LEK™

SPECIAL REPORT

Access and Impact:

Unlocking a Value-Based Health System in India

Contents

Executive summary 3

Introduction 5

Key challenges 7

Points of deliberation 10

Conclusion 16

About the authors 18

Participating experts 19

About L.E.K. Consulting
L.E.K. Consulting is a premier global strategy consulting firm that partners with clients to solve their most critical business challenges and deliver high-impact outcomes. We bring deep industry expertise and rigorous, evidence-based insight to global corporations, growth companies, and private equity investors, helping them turn strategy into action. Founded more than 40 years ago, L.E.K. now operates across 27 offices worldwide. Learn more at **lek.com**.

Executive summary

India is at a defining moment in the evolution of its health insurance and healthcare delivery ecosystem. The rapid rise of non-communicable diseases, particularly cardiovascular disease (CVD), is reshaping healthcare demand, financing priorities and long-term policy objectives. While the scale of this challenge is considerable, it presents an opportunity to reposition health insurance as a platform for long-term, patient-centric and financially sustainable care that measurably improves quality of life.

India's CVD profile is structurally distinct from global trends. Earlier onset, higher prevalence during productive working years and prolonged disease trajectories demand a shift away from episodic, hospitalization-centric insurance models toward approaches that support prevention, early intervention and lifelong disease management. A critical enabler of this shift is the effective integration of modern treatments and medical technologies into insurance design and care delivery.

In cardiovascular care, medical technology directly influences procedural success, complication rates, re-admissions, long-term mortality and health-related quality of life. Recognizing technological advancement as a core determinant of value across the care continuum is therefore essential.

Encouragingly, many of the structural enablers required for this transition are evolving at a rapid pace. Commercial health insurance has expanded rapidly, public programs such as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) have standardized access to minimal mandatory care at a massive scale. The move of the Insurance Regulatory and Development Authority of India (IRDAI) toward principle-based regulation has helped establish a more coherent and efficient regulatory framework. This shift has created unprecedented flexibility for product design and innovation, resulting in faster product approvals, reduced waiting periods for pre-existing conditions, improved portability, expanded coverage for chronic diseases and delivery of large-scale digital health initiatives.

Yet public and private systems still face shared challenges such as affordability, outcome measurement, data maturity and trust. Addressing these gaps will require coordinated public-private learning rather than parallel evolution. Fragmented care pathways, unclear coverage boundaries and persistent payer-provider friction continue to undermine patient experience, financial protection and system efficiency.

Stakeholder deliberations reflect broad alignment across insurers, regulators, clinicians, providers, medtech companies and patient representatives around a shared ambition: to move from transactional reimbursement toward integrated, patient-centric and value-based health insurance. There is growing recognition that no single stakeholder can drive this transformation independently. Sustainable progress will depend on coordinated ecosystem action, anchored in structured dialogue, data transparency, standardized yet flexible clinical pathways, digital infrastructure, and regulatory pragmatism.

India's health insurance policy environment has thus evolved from a constraint into a catalyst. The next phase of impact lies in execution: translating policy intent into scalable operating models that improve patient experience and outcomes while reducing friction and aligning incentives across the care journey.

