

AYUSH

SERVICES SECTOR STUDY



Ārogyārtha Saṁvardhaka

आरोग्यार्थ संवर्धक

The Driver of Health and Economic Prosperity



RIS
Research and Information System
for Developing Countries
विकासशील देशों की अनुसंधान एवं सूचना प्रणाली



Ministry of
Ayush
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for Developing Countries**

विकासशील देशों की अनुसंधान एवं सूचना प्रणाली

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भारत सरकार



Minister of State
(Independent Charge) of
Ministry of Ayush and
Minister of State in
Ministry of Health and Family Welfare
Government of India

प्रतापराव जाधव
PRATAPRAO JADHAV



FOREWORD

It gives me immense pleasure to present this landmark study on the economic landscape of India's Ayush service sector. Since millennia, our traditional systems of medicine, namely Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homoeopathy, have served as vital pillars of healthcare, emphasising balance, prevention, and harmony between humanity and nature. Today, under the visionary guidance of our Hon'ble Prime Minister Shri Narendra Modi Ji, this timeless wisdom is being carried from its roots to a global outreach.

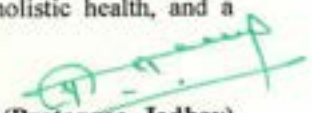
The Ayush sector is now witnessing unprecedented global attention. Citizens, investors, scientists, scholars, and public-health leaders across the world are increasingly turning to our traditional systems for sustainable, inclusive, and holistic solutions. Yet, for all this enthusiasm, the supply side of the Ayush economy had long remained unmeasured, including its enterprises, its revenues, its workforce, and its readiness for the world. This report fills that gap. By surveying establishments across States of India, it presents, for the first time, a rigorous economic account of a sector that now generates US\$36.92 billion and directly supports 1.76 million livelihoods.

These findings affirm what we have long believed, that Ayush is not merely a cultural inheritance but a dynamic, high-growth engine of India's economy, expanding faster than the broader economy, deeply rooted in our heartland, and increasingly the preferred choice of more than half our population. The sector's remarkable momentum in wellness tourism, particularly therapeutical wellness and medical value travel, reflects a truth the world is rediscovering, that prevention, well-being, and holistic care are the future of global health.

The Ministry of Ayush, since its creation in 2014, has worked steadily to strengthen the institutional foundations of this sector, across research, education, quality standards, digital infrastructure, and international cooperation. This study is a natural extension of that commitment. It transforms an indistinct cultural asset into a visible, plannable, and investable economic sector, and provided policymakers the data infrastructure that good governance demands.

I sincerely acknowledge all those who have contributed to the common cause of Ayush's growth, including our practitioners, researchers, entrepreneurs, and institutions, whose collective efforts have not only advanced this sector but the larger goal of global well-being. I also extend my appreciation to the Forum on Indian Traditional Medicine (FITM) at the Research and Information System for Developing Countries (RIS) for their scholarship in bringing this study to fruition, and the Ministry of Ayush for their valuable contributions.

It is my firm conviction that this report will serve as a valuable resource and an inspiration for all who are invested in the vision of making Ayush a globally respected and accessible system of holistic health, and a cornerstone of a healthy, Self-Reliant India by 2047.


(Prataprao Jadhav)

30 June, 2026
New Delhi

आपका आहार ही सर्वश्रेष्ठ औषधि है

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MESSAGE

This report marks a significant milestone in the evidence-based governance of India's traditional medicine systems. For the first time, the economic contribution of the Ayush service sector has been measured from the supply side through a nationally scaled, establishment-level survey of establishments across all major Ayush systems, spanning the reference period FY2022-23 to FY2024-25. It complements the demand-side picture established by the 79th NSSO round, and together with it, completes our understanding of the sector's scale, structure, and strategic potential.

The headline finding is consequential for policy. The Ayush service economy generated US\$36.92 billion in FY2024-25, growing at approximately 17 per cent annually, a rate that comfortably exceeds nominal GDP growth and the global medical-travel market. The study documents a commercially healthy sector, and identifies medical value travel as a high-value opportunity grounded in India's structural advantage in residential, immersive wellness care.

Equally important, the report through rigorous statistical analysis, isolates important institutional levers, that determine whether clinical capacity translates into international patient capture. The sector's central characterisation through the report provides policymakers with a clear, actionable, and time-bound reform agenda.

