11 STUDY AREAS. ONE EVIDENCE-LED VIEW.

India's preventive healthcare economy

Market momentum, unmet needs and the gap between health awareness and sustained action.

A consolidated desktop intelligence report combining quantitative evidence and qualitative insights from the 11 selected studies. Duplicate claims are consolidated; competing definitions and inconsistent figures remain visible.

Research periods span 2019–2026; forecast horizons extend to 2036 in the source studies. This is a synthesis of supplied research, not independent verification or new primary research.

Preventive monitoring • imagery retained from the Industry study.

RESEARCH LENS

Consumers, patients & communities

Urban and semi-urban core; rural and underserved contexts retained.

Executive overview

READ THE SIGNAL, NOT JUST THE SIZE

$197B

Broad preventive market

Projected for 2025 • 22% CAGR. Redseer / Kalaari attribution [E01, E02, E08]. Not an achieved result.

22%

Annual check-up package access

Eligible Indians annually [E06]. A separate urban-adult estimate is 30% [E09]; denominators differ.

39.4%

Out-of-pocket health expenditure

Share of total health expenditure, 2021–22. Economic Survey 2024–25 [E09]. Conflicting dating flagged in §08.

CONSOLIDATED INTERPRETATION

Growth is visible. Inclusion and follow-through are not yet assured.

Large forecasts and expanding digital infrastructure sit alongside low routine screening, fragmented care journeys and unequal spending. The evidence supports testing affordable, trusted pathways from screening to understanding to follow-up—not assuming that market size alone proves product demand.

01 **Markets & forecasts** — Market size • forecast

02 **People & demand** — Industry • population size

03 **Opportunity landscape** — Business potential • existing • untapped

04 **Industry shortcomings** — Access • trust • interoperability

05 **Capital & investors** — Funding • commercial evidence

06 **Communities** — Inclusion • delivery networks

07 **Trends & future outlook** — Technology • policy • strategic implications

08 **Evidence & source register** — Provenance • confidence • unresolved claims

01 / RESEARCH INTELLIGENCE

A growing market—not a single market definition

Market size & forecast • Keep broad wellness, insurance, diagnostics and digital-health estimates separate.

BROAD PREVENTIVE ECONOMY

$197B

Projected for 2025 at 22% CAGR, spanning fitness, wellness, foods and supplements, early diagnostics and health tracking.

Analytical • Redseer / Kalaari as attributed in the supplied studies [E01, E02, E08].

>$500B by 2030

Kalaari projection repeated in Industry Shortcomings [E09]. A forecast, not realised revenue.

Market momentum is not equivalent to an addressable product market.

The Existing Opportunity study also reports a preventive market of $4.8B in 2024, projected to $9.3B by 2030 at ~11.7% CAGR [E06]. Its perimeter is not reconciled with the $197B broad definition. Do not aggregate, average or derive market share across the two.

Insurance gross written premium measures premium volume, not preventive-service revenue. Digital health includes curative care. Diagnostics includes testing beyond prevention. These adjacent pools indicate commercial context, not additive components of a validated total.

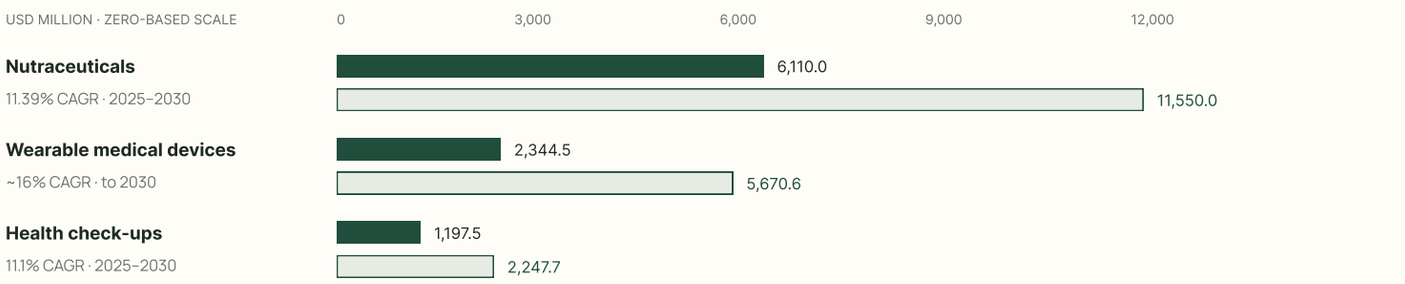
SOURCE INCONSISTENCY

$638B is not a validated preventive-market figure.

