capacity accounts for roughly 60% of India's hospital beds nationally, a reversal of the public-majority norm typical in OECD healthcare systems.

Analysis. This disparity is not simply a North-South divide, though it correlates with it: Rajasthan (0.82) and Madhya Pradesh (0.50) sit at different ends despite geographic proximity, while Karnataka (0.83) lags Kerala and Tamil Nadu within the South itself. NITI Aayog's State Health Index corroborates the pattern on outcomes rather than infrastructure alone — Kerala, Tamil Nadu, and Telangana have consistently ranked as top performers among larger states, with composite scores (e.g. Kerala ~88 vs. Bihar ~31 on one recent index round) reflecting decades of differentiated public-health investment, not a single policy cycle.

A 5.4x Gap Separates Kerala and Bihar in Public Bed Density



Note: Government hospital beds only (PHC/CHC/sub-district/district hospitals and medical colleges); excludes private capacity, which is estimated to add roughly 60% to total bed count nationally. Source: Ministry of Health & Family Welfare (Lok Sabha reply, J.P. Nadda); The South First analysis of MoHFW data.

Implication. The bed-density gap is the clearest single indicator in this report of where organised private capital should logically flow to address genuine unmet need — Uttar Pradesh, Bihar, and Madhya Pradesh combined represent close to 400 million people at less than half the national-average public bed density, yet (per Section 3.1) organised hospital-chain investment remains concentrated in already better-served metro

markets. This gap between where need is highest and where capital currently concentrates is a structural, multi-year opportunity, not a short-term dislocation.

4.2 Major Healthcare Clusters

Three metro clusters account for the large majority of organised, capital-intensive healthcare activity: Delhi-NCR (hospital chains including Max, Fortis, Apollo; Dr Lal PathLabs' historical base; large PSU/AIIMS tertiary capacity); Mumbai/West India (Metropolis' historical stronghold; API and formulation manufacturing per Section 3.2.2; large private hospital groups); and the Bengaluru-Hyderabad-Chennai South India corridor (detailed in Section 4.3). This concentration extends into R&D and innovation infrastructure specifically: healthcare-related Global Capability Centres (GCCs) — R&D and innovation units of multinational pharma/MedTech majors including Novartis, Pfizer, Abbott, Siemens Healthineers, and Eli Lilly — are approximately 85% concentrated across just four cities (Bengaluru, Hyderabad, Mumbai, Delhi-NCR), with Bengaluru alone hosting roughly a third of the total.

Implication. GCC concentration (85% in four cities) is even tighter than hospital-chain or diagnostics-chain geographic concentration discussed elsewhere in this report, indicating that India's innovation-and-R&D healthcare economy is structurally more metro-concentrated than its healthcare-delivery economy — a distinction relevant to Section 10's investment-theme prioritisation by geography.

4.3 South India Healthcare & Life Sciences Ecosystem

Fact. South India's life-sciences geography is specialised rather than uniform across its constituent cities. Hyderabad's bulk-chemical industrial base underpins API and vaccine manufacturing (Section 3.2.3, 3.7.3); Bengaluru's scientific talent pool anchors biotechnology and biosimilar development (Section 3.7.2); Chennai's engineering and manufacturing infrastructure supports formulations and medical devices (Section 3.4); and Visakhapatnam is an emerging dedicated pharmaceutical production hub. NITI Aayog's 2026 bioeconomy roadmap explicitly names Hyderabad and Bengaluru as “twin hubs” expected to drive India's bioeconomy growth toward a \$1.36 trillion target by 2040, crediting Telangana, Karnataka, and Gujarat state-level incentives (subsidised land, single-window facilitation) for accelerating this clustering.

Analysis. This is genuine functional specialisation, not three cities competing for the same investment — a CDMO or biosimilar investor's location decision should be informed by which specific capability (bulk API, biologics science talent, or device engineering) the investment requires, rather than treating “South India” as a single undifferentiated destination. India's global pharma/API export share remains only 2.8% against a \$1.3 trillion global import demand (including \$261.2 billion of APIs specifically) — per NITI Aayog, this headroom is the structural rationale for continued South Indian cluster investment across all three specialisations simultaneously rather than a signal that the opportunity is concentrated in just one city.

4.4 State-Wise Opportunities and Emerging Tier-2/3 Markets

The organised-delivery expansion patterns already detailed in Sections 3.1 and 3.3 — hospital hub-and-spoke rollouts, diagnostics chains' Tier-2/3 collection-centre networks — are the primary current vehicle for addressing the bed-density and access gaps identified in Section 4.1. PM-JAY empanelment data (36,229 hospitals nationally, per Section 3.1) skews toward exactly the underserved states flagged here: Uttar Pradesh alone hosts the highest count of Ayushman Arogya Mandirs (23,646), followed by Rajasthan, Maharashtra, Madhya Pradesh, and Bihar — meaning public digital/scheme infrastructure is, in relative terms, ahead of organised private delivery capacity in several of the lowest-bed-density states.

Implication. This creates a specific, near-term opportunity structure: states with high PM-JAY/AAM density but low organised-private-bed density (Uttar Pradesh, Madhya Pradesh, Bihar) offer a pre-built demand-side and scheme-reimbursement infrastructure for private operators willing to build supply — lowering the go-to-market risk relative to markets with neither public nor private infrastructure in place.

4.5 Medical Tourism Hubs

Medical tourism market sizing and growth trends are covered in Section 3.8; the geographic pattern specifically follows the tertiary-care clusters already identified in Sections 4.2–4.3. Chennai is widely regarded as India's leading medical-tourism destination given its concentration of accredited multi-specialty and cardiac-care hospitals; Delhi-NCR and Mumbai attract high-complexity oncology and transplant volumes; and Kerala has built a distinct, separate wellness/Ayurveda tourism niche alongside conventional medical tourism. Private multi-specialty hospitals captured roughly 66% of medical tourism revenue in 2025.

Opportunities and Risks

Opportunities:

- Underserved large states (Uttar Pradesh, Bihar, Madhya Pradesh) combine the lowest bed density with pre-built PM-JAY scheme infrastructure — the clearest near-term expansion opportunity identified in this section (Section 4.4).
- South India's functional specialisation (Hyderabad/API, Bengaluru/biotech, Chennai/devices) supports simultaneous, differentiated investment across all three cities rather than forcing a single-location choice.
- India's low global pharma/API export share (2.8%) against \$1.3 trillion global import demand implies substantial multi-year headroom for South Indian manufacturing capacity specifically.

Risks:

- Organised capital continues to concentrate in already better-served metro markets even as the largest unmet need sits in underserved large states — a persistent allocation mismatch rather than a temporary one.
- Innovation/R&D infrastructure (GCCs) is even more geographically concentrated (85% in four cities) than delivery infrastructure, meaning talent and innovation ecosystems may lag physical capacity expansion into Tier-2/3 markets.
- State-level policy and incentive divergence (land subsidies, single-window clearances) means execution risk and timeline vary materially by state even within the same specialisation cluster.

Section 4 — Summary Implications

1. The 5.4x gap in public bed density between Kerala and Bihar is the clearest quantified evidence in this report of where genuine unmet healthcare need sits geographically — a direct input to Section 10's Tier-2/3 investment theme.
2. South India's three-city specialisation (Hyderabad/API, Bengaluru/biotech, Chennai/devices) should be treated as three distinct location decisions tied to specific capability requirements, not a single "South India" investment thesis.
3. States combining low organised-private capacity with high PM-JAY/public-scheme penetration (UP, Bihar, MP) offer the most de-risked near-term expansion opportunity, since demand-side reimbursement infrastructure already exists ahead of supply.

Sources: Ministry of Health & Family Welfare (Lok Sabha replies, J.P. Nadda); The South First (state-wise government hospital bed density analysis, December 2024); Knight Frank/Berkadia (hospital bed shortfall estimate); NITI Aayog (State Health Index, 5th edition; Roadmap for Building India as a Leading BioEconomy Powerhouse by 2035; pharma/API export share report, Q4 FY26); eHealth Magazine (healthcare GCC geographic concentration); Deccan Centre/South India pharmaceutical industry analysis; Coherent Market Insights, Mordor Intelligence (medical tourism, Section 3.8 cross-reference).

5. Healthcare Investment and Funding Landscape

Capital, not just demand, has become a defining force in Indian healthcare over the past five years. This section maps the funding ecosystem that now sits alongside the segment-level dynamics discussed in Section 3 and the geographic patterns discussed in Section 4 — private equity, venture capital, strategic/corporate capital, foreign investment, and the mergers-and-acquisitions market through which much of this capital is ultimately deployed or realised.

5.1 The Healthcare Funding Ecosystem

Healthcare capital formation in India is no longer a single pipeline. At least five distinct pools now operate in parallel: private equity buyout and growth capital (Section 5.2); venture capital for early- and growth-stage healthtech and biotech (Section 5.3); strategic capital from domestic conglomerates entering healthcare as a core or adjacent business (Section 5.4); foreign institutional and sovereign capital, which overlaps with both PE and FDI channels (Section 5.5); and the public markets, which increasingly serve as an exit route for the other four (Section 5.10). All of these pools ultimately transact through the mergers-and-acquisitions market covered in Section 5.6.

Fact. Since 2020, India's healthcare sector has recorded US\$14.5 billion in cumulative PE/VC investment, with 58% of that total concentrated in just 2023 and 2024 — a sharp acceleration rather than a steady build-up. This sits within a much larger national PE/VC market that invested US\$56 billion across India in 2024 and roughly US\$33 billion in 2025.