Under the visionary leadership of the Hon'ble Prime Minister, and since the establishment of the Ministry of Ayush in 2014, the sector has witnessed sustained institutional strengthening, viz. spanning research and development, the Ayush Grid and digital health infrastructure, education and regulatory standards, quality control, and International cooperation, including landmark engagement with the World Health Organization and the establishment of the Global Traditional Medicine Centre (GTMC), Jamnagar. This study adds to these efforts by adding a robust, replicable measurement baseline, one that should be sustained as a regular series to guide investment, planning, and Vision 2047 calibration.

I place on record my sincere appreciation for the Forum on Indian Traditional Medicine (FITM) at the Research and Information System for Developing Countries (RIS), whose policy-research expertise and methodological rigour have been central to this undertaking. I also acknowledge the contributions of the participating establishments, practitioners, researchers, and officials of the Ministry whose insights have shaped this report.

I am confident that this publication will serve as a useful reference for policymakers, researchers, investors, and stakeholders engaged in advancing a globally credible, economically scalable, and evidence-enabled Ayush ecosystem.

(Rajesh Kotecha)

PREFACE

Professor Sachin Kumar Sharma
Director General, RIS



Traditional Medicine is entering a defining moment. As populations age, lifestyle-related conditions rise, and health systems everywhere search for sustainable and preventive approaches, the world is turning with renewed seriousness to systems of knowledge that emphasise balance, prevention, and holistic well-being. India, custodian of an unbroken civilisational tradition in Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homoeopathy, is uniquely placed in this transition. Yet for a sector of such depth and reach, the Ayush economy has long been understood more through conviction than through measurement.

The Research and Information System for Developing Countries (RIS), through the Forum on Indian Traditional Medicine (FITM), has worked over successive years to close this gap. Our earlier study, *Ayush Sector in India: Prospects and Challenges*, offered the first credible estimate of the sector's overall market size. The present Report carries that endeavour decisively forward. For the first time, it measures the Ayush services economy from the supply side, through a nationally scaled, establishment-level survey of 15,914 enterprises spanning all six systems and every category of provider, from the individual practitioner to the accredited hospital and the international wellness resort.

The findings reframe how the sector should be understood. An Ayush services economy of approximately US\$36.92 billion, growing at close to 17 per cent annually and supporting 1.76 million livelihoods, is no longer a peripheral cultural asset. It is a dynamic, knowledge-based service economy, expanding faster than the broader economy and increasingly integrated into global wellness and healthcare markets. Viewed through the lens of trade in services, Medical Value Travel and wellness tourism represent a distinctive, difficult-to-replicate export opportunity, in which traditional knowledge is converted into internationally tradable value.

Consistent with the analytical tradition of RIS, this Report is grounded in rigorous, primary evidence rather than assertion. It situates Ayush within established frameworks of value-chain analysis, enterprise formalisation, global market integration, and sectoral innovation, while drawing thoughtfully on the conceptual vocabulary of the Indian Knowledge System. In doing so, it speaks not only to India but to the wider Global South, where traditional systems of medicine remain central to health, livelihoods, and development, and where the institutional questions of standards, evidence, accreditation, and trade are increasingly shared.

The Report is equally clear-eyed about what the sector's potential requires. Realising it will depend on strengthening the institutional foundations of the Ayush economy, namely quality accreditation, digital readiness, evidence generation, internationally calibrated standards, and a sustained statistical base. These are precisely the conditions that determine whether a knowledge-rich sector can compete credibly in international markets, and they define a clear and achievable agenda for policy.

Established within RIS by the Ministry of Ayush, the Forum on Indian Traditional Medicine (FITM) has, over the years, matured into a dedicated policy platform for Indian Traditional Medicine, and its contribution to this Report has been central. Through sustained research, stakeholder consultation, and engagement on standards, market access, and international cooperation, FITM has become an important unit shaping Ayush policy and India's Traditional Medicine diplomacy. Its work carries particular value for the Global South, where many countries hold rich traditional-medicine traditions of their own and stand to gain from shared frameworks for evidence, regulation, and trade. In advancing this agenda, FITM helps position India not only as a practitioner of Traditional Medicine, but as a partner in building the institutional architecture through which such knowledge can be recognised and exchanged across the developing world.