The Market Forecast cover labels $638B as the healthcare market in 2025, while its first data card describes a $197B preventive projection beneath a $638B headline [E03]. The mismatch is retained as an unresolved source issue.

QUANTITATIVE / SEGMENT TRAJECTORIES

Selected India markets, 2024 ↠ 2030



Source: Business Potential quantitative evidence [E05]; supplied attribution includes Grand View Research / Horizon for segment market reports. Forecasts are shown as endpoints only; no interpolated annual path is asserted. Segments may overlap and must not be summed.

MARKET / GEOGRAPHY	BASE ESTIMATE	PROJECTION	EVIDENCE & COMPARABILITY
Digital health · India	$8.79B · 2024	$47.80B · 2033 17.67% CAGR	Analytical [E03, E05]. A separate estimate series—not a lower bound.
Digital health · India	$14.50B · 2024	$106.97B · 2033 25.12% CAGR	Market estimate / projection [E09]. Conflicts with the $8.79B series; definitions not reconciled.
Health insurance · India (GWP)	$15.06B · 2024	$46.37B · 2030 20.9% CAGR (2025–30)	Analytical [E03]. E05 also reports $28.52B by 2031 at different segment scope.
Diagnostic laboratories · India	₹1.54T · FY2024	₹2.98T · FY2030 ~11.70% CAGR	CareEdge Ratings (2025), as cited [E03]. Not the $11.38B diagnostic-testing definition.

Other outlook series retained in the source register: digital healthcare $8.11B (2024) → $68.15B (2035), 21.48% CAGR; corporate wellness $2.60B (2025) → $4.07B (2034), 5.09% CAGR [E03]. All are India projections; none establish realised outcomes.

02 / RESEARCH INTELLIGENCE

People, disease burden & the prevention mindset

Industry & population size • Large need and digital reach do not automatically translate into paying, retained users.

QUANTITATIVE / INDIA, 2025

AUDIENCE / INDIA	REPORTED SCALE	INTERPRETATION BOUNDARY
Adults aged 25–55	490M	Source-labelled “SAM” [E04]. Age alone does not establish serviceability.
Digitally engaged, urban / semi-urban, lifestyle risk	180–220M	Source-labelled “SOM” [E04]. Treat as a study audience estimate, not validated obtainable demand.
Internet / smartphone users	759M / 700M	Early 2025 / 2025 [E04]. Reach indicators; people may overlap.

~1.44B

Total population reported in the Population Size study [E04]. Urban / semi-urban Tier 1–3 population: ~507–540M (~36–38%).

Empirical / analytical labels inherited. These are source estimates, not a newly verified census.

The Industry study describes urban and semi-urban consumers using smartphones, health apps and wearables, managing diabetes, hypertension, cardiovascular conditions and obesity. It attributes a shift towards proactive monitoring to the post-COVID period [E01; source confidence: High].

Existing Opportunity reports 820M smartphone users in 2024, versus 700M in 2025 in Population Size. Do not present the two estimates as a time-series decline; methodology is unresolved [E06 vs E04].

HEALTH NEED / INDIA	QUANTITATIVE SIGNAL	DATE & EVIDENCE	QUALITATIVE CONNECTION
Diabetes / pre-diabetes	101M / 136M	2023 in Untapped Opportunity [E07]; empirical. Also repeated in E04 and E06.	Early identification and sustained follow-up are relevant; do not sum with hypertension counts.
Hypertension	188–220M adults	E04 estimate; awareness ~37%, treatment ~30%, control ~15%. E06 reports 188.3M (2023).	Monitoring access alone does not close the awareness-to-control pathway.
Cardiovascular disease	54.5M	E04 estimate; ~28% of deaths. E07 cites 27% (ICMR, 2023).	Population and mortality measures are different; dated source estimates need careful reuse.

QUALITATIVE INSIGHT

Prevention becomes part of identity

Urban millennials and Gen Z increasingly treat fitness, nutrition and preventive diagnostics as identity and social signals, not only responses to illness.

Observational synthesis • Population Size [E04]. Qualitative section average confidence reported as 84.3%; not a probability.

EVIDENCE-SUPPORTED IMPLICATION

Frame prevention as an everyday routine, but test whether identity-led engagement persists beyond episodic health anxiety.

QUALITATIVE INSIGHT

Awareness does not guarantee action

The Untapped Opportunity study describes health anxiety without health action, driven by distrust and friction in existing platforms.