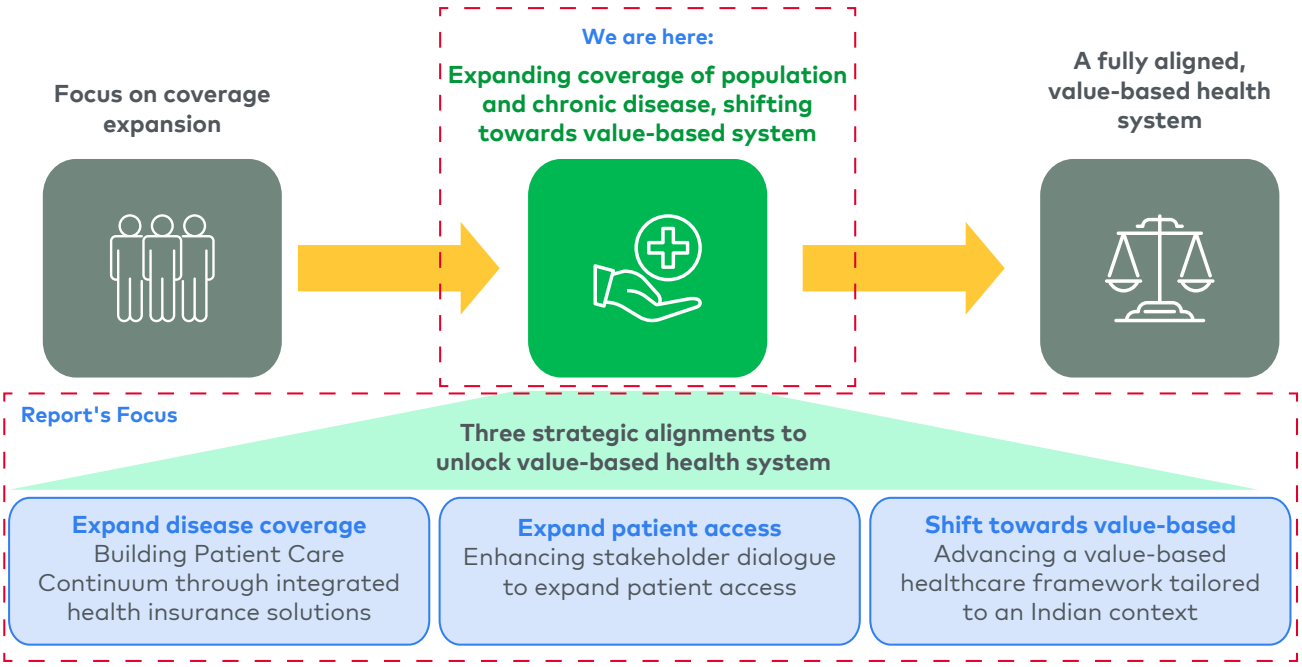
Introduction

Over the past several years, our work to enable India's ever-evolving health insurance and reimbursement landscape, with a focus on medtech, has systematically examined the structural constraints of the current reimbursement ecosystem, ranging from affordability challenges and high out-of-pocket expenditures to fragmented reimbursement pathways and decision-making, capacity limitations in health technology assessment (HTA), inadequate stakeholder engagement and limited integration of real-world evidence into policy design.

Earlier publications in this series (see references 1–5) focused on diagnosing these challenges and proposing foundational reforms. These included the need for more transparent and inclusive governance mechanisms, fit-for-purpose HTA frameworks, improved data infrastructure and predictability, and early experiments with value-based incentives, particularly for medical technologies that play a critical role in determining clinical outcomes. Collectively, the proposed recommendations underscored that while schemes such as Ayushman Bharat PM-JAY have significantly expanded access to minimal mandatory care, continued policy reforms are required to deliver a more patient-centric, coordinated and outcome-focused healthcare journey.

Building on this trajectory, this year's report examines how health insurance in India must evolve to support continuum-of-care models for chronic cardiovascular diseases, improve patient experiences and health outcomes, and advance a more consistent, context-appropriate understanding of value in healthcare delivery across stakeholders within the Indian health system.

Figure 1
The current report will focus on the potential initiatives to align incentives across insurance design, partnerships, and reimbursement to unlock a value-based health system



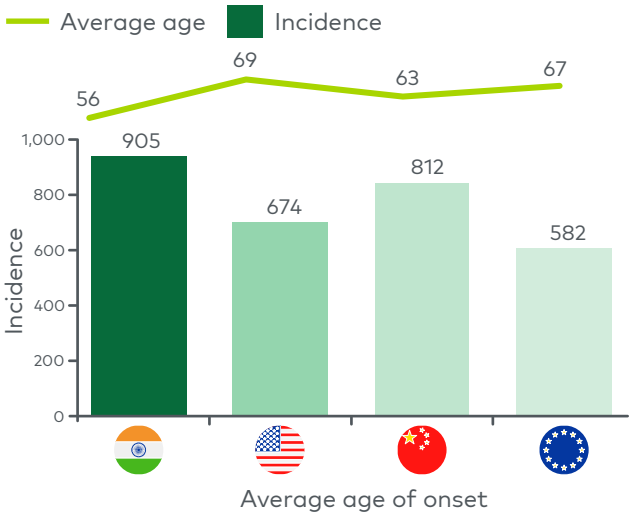
Key challenges

Reimagining insurance for rapidly evolving CVD-related disease burden

In India, CVD is one of the fastest-growing health burdens, appearing approximately 10 years earlier than the global average (see Figure 2). Several patients experience their first myocardial infarction in their early 50s, making CVD a long-term, chronic and financially draining disease to manage. Traditional insurance models, designed primarily around managing acute episodes, capture only a fraction of the value that high-quality, technology-enabled care can deliver across the patient journey. The primary cost burden lies not in a single intervention but in recurrent hospitalizations, prolonged medication, diagnostics and complication management. With the ongoing advancements in medical technology to improve health outcomes and quality of life, insurers must adopt innovative coverage frameworks that support comprehensive, long-term management of chronic conditions such as CVD.