I compliment the FITM team – Dr. Sarin, Mr. Pragyan Agarwal, Dr. Dinesh Kumar, Dr. Sanket Chavan and its former Coordinator Dr. Namrata Pathak, supported by the able expertise of Prof. Surya Bhushan, whose collective effort has produced an analysis of this scope and rigour, undertaken in partnership with the Ministry of Ayush. It is my hope that policymakers, investors, researchers, and international partners will find in this Report a reliable evidentiary foundation for advancing the Ayush sector as a pillar of Viksit Bharat@2047. RIS remains committed to serving as an effective think-tank of the developing world, and to advancing Traditional Medicine as a shared contribution to global health and well-being.



Sachin Kumar Sharma
Director General

Research and Information System for Developing Countries (RIS)

MESSAGE

Over the past decade, India's Ayush sector has grown at a pace that few would have anticipated. This growth has been visible everywhere on the ground: in the steady rise of Ayush clinics and wellness centres, the expansion of therapy and Panchakarma services, the growing number of international patients seeking Ayurvedic care, and the emergence of Ayush as a considered lifestyle choice for millions. Yet this remarkable momentum, so apparent in everyday experience, had not been adequately captured at the macroeconomic level. The Ayush services economy remained largely unmeasured, its contribution to output, employment, and exports understood more through impression than through evidence. It was to close this gap that the present study was conceived.

Unlike our earlier work on the Ayush manufacturing sector, which could draw upon established production and trade statistics, the services economy is dispersed, partly informal, and poorly reflected in existing datasets. A credible measurement was therefore possible only through a primary, establishment-level survey. FITM at RIS undertook precisely this: a nationally scaled survey of 15,914 enterprises across all six Ayush systems and every category of provider, from the individual practitioner to the accredited hospital and the international wellness resort. The outcome, for the first time, is a supply-side estimate of the Ayush services economy grounded in field evidence rather than assumption.

The relevance of this exercise extends well beyond a single headline figure. By measuring the sector as it actually operates, the Report offers policymakers a firmer basis for decisions on regulation, skilling, quality accreditation, and trade; it gives investors and entrepreneurs a clearer map of a fast-growing market; and it strengthens India's hand in international engagement on Traditional Medicine, where credible data is increasingly the currency of cooperation. It is my hope that the Report will serve as a durable reference for all who work to advance the sector.

A study of this scale is possible only through collective effort. I record my deep gratitude to the Ministry of Ayush, whose support made this endeavour possible, and whose vision of an evidence-led Ayush ecosystem this Report seeks to serve. I am equally thankful for the enthusiasm shown by stakeholders across the country: the practitioners, establishments, and state-level teams whose willing participation gave the survey both its reach and its reliability.

I extend my sincere thanks to the members of the Governing Board of FITM, eminent practitioners, scholars, and institution-builders drawn from across India's Ayush systems, whose counsel continues to shape our work and lend it credibility. I am grateful to the Research and Information System for Developing Countries (RIS) for hosting and nurturing FITM, and in particular to the Director General, Professor Sachin Kumar Sharma, for his constant encouragement and intellectual guidance. My thanks also go to my fellow team members of FITM, my predecessor and its former Coordinator, RIS faculty, the survey teams, and the external experts whose dedication is reflected in every page of this Report.

Since its establishment by the Ministry of Ayush, FITM at RIS has served as a dedicated platform for evidence-based policymaking in Indian Traditional Medicine. Our earlier study on the Ayush manufacturing sector helped, for the first time, to place a credible figure on the size of the industry, and informed much of the policy conversation that followed. Alongside it, our work on Ayush exports and regulatory barriers, the G20 Primer on Traditional Medicine, the Traditional Medicine Review, and a series of policy briefs have contributed to informed decision-making at both the national and international levels. The present Report continues this tradition, and reflects FITM's contributory role in shaping Ayush policy at home and in Traditional Medicine cooperation with partner countries, many of them in the Global South, that share India's rich heritage of traditional healing.

I am confident that this Report will prove valuable to policymakers, researchers, industry, and international partners alike. FITM remains committed to building the evidence base on which the next phase of the Ayush sector's growth can securely rest.

Dr. Sarin N.S.

Coordinator, Forum on Indian Traditional Medicine (FITM)

Research and Information System for Developing Countries (RIS)

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This study has benefited from the guidance, contributions and cooperation of several individuals and institutions at different stages of its development. Their role in shaping the study, facilitating its field implementation and supporting the preparation of this report is gratefully acknowledged.