Analysis. Healthcare therefore remains a modest single-digit share of India's overall private-capital market by value, but industry trackers describe it as one of the most consistently funded verticals within that market, with PE and VC together deploying roughly US\$2–3 billion or more every year regardless of the broader market's cyclicalities.

Implication. Treating “healthcare investment” as one number obscures more than it reveals; the remainder of this section deliberately separates PE, VC, strategic, foreign and M&A activity because each channel now has a different risk appetite, ticket size and time horizon.

5.2 Private Equity (PE) Investments

Fact. PE inflows into Indian healthcare and pharmaceuticals reached a then-record US\$5.5 billion in 2023 (+25% year-on-year), before cooling to roughly US\$5.33 billion across the first eleven months of 2024 — a 14% decline versus Venture Intelligence's full-year-2023 figure of US\$6.26 billion. Over the five years to 2024, cumulative PE and sovereign-fund investment into the sector reached approximately US\$15.5 billion, of which hospitals alone absorbed 68% of PE dollars in 2022–2024 (US\$4.96 billion, close to 40% of total healthcare deal value).

That hospital-platform wave is well documented: Temasek's US\$2 billion investment in Manipal Health (2023) financed its subsequent acquisitions of AMRI and Sahyadri; Blackstone and TPG jointly built a large platform through CARE Hospitals and KIMS Health (~US\$1 billion combined); KKR acquired a 54% stake in cancer-care chain HCG from CVC Capital for around US\$400 million; and cumulative PE investment into Kerala's hospital sector alone has crossed ₹50,000 crore (~US\$6 billion) over three years, led by KKR, Blackstone and TPG.

Analysis. The more recent quarterly data show PE activity settling into a narrower, steadier band even as headline deal-making elsewhere accelerates: US\$425 million in Q3 2025 (32 deals, –27% quarter-on-

quarter), US\$476 million in Q4 2025, US\$456 million in Q1 2026 and US\$444 million in Q2 2026, per Grant Thornton Bharat's Dealtracker. Returns on the earlier buyout wave have been strong — KKR realised roughly 5.6x on Max Healthcare and CVC Capital roughly 3.4x on an earlier hospital investment — which continues to draw sponsor interest even as fresh primary deployment has moderated.

Implication. PE appears to have moved from an acquisition-and-platform-building phase (2022–2024, concentrated in hospitals) into a steadier deployment phase now weighted toward pharma services, wellness and health tech, while capital-intensive platform consolidation has migrated toward strategic M&A and public-market exits (Sections 5.6 and 5.10).

Metric (US\$ million)	Q3 2025	Q4 2025	Q1 2026	Q2 2026
PE investment value	425	476	456	444
M&A deal value	2,500	1,588	915	13,209

Note: Calendar quarters (Q3 2025 = Jul–Sep 2025, etc.). Q2 2026's M&A figure is dominated by a single transaction — see Section 5.6. Source: Grant Thornton Bharat, Pharma and Healthcare Dealtracker.

5.3 Venture Capital (VC) Investments

Fact. HealthTech-specific venture funding in India totalled roughly US\$9.35 billion cumulatively over the last ten years, peaking at US\$2.83 billion in 2021 (Tracxn). Reported deal flow has since fallen sharply: from US\$42.5 million across 19 rounds in January 2025 to just US\$665,000 across 2 rounds in January 2026 — a roughly 98% year-on-year decline for that month specifically.

This has not stopped fresh fund formation. HealthKois launched a US\$400 million fund in 2025 targeting early- and growth-stage healthtech and biopharma companies, and specialist and generalist investors — General Catalyst, Eight Roads Ventures, F-Prime Capital, Rainmatter, Prime Venture Partners, Leo Capital and Singularity AMC — remain active at the smaller end: Prime Venture Partners and Leo Capital invested US\$13 million in StainX Bioworks, while Singularity AMC, Rainmatter, Eight Roads Ventures, F-Prime Capital and angel investors put US\$10 million into Immuneel Therapeutics (both 2026).

Analysis. The gap between large new fund vehicles (US\$400 million-plus) and shrinking reported deal counts most likely reflects a valuation reset and a mix shift rather than a collapse in investor appetite: Bain & Company estimates roughly 30% of healthtech VC now flows into MedTech and diagnostics rather than pure telemedicine, a segment reclassification that narrow “HealthTech” trackers can understate.

Implication. This funding pull-back is consistent with the platform-consolidation phase already noted in Section 3's digital-health overview, rather than evidence of a demand-side failure in digital health itself.

5.4 Strategic Investments

Fact. India's largest conglomerates have entered healthcare as strategic, non-financial investors alongside traditional PE. Adani Group earmarked roughly US\$4 billion for a healthcare foray through Adani Health Ventures, including a joint bid with Apollo Hospitals for a majority stake in diagnostics chain Metropolis Healthcare valued at approximately US\$1 billion. Reliance Industries' Reliance Digital Health acquired a 45% stake in US-based Health Alliance Group for US\$10 million to build a virtual diagnostics and care platform. Tata's 1mg has scaled its own diagnostics business to the ₹500–1,000 crore range, growing over 40% year-on-year in FY26 across 19 NABL- and CAP-accredited laboratories. Bajaj Group is separately building hospital assets.

Strategic consolidation is also occurring between existing operators: Apollo Health and Lifestyle's Apollo Cradle and Apollo Fertility businesses combined with Kids Clinic India's Cloudnine maternity and fertility operations to form one of India's largest integrated maternity-and-fertility platforms.

Analysis. Strategic investors differ from financial sponsors in intent: Reliance and Tata are building adjacent distribution and data assets around existing consumer franchises, while Adani is entering healthcare at conglomerate scale as a new core business — neither is operating on a defined-exit-horizon basis the way a PE fund does.

Implication. Strategic buyers now compete directly with PE for the same scale platform assets (Metropolis is the clearest example), which supports valuations across the sector but also raises consolidation pressure on smaller independent operators who cannot match either investor class's balance sheet.

5.5 Foreign Investments

Fact. Foreign Direct Investment into India's pharmaceuticals and medical devices sector reached ₹19,134.4 crore (~US\$2.3 billion) in FY2024-25, of which ₹11,888 crore (~US\$1.43 billion) arrived between April and December 2024, plus 13 approved brownfield-project proposals worth ₹7,246.4 crore (~US\$872 million), per the Department of Pharmaceuticals. This continues a rising trend from US\$2.05 billion in FY2022-23 (+45.4% year-on-year).

Separately, and in much larger volume, foreign PE and sovereign capital dominates investment into hospital platforms specifically: Singapore's Temasek and GIC; US-based Blackstone, TPG, KKR, Warburg Pincus, Advent International and CVC Capital Partners; Sweden's EQT; Denmark's Novo Holdings; and Malaysia's IHH Healthcare have all taken direct stakes in Indian hospital chains (Sections 5.2 and 5.10). Under the Consolidated FDI Policy, greenfield pharma projects qualify for 100% FDI via the automatic route, while brownfield expansions of existing facilities are capped at 74% automatic, with anything higher requiring government approval.

Analysis. Official pharma-FDI statistics (tracked by the Department of Pharmaceuticals under the PLI-linked reporting framework) capture manufacturing-linked capital specifically; the much larger pool of foreign capital flowing into hospital and delivery platforms shows up in PE/VC statistics rather than classic sectoral FDI data. Total foreign capital into Indian healthcare is therefore materially larger than the ~US\$2.3 billion pharma-FDI headline alone suggests.

Implication. Policy and market tracking should treat "FDI into manufacturing" (PLI-linked, subject to the greenfield/brownfield distinction) and "foreign PE into delivery and services" (governed by sectoral caps and RBI/FEMA rules) as two separate pools facing different approval pathways, rather than reading a single FDI number as the full measure of foreign participation in Indian healthcare.

5.6 Mergers & Acquisitions (M&A)

Fact. India's healthcare and pharma M&A ran at a cumulative US\$35 billion from 2018 to 2022. Quarterly activity has since been volatile: Q3 2025 M&A totalled US\$2.5 billion across 36 deals (+57% quarter-on-quarter), headlined by Torrent Pharma's US\$1.4 billion acquisition of a 46% stake in JB Chemicals & Pharmaceuticals; Q4 2025 fell to US\$1,588 million; Q1 2026 fell further to US\$915 million; and Q2 2026 hit an all-time record of US\$13,209 million — almost entirely (89%) driven by a single transaction, Sun Pharmaceutical Industries' US\$11.75 billion acquisition of US drugmaker Organon & Co.

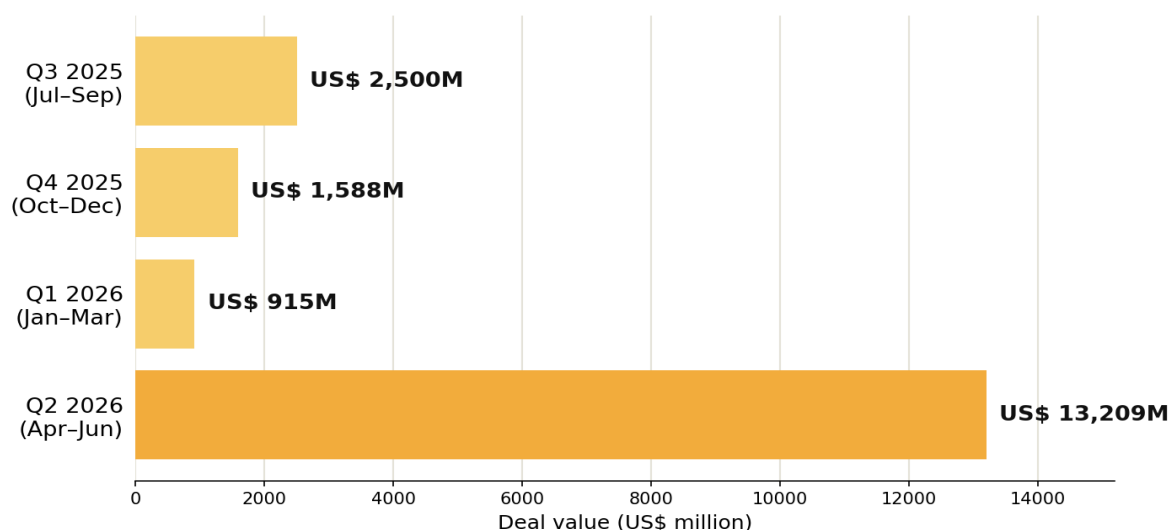
The rest of Q2 2026's largest deals were also outbound: API maker Gujarat Themis Biosyn acquired Sanofi's tuberculosis and anti-infective portfolio for US\$183 million, and Zydus Worldwide acquired US-based

Assertio Holdings for US\$166.4 million. Outbound M&A activity overall grew 5.3x quarter-on-quarter in Q3 2025 alone. Domestically, the standout was the Apollo Cradle/Fertility-Cloudnine combination noted in Section 5.4; domestic consolidation accounted for 73% of total deal value in Q3 2025.