Figure 2
Cardiovascular disease burden and age of onset (India vs. global)

Cardiovascular disease burden and age of cardiovascular disease onset (2022*)
Incidence, average age



Country/region	Typical age
	~53-58 years (INTERHEART mean ≈53; Indian ACS cohorts ~58)
	Men 65.6; Women 72.0 (AHA 2024)
	~63 years
	~63-70 years overall (varies by country, e.g., German registries show median ≈70)

*The most recent available data points have been used where possible; however, sources vary by year depending on data availability and credibility
Source: World Heart Federation; Lancet INTERHEART study; CREATE registry, Lancet ICMR-INDIAB study, Journal of the American Medical Association; AHA= American Heart Association

Managing persistent payer-provider friction to improve patient journey and affordability

Health insurance now covers nearly 70% of India's population through a combination of public and private programs, with care delivered across both public and private hospital networks. As insurance penetration has expanded, payers and providers have become increasingly interdependent. According to the India Hospital Insights Survey 2025, both public and private insurance schemes are viewed as important growth segments by private hospitals, underscoring the central role of insurance in healthcare delivery.

Despite this interdependence, payer-provider collaboration remains fragmented. Persistent points of friction include non-viable reimbursement rates, rigid and outdated package structures, non-standardized clinical pathways, documentation gaps and inconsistent interpretation of medical necessity. At the same time, insurers face legitimate concerns around treatment overuse, escalating costs, and fraud and abuse risks. Together, these misalignments lead to delays, denials, unexpected out-of-pocket payments and administrative inefficiencies, ultimately affecting the patient experience, affordability and trust in the system.

For health insurance to function in line with its intended objective, providing financial protection while enabling timely, appropriate care, these points of friction must be addressed structurally rather than transactionally.

Implementing value-based healthcare for India's health system

Senior stakeholders in India's healthcare ecosystem (i.e., participants in the RTM) broadly recognize the need to move from cost-based reimbursement toward value-based healthcare (VBHC). However, implementation has been hampered by fragmented definitions of value, limited availability of outcomes data and misaligned incentives across stakeholders.

Procurement and reimbursement practices, particularly in the public sector, continue to be dominated by L1 (lowest-price) norms, limiting the ability to reward innovation, differentiated outcomes or long-term cost savings. While the introduction of HTA and the proposed VBHC policy framework, which link hospital payments and incentives to National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditation and outcome-based indicators under PM-JAY, represent welcome and progressive steps, policy pull-through in practice remains limited and continues to be a significant roadblock to implementation.

These challenges are further compounded by weak data foundations. Standardized, interoperable data on costs, clinical outcomes, quality and patient experience remain fragmented and are often confined to claims data rather than provider-level clinical information. This constrains the ability to measure value meaningfully, increases the risk of gaming and raises administrative burdens when new measurement frameworks are layered on without leveraging existing data systems. As a result, the principle that "what cannot be measured cannot be improved" remains a critical barrier to the effective adoption of VBHC in India.

India's reimbursement payments are split into procedure fees and implant fees (for commonly used therapies) which are brand neutral and cost conscious.

Points of deliberation

Proposed change 1: Continuum of care models must replace episodic, hospitalization-based approaches, offering end-to-end coverage

Insurance models must evolve from reactive, hospitalization-centric coverage toward integrated continuum-of-care frameworks that span prevention, early diagnosis, treatment, follow-up and long-term disease management.

Key enablers include:

- **Differentiated approaches for general and high-risk populations:** There is a strong need to move beyond one-size-fits-all policies toward differentiated approaches for general and high-risk populations. These include disease-specific care pathways, targeted top-up products (such as CVD-specific solutions that complement base health insurance) and incentive-based models that reward lifestyle modification, treatment adherence and reduced hospitalization. While some insurers have advanced product innovation to accommodate evolving needs, significant scope remains to scale these solutions effectively at a population level.
- **End-to-end coverage, even when reimbursement remains episodic**: Expanding CVD coverage to include evidence-based, value-driven and clinically necessary interventions, rather than reimbursing only pre-specified procedures, can significantly reduce patient financial shock and care fragmentation. Such an approach better aligns insurance coverage with real-world clinical practice where multiple diagnostics, devices and adjunct procedures are often required to manage complex cardiac events.
- **Upgrading coverage over time:** Advances in medical technology, the shift toward outpatient and short-stay procedures, and IRDAI-led regulatory improvements, such as reduced pre-existing disease lookback periods, greater flexibility for high-sum-assured products (including unlimited sum insured for specific surgeries), shorter moratoriums and revised waiting periods, have materially altered what coverage looks like today. Upgradable coverage frameworks that allow policyholders to migrate to enhanced plans with continuity benefits as medical standards evolve should become a core feature, making periodic policy review an integral part of both financial and health planning.