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We place on record our appreciation for the guidance and institutional support provided by Prof. Sachin Chaturvedi, Former Director General, RIS and Vice-Chancellor, Nalanda University, who steered the conceptualisation and implementation framework of the study and provided institutional backing during its fieldwork and subsequent development. We are also grateful to Dr. G.C. Manna, Former Director General, National Sample Survey Office (NSSO); Prof. T.C. James, Former Visiting Fellow, RIS, New Delhi; and Shri Rajiv Vasudevan, CEO, Apollo AyurVAID Hospitals, for their valuable suggestions and inputs during the planning and methodological development of the study.

We sincerely acknowledge the survey agencies and their leadership, Mr. Sanjay Bhardwaj and Mr. Sanjay Vijayvergiya of Forvis Mazars, and Mr. Ganji Venkatesh and Ms. Ayushi Oli of IMRB Kantar, for undertaking the extensive field data collection across the country and for their close coordination with FITM throughout the survey process. Their contribution was central to the completion of the field study.

We also acknowledge the professional and industry associations representing different segments of Ayush, including the Ayurveda Medical Association of India (AMAI), Ayurvedic Medicine Manufacturers Organisation of India (AMMOI), National Integrated Medical Association (NIMA), Ayurveda Hospital Management Association (AHMA), Siddha Hospital Management Association (SHMA), and Yoga Association of Mysuru, and their leadership, for reaching out to their members and facilitating their participation in the field survey.

We are grateful to the senior faculty members of RIS, Prof. S.K. Mohanty, Former Distinguished Fellow, RIS; Dr. Pankaj Vashisht; Prof. Prabir De; and Dr. Sabyasachi Saha, for their comments, suggestions and intellectual inputs at different stages of the study and during the preparation of the report. We also place on record our appreciation for the Members of the FITM Governing Board for their insightful counsel and constructive suggestions at various stages of the planning and execution of the study.

We acknowledge the contribution of the institutional publication team - Mr. Sanjay Singh, Mr. Sachin Singhal, Mr. Sanjeev Karna and Ms. Oli Borah and Mr. Vikash Barwal of Oneify Designs, for their assistance in bringing the report to its final published form.

Finally, our deepest gratitude is due to all the Ayush-based service establishments that participated in the study, and to their clinicians, administrators, management staff and therapeutic personnel, who generously extended their time, cooperation and assistance during site visits and data collection. This study would not have been possible without their participation. The Ayush services sector ultimately draws its strength from the commitment and everyday work of the people who sustain these institutions and serve their communities.

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List of Abbreviations

Abbreviation	Expansion
AAM-Ayush	Ayushman Arogya Mandir (Ayush)
AB-PMJAY	Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
AHMIS	Ayush Hospital Management Information System
AHPI	Association of Healthcare Providers (India)
AI	Artificial Intelligence
ALOS	Average Length of Stay
ATAB	Ayurveda Training Accreditation Board
AVS	Arya Vaidya Sala, Kottakkal
Ayush	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy
AYUSHEXCIL	Ayush Export Promotion Council
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BERISM	Board of Ethics and Registration for Indian Systems of Medicine
BHMS	Bachelor of Homoeopathic Medicine and Surgery
BIS	Bureau of Indian Standards
BOA	Board of Ayurveda
BSMS	Bachelor of Siddha Medicine and Surgery
BUMS	Bachelor of Unani Medicine and Surgery
BUSS	Board of Unani, Siddha and Sowa-Rigpa
CAGR	Compound Annual Growth Rate
CCH	Central Council of Homoeopathy
CCIM	Central Council of Indian Medicine
CEA	Clinical Establishments (Registration and Regulation) Act, 2010
CGHS	Central Government Health Scheme
CHC	Community Health Centre

Abbreviation	Expansion
CII	Confederation of Indian Industry
CMPR	Centre for Medicinal Plants Research
COVID-19	Coronavirus Disease 2019
DG	Director General
EHR	Electronic Health Record
ESG	Environmental, Social and Governance
FICCI	Federation of Indian Chambers of Commerce and Industry
FITM	Forum on Indian Traditional Medicine
FLFP	Female Labour Force Participation
FMCG	Fast-Moving Consumer Goods
FY	Financial Year
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HSSC	Healthcare Sector Skill Council
ICT	Information and Communication Technology
IIM	Indian Institute of Management
IIPS	International Institute for Population Sciences
IMC	IMC Chamber of Commerce and Industry
IPD	Inpatient Department
IRDAI	Insurance Regulatory and Development Authority of India
ISM&H	Indian Systems of Medicine and Homoeopathy
ISO	International Organization for Standardization
ISPA	International Spa Association
JCI	Joint Commission International
KII	Key Informant Interview
LR	Likelihood Ratio