Analysis. Grant Thornton Bharat notes that the largest recent deals have focused on acquiring established portfolios, brands and therapeutic franchises rather than adding manufacturing capacity — Indian pharma majors are increasingly using M&A to buy market access and complete their portfolios rather than only to build capacity.

Implication. A single outbound mega-deal can now swing India's entire quarterly healthcare M&A statistic by an order of magnitude, as Sun Pharma–Organon did in Q2 2026. Readers of headline M&A figures should check for this kind of concentration before drawing trend conclusions; excluding that one transaction, underlying deal-making in Q2 2026 was broadly in line with the prior two quarters.

India Healthcare & Pharma M&A Deal Value by Quarter



Source: Grant Thornton Bharat, Pharma and Healthcare Dealtracker (quarterly reports, Q3 2025–Q2 2026).

5.7 Segment-wise Investment Trends

Fact. Hospitals and clinics remain the largest single destination for healthcare PE/VC capital — 60% of all healthcare PE/VC investment since 2020, rising to 68% of PE dollars specifically in 2022–2024. Healthtech ranks second in cumulative dollars but has seen sharply reduced deal flow in the most recent reporting period (Section 5.3). Pharma and pharma services (CDMO/CRO) is described by industry trackers as the strongest current thematic bid within PE, and dominates recent M&A value given the Sun Pharma–Organon, Torrent–JB Chemicals and Gujarat Themis Biosyn transactions (Section 5.6). Diagnostics is consolidating, evidenced by the Adani–Apollo pursuit of Metropolis and Tata 1mg's organic scale-up (Section 5.4). Single-specialty chains — fertility and maternity care (Cloudnine, Indira IVF), dialysis (Quadria Capital-backed platforms), oncology and eye care — represent a distinct “unbundling” theme, valued by investors for being more asset-light and faster to scale than multi-specialty hospitals.

Analysis. Capital is bifurcating along two axes at once: by segment (hospitals and pharma services attracting the largest cheques while healthtech cools) and by structure (large multi-specialty platforms versus smaller, faster-to-scale single-specialty chains).

Implication. New entrants should treat “healthcare investment” as at least four distinct sub-markets — hospital platforms, pharma/pharma services, diagnostics, and single-specialty chains — each with different capital providers, deal sizes and return profiles (Section 5.8), rather than one undifferentiated sector.

5.8 Deal Size Trends

Fact. At the top end, India’s broader PE/VC market recorded 69 “mega deals” (above US\$100 million each) worth US\$21.3 billion in 2025, down 9.2% from 76 deals worth US\$21.6 billion in 2024; healthcare’s largest transactions now sit within and above this band. Manipal Health Enterprises filed for a ~US\$1.17 billion IPO in March 2026; a 25% stake in Cloudnine Hospitals drew binding interest at a valuation of roughly ₹10,000 crore (~US\$1.2 billion) from KKR, TPG Capital, Warburg Pincus, Advent International, CVC Capital Partners, Permira and Kedaara Capital; and cumulative PE investment into Kerala’s hospital sector alone has crossed ₹50,000 crore (~US\$6 billion) over three years. At the other end, early-stage healthcare and biotech cheques remain in the US\$10–30 million range (StainX Bioworks US\$13 million, Immuneel Therapeutics US\$10 million, both 2026).

Analysis. Deal sizes have become sharply bimodal: platform-scale hospital, diagnostics and pharma buyouts now regularly clear US\$300 million to US\$1 billion-plus, and in the case of Sun Pharma–Organon approach US\$12 billion, while venture and early-growth healthtech/biotech cheques remain an order of magnitude smaller.

Implication. Mid-market deals in the US\$30–150 million range appear to be the least populated band in current deal-flow data — a structural financing gap for single-specialty and regional operators that have outgrown venture capital but are not yet large enough for control buyouts.

5.9 Investment Themes

Across PE, VC, strategic and M&A activity, seven themes recur consistently in the data reviewed above:

- Consolidation and platform buyouts in hospitals and diagnostics, led by a recurring set of global sponsors (Section 5.10).
- Single-specialty “unbundling” — fertility, oncology, dialysis and eye care — valued for asset-light, faster-to-scale economics.
- Pharma services (CDMO/CRO) as the strongest current thematic bid within PE, and a dominant share of recent M&A value.
- An AI-enabled premium within healthtech funding even as overall healthtech deal volume falls.
- Outbound M&A by Indian pharma majors acquiring global brands and therapeutic franchises (Sun Pharma–Organon, Zydus–Assertio, Gujarat Themis Biosyn–Sanofi).
- Large domestic conglomerates (Reliance, Adani, Tata, Bajaj) entering healthcare as strategic, non-exit-driven investors.
- Continued Tier-2/3 city expansion capital tied to hospital hub-and-spoke models, cross-referencing Section 4.4.

5.10 Investor Activity

Fact. The global financial sponsors most active in Indian healthcare currently include Blackstone, TPG, KKR, Temasek, EQT, CVC Capital Partners, Warburg Pincus, Advent International, Permira, Kedaara Capital, Quadria Capital, True North and Malaysia’s IHH Healthcare — many holding or bidding for controlling stakes

in the same handful of large hospital platforms (Sahyadri, Cloudnine, CARE/KIMS, Manipal) simultaneously. Strategic/corporate investors — Reliance, Adani, Tata and Bajaj — form a newer, parallel investor class (Section 5.4). Early-stage activity is led by HealthKois, General Catalyst, Eight Roads Ventures, F-Prime Capital, Rainmatter, Prime Venture Partners, Leo Capital and Singularity AMC.

Exit activity has been a differentiator for the sector: healthcare accounted for 17–18% of total Indian PE exits between 2021 and 2024, and realised returns have been strong (KKR's ~5.6x on Max Healthcare; CVC Capital's ~3.4x on an earlier hospital investment). Public markets are an increasingly active exit route in their own right: Q3 2025 alone saw three healthcare/pharma IPOs worth US\$428 million and one QIP worth US\$88 million, and Manipal's own ~US\$1.17 billion IPO filing in 2026 will let existing investors — Temasek, TPG and Novo Holdings — realise part of their position through a public listing rather than a secondary sale.

Analysis. The same eight-to-ten global funds recur across almost every large disclosed transaction, indicating real capital concentration at the top of the market even though deal volume, in count terms, remains distributed across many smaller regional and specialty transactions.

Implication. Strategic partners or later entrants evaluating large-platform opportunities should assess competitive dynamics against this recurring investor set directly, rather than treating the market as a fragmented, open field.

Opportunities and Risks

Opportunities:

- Healthcare has remained one of India's most consistently funded PE/VC sectors (roughly US\$2–3 billion-plus deployed annually) even through a broader market slowdown, providing a durable, less cyclical capital base for expansion.
- Outbound M&A capability — exemplified by Sun Pharma's US\$11.75 billion Organon acquisition — shows Indian pharma majors now have the balance-sheet scale to acquire global brands and therapeutic franchises rather than only receive inbound capital.
- The entry of large domestic conglomerates (Reliance, Adani, Tata, Bajaj) as strategic, non-exit-driven investors diversifies the capital base beyond financial sponsors and can support longer investment horizons for large assets.
- Strong realised PE returns (KKR's ~5.6x on Max Healthcare, CVC's ~3.4x on an earlier deal) continue to draw fresh global sponsor interest and dry powder into the sector.

Risks:

- Headline M&A figures can be dominated by a single transaction — 89% of Q2 2026's record US\$13.2 billion came from one deal — which can overstate underlying deal-making momentum if read without disaggregation.
- HealthTech-specific VC funding has fallen sharply year-on-year (Tracxn shows a ~98% drop for January 2026 versus January 2025), suggesting a genuine repricing or consolidation phase in digital-health financing specifically.
- PE-driven hospital consolidation, and the concentration of a handful of global sponsors across the same platforms (Kerala's hospital sector being the clearest example), has drawn scrutiny over affordability and access implications.
- Fresh PE deployment has stayed in a narrow US\$425–476 million quarterly band through Q2 2026 even as M&A activity has spiked — a sign that financial sponsors may currently be more focused on realising existing positions than committing significant new primary capital.