Qualitative [E07]. Related quantitative signal: only 22% of eligible Indians access annual check-up packages [E06].

EVIDENCE-SUPPORTED IMPLICATION

Reduce booking and follow-up friction. The quantitative gap supports a need hypothesis, not proof that UX is the sole cause.

QUALITATIVE INSIGHT

Protection before access

Consumers often view insurance primarily as financial risk protection rather than an enabler of everyday healthcare access.

Qualitative • Population Size [E04]. Economic Survey OOPE evidence provides financial context [E09].

EVIDENCE-SUPPORTED IMPLICATION

Explain preventive benefits and total cost in plain language; avoid promising savings or clinical outcomes not demonstrated in the studies.

03 / RESEARCH INTELLIGENCE

Where the opportunity is already visible—and still unserved

Business potential • Existing opportunity segments • Untapped opportunity segments. Signals for prioritisation, not a ranked investment recommendation.

EXISTING / DEMONSTRATED SPEND

Improve conversion and continuity.

Insurance premiums, diagnostics, nutrition and monitoring already generate measurable expenditure. A product opportunity must still show who pays, for what, how often and at what delivery cost.

UNTAPPED / UNMET NEED

Build for excluded contexts.

Pre-diabetes, semi-urban access, women, older adults and informal workers show underserved needs. Disease burden and population size are not equivalent to willingness to pay or a commercially obtainable market.

QUANTITATIVE EVIDENCE → QUALITATIVE IMPLICATION

Existing commercial pathways

SEGMENT	DEMAND / REVENUE SIGNAL	QUALITATIVE NEED	EVIDENCE-SUPPORTED IMPLICATION
Preventive screening	$1,197.5M revenue · 2024; projected $2,247.7M by 2030 [E05]. 22% package access annually [E06].	Consumers may receive reports without accessible, actionable interpretation [E10].	Connect booking, plain-language results and clinician follow-up; measure completed journeys, not test orders alone.
Wellness-linked insurance	$15.06–16.17B GWP · 2024–25 [E05]. First-time buyers: 45% in FY2023–24 [E06].	Insurance jargon and opaque terms deter first-time buyers [E10].	Explain exclusions, total price and preventive benefits before purchase. Keep insurer and platform attribution visible.
Health monitoring	$2,344.5M wearable medical devices · 2024 [E05]. Smart wearables: 54.35% health / fitness revenue share.	Budget-device accuracy varies; health metrics can be difficult to interpret [E10].	Separate wellness tracking from clinical claims. Offer meaningful feedback and escalation instead of unexplained scores.

Nutrition & wellness	$6.11B nutraceuticals · 2024 [E05]; 74% say food choices are rooted in cultural heritage [E08].	Trust, cultural fit and comprehensible efficacy claims shape adoption [E07, E08].	Localise nutrition guidance and clearly state the evidence behind claims; supplements are not a substitute for care.
Employer-led prevention	$830M corporate wellness · 2024; 68% of large enterprises offer a preventive programme [E06].	Employer cover can be a first insurance touchpoint; passive enrolment is not active participation [E10].	Test opt-in screening and continuity journeys. Corporate market estimates differ across studies; see §08.

Structurally underserved audiences

AUDIENCE / INDIA	QUANTITATIVE SIGNAL	QUALITATIVE BARRIER	IMPLICATION TO TEST
Pre-diabetes / cardiometabolic risk	136M pre-diabetics; 101M diagnosed diabetics · 2023 [E07]. Only 9% of at-risk people report structured cardiology screening.	Diagnosis fears, myths and low comprehension can limit follow-up [E10].	Risk-sensitive education and accessible clinical navigation, without converting screening into self-diagnosis.
Semi-urban households	~180M people; screening centre density 1 per 94,000 vs 1 per 18,000 in metros [E07].	English-first navigation and high-literacy assumptions exclude users [E10].	Vernacular, assisted booking and local care networks; price and last-mile delivery need validation.
Women's preventive health	$2.1B women's health / femtech estimate · 2024; only 14% report dedicated preventive service access [E07].	Gender and socioeconomic barriers compound differential health needs [E10].	Privacy-safe, life-stage-sensitive services with affordable referral options. Not a forecast of conversion.
Older adults / caregivers	194M aged 60+ projected by 2031; only 18% of health apps / services designed for elderly accessibility [E07].	Small text, complex flows and absent caregiver features limit access [E10].	Large text, voice guidance and consented caregiver access; test use with older adults directly.
MSME & gig workers	~63M MSMEs, >110M workers; <4% access structured occupational prevention. ~15M gig workers · 2024 [E07].	Employer-tied channels miss informal and non-salaried workers [E07].	Explore portable benefits and community channels. E07's "effectively 0%" gig-benefit claim is not independently established.
Mental & adolescent wellbeing	197M with mental health conditions (NIMHANS, 2022 as attributed); <6% of surveyed prevention platforms address mental wellness [E07].	Reported platform coverage suggests a missing preventive-support pathway; this is an interpretation, not a new user finding.	Integrate appropriate support and referral, with visible scope and safeguarding. Survey denominator is not supplied.