- **Move towards modular health insurance policies:**
  In line with IRDAI's 2024 Master Circular, insurers can offer modular plans with optional add-ons and riders to address varied healthcare needs. For example, a rider covering modern treatments will allow policyholders to opt for superior coverage based on their preferences, at an incremental premium.

From an actuarial perspective, this shift moves focus from short-term claim payouts toward lifetime cost optimization, particularly relevant for chronic diseases, where preventing even a single rehospitalization can materially improve long-term loss ratios. Due to favorable regulatory changes, insurers are increasingly experimenting with disease-specific solutions, including diabetes- and CVD-focused products and incentive-based models. However, challenges persist due to limited engagement, small risk pools, pricing uncertainty and inadequate longitudinal data for robust actuarial pricing. Unlocking the next phase of innovation will require not only regulatory flexibility, but also regulator-led frameworks for data sharing, clinical pathway standardization and outcome measurement, enabling insurers, providers and medtech companies to jointly design scalable, sustainable and value-based care models.

Proposed change 2: Reduction in payer-provider friction through strengthening engagement, standardization of clinical pathways, co-created outcomes-focused contracting models and digitization

Most payer-provider disputes arise not from malpractice or intent, but from a mismatch between static insurance packages and dynamic clinical realities. While most cases follow predictable treatment pathways, a meaningful minority require deviations due to disease complexity, complications or the use of evolving medical technologies. The India Hospital Insights Survey 2025 points towards the need to increase the volume of payer contracts, develop partnerships with payers to offer bundled payment etc. for effectively managing payer relationships among private hospitals (Figure 3). A structured framework is therefore needed to standardize care where possible while allowing flexibility where necessary, without ambiguity, delays or financial shock for patients.

Key elements of such a framework include:

- **Nationally aligned standard care pathways (covering approximately 80%-90% of cases):**
  Evidence-based, specialty-specific standard treatment workflows covering about 80%-90% of common disease presentations, with mechanisms for periodic updates to reflect advances in medical practice and technology, can be developed and implemented. These pathways should define standard

diagnostics, procedures, length of stay, consumables and expected pre- and post-procedure care (including medicines and follow-up). Existing guidelines developed by the Indian Council of Medical Research can serve as a strong starting point. Once established, these pathways could form the default "auto-approval" zone, significantly reducing pre-authorization friction and claims disputes.

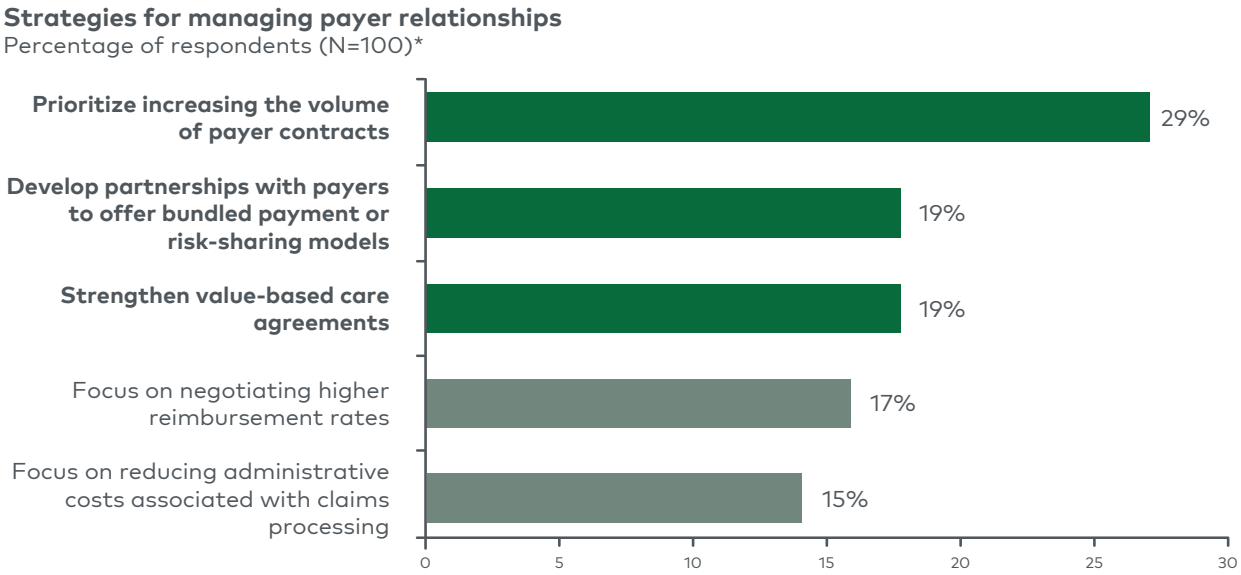
- **Trust built through collaboration and digital transparency:**
  Joint training programs for hospitals, Third Party Administrators (TPAs), and insurers on evolving clinical standards and medical advancements can improve clarity and alignment across stakeholders. Enhanced engagement through transparent claim authorization processes, digitized workflows and continuous feedback mechanisms will be critical to strengthening trust between payers, providers and patients.