Section 5 — Summary Implications

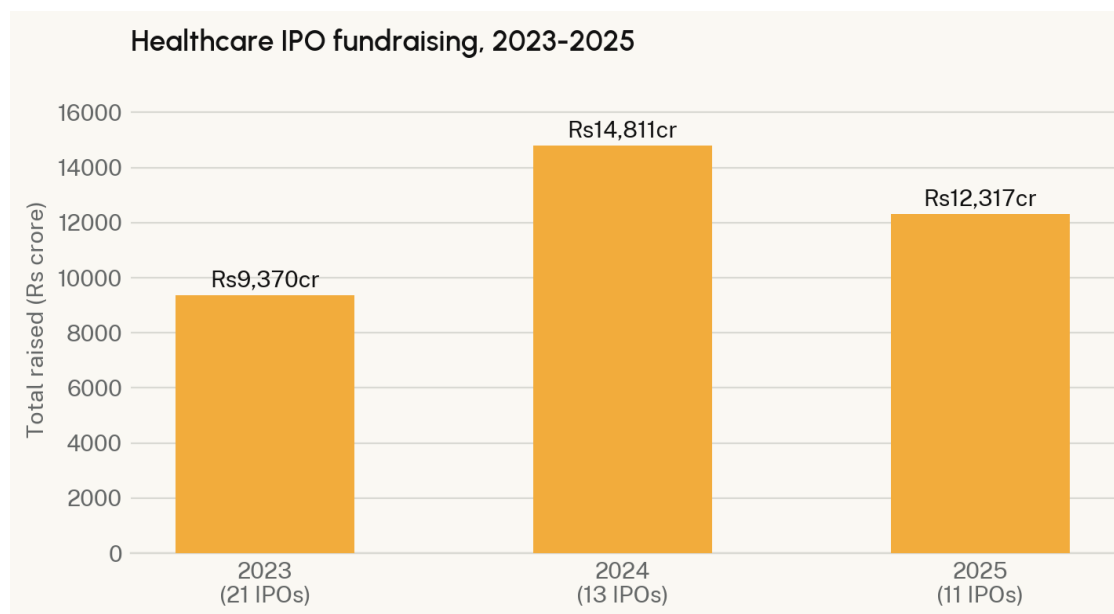
1. Healthcare investment in India is no longer a single capital pool: PE, VC, strategic/corporate capital, foreign institutional capital and public-market exits now behave as distinct channels with different risk appetites, ticket sizes and time horizons, and should be analysed separately rather than aggregated into one “investment” figure.
2. Deal-making has become sharply bimodal — a small number of platform-scale hospital, diagnostics and pharma transactions (increasingly US\$300 million to multi-billion-dollar, as with Sun Pharma–Organon) sit alongside a much larger number of sub-US\$30 million early-stage healthtech and biotech cheques, leaving a thin mid-market band that is likely the sector’s next financing gap.
3. The shift toward outbound M&A by Indian pharma majors and the entry of domestic conglomerates as strategic investors mark a structural change from India’s healthcare capital story being primarily “capital in” to one that increasingly includes “capital out” and non-financial-sponsor ownership — a dynamic that should inform how later investment themes in this report are prioritised.

Sources: EY-IVCA PE/VC Monthly and Quarterly Roundups (2025–2026); Grant Thornton Bharat, Pharma and Healthcare Dealtracker (Q3 2025–Q2 2026); Venture Intelligence/Business Standard (PE-VC India annual data, 2024–2025); Center for the Advanced Study of India (CASI), “Private Equity and Indian Healthcare”; Medical Buyer (PE/VC cumulative investment analysis); Tracxn, HealthTech in India sector report; Department of Pharmaceuticals, Government of India (FDI data, FY2024-25); DPIIT Consolidated FDI Policy; DealStreetAsia (Grant Thornton M&A data, Q2 2026); Outlook Business, Medical Buyer (hospital-sector PE bidding activity); eHealth Magazine (HealthKois fund); Growth List (global healthcare-startup funding benchmarks, comparative context); Bain & Company, Healthcare Private Equity Market 2025.

6. IPO & Capital Markets Landscape

Healthcare IPO Activity

Fact. Healthcare IPO activity has shifted from fewer/larger to more numerous/smaller deals: 13 IPOs raised ₹14,811 crore in 2024 (avg. ₹1,531 cr), while 11 IPOs raised ₹12,317 crore in 2025 (avg. ₹1,120 cr) — total capital raised stayed roughly flat even as deal count rose 57%. Listing-day gains softened in parallel, from 19.26% (2024) to 14.07% (2025).



Source: Business Standard (Capitaline data).

Notable listings: Sai Life Sciences (CDMO, ₹3,043 cr), Sagility India (payer/provider outsourcing, ₹2,106 cr, +3.5% debut), and Suraksha Diagnostic (₹846 cr, an OFS-only issue that listed at a 0.9% discount on weak 1.27x subscription).

Analysis. Falling deal count alongside flat proceeds, followed by falling average size, signals a maturing, more selective IPO window — issuers with genuine scale still command strong capital access, while smaller/OFS-heavy issues face a more discerning secondary market.

Implication. Issue quality — not just sector tailwinds — is now the differentiator for IPO reception; promoters should expect softer listing-day pops than the 2024 vintage and should structure primary-heavy issues to sustain investor confidence.

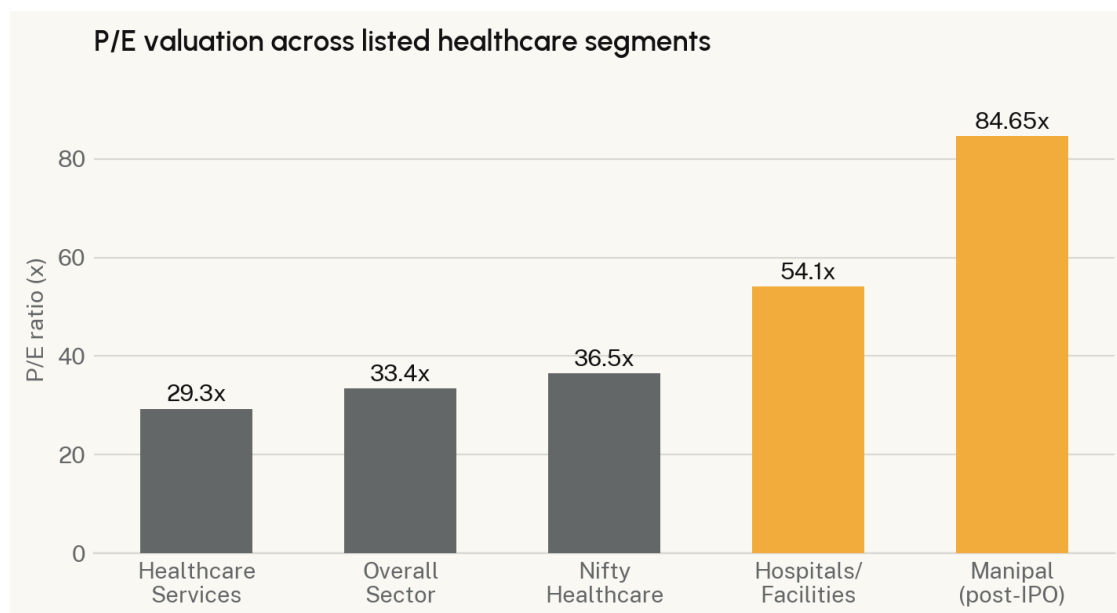
Manipal Health Enterprises IPO — Landmark Case Study

Fact. Manipal's ₹9,275 crore IPO (August 2026) — alone worth ~75% of the entire 2025 healthcare IPO cohort combined — priced at ₹560–590/share, was subscribed 4.92x (institutional-led: QIB 8.25x vs. NII 1.02x), and listed at ₹655 (+11%), valuing the company at ~₹86,157 crore and 84.65x FY26 earnings — a new high-water mark for the sector. FY26 revenue grew 26% to ₹10,520 crore, but PAT fell ~15% to ₹916.5 crore on acquisition-related borrowing costs; ₹5,378 crore of proceeds go directly to debt repayment.

Analysis. The IPO's reception — strong institutional demand despite a profit decline and a weak grey-market signal pre-listing — shows public markets pricing Manipal on scale, brand, and network breadth rather than trailing profitability, consistent with the RONW-compression pattern flagged in Section 3.1.

Implication. Manipal now sets the reference valuation ceiling for the hospital segment; any subsequent listing or M&A valuation will be benchmarked against this multiple, raising the bar for the next wave of hospital IPOs while also raising the risk of disappointment if growth decelerates post-listing.

Valuations Across Listed Sub-Segments



Source: NSE Indices Factsheet; Simply Wall St (BSE-based sector aggregates); company IPO listing data.

Fact. Hospitals trade at a persistent premium (54.1x) to the broader healthcare basket (33.4x) and diagnostics-weighted services segment (29.3x); overall sector market cap grew from ₹14.1 lakh crore to ₹30.5 lakh crore between December 2022 and December 2025 — roughly 2.2x in three years.

Analysis. This premium directly mirrors the ARPOB/margin-quality findings from Section 3.1 — public markets reward operating leverage and brand-driven pricing power in hospitals more richly than the comparatively commoditised diagnostics/services segment.

Implication. A flat sector multiple is inappropriate for valuation work — hospitals warrant a structurally higher multiple than diagnostics or pharma-services peers, and this gap should be explicitly modelled in any comparable-companies analysis.

Capital-Market Trends Beyond IPO

Fact. QIPs raised ₹62,954 crore market-wide in FY25-26, with healthcare-sector precedents including Poly Medicure (₹400 cr) and repeat use by Aurobindo Pharma and Natco Pharma. Private-market commentary (InsightRx, 2026) notes quality hospital platforms transacting at high-teens EV/EBITDA privately, while flagging that secondary sales between PE sponsors are increasingly substituting for genuine IPO/strategic exits, and that the 2020-22 digital-health investment vintage will likely return well below cost.