BUSINESS POTENTIAL / VALIDATION GATE

Do not confuse a need gap with a ready-to-pay market.

Market Size reports ₹4,000–₹10,000 annual spend among health-conscious Indians [E02]; Existing Opportunity reports ₹4,200–₹7,800 among urban Indians (2024) [E06]. Different cohorts make these non-interchangeable. Test affordability, retention and unit economics within the chosen audience.

04 / RESEARCH INTELLIGENCE

The system breaks between intent and outcomes

Industry shortcomings • Affordability, fragmented records and low follow-through weaken otherwise compelling growth signals.

QUANTITATIVE / FINANCIAL EXPOSURE

Out-of-pocket spending has fallen, but remains material.

Share of India's total health expenditure • 0–100% scale

Economic Survey 2024–25, tabled 31 January 2025, as cited in [E09]. Fiscal data periods are not publication years.

QUANTITATIVE / ACCESS & CONTINUITY

30% annual check-ups

Urban adults only [E09]; not the same denominator as 22% of eligible Indians accessing packages in [E06].

31% Day-30 retention

Reported for Indian health-app downloaders [E07, analytical]. Sample and app mix are not supplied; causation is not established.

70% / 83%

Public-sector share of the Health Facility / Health Professional registries [E09]. Coverage of private consumer touchpoints remains a concern.

QUALITATIVE INSIGHT

QUALITATIVE INSIGHT

QUALITATIVE INSIGHT

Fragmented journeys

Consumers navigate disconnected apps for diagnostics, insurance, fitness, consultation and medication. Data portability and care handoffs remain nascent.

Qualitative synthesis [E10]. ABDM account scale does not prove consumer-facing integration.

EVIDENCE-SUPPORTED IMPLICATION

Prioritise continuity and consented record sharing. Measure whether users complete follow-up across providers.

Trust is an interaction requirement

Privacy anxiety, opaque AI reasoning, rushed interactions and unclear claims undermine confidence in healthcare tools.

Qualitative [E04, E10]. Evidence links trust and engagement, but does not quantify a causal conversion uplift.

EVIDENCE-SUPPORTED IMPLICATION

Show why a recommendation is made, its source, limitations and clinical escalation route; use specific, revocable consent.

Screening without follow-through

Fear, myths and limited health literacy can interrupt adherence. Urban Karnataka research reported only 20.2% of newly detected hypertensives seeking follow-up.

Local study reported in [E10]; 34.71% of diabetes–hypertension comorbid cases untreated. Do not generalise nationally.

EVIDENCE-SUPPORTED IMPLICATION

Design reminders, accessible report interpretation and care navigation. Local evidence motivates testing, not a national outcome claim.

UNRESOLVED SOURCE ARITHMETIC

Private-record sharing needs correction before reuse.

E09 states that 2% of 35 crore linked reports is approximately 7 lakh records (February 2024). Those values are not arithmetically consistent: 2% of 35 crore is 70 lakh. This report preserves the claim as a flagged issue, not reliable chart evidence.

05 / RESEARCH INTELLIGENCE

Capital is available; the funding perimeter matters

Venture capitalists & investors • Healthtech, overall healthcare PE–VC and prevention-specific funding are distinct evidence pools.

REPORTED FUNDING / INDIA

$828M

Indian health-tech startup funding in H1 2025; also reported as ₹7,095 crore [E05, E08].

Observational in Venture Capitalists; analytical in Business Potential. Duplicate funding claim counted once.

~$1B / 40+ startups

Preventive technology startups over 2019–2022, as attributed in E05 / E08. Historical baseline, not 2025 capital availability.

QUALITATIVE / INVESTOR LANDSCAPE

An industry thesis is not a funding commitment.