- **Digital pre-authorization and documentation workflows:**
  While many insurers and hospitals have digitized systems in place, interoperability and uniform data standards remain limited. As healthcare delivery becomes increasingly technology-enabled, insurance claims processing systems must evolve in parallel. A shift from free-text documentation and scanned PDFs toward structured digital data fields can enable faster review, reduce interpretation risk and improve consistency. Integration with Ayushman Bharat Digital Mission (ABDM) and national claims exchanges can further enhance efficiency, enable system-level learning and reduce friction across stakeholders.

- **Clear definition of 'allowable deviations' with fast track approval mechanisms:**
  Explicitly defining allowable deviations, such as clinical complications, relevant co-morbidities and use of advanced therapies, can reduce ambiguity and disputes. Replacing rigid single-price packages with documented price corridors supported by real-time escalation pathways and predefined service level agreements can enable faster approvals, predictable payouts and reduced financial burden for patients.

- **Central repository with continuous updating:**
  Clinical pathways, deviation rules and pricing bands should be hosted in a national digital repository and updated periodically by multi-stakeholder expert committees consisting of clinicians, payers and HTA bodies. Such a repository would reflect new evidence, pricing changes and technology adoption while ensuring consistent interpretation across insurers, TPAs and providers.

Figure 3
Strategies for managing payer relationships among private hospitals



*Survey question: What is your primary strategy for managing relationships with payers?
Source: L.E.K. 2025 APAC Hospital Priorities Survey
Note: APAC= Asia-Pacific

Proposed change 3: Transition from cost-based to value-based procurement combining clinical outcomes, cost-effectiveness, equity, feasibility and patient experience

In order to adopt a true value-based care model, India should prioritize clinical effectiveness, affordability, quality of care, patient-reported outcome measures, and care-efficiency measures that generate a system-wide impact and long-term system efficiency.

A VBHC model for India should consider the following:

- **Alignment on the uniform definition of value:**
  Currently, the concept of value is perceived differently by different stakeholders across the healthcare ecosystem due to the absence of a unified definition of "value" that works throughout India's highly fragmented public and private healthcare landscape. Efforts need to be made to unify the value perception of each stakeholder for the common mission of keeping patients at the core. Centralized efforts should be made to define and measure value objectively, enabling equitable distribution of incentives across all stakeholder groups.

- **HTA as a value enabler, not just a cost-effectiveness filter:**
  The current orientation of HTA in India revolves mostly around cost-effectiveness, while other critical dimensions of value such as level of innovation, therapy adoption, ease of use and long-term outcomes are often underweighted. A balanced HTA approach that incorporates these important considerations is needed to support medtech innovations in line with changing patient needs.