Analysis. IPO is one of several exit/funding routes now available to scaled healthcare platforms alongside QIP and strategic sale, but the “IPO window” itself is selective — evident in PharmEasy's cautious, still-unlisted return to the market after its 2022-23 reset.

Implication. Capital markets are rewarding operational proof points over growth narratives alone; promoters should treat listing readiness as an operating-metrics exercise, not just a documentation exercise.

Section 6 — Summary Implications

1. IPO issuance is maturing — smaller, more selective deals with softer listing pops are the new normal; issue quality now matters more than sector tailwind alone.
2. Manipal's ~85x listing multiple resets the sector's valuation ceiling and will anchor comparables for future hospital IPOs and M&A (Sections 6–7).
3. Hospitals command a durable valuation premium over diagnostics/pharma-services peers — this gap should be explicit in any DCF or comparable-companies exercise.
4. IPO, QIP, and secondary PE sale now coexist as parallel capital/exit routes; digital health's weak 2020–22 vintage return is dampening its access to all three.

Sources: Business Standard (IPO fundraising data via Capitaline); NSE Indices Factsheet; Simply Wall St (BSE-based sector aggregates); Chittorgarh, IPO Watch, India Infoline, IndMoney, Business Today (Manipal IPO reporting); InsightRx Private Equity in Indian Healthcare 2026; Prime Database (QIP data).

7. Technology & Future of Healthcare

Technology is no longer a support function bolted onto Indian healthcare delivery — it is increasingly the layer through which access, diagnosis, and treatment decisions are made. This section surveys the eleven technology vectors reshaping the sector's near- and medium-term trajectory, building on the digital-health market sizing already covered in Section 3.7 and the ABDM/insurance-technology context in Sections 2.6 and 3.7; the focus here is what each technology does differently for clinical and business outcomes, not a repeat of market-size figures already established elsewhere in this report.

7.1 AI & Generative AI

Fact. Analyst estimates of India's AI-in-healthcare market diverge sharply by scope: IMARC sizes it at USD 435.7 million in 2025 rising to USD 4.77 billion by 2034 (29.6% CAGR), Markets and Markets at USD 791.2 million in 2025, and Market Research Future at USD 1.26 billion for 2024 rising to USD 18.55 billion by 2035 (27.7% CAGR). India's generative AI market specifically (all sectors) is estimated at USD 1.5–2.2 billion in 2025, with healthcare cited as one of the fastest-adopting verticals alongside IT services and fintech.

Analysis. As with the overall market-size dispersion noted in Section 2.2, the gap here is definitional — narrower estimates track pure clinical-AI software (diagnostic imaging, triage, documentation), while wider ones fold in AI-enabled services and IT-outsourcing revenue attributable to healthcare clients. Software already commands roughly 61% share of India's AI-in-healthcare spend, reflecting a market still concentrated in point diagnostic and administrative tools rather than integrated clinical decision-support deployed at scale.

Implication. Regardless of which estimate is used, the CAGR range (28–30%) is consistently the highest of any technology vector in this section, making AI/GenAI tooling the most capital-efficient near-term investment lever for hospital chains and diagnostics networks seeking to offset the specialist and radiologist shortages flagged in Section 3.1 and Section 4.1.

7.2 Robotics

Fact. India's surgical robotics market was valued at approximately USD 851 million in 2023 and is projected to approach USD 4 billion by FY2031; a narrower market-sizing puts the 2025 base at USD 117 million growing to USD 251 million by 2030 (16.5% CAGR). Domestically developed systems are now the volume leader: SS Innovations' SSI Mantra platform, priced at roughly one-third of the imported da Vinci system, has surpassed 168 installations and 6,000-plus procedures as of end-2025, outselling da Vinci in India and completing telesurgery over distances exceeding 280 km at 35–40 millisecond latency.

Analysis. SSI Mantra's traction illustrates a distinctly Indian pattern already seen elsewhere in this report (the SSI Mudra diagnostics/MedTech import-substitution theme, Section 3.4): affordability-engineered, domestically manufactured technology outcompeting premium imports on unit economics rather than features alone. Even so, less than 1% of eligible global surgical volume currently uses robotic-assisted techniques, and India's installed base remains concentrated in metro tertiary centres, mirroring the geographic concentration pattern documented in Section 4.2.

Implication. Modular, lower-capex robotic platforms are the more realistic Tier-2/3 expansion vehicle than premium imported systems, directly reinforcing the Tier-2/3 opportunity thesis in Section 4.4; telesurgery capability additionally offers a partial technological answer to the specialist-distribution gap identified in Section 4.1, though regulatory and credentialing frameworks for remote surgery remain immature.

7.3 Digital Healthcare

Fact. The Ayushman Bharat Digital Mission (ABDM) has linked over 104 crore (1.04 billion) health records to more than 93 crore ABHA digital health IDs as of mid-2026, doubling from 50 crore linked records in February 2025 in just fifteen months; more than 450 public and private health-tech platforms are now integrated with the ecosystem. The relaunched Aarogya Setu 2.0 (June 2026) and the National Health Claims Exchange (NHCX) for paperless insurance settlement extend this backbone into citizen-facing services and claims processing respectively.

Analysis. ABDM's growth curve is now compounding rather than linear — nearly 10 crore records are being linked every two to three months — and state-level adoption is led by exactly the underserved, high-population states (Uttar Pradesh, Andhra Pradesh, Bihar) flagged as capital-allocation priorities in Section 4.4, meaning the digital public-goods layer is arguably ahead of physical private-delivery capacity in these geographies, not behind it.

Implication. For any organised provider, payer, or diagnostics operator, ABDM/ABHA integration is transitioning from a compliance checkbox to a distribution advantage: NHCX-linked claims and ABHA-linked records lower the customer-acquisition and reimbursement friction that has historically slowed insurance-linked expansion in Tier-2/3 markets (Section 2.6).

7.4 Telemedicine

Fact. India's telemedicine market is estimated at USD 3.76 billion in 2025, projected to reach USD 20.02 billion by 2034 (20.4% CAGR); teleradiology is the largest application segment at 34% share. eSanjeevani, the government's free national teleconsultation service, has served over 47 crore (470 million) patients cumulatively and crossed 276 million consultations by late 2024, making it the largest documented government-led telemedicine programme globally.

Analysis. India is a partial outlier on the global post-pandemic telehealth trend: Bain & Company's 2025 healthcare-consumer research found telehealth usage settling back toward, or below, pre-COVID levels in most markets except India, where public-sector teleconsultation volumes (driven by eSanjeevani's rural/HWC distribution model) have continued to compound rather than plateau — a structurally different adoption curve from consumer-app-led telehealth in the West.

Implication. Private telemedicine platforms are increasingly competing for share of a public-anchored base rather than creating a new market from scratch; differentiation is shifting toward specialist access, chronic disease follow-up, and mental-health verticals rather than routine primary-care teleconsultation, where eSanjeevani has effectively set a free price ceiling.

7.5 Genomics

Fact. India's genomics market is estimated between USD 1.67 billion (2025, 7.4% CAGR to 2030) and USD 2.5 billion (2025, 15.9% CAGR to 2034) depending on scope, while the narrower next-generation sequencing segment alone is sized at USD 283.7 million in 2025, growing at 19.7% CAGR to 2034. Diagnostics is the largest sequencing application at 38.9% share; academic and research institutions still account for the largest end-user share (41.7%), ahead of clinical adoption.

Analysis. The research-over-clinical skew is the key structural signal: government-backed population genomics programmes (the Genome India project and the Phenome India National Biobank launched in 2025 under CSIR) are building the population-reference data infrastructure that clinical genomics ultimately

depends on, but translation into routine diagnostic and therapeutic use is still early, concentrated in oncology and rare-disease testing at a handful of urban academic and corporate labs.

Implication. Genomics is a multi-year infrastructure bet rather than a near-term revenue line for most operators; the more immediate commercial opportunity sits in oncology-linked diagnostic testing (cross-referencing Section 3.3's diagnostics chain economics) rather than broad-based consumer genetic testing, where reimbursement and clinical-utility pathways remain unsettled in India.

7.6 Precision Medicine

Fact. India's precision medicine market is estimated at USD 2.4–2.7 billion in 2024/2025, projected to reach USD 6.5–7.0 billion by 2033/2034 (11–13% CAGR). Oncology is the largest application at 32% share and gene sequencing the largest technology category at 25% share; the Department of Biotechnology has named precision biotherapeutics a priority under its BioE3 policy and has backed dedicated Centres for Advanced Genomics and Precision Medicine to accelerate translational research.

Analysis. Industry commentary frames India as being at an inflection point — “the stage is set, but the performance is just beginning” — with policy infrastructure (BioE3, biobanking) now in place ahead of widespread clinical deployment. This mirrors the genomics pattern above: India is building the population-scale data and institutional infrastructure precision medicine requires, but per-patient clinical adoption of targeted, biomarker-guided therapy selection remains concentrated in leading oncology centres rather than the broader hospital network.

Implication. The largest near-term commercial opportunity is in precision oncology diagnostics bundled with hospital cancer-care programmes, where genomic profiling directly informs treatment selection and can be priced into existing oncology care pathways rather than sold as a standalone consumer diagnostic.

7.7 Wearables

Fact. India's medical wearables market was valued at USD 1.04 billion in 2024, projected to reach USD 4.2 billion by 2033 (15.5% CAGR); health and fitness tracking accounts for 54% of the broader smart-wearables market by volume, while chronic-disease remote-monitoring wearables (ECG-capable smartwatches, continuous glucose monitors, cardiac patches) are growing faster at approximately 24.7% CAGR through 2030.