Kalaari Capital's preventive-healthcare analysis frames prevention as an emerging growth frontier [E01]. The Venture Capitalists study describes urban prevention as mainstream and highlights health behaviour, digital infrastructure and public–private partnerships [E08; qualitative section confidence: Medium-High].

These signals support commercial exploration. They do not establish an individual fund's current cheque size, investment stage, portfolio fit or willingness to fund a specific product. No new investor shortlist or portfolio relationship is asserted here.

For product builders, the evidence-supported task is to substantiate recurring demand, continuity of engagement and a credible delivery model—not use a broad industry forecast as proof of investment readiness.

Named capital context retained: Kalaari Capital as industry-analysis source. E08 also cites a TrueMeds $85M Series C within a broader 2025 startup-funding claim; that is not prevention-specific funding.

CAPITAL POOL	PERIOD	REPORTED VALUE	EVIDENCE / LIMITATION
Indian healthtech startups	2024	>$700M · >78 deals	Observational [E08]. Not total healthcare investment.
Indian healthtech startups	2014–2024 cumulative	~$7.25B	Observational [E08]. Cumulative stock cannot be compared as a single-year flow.
Healthcare PE–VC	Jan–Nov 2024	$5.33B · 57 deals	Observational [E08]; source cites 14% drop from $6.26B in 2023. Periods differ.
Healthcare deals	Q1 2025	₹22,279 crore ($2.6B) 71 deals	Observational [E08]. Includes specialty pharma, biotech, digital health and CRAMS.
Healthcare private equity	Q2 CY25	₹4,900 crore ($572M) 33 deals	Repeated in E05 and E08. Private equity only; not interchangeable with PE–VC totals.
Healthcare PE–VC	Q3 2025	₹4,435 crore ($500M)	Observational [E08]. Retain source currency conversions; no new conversion applied.

CAPITAL CLAIM / DO NOT CHART AS A VALIDATED TREND

The $9.9B full-year 2025 claim is unresolved.

E08 labels $9.9B as full-year Indian HealthTech funding, while also reporting $11B across 936 deals for all Indian startups in 2025 and $828M for health-tech in H1. The scope / provenance is not reconciled. Keep it visible as a source claim requiring confirmation, not independent proof of sector maturity.

06 / RESEARCH INTELLIGENCE

Communities are the delivery context, not the residual market

Communities • Household decision-making, local infrastructure and trust determine whether prevention reaches beyond affluent urban users.

QUANTITATIVE / DISTRIBUTION OF ACCESS

A concentrated preventive economy

Wealthiest share of Indians **35%**

Their share of preventive spending **98%**

Both bars use a 0–100% scale but different denominators: population vs expenditure. Analytical source claim [E02, E11]; E11 attributes it to GOQii India Fit Report 2024 / Medical Buyer 2025. Not independently confirmed.

Redseer (2022), as cited in E11, reports 40% of surveyed Indians highly inclined towards preventive health. Inclination is not actual uptake; the survey population is not interchangeable with the spending cohort.

25–36% infrastructure shortfalls

Across Sub-Centres, PHCs and CHCs, as reported by PRS India (2024) in Communities [E11]. Digital alternatives cannot assume that clinical touchpoints are readily available.

State delivery context retained: Tamil Nadu's Makkale Thedi Maruthuvam doorstep screening (Frontiers in Public Health, 2024). This is a programme example, not evidence of nationwide coverage.

QUALITATIVE INSIGHT

Household-level care

Hypertension and diabetes cluster within households. Family members and caregivers influence screening and follow-up decisions.

Empirical / analytical • PMC / NFHS-5 (2025), as cited in Communities [E11].

EVIDENCE-SUPPORTED IMPLICATION

Support multi-member planning and consented caregiver roles. Do not expose private records by default within a household.

QUALITATIVE INSIGHT

Assisted, local pathways

Community users face literacy, trust and physical-access constraints that a high-literacy, self-service app may not resolve.

Communities [E11] and semi-urban UX barriers [E10]; infrastructure shortfalls provide context, not causal proof.

EVIDENCE-SUPPORTED IMPLICATION

Test vernacular, low-friction flows with local providers and community health workers; keep offline and clinical handoffs explicit.

QUALITATIVE INSIGHT

Financial protection in context

Households need prevention framed in accessible health and cost terms. E11 cites about 400M uninsured Indians, attributed to NITI Aayog.

Communities [E11]. "Uninsured" segment definition is not supplied; it is not the complement of the 37% coverage estimate.

EVIDENCE-SUPPORTED IMPLICATION

Validate affordable payment and protection models locally. Do not assume insurer or public reimbursement for digital services.