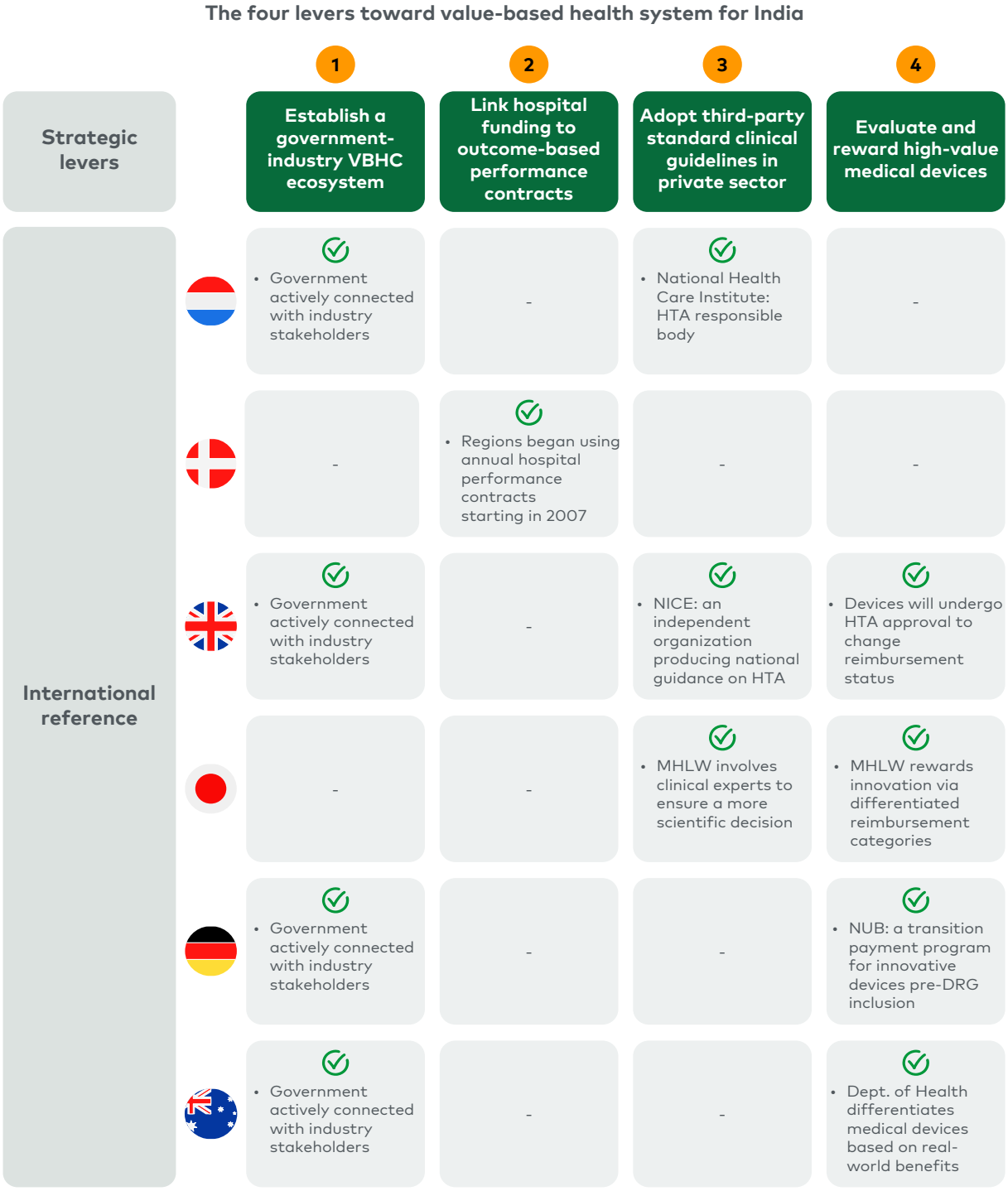
- **Procurement shift from L1-driven pricing to outcome-informed purchasing decisions:**
  The UK's Value-Based Procurement pilot has successfully demonstrated that when procurement specifications incorporate clinical outcomes, system-efficiency parameters, total cost of care, long-term evidence, quality standards and real-world performance data, it is possible to achieve both affordability and superior outcomes. Some states in India have tried to implement a value-based framework and can act as leaders in the discussion. Hospitals should be enabled to move toward outcome-adjusted value where reinterventions, re-admissions, complications and length of stay are explicitly considered.

- **Brand neutrality reconciliation with innovation incentives in medtech:**
  India's VBHC model must be designed in such a manner that it can distinguish between baseline equivalence, where brand neutrality is appropriate, and introduce mechanisms to assign product-level categories through comprehensive evaluation, ensuring that value differentiation is appropriately rewarded.

- **Making data the backbone of VBHC:**
  For VBHC to function, methodical data collection and management are key to enable efficient, cost-effective and patient-centric care. Interventions such as electronic health records and processing claims and billing data using the National Health Claims Exchange Database can act as enablers to operate efficient VBHC models without overly burdening the existing administrative systems. The collected data metrics must be measurable, resistant to manipulation and meaningful for decision-making and can further be used for workflow optimization and evaluation of the identified value metrics.