Abbreviation	Expansion
MARB-ISM	Medical Assessment and Rating Board for Indian Systems of Medicine
MDNIY	Morarji Desai National Institute of Yoga
MLE	Maximum Likelihood Estimation
MoHFW	Ministry of Health and Family Welfare
MoS	Minister of State
MSME	Micro, Small and Medium Enterprises
MVT	Medical Value Travel
MVTF	Medical Value Travel Facilitator
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NAM	National Ayush Mission
NAMASTE	National Ayush Morbidity and Standardized Terminologies Electronic Portal
NCH	National Commission for Homoeopathy
NCISM	National Commission for Indian System of Medicine
NCVET	National Council for Vocational Education and Training
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHA	National Health Authority
NHP	National Health Policy
NSQF	National Skills Qualifications Framework
NSS / NSSO	National Sample Survey / National Sample Survey Office
OLS	Ordinary Least Squares
OPD	Outpatient Department
PHC	Primary Health Centre
PIB	Press Information Bureau
PM	Prime Minister
QCI	Quality Council of India

Abbreviation	Expansion
RBNQA	Ramkrishna Bajaj National Quality Award
RGHS	Rajasthan Government Health Scheme
RIS	Research and Information System for Developing Countries
RPL	Recognition of Prior Learning
SEPC	Services Export Promotion Council
SME	Small and Medium Enterprise
SVC	Service Value Chain
T&CM	Traditional and Complementary Medicine
TA	Thematic Analysis
TCM	Traditional Chinese Medicine
UG	Undergraduate
UHC	Universal Health Coverage
US\$	United States Dollar
UT	Union Territory
WHO	World Health Organization
YCB	Yoga Certification Board

Note on Transliteration and Diacritical Marks

This report uses the International Alphabet of Sanskrit Transliteration (IAST) for the Sanskrit terms it employs - the four-pillar analytical framework introduced in Chapter 2 and applied through Chapters 3 to 6, the nine Sanskrit-named recommendations of Chapter 6 together with their component frameworks, and the classical texts cited in the chapter epigraphs. IAST diacritical marks indicate vowel length and consonant articulation that are phonemically significant in Sanskrit but have no equivalent in unmarked Roman script; omitting them can alter the intended word (for instance, *āsana*, “posture,” is distinct from *āśana*, which is not a standard term).

Diacritics used in this report

Mark	Represents	Pronunciation guide	Examples in this report
ā / Ā	long a	as in “father”	<i>Prārambha, Jñāna, Punarnavā, Muktā</i>
ī / Ī	long i	as in “machine”	<i>Sthānīya, Nirīkṣaṇa, Indranīla</i>
ū / Ū	long u	as in “rule”	<i>Sūtradhāra, Setu Mūla, Nyāya Sūtras</i>
ṛ / Ṛ	vocalic r	a short flap, close to “rri”	<i>Dṛśya Setu, Aṣṭāṅgahṛdaya</i>
ṁ / Ṃ	<i>anusvāra</i> (nasalisation)	nasal sound after a vowel	<i>Setu Saṁyoga</i>
ṇ / Ṇ	guttural n	as in “sing” (before k / g)	<i>Lokasaṅgraha, Aṣṭāṅgahṛdaya</i>
ñ / Ñ	palatal n	as in Spanish “año”	<i>Jñāna, Vijñāna, Prajñā</i>
ṭ / Ṭ	retroflex t	tongue curled back	<i>Aṣṭāṅgahṛdaya</i>
ḍ / Ḍ	retroflex d	tongue curled back	<i>Pūrvakhaṇḍa</i>
ṇ / Ṇ	retroflex n	tongue curled back	<i>Pramāṇa, Anukaraṇa, Māṇikyā</i>
ś / Ś	palatal sh	soft “sh,” as in “shine” said gently	<i>Vaiśvika, Kauśalya, Kośa, Setu Viśva</i>
ṣ / Ṣ	retroflex sh	harder “sh,” tongue curled back	<i>Utkarṣa, Navonmeṣa, Rakṣā, Puṣyarāga</i>

The visarga (ḥ / Ḥ), a light final ‘h’ echo, occurs in the Devanagari epigraphs but not in any transliterated term in this report.