COMMUNITY DELIVERY / SOURCE-SUPPORTED PRINCIPLE

Complement existing care networks rather than bypass them.

The community appendix calls for alignment with ABDM, NPCDCS screening workflows and registered-practitioner teleconsultation. Privacy-safe information and referral should support—not replace—qualified clinical care [E11; source confidence: High].

07 / RESEARCH INTELLIGENCE

From episodic screening to longitudinal prevention

Current trends & future outlook • Separate observed infrastructure from forecast market outcomes and proposed product responses.

73.98 crore

49.06 crore

340M+

ABHA accounts created

739.8M • February 2025 [E05, E08]. Empirical in E08; not unique active preventive-care users.

Health records linked

490.6M • February 2025 [E05, E08]. Records are not patients or completed care journeys.

eSanjeevani consultations

Cumulative service consultations; PM Modi at the 78th World Health Assembly, as cited in E10. Not annual or unique-user volume.

TREND	OBSERVED / REPORTED EVIDENCE	QUALITATIVE INSIGHT	IMPLICATION • NOT A FORECAST
Interoperability & longitudinal records	3.63 lakh registered facilities alongside ABHA / record counts, February 2025 [E08]. U-WIN launched September 2024 [E10].	Infrastructure creates new possibilities, but consumer-facing integration remains nascent [E10].	Test portable histories and consented care handoffs. Infrastructure adoption must be measured at the user journey level.
AI + IoT personalisation	AI / wearable product launches and adaptive coaching described in E10; no causal clinical benefit quantified.	Opaque recommendations and inconsistent budget-device accuracy erode trust [E10].	Expose the reasoning, evidence and limitations. Distinguish informational wellness support from regulated diagnosis.
Insurance–wellness convergence	SAHI share of non-life insurance: 41% in Apr–Dec FY25, from 30% in FY20 [E03, E08].	Rewards, fitness incentives and preventive benefits shift the journey beyond passive policy ownership [E10].	Make benefits understandable and optional. Evaluate sustained participation rather than only acquisition.
Tier II / III expansion	Healthcare demand projected 16–18% CAGR vs 12–14% in metros; +40M Tier II residents expected by FY27 [E03].	Semi-urban language, literacy and affordability needs differ from metro assumptions [E10].	Treat expansion as a forecast-led hypothesis. Validate local provider coverage, onboarding and payment behaviour.

EVIDENCE-SUPPORTED DIRECTION

Build the loop, not another silo.

Explain risk → enable appropriate screening → interpret results → connect clinical care → support follow-up. This is a design synthesis of the qualitative findings, not a tested intervention or a claimed health outcome.

WHAT STILL NEEDS TO BE ESTABLISHED

Who completes follow-up after screening? Which audience can afford the service? Does consented interoperability improve continuity? What supports retention beyond 30 days? Which claims require clinical and regulatory review?

These are proposed research questions. The supplied studies do not answer them through a consolidated primary-user study.

POLICY & COMPLIANCE / ATTRIBUTED CONTEXT

Use the source appendices as research context, not legal clearance.

DPDP Act 2023, ABDM data policy, telemedicine practice guidelines, IRDAI and FSSAI requirements recur across the studies. Their legal interpretations and confidence scores are inherited claims. Applicability, amendments and enforcement status require qualified review before a product launch.

08 / RESEARCH INTELLIGENCE

Evidence, confidence & the unresolved claims register

One consolidated register for all 11 read-only studies. Bracketed E-codes trace evidence to its originating study; source references are inherited, not newly verified.

QUANTITATIVE EVIDENCE

Numbers retain units, India / local geography, base year and projection status. Analytical forecasts are not treated as achieved results. Repeated figures are cited once with multiple E-codes where relevant.

QUALITATIVE INSIGHTS & IMPLICATIONS

Themes summarise source observations or expert interpretations. Implications are clearly marked synthesis, not primary findings, participant quotations, clinical outcomes or demonstrated commercial effects.

SOURCE-ATTRIBUTED CONFIDENCE

High, Medium-High and percentage scores are reproduced where explicitly stated. They are not statistical confidence intervals, probabilities of success or an independent quality assessment. No new average is calculated.