The path forward is evolutionary rather than revolutionary and is grounded in pragmatism, phased execution and continuous learning while keeping patients, equity and long-term system sustainability at the center of this value equation. Learnings from international references emphasize on strategic levers critical for a successful VBHC adoption in India (Figure 4):

Figure 4
Four strategic levers can accelerate VBHC adoption in India, addressing systemic gaps and aligning with internationally validated best practices



Note: VBHC=value-based healthcare; HTA= Health Technology Assessment; NICE: National Institute for Health and Care Excellence; MHLW=Ministry of Health, Labour and Welfare; NUB: Neue Untersuchungs- und Behandlungsmethoden (German for New Examination and Treatment Methods); DRG= Diagnosis-Related Group
Source: L.E.K. Research and analysis

Conclusion

Several senior leaders across insurance, healthcare delivery, regulation, patient advocacy, medtech, and health economics participated in the roundtable meeting discussions reinforcing a pivotal transition underway in India's health system: chronic conditions such as cardiovascular disease can no longer be managed through episodic, hospitalization-centric insurance constructs. Instead, there is a growing alignment that insurance must evolve into an active enabler of lifelong care by integrating prevention, early intervention, and sustained disease management around the patient rather than the event. This shift is not incremental; it requires re-anchoring product design, risk pooling, and reimbursement logic to reflect real-world disease trajectories and long-term value.

Crucially, the ecosystem now has regulatory and technical capability to act. Introduction of innovative disease-centric products, including incentive-based models focusing on overall cardiovascular care provides an important opportunity to build a strong foundation for a more responsive insurance system. However, to realize this potential, a more coordinated approach is essential across stakeholders. This includes strengthening payer-provider collaboration through adoption of standardized clinical pathways with room for case-based flexibilities, and outcome-linked incentives to further enhance the system capabilities. In parallel, investment in robust, interoperable data infrastructure will be critical to enable data sharing, outcomes measurement, and evidence-based decision-making. Targeted pilots in value-based healthcare, particularly in conditions such as CVD, can further support in operationalizing these models and generate scalable learnings.

Overall, the roundtable reinforced that India's transition toward a value-based health system is both a necessity and achievable. This could help improve affordability, patient experience, and health outcomes, laying the foundation for a more resilient, equitable, and future-ready health insurance system.

References

- Structuring unstructured medical device reimbursement in India (2021), https://www.lek.com/insights/medtech/structuring-unstructured-medical-device-reimbursement-india
- Proposed changes to medical device reimbursement evaluation pathway: addendum to "Structuring the unstructured medical device reimbursement in India" (2022), https://www.lek.com/insights/medtech/proposed-changes-medical-device-reimbursement-evaluation-pathway
- Unlocking the potential of medical device reimbursement for better health outcomes (2023), https://www.lek.com/insights/medical-equipment/unlocking-potential-medical-device-reimbursement-better-health-outcomes
- Collaborating for a robust medical device reimbursement pathway in India (2024), https://www.lek.com/insights/medical-equipment/collaborating-robust-medical-device-reimbursement-pathway-india
- Bridge the gap: unlocking innovative medical device access in India via evidence-based reimbursement models (2025), https://www.lek.com/insights/healthcare-services/bridge-gap-unlocking-innovative-medical-device-access-india-evidence
- India Hospital Insights Survey (2025), https://www.lek.com/insights/hea/sea/ar/india-hospital-insights-survey
- Rosengren, A., et al. (2004). Association of psychosocial risk factors with risk of acute myocardial infarction in 11119 cases and 13648 controls from 52 countries (the INTERHEART study). Lancet.2004; 364:953-962.
- Anjana, R.M., et al. (2023). Metabolic non-communicable disease health report of India: the ICMR-INDIAB national cross-sectional study (ICMR-INDIAB-17). Lancet Diabetes & Endocrinology; volume 11, issue 7, P474-489.

About the authors

Stephen Sunderland
Stephen Sunderland is a Partner based in L.E.K. Consulting's Singapore office. Stephen has 25 years of experience collaborating with multinational corporations, midsize companies, social enterprises and nonprofits, financial investors, and governments. He leads L.E.K.'s Healthcare and Life Sciences practice in Southeast Asia as well as our medtech practice in APAC.

Arnaud Bauer
Arnaud Bauer is a Partner based in L.E.K. Consulting's Dubai office. Arnaud is the Healthcare Services Practice Leader in SEA and GCC. With about 20 years of experience in healthcare consulting, his work spans the entire care continuum and multiple care settings. He has advised government agencies on several projects for healthcare investment planning and promotion across Asia-Pacific and the Middle East.