What carries diacritics, and what does not

Diacritics are applied selectively, to keep the report readable for a general audience while remaining precise where precision matters:

- Diacritics ARE used for: the analytical framework terms coined for this study (the Chapter 2 pillars and their component stages); the nine Sanskrit names given to the recommendations in Chapter 6, together with the nine gem-standards of *Navaratna Mānaka*, the four steps of *Ārogya Sopāna* and the three tracks of *Dṛśya Setu*; the epistemological vocabulary of the *Nyāya Sūtras* cited in Annexure II; and the titles of classical texts cited in the chapter epigraphs.
- Diacritics are NOT used for: the names of the Ayush systems themselves (Ayurveda, Yoga, Unani, Siddha, Homoeopathy, So-wa-Rigpa, Panchakarma), institutional and programme names (Ayush, AYUSHXCIL, Ayush Quality Mark, Ayushman Arogya Mandir), or common loan-words now standard in English (yoga, guru, ayurveda, mantra). These follow conventional usage in Government of India publications and in international reporting on Traditional Medicine.
- Two Yoga-practice terms are treated as diacritic-bearing because they name specific classical concepts rather than a generic activity: *āsana* (posture) and *prāṇāyāma* (breath regulation).

A complete list of every diacritic-bearing term used in this report, with its meaning and the chapters in which it appears, is provided at Annexure III — Glossary of Sanskrit Terms.

Executive Summary

Global Resonance of Traditional Medicine. Traditional Medicine occupies position as an integral component of people-centred healthcare within global healthcare landscape today. The World Health Organization's Global Traditional Medicine Strategy 2025–2034 positions Traditional Medicine as a key pillar of future health systems. This growing acceptance is also reflected in market trends. The global Traditional Medicine sector was valued at US\$605.6 billion in 2024 and is

projected to exceed US\$1 trillion by 2029. Notably, service delivery, including clinics, hospitals, Ayush-based Wellness centres, and practitioners, accounts for more than half of the sector's value and represents its fastest-growing segment. The expansion of Traditional Medicine is occurring alongside the rapid growth of the global wellness economy, highlighting the increasing demand for holistic and preventive healthcare solutions worldwide.

Global Traditional Medicine Market (2024)	Global Traditional Medicine Services Segment (2024)	Global Traditional Medicine Services Annual Average Growth rate 2023-24
US\$605.6 Billion	US\$348 Billion	11.8%





India's Strategic Position in the Global Traditional Medicine Landscape. India, as the nurturer of Ayush, including Ayurveda, Yoga, Unani, Siddha, Sowa-Rigpa, and Homoeopathy, and host of the WHO Global Traditional Medicine Centre in Jamnagar, Gujarat, has emerged as a lead player in Traditional Medicine. At the domestic level, Ayush has already become an actively preferred healthcare choice. According to the 79th NSSO Round (2022–23), nearly half of the national population reported using Ayush services during the preceding year, with trust and perceived effectiveness serving as the primary determinants of adoption. These trends indicate that Ayush is an active and expanding component of India's healthcare system.

Filling the Evidence Gap in the Ayush Services Economy. While the Ayush sector's clinical footprint is widely recognised, its economic contribution measured by revenue, employment, and growth dynamics had never been systematically quantified at a national scale. The size, structure, employment contribution, and economic significance of Ayush clinics, hospitals, Ayush-based Wellness centres, and day-care establishments had never been measured comprehensively. This lack of evidence constrained informed policymaking and limited the sector's ability to demonstrate its contribution to the broader healthcare and Ayush-based Wellness economy.

The study seeks to answer four key questions:

1. What is the current total size of the Ayush services economy in terms of revenue, how is revenue distributed across systems and facility types, how fast is it growing, and what factors are driving its growth trajectory?
2. How many people are employed in the Ayush services sector, and what is the gender composition of this workforce?
3. How much revenue does the Ayush sector generate through medical value travel, and which institutional, operational, and market factors determine its ability to attract and serve patients?
4. How large could the Ayush services sector become by 2047 under alternative growth scenarios, and what institutional reforms, investments, and policy interventions are required to realise its highest-potential trajectory?