Study-to-evidence register

STUDY REFERENCE	CONSOLIDATED COVERAGE	SUPPLIED SOURCE ATTRIBUTION	EVIDENCE / CONFIDENCE
E01 / Industry	Industry definition, consumer profile and prevention shift.	Kalaari Capital; IBEF; BW Healthcare World; Redseer; Care Health Insurance Trends Report 2025; IMARC; YourStory.	Empirical / observational / analytical / expert consensus. Source attribution: High.
E02 / Market Size	Broad $197B projection; spending concentration, adoption and behaviour.	Redseer (including attribution via Kamath / X); PwC Voice of the Consumer 2025; government statements.	Market cover reports 92.5% average confidence. Qualitative section: Medium-High. No consolidated score inferred.

E03 / Market Forecast	India market trajectories, base years, CAGR and projection horizons.	Industry / market reports as attributed; CareEdge Ratings 2025 for diagnostic laboratories.	Mainly analytical forecasts; empirical and observational context. Qualitative section: Medium-High to High.
E04 / Population Size	Population, digital reach, disease burden and consumer mental models.	Institutional surveys, government reports, NFHS-5 and peer-reviewed research as described in source.	Empirical / analytical / observational. Qualitative average confidence: 84.3%, as reported.
E05 / Business Potential	Revenue pools, paying behaviour, distribution and repeat funding evidence.	Grand View Research / Horizon segment reports; IBEF 2025; Policybazaar platform data; ORF January 2026.	Mixed empirical / analytical / observational. Regulatory appendix: High; not a confidence assignment to every market figure.
E06 / Existing Opportunity	Screening penetration, established segments and unmet care-journey needs.	Market evidence and systematic / empirical studies as attributed in the source report.	Empirical / analytical / observational. Point-level confidence not visible for every retained metric.
E07 / Untapped Opportunity	Pre-diabetes, women, older adults, semi-urban and occupational access gaps.	ICMR 2023; NIMHANS 2022 (source attribution); government / survey / market evidence.	Empirical / analytical / observational. Survey sample and method absent for several platform-access estimates.
E08 / Venture Capitalists	Capital pools, startup ecosystem and investment context.	Funding / investment reports as cited; Redseer via Kamath / X; PwC India; IJICBM 2025 Vol. 35.	Funding mainly observational. Qualitative section: Medium-High. Investor commitments are not documented.
E09 / Industry Shortcomings	OOPE, system access, record sharing and preventive care gaps.	Economic Survey 2024–25; National Health Accounts; IBEF / PIB; PMC / Nature; ICLG Digital Health India 2025.	Appendix confidence ranges include High (88–95%). Applies to its framework rows, not independent validation.
E10 / Trends & Future Outlook	Interoperability, AI, insurance convergence, inclusion and care continuity.	IBEF 2025; WHO South-East Asia 2023; PLOS Global Public Health 2024; ICLG 2025; NFHS-5; cited local studies.	Qualitative and quantitative material are mixed in source. Appendix confidence: High (88–95%), as reported.
E11 / Communities	Concentration, household health, financial barriers and delivery networks.	GOQii India Fit Report 2024; Medical Buyer 2025; Redseer 2022; PRS India 2024; Frontiers 2024–25; NITI Aayog; PMC / NFHS-5 2025.	Empirical / analytical / expert consensus. Community policy appendix: High. Historical OOPE dating retained.