Analysis. The bifurcation between consumer fitness wearables and clinical-grade monitoring wearables is widening rather than converging: insurers are now offering premium rebates and free devices tied to activity targets, creating a direct underwriting-linked adoption channel that did not exist five years ago, while clinical-grade continuous monitoring is being pulled by the same chronic-disease burden — 77 million diabetics today, projected to reach 134 million by 2045 — driving the home-monitoring device demand discussed in Section 7.8 below.

Implication. Wearables are becoming a distribution and engagement channel for insurers and hospital chronic-care programmes as much as a standalone device category; partnerships that link wearable data to underwriting or care-management workflows are likely to capture more value than hardware sales alone.

7.8 Remote Patient Monitoring

Fact. India's dedicated RPM devices market (excluding glucose and neurological monitors) was valued at USD 53.3 million in 2025, a modest 4.2% CAGR from 2020–25; the broader home-healthcare-monitoring

devices category, which includes RPM-enabled blood pressure, glucose, and pulse-oximetry devices, is larger and faster-growing at USD 895.5 million in 2025 rising to USD 3.33 billion by 2034 (15.2% CAGR).

Analysis. The gap between the narrow RPM-devices figure and the broader connected home-monitoring figure reflects where the real growth is occurring: not in dedicated hospital-grade RPM hardware, but in mass-market connected devices (smart BP cuffs, glucometers) that feed data into telemedicine and chronic-care platforms. This is consistent with the chronic-disease burden driving Section 7.7's wearables demand and the hypertension prevalence of 22.6% nationally that underlies both markets.

Implication. RPM's commercial value in India is likely to be captured primarily by whoever owns the care-management workflow around the data (telemedicine platforms, insurers, hospital chronic-disease programmes) rather than by device manufacturers alone, favouring integrated platform plays over hardware-only entrants.

7.9 AI-enabled Drug Discovery

Fact. India's AI-in-drug-discovery market is estimated at USD 497–642 million in 2025/2026, projected to reach USD 6.0–6.4 billion by 2035 (approximately 29% CAGR), broadly in line with the global market's 23% CAGR trajectory from USD 24.5 billion (2026) to USD 160.5 billion (2035). In a domestic milestone, Peptris Technologies' PEPR124 (RT001), repurposed for Duchenne muscular dystrophy using generative AI and licensed to Revio Therapeutics in March 2025, is cited as India's first AI-discovered drug candidate, with Peptris retaining BRICS commercialisation rights.

Analysis. The PEPR124 case is illustrative of where Indian AI-drug-discovery capability is actually strongest: drug repositioning and repurposing of already-safety-validated compounds, rather than de novo molecule discovery for entirely new targets, which remains dominated by well-capitalised US platforms (Exscientia, Absci, Recursion). This plays to India's existing generics and CDMO cost advantage (Section 3.2) rather than requiring it to out-invest global R&D-stage biotech.

Implication. For Indian pharma and CDMO players, the more defensible near-term strategy is AI-enabled repurposing and biosimilar/generic optimisation pipelines rather than competing directly in first-in-class de novo drug design, where capital intensity and clinical-trial risk are structurally higher and better suited to global biotech balance sheets.

7.10 Automation

Fact. The global healthcare robotic process automation (RPA) market reached approximately USD 2.8 billion in 2025, growing at a 26% CAGR to 2034; broader healthcare automation (RPA plus intelligent document processing, pharmacy and hospital robotics) is estimated near USD 13.4 billion in 2025. India-specific market sizing is thin, but adoption is documented across claims processing, appointment scheduling, inventory management, and revenue-cycle workflows at major hospital chains and insurers.

Analysis. Automation's business case in India is less about cost replacement (as in mature Western labour markets) and more about a structural capacity constraint: Section 4's Risks noted 20–30% annual nurse attrition at major chains and a projected 2 million nurse shortfall by 2030, alongside acute super-specialist scarcity. Automation of scheduling, billing, claims, and documentation is therefore better framed as a manpower-shortage mitigation tool than a pure margin lever.

Implication. Hospital operators facing the staffing constraints documented in Section 4 should prioritise automation investment in administrative and revenue-cycle workflows first, freeing clinical staff capacity,

rather than treating automation primarily as a cost-cutting initiative — the workforce math makes the former case stronger in India's current labour market than the latter.

7.11 Emerging Healthcare Technologies

Fact. India's 3D-printing market (all industries) is projected to grow from USD 276.2 million in 2025 to USD 762.6 million by 2030 (22.5% CAGR, ahead of the 17.2% global rate), with medical devices a named growth vertical alongside aerospace and automotive; documented clinical use cases include Medanta Gurugram's 3D-printed titanium vertebral implant (India's first such reconstruction) and Bengaluru-based Altem Technologies' bioprinting partnership with Sweden's CELLINK. Quantum-computing applications in molecular simulation for drug discovery, and early digital-twin and brain-computer-interface research, remain at a pre-commercial, research-institution stage in India.

Analysis. These technologies sit at markedly different points on the maturity curve within a single subsection: 3D printing and bioprinting already have documented clinical and commercial deployments in India, quantum-assisted drug discovery is a credible but still largely theoretical near-term lever globally, and brain-computer interfaces / digital twins remain research-stage even in the most advanced global markets. Treating all eleven vectors in this section as equally investable would understate this difference.

Implication. For investors and operators, 3D printing/bioprinting merits the same near-term evaluation lens applied to the other technologies in this section; quantum computing and BCI/digital-twin applications are more appropriately tracked as long-horizon research bets or acquisition-of-capability plays than as items with a defensible India-specific market-sizing case today.

Opportunities and Risks

Opportunities:

- AI/GenAI diagnostic and administrative tooling offers the highest risk-adjusted near-term return of any technology vector in this section, directly addressing the radiologist and specialist shortages identified in Sections 3.1 and 4.1.
- Domestically manufactured, affordability-engineered platforms (SSi Mantra in robotics, Peptris in AI drug repurposing) are outcompeting premium imports on unit economics — a repeatable import-substitution playbook for MedTech investors already seen in Section 3.4.
- ABDM/ABHA integration is shifting from compliance overhead to a genuine distribution and reimbursement advantage, particularly for providers and insurers expanding into the underserved states prioritised in Section 4.4.

Risks:

- Analyst market-size estimates across almost every technology in this section diverge by 2–3x depending on scope definition, mirroring the overall market-sizing dispersion in Section 2.2; capital-allocation decisions should rely on the narrower, more defensible estimates rather than the most optimistic figure available.
- Clinical and regulatory translation lags commercial hype in genomics, precision medicine, and AI-enabled drug discovery, where research- and academic-institution adoption still exceeds routine clinical or patient-facing deployment.
- Telemedicine and RPM value capture is shifting toward whoever owns the underlying care-management workflow (public platforms, insurers, hospital chronic-care programmes) rather than toward hardware or point-solution vendors, compressing standalone device-company margins.

Section 7 — Summary Implications

1. AI/Generative AI and robotics are the two most capital-efficient technology bets in the near term, both directly addressing the workforce and specialist-access constraints already quantified in Sections 3.1 and 4.1.
2. ABDM's compounding scale (104 crore-plus linked records, doubling in fifteen months) has turned India's digital health backbone into a distribution asset that providers and insurers should integrate with proactively rather than treat as a regulatory formality.
3. Genomics, precision medicine, and frontier technologies (quantum computing, BCI, digital twins) remain multi-year infrastructure and research bets rather than near-term revenue lines, and should be underwritten and evaluated on a different timeline than the more commercially mature technologies in this section.

Sources: IMARC Group (AI in Healthcare, Genomics, Precision Medicine, Telemedicine, Medical Wearables, Home Healthcare Monitoring, 3D Printing market reports, India editions); MarketsandMarkets (AI in Healthcare, Generative AI, Surgical Robots, Wearables in Pharma & Biotech, RPA in Healthcare, 3D Printing — India editions); Market Research Future; Grand View Research (Generative AI in Healthcare); GlobalData (Remote Patient Monitoring Devices); Precedence Research (RPA in Healthcare); Ministry of Health & Family Welfare / National Health Authority / PIB (ABDM, ABHA, Aarogya Setu 2.0, NHCX disclosures, 2026); Oxford Open Digital Health (eSanjeevani adoption study, 2025); Bain & Company (telehealth consumer research, 2025); BioSpectrum India (precision oncology, Peptris/PEPR124); Department of Biotechnology (BioE3 policy); The Week; Drishti IAS; Seeking Alpha / Nasdaq (SS Innovations disclosures); The Quint; Outlook India (3D printing in Indian healthcare).

8. Key Investment Themes 2026–2030

This section screens the candidate 2026–30 investment themes on a common basis — market size and growth, margin and capital-intensity profile, competitive/consolidation stage, and current investment activity — to separate genuinely differentiated opportunities from themes that are simply well-covered. Consistent with the segment analyses in Sections 3 and 5, each theme is assessed on the evidence available as of mid-2026; where sources diverge materially, the range is noted rather than a single point estimate.