The study is based on one of the largest establishment-level surveys undertaken in the Ayush services sector: 15,914 establishments surveyed across states of India. Recognising that Ayush enterprises are highly clustered in some states and broadly dispersed in others, the survey used a dual-track design - Track 1 conducted wide enumeration in states with high concentrations of Ayush systems (such as Kerala, Tamil Nadu, and Karnataka), while Track 2 applied a stratified, multi-stage probability sampling design across additional states.

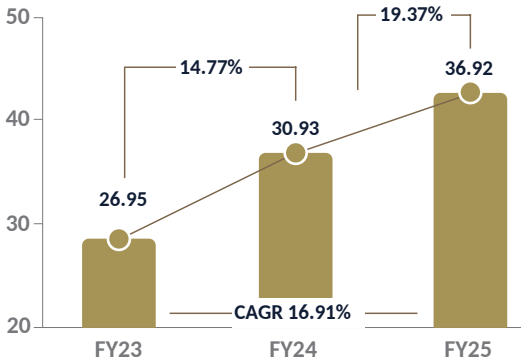
The survey covers five categories of establishments - Clinic, Day Care centre, Hospital, Educational Institute, and Ayush-based Wellness (comprising Yoga Centres, Spas and Resorts offering Ayush services), spanning the full spectrum of clinical care, therapeutic services, Ayush-based Wellness offerings, and training within the Ayush ecosystem.



Key Findings

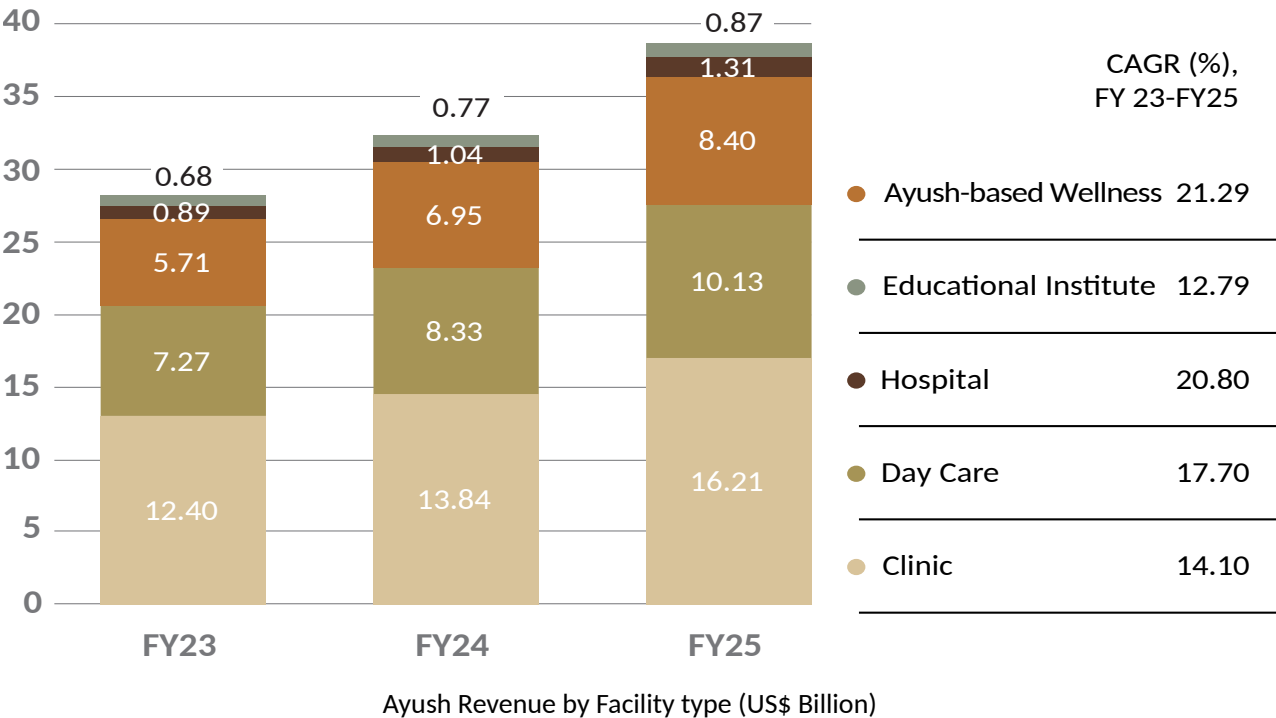
15,914 Establishments Surveyed	US\$36.92 Billion Ayush Services Sector Revenue FY25 Estimate	16.91% CAGR (FY 2023-25)	1.76 Million Employment
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A US\$36.92 Billion Ayush Services Economy. India's Ayush services sector was valued at US\$36.92 billion in FY25, up from US\$26.95 billion in FY23, recording a CAGR of 16.91 per cent. Growth accelerated from 14.77 per cent in FY24 to 19.37 per cent in FY25, significantly outpacing India's nominal GDP growth of 9.7 per cent during FY25 and surpassing the global Traditional Medicine services sector growth rate of 11.8 per cent recorded in FY 24 (the latest available estimate). These trends position Ayush among India's fastest-growing services industries.