Do not silently reconcile these claims

ISSUE	SOURCE CLAIMS RETAINED	TREATMENT IN THIS SYNTHESIS
Market perimeter	$197B projected by 2025 [E02, E08]; $197–210B "valued" in 2024–25 [E04]; $4.8B in 2024 → $9.3B by 2030 [E06].	Different definitions / projection labels remain unresolved. Do not average or sum. Broad $197B is labelled a projection.
Digital health definitions	$8.79B → $47.80B (2024–2033), 17.67% [E05]; $14.50B → $106.97B (2024–2033), 25.12% [E09]; $8.11B → $68.15B (2024–2035), 21.48% [E03].	Separate estimate series; no constructed "range" or consensus forecast. The $50B health-tech projection [E03, E08] is another perimeter.
OOPE dating / values	47.1% in 2019–20 [E11]; 47.1% in 2021–22 [E07]; 47.1% in 2023 [E06]; 39.4% in 2021–22 [E09, Economic Survey 2024–25].	Use E09's dated Survey series for the chart. Conflicting 47.1% dates remain visible; no synthetic trend line.
Disease estimates	Diabetes: 74M in 2021 [E03], 77M+ [E05, date absent], 101M in 2023 [E06, E07]. NCD mortality: ~60% [E03], 61% [E05], 66% [E09].	Do not treat these as one measured trend or updated national consensus. Preserve study, date and case-definition caveats.
Screening denominators	22% of eligible Indians access annual check-up packages [E06]; 22% of Indians receive any annual check-up [E07]; 30% of urban adults [E09].	Different eligibility / service / geography denominators. No unified national penetration rate is inferred.
Insurance coverage vs penetration	37% coverage [E06, E07]; 0.4% of GDP and 18% urban / 14% rural coverage [E03]; E11 cites 0.35% penetration and ~400M uninsured.	Premium-to-GDP penetration is not population coverage. Survey basis and "uninsured" segment scope are not reconciled.
Corporate wellness	$822M · 2024, 15.2% CAGR [E07]; $830M · 2024 [E06]; $2.60B · 2025 → $4.07B · 2034, 5.09% [E03].	Different market estimates. Do not plot as a one-year jump or use interchangeably for business sizing.
Record-share arithmetic	2% of 35 crore linked records described as ~7 lakh [E09; February 2024].	Arithmetic mismatch: 2% is 70 lakh. The supplied private-record count is flagged, not corrected into evidence.
Funding scope	$9.9B full-year HealthTech funding [E08] alongside $828M H1 health-tech and $11B all-startup funding in 2025.	Requires provenance and scope confirmation. Not charted as an established sector time series.
Audience estimates	700M smartphone users · 2025 [E04] vs 820M · 2024 [E06]; under-35 population ~600M [E07] vs >65% of population [E10].	Do not infer decline or combine demographic denominators; methods and date alignment are missing.

Consolidated source pointers

Exact URLs below are retained from the Industry study's citations. Other report references are named in the study register; URLs, samples, publication dates or claim-level mappings not supplied are not invented. Source titles and links do not imply independent verification.

S01 **Kalaari Capital**
Preventive Healthcare: The New Frontier in India's Health Revolution
https://kalaari.com/preventive-healthcare-the-new-frontier-in-indias-health-revolution/

S02 **IBEF**
Preventive Healthcare in India
https://www.ibef.org/blogs/preventive-healthcare-in-india

S03 **BW Healthcare World**
Consumer Wellness Revolution in India – Preventive to Predictive
https://www.bwhealthcareworld.com/article/consumer-wellness-revolution-in-india-%E2%80%93-preventive-to-predictive-513133

S04 **RedSeer**
State of Preventive Health in India
https://redseer.com/reports/state-of-preventive-health-in-india/

S05 **Care Health Insurance Trends Report 2025 / The Hans India**
Preventive Health, Digital Renewals and Senior Care Lead India's Evolving Insurance Behavior
https://www.thehansindia.com/business/preventive-health-digital-renewals-and-senior-care-lead-indias-evolving-insurance-behaviour-care-health-insurance-trends-report-2025-1034743

S06 **IMARC Group**
India Health Insurance Market Size, Share | Growth 2034
https://www.imarcgroup.com/india-health-insurance-market

S07 **YourStory**
Preventative Healthcare: A Wake-Up Call for India
https://yourstory.com/2025/02/preventative-healthcare-indias-reality-check

RECURRING POLICY CONTEXT	ATTRIBUTED REFERENCE	SOURCE CONFIDENCE / LIMIT
ABDM data policy	IBEF / PIB 2025; MoHFW policy documents 2022–24; NHA participation standards 2023 [E04, E05, E07, E09–E11].	High; E09 / E10 framework rows: 95%. Not a legal-readiness certification.
DPDP Act 2023	MeitY Gazette; ICLG Digital Health India 2025; PMC / Nature 2024 [E04, E07, E09–E11].	High; E09 / E10 framework rows: 93%. Interpretations require current qualified review.
Telemedicine guidelines	MoHFW / NMC guidelines 2020; source appendices variously describe updates in 2022 or 2023 [E04, E07, E09–E11].	High; E09 / E10 framework rows: 92%. Update dates are not reconciled here.
Insurance, devices & supplements	IRDAI Annual Report 2023–24 / reforms 2024; Medical Devices Rules 2017; FSSAI Health Supplement Regulations 2022 [E04, E05, E07, E10].	Source-attributed regulatory context. Product-specific applicability is not established by this synthesis.

RESEARCH STATUS / CONCLUSION

A coherent evidence base, with its boundaries intact.

All 11 study areas are represented in this new consolidated report. Source frames remain unchanged. This report does not adopt the sources' claims of "verified", "compliance-validated" or "audit-ready" as an independent assurance. Confirm primary publications and resolve the flagged claims before external decision-making.