8.1 Investment Attractiveness Matrix

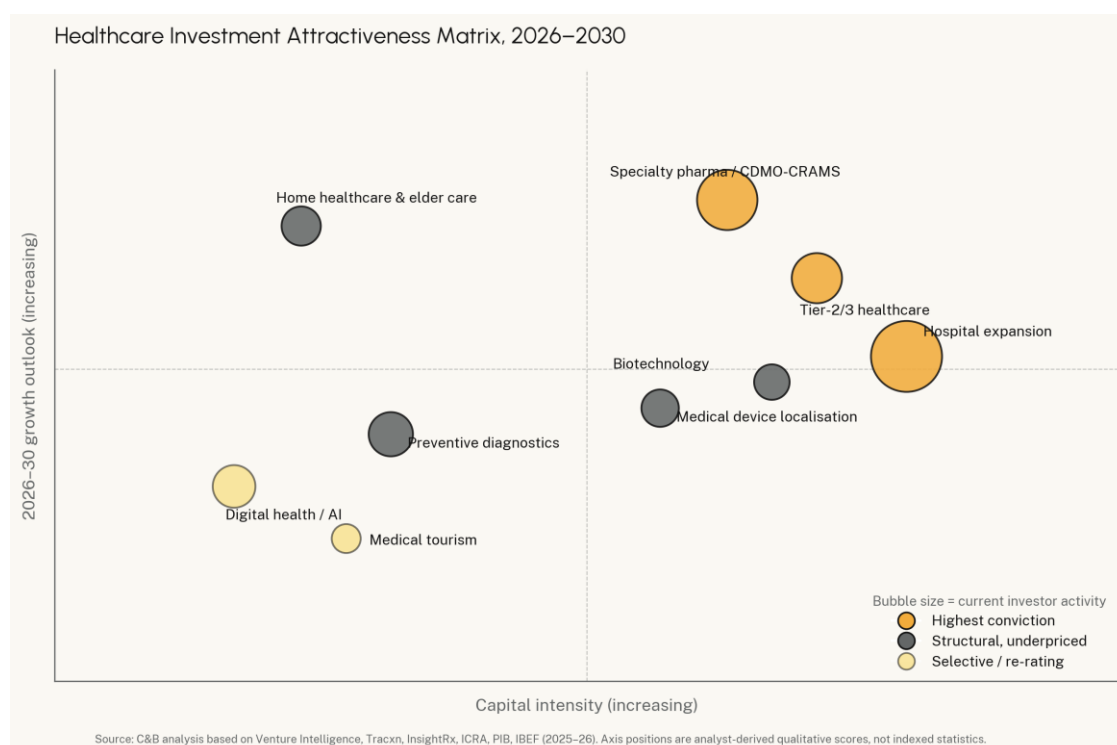


Fig 8.1: Capital intensity vs. 2026–30 growth outlook, bubble size indicates current investor activity. Axis positions are analyst-derived qualitative scores based on the evidence in the table below, not an indexed statistic. Source: C&B analysis based on Venture Intelligence, Tracxn, InsightRx, ICRA, PIB, IBEF (2025–26).

8.2 Theme Scorecard

Theme	Growth Outlook 2026-30	Capital Intensity	Investor Activity (Fact Base)	Suitable Capital	Implication
Hospital expansion	High	High	PE/VC ~US\$5.5bn (2023, +25% YoY); Manipal Health IPO filed ~US\$1.17bn (Mar-26); high-teens EV/EBITDA entry multiples	Term debt + PE growth capital + IPO exit	Most crowded theme; entry pricing, not thesis validity, is now the key risk
Tier-2/3 healthcare	High	Moderate-High	~22,000 new private beds over 3-5 yrs, disproportionately non-metro; embedded within hospital PE flows	Structured debt + asset-light/franchise PE	Genuine multi-year runway on bed-density gap (1.3 vs OECD 4.3/'000); less crowded than flagship metro assets
Specialty pharma / CDMO-CRAMS	High	High	ICRA: ₹42,000-45,000cr FY26 pharma capex; ₹1.40-1.45 lakh cr cumulative FY26-30; capacity tripling at scale players	Term debt/equipment finance + strategic-PE equity	Strongest thematic bid in pharma services; China+1 diversification is the structural tailwind
Medical device localisation	Moderate	High	PLI outlay ₹3,420cr; realised investment ₹1,153cr (Jul-26) against a US\$4.8bn import-export gap (FY25)	Term debt (PLI-linked capex) + growth equity	Scheme sunsets FY26-27; post-PLI cost competitiveness is the underwriting question
Biotechnology	Moderate-High	High	Embedded in CDMO/pharma capex flows; biosimilars, genomics gaining dedicated investor interest	VC (early stage) + strategic/PE (scale-up)	Longer gestation, but rides the same global biologics/GLP-1 outsourcing wave as CDMO
Preventive diagnostics	Moderate	Low-Moderate	Consolidation-led; organised chains continuing roll-up of unorganised, fragmented labs	PE roll-up equity + working capital debt	Steady, cash-generative; fits consolidation-focused PE more than growth-stage VC

Theme	Growth Outlook 2026-30	Capital Intensity	Investor Activity (Fact Base)	Suitable Capital	Implication
Home healthcare & elder care	High	Low	Market est. US\$12-16bn (2025) across sources, 9-16% CAGR; still nascent institutional investment	VC / growth equity; limited debt suitability (asset-light)	Highest growth-to-capital-intensity ratio on the matrix; underfunded relative to demographic tailwind
Digital health / AI	Moderate (re-rating)	Low	India funding fell sharply YoY (Tracxn); H1-26 ~US\$310mn raised, concentrated in AI, oncology, genomics	VC, increasingly selective	Capital concentrating into fewer, clinically-validated players; broad-based thesis has weakened
Medical tourism	Moderate	Low-Moderate	Embedded within hospital operators' international-patient programmes; limited dedicated deal data	Strategic capital via existing hospital platforms	Adjacent revenue stream for hospital assets rather than a standalone investable theme

Note: "Investor Activity" cites the most recent disclosed, verifiable data point per theme; figures mix FY and calendar-year references as reported by the original source and are not restated to a common period. Where a theme's funding data is a subset of a broader segment (e.g., Tier-2/3 within hospital PE), this is noted rather than treated as a separately tracked pool of capital.

8.3 Reading the Matrix

Fact. Hospital expansion, Tier-2/3 healthcare and Specialty pharma/CDMO-CRAMS combine high growth with high capital intensity, and entry multiples on quality hospital and CDMO platforms have moved into high-teens EV/EBITDA.

Analysis. Pricing, not the underlying growth case, is now the binding constraint on incremental capital deployment in these three themes — they are already the most heavily capitalised segments of Indian healthcare.

Implication. New capital is better directed at platform-building — brownfield capacity, bolt-on M&A — than at fresh-entry multiples on scarce assets. By contrast, Medical device localisation, Biotechnology, Preventive diagnostics and Home healthcare & elder care show durable structural tailwinds without proportionate institutional capital yet committed; home healthcare and elder care in particular show the highest growth-to-capital-intensity ratio on the matrix, offering the more attractive risk-adjusted entry points for growth equity over 2026-30. Digital health/AI and Medical tourism sit in a selective, re-rating quadrant: India-specific HealthTech funding contracted sharply through 2025-26, with capital concentrating into a small number of clinically validated, AI-enabled players rather than disappearing outright — both are better approached as enabling layers within other themes than as standalone theses.

8.4 Corporate Finance Implication

For lenders and PE investors evaluating this decade's healthcare deployment, the practical takeaway is a barbell: continue funding the high-conviction, capital-intensive themes through structured/term debt and scaled PE where platforms already exist, while allocating growth-equity capital toward the underpriced,

asset-light themes — home healthcare, elder care, preventive diagnostics — before they re-rate. Digital health and medical tourism are best underwritten as adjacencies within a portfolio company's broader strategy rather than as freestanding theses.

Conclusion

Indian healthcare presents a structurally under-penetrated, financing-formalising market in which growth is broad-based but capital access is not. Government health expenditure has risen and out-of-pocket spending has fallen for a decade; PM-JAY and the ABDM digital backbone have expanded the addressable, organised-care population; and public capital markets have matured alongside private investment, culminating in Manipal Health Enterprises' landmark 2026 listing. Against this backdrop, the report's segment analysis (Section 3), geographic analysis (Section 4), funding and IPO data (Sections 5–6), technology outlook (Section 7) and investment-theme scorecard (Section 8) converge on a consistent conclusion: fragmentation, not headline market growth, remains the primary source of organised-sector opportunity, and margin quality — not scale alone — is what the market rewards.

Fact. Hospital expansion, Tier-2/3 healthcare and specialty pharma/CDMO-CRAMS are the three most heavily capitalised investment themes in Indian healthcare today, with entry multiples on quality platforms now in the high-teens EV/EBITDA range (Section 8.2–8.3).

Analysis. This concentration of capital has not been matched by a proportionate re-rating of medical device localisation, biotechnology, preventive diagnostics or home healthcare and elder care — segments with equally durable structural tailwinds (PLI incentives, demographic ageing, biologics/genomics demand, consolidation-led roll-up economics) but comparatively little institutional capital committed to date.

Implication. The report's overall investment thesis is a barbell: continue funding the high-conviction, capital-intensive themes — hospitals, Tier-2/3 expansion, CDMO/CRAMS — through structured and term debt alongside scaled private equity where platforms already exist, while directing growth-equity capital toward the underpriced, asset-light themes before they re-rate (Section 8.4).

Three risks bear directly on this thesis and should anchor any diligence or credit process built on this report: US generic-drug tariffs (2026–2029) for pharmaceutical exporters (Section 3.2); the hospital sector's binding manpower constraint, which caps the achievable ramp-up speed of funded capacity regardless of available capital (Section 3.1); and the still-unnotified e-pharmacy regulatory framework, an unresolved overhang nearly a decade after draft rules were first published (Section 3.6). Wide, definitionally inconsistent market-size estimates also persist across almost every segment covered in this report; the reconciled base-case figures set out in each section, and consolidated for reference in the Appendix that follows, should be preferred over unreconciled top-down sizing for any valuation or financing work.

Taken together, the evidence supports continued, selective capital deployment into Indian healthcare across the 2026–2030 period — with the clearest risk-adjusted returns available not in the sector's best-known, most-crowded themes, but in the structurally sound segments that organised capital has not yet fully priced in.