Special thanks

Special thanks to our former colleagues **Ashwin Goel** and **Amrita Mukherjee**, whose knowledge and expertise contributed significantly to the final composition of this report.

Participating experts

(In alphabetical order)

- Dr. Aamir Sohail, Assistant Professor, Patna University
- Dr. Abha Mehndiratta, Non-resident fellow, Centre for Global Development
- Dr. Anita Saxena, Executive Director Pediatric Cardiology, Fortis Escorts Heart Institute
- Arif Fahim, Regional Director, Health Economics and Reimbursement, Asia Pacific, Abbott
- Arthi Chandran, Divisional Vice President, Health Economics & Reimbursement, Abbott
- Atul Gujrathi, Joint President – Claims, HDFC Ergo General Insurance
- Dr. Chirag Doshi, Director, U.N. Mehta Institute of Cardiology & Research Centre (UNMICRC)
- Dr. Deepika Singh Saraf, Senior Public Health Expert and Advisor, Center for Health Innovation & Policy Foundation
- Dr. Dharna Gupta, Associate Manager, Health Economics & Reimbursement, Abbott
- Himani Sethi, Director, Programs, ACCESS Health International
- Dr. Indu Bhushan, Former-CEO, National Health Authority
- Ishteyaque Amjad, Managing Director, Policy and Global Government Affairs, South Asia, Abbott
- Lalit Baveja, Healthcare Management Consultant
- Manish Sen, Executive Vice President and Appointed Actuary, Niva Bupa Health Insurance
- Meenakshi Gandhi, General Manager – Insurance Vertical, Fortis Healthcare
- Meera Parthasarathy, Former General Manager, The Oriental Insurance Company Limited
- Dr. Monika Pusha, Associate Director, Health Economics & Reimbursement, India & Southeast Asia Projects, Abbott

- Dr. (Maj) Mukund Kulkarni, Chief Business Officer- Life & Health Verticals, Insurance Information Bureau of India
- Nikhil Jadhav, Head – Strategy & Operations, Heart Health India Foundation
- Pankaj Goyal, National Sales Manager – Heart Failure, Abbott
- Priya Jagasia, Divisional Vice President, Regulatory, Clinical, Reimbursement and Strategic Initiatives, Abbott
- Rahul Sharma, Country Manager – Electrophysiology, Abbott
- Rakesh Gandhi, Deputy General Manager, National Insurance Company Limited
- Dr. Ratna Devi, CEO and Co-founder, Dakshayani and Amaravati Health and Education
- Sameer Poddar, Executive Vice President & Head - Domestic Sales, Max Healthcare
- Sandeep Dawar, Senior General Manager - Marketing, Medanta - The Medicity, Gurgaon
- Dr. Sandeep Sharma, Retd. General Manager, HSE Medical, Indian Oil Corporation
- Dr. S. Dhananjaya Naidu, Lead Partnership, and Innovations, Access Health International
- Segar Sampathkumar, Former Director – Health, General Insurance Council
- Dr. Subhash Chandra, Chairman - Interventional Cardiology - Cardiology & Structural Heart Disease, BLK-Max Super Speciality Hospital
- Dr. Sudha Chandrasekhar, Advisor - Health System Transformation Platform, Karnataka
- Dr. (Col.) Sunil Verma, Senior Advisor (Hospital Administration), Professor of Hospital Administration, AFMC, Pune
- Dr. Sutapa B. Neogi, Director, International Institute of Health Management Research (IIHMR), Delhi
- Dr. Vijay Sankaran, Chief Claims Officer, MediAssist TPA
- Dr. Vinod Rayla - MBBS, FIII, Healthcare & Health Insurance Professional
- Dr. Vivekanandan Perumal, Professor & Head, School of Biological Sciences, Indian Institute of Technology – Delhi

- Yegnapriya Bharath, Former Chief General Manager, Insurance Regulatory and Development Authority of India
- Dr. Yogesh K Gurav, Scientist F, ICMR National Institute of Translational Virology & AIDS Research (ICMR-NITVAR), Pune
- Dr. UB Gandhi, Deputy Director, PMJAY-MA, Govt. of Gujarat

Disclaimer

This scientific initiative has been made possible with the support of St. Jude Medical India Pvt. Ltd. (SJM, now Abbott). The opinions expressed in this paper reflect the opinions of the group of participants at the annual healthcare payers roundtable hosted by SJM and are purely academic and personal in nature. Abbott and L.E.K. Consulting do not have any influence on the expressed views in any form.