9. Appendix — Healthcare Data Book

This Appendix consolidates the key facts and figures cited across Sections 1–8 into a single reference. It reproduces headline figures only; source-level detail, definitional caveats and the reconciliation of conflicting estimates are set out in the section referenced against each table. Where sources diverge materially, the range reported in the originating section is retained here rather than collapsed to a single point estimate.

9.1 Macro & Market Sizing

Metric	Value	Section
Domestic healthcare market size	USD 400–420 bn (2025 base case); range USD 180–420 bn by scope	1.1, 2.2
Healthcare expenditure, % of GDP	3.58% (2000–2022 avg.) vs. 6.74% world average	1.1, 2.3
Government health expenditure (GHE), % of GDP	1.15% → 1.43–1.48% over the past decade	1.1, 2.3
Out-of-pocket expenditure (OOPE), % of THE	64.2% (2013-14) → 43.4% (2022-23)	1.1, 2.3
Private hospital share of hospital market (by value)	59%	2.4

9.2 Segment-Wise Market Sizing (Section 3)

Segment	Market Size & Growth	Section
Hospitals & Healthcare Delivery	USD 193.4 bn (2025) → USD 364.6 bn (2034), 7.3% CAGR (IMARC); alt. range USD 104.7–197.3 bn	3.1
Pharmaceuticals	~USD 60 bn (FY25) → USD 130 bn target (FY30, Economic Survey/PIB); alt. ~USD 55 bn (Bain/IBEF)	3.2
Diagnostics	~₹1.1 lakh cr (~USD 13 bn, 2026); IMARC "diagnostic labs" USD 10.95 bn (2025) → USD 28.53 bn (2034), 11.23% CAGR	3.3
Medical Devices & MedTech	USD 12–15 bn (FY26, InsightRx, 12–15% CAGR) to USD 19.11 bn (2025) → USD 31.85 bn (2034), 5.83% CAGR (IMARC)	3.4
Health Insurance (GWP)	₹1,27,417 cr (~USD 15.3 bn), FY25, +9.19% YoY (IRDAI)	3.5
Retail Pharmacy & E-Pharmacy	USD 27–30 bn (2025), ~9–10% CAGR	3.6

Biotechnology (bioeconomy)	USD 195 bn (2025), up from USD 10 bn (2014), ~18% CAGR	3.7
Digital Health / HealthTech	~USD 21 bn opportunity by 2025 (broad definition); telemedicine narrower at USD 3.6–4.2 bn	3.8

9.3 Geographic & State-Level Data (Section 4)

Metric	Value	Section
Government hospital-bed density	0.79 beds/1,000 population vs. NHP 2017 target of 2.0 and global average of 2.7	4.1
All-India bed density incl. private capacity	1.3 beds/1,000; implies a shortfall of ~2.4 million beds nationally	4.1
Public bed-density gap, best-vs. worst-served large states	5.4x (Kerala vs. Bihar)	4.1
Private healthcare infrastructure concentration	15 states account for ~69–70% of private infrastructure	1.2, 4.1

9.4 Investment, Funding & M&A Data (Section 5)

Metric	Value	Section
Cumulative healthcare PE/VC investment	US\$14.5 bn since 2020 (58% concentrated in 2023–24)	5.1
PE inflows into healthcare & pharma	US\$5.5 bn in 2023 (+25% YoY); ~US\$5.33 bn across first 11 months of 2024	5.2
HealthTech-specific VC funding	~US\$9.35 bn cumulative over 10 years; peaked at US\$2.83 bn (2021); fell from US\$42.5 mn (Jan 2025) to US\$0.665 mn (Jan 2026), ~98% decline	5.3
FDI into pharmaceuticals & medical devices	₹19,134.4 cr (~US\$2.3 bn), FY2024-25	5.5
Healthcare & pharma M&A	US\$35 bn cumulative, 2018–2022; US\$2.5 bn / 36 deals in Q3 2025 alone (+57% QoQ)	5.6
India PE/VC "mega deals" (>US\$100 mn, market-wide)	69 deals worth US\$21.3 bn (2025), down from 76 deals / US\$21.6 bn (2024)	5.10

9.5 IPO & Capital Markets Data (Section 6)

Metric	Value	Section
Healthcare IPO count & proceeds	13 IPOs / ₹14,811 cr (2024, avg. ₹1,531 cr) vs. 11 IPOs / ₹12,317 cr (2025, avg. ₹1,120 cr)	6.1
Average listing-day gain	19.26% (2024) → 14.07% (2025)	6.1

Manipal Health Enterprises IPO	₹9,275 cr (Aug 2026); priced ₹560–590/share; subscribed 4.92x; listed at ₹655 (+11%); ~₹86,157 cr valuation, 84.65x FY26 earnings	6.2
Sector valuation multiples	Hospitals 54.1x vs. broader healthcare basket 33.4x vs. diagnostics-weighted services 29.3x	6.3
Listed healthcare sector market cap	₹14.1 lakh cr (Dec 2022) → ₹30.5 lakh cr (Dec 2025), ~2.2x	6.3
QIPs raised market-wide	₹62,954 cr, FY25-26 (incl. healthcare precedents: Poly Medicure ₹400 cr)	6.4

9.6 Technology & Digital Health Market Sizing (Section 7)

Sub-segment	Market Size & Growth	Section
AI in Healthcare (India)	USD 435.7 mn (2025) → USD 4.77 bn (2034), 29.6% CAGR (IMARC); alt. estimates USD 791.2 mn (MnM) to USD 1.26–18.55 bn range (MRFR, 2024–2035)	7.1
Surgical Robotics (India)	USD 851 mn (2023) → ~USD 4 bn (FY2031); narrower estimate USD 117 mn (2025) → USD 251 mn (2030), 16.5% CAGR	7.2
ABDM digital infrastructure	104+ crore linked health records; 93+ crore ABHA IDs; 450+ platforms integrated (mid-2026)	7.3
Telemedicine (India)	USD 3.76 bn (2025) → USD 20.02 bn (2034), 20.4% CAGR; eSanjeevani has served 47+ crore patients cumulatively	7.4
Genomics (India)	USD 1.67–2.5 bn (2025) depending on scope; NGS segment alone USD 283.7 mn (2025), 19.7% CAGR	7.5
Precision Medicine (India)	USD 2.4–2.7 bn (2024/25) → USD 6.5–7.0 bn (2033/34), 11–13% CAGR	7.6
Medical Wearables (India)	USD 1.04 bn (2024) → USD 4.2 bn (2033), 15.5% CAGR	7.7
Remote Patient Monitoring (India)	USD 53.3 mn (2025, narrow definition, 4.2% CAGR); broader home-monitoring devices USD 895.5 mn (2025) → USD 3.33 bn (2034), 15.2% CAGR	7.8
AI-enabled Drug Discovery (India)	USD 497–642 mn (2025/26) → USD 6.0–6.4 bn (2035), ~29% CAGR	7.9
Healthcare RPA (global)	USD 2.8 bn (2025), 26% CAGR; broader healthcare automation ~USD 13.4 bn (2025)	7.10
3D Printing (India, all industries)	USD 276.2 mn (2025) → USD 762.6 mn (2030), 22.5% CAGR	7.11

9.7 Investment Theme Scorecard Summary (Section 8)

The full Investment Attractiveness Matrix and Theme Scorecard, with growth outlook, capital intensity, investor activity and suitable capital structure for each of the ten screened themes, appear in Section 8.1–8.2. The table below summarises the resulting read on capital positioning (Section 8.3–8.4).

Positioning	Themes	Read
Most heavily capitalised (crowded)	Hospital expansion; Tier-2/3 healthcare; Specialty pharma / CDMO-CRAMS	Entry pricing, not thesis validity, is now the key risk; high-teens EV/EBITDA multiples on quality platforms
Underpriced, structural tailwinds	Medical device localisation; Biotechnology; Preventive diagnostics; Home healthcare & elder care	Durable tailwinds without proportionate institutional capital yet committed; better risk-adjusted entry points
Selective, re-rating	Digital health / AI; Medical tourism	Funding has contracted and concentrated into fewer, validated players; better approached as enabling layers within other themes than as standalone theses

9.8 Glossary of Abbreviations

Abbreviation	Definition
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account (digital health ID)
API	Active Pharmaceutical Ingredient
CAGR	Compound Annual Growth Rate
CDMO / CRAMS	Contract Development & Manufacturing Organisation / Contract Research and Manufacturing Services
FDI	Foreign Direct Investment
GHE	Government Health Expenditure
GST	Goods and Services Tax
GWP	Gross Written Premium
IPO	Initial Public Offering
KSM	Key Starting Material
M&A	Mergers & Acquisitions
MSME	Micro, Small and Medium Enterprise
NHA	National Health Accounts
OOPE	Out-of-Pocket Expenditure
PE	Private Equity

PLI	Production Linked Incentive
PM-JAY	Pradhan Mantri Jan Arogya Yojana (Ayushman Bharat)
QIP	Qualified Institutional Placement
RPA	Robotic Process Automation
RPM	Remote Patient Monitoring
THE	Total Health Expenditure
VC	Venture Capital
WHO	World Health Organization

9.9 Note on Data & Sources

All figures in this Appendix are drawn directly from Sections 1–8 of this report and carry forward the same source attribution, reporting period and reconciliation approach set out in the originating section; no new data has been introduced here. Where a section presents a range of estimates from different research houses, that range — rather than a single collapsed figure — is preserved in this data book. Readers requiring full citations, methodology notes or source-level detail for any figure should refer to the "Summary Implications" and "Sources" text at the close of the relevant section.