Clinics and Day Care Centres at the Core of Ayush Service Delivery. Clinics dominate the Ayush services economy, generating US\$16.21 billion in FY25 and accounting for 43.9 per cent of total sector revenue. Their extensive reach and role as the primary point of patient interaction make them the backbone of Ayush service delivery. Day Care Centres are the second-largest segment, contributing US\$10.13 billion and 27.4 per cent of total revenue. Together, Clinics and Day Care Centres account for over 71 per cent of sector revenue,

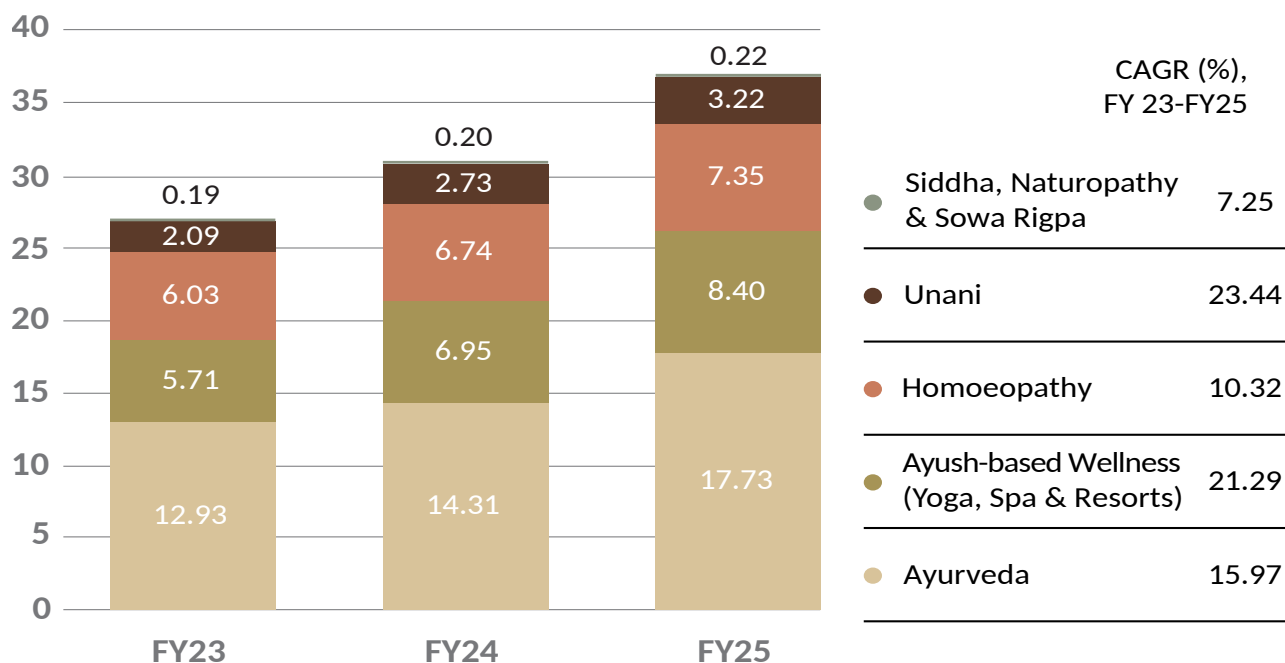
underscoring the central role of outpatient and non-residential care in the Ayush ecosystem. While Hospitals, Ayush-based Wellness, and Educational Institutions contribute a relatively smaller share of revenue, they perform critical functions in specialised treatment, wellness tourism, medical value travel, and human capital development. Together, these facilities create a balanced services ecosystem that supports both current scale and future growth.



Ayurveda Dominates, Ayush-based Wellness Drives Expansion.

Ayurveda remains the largest system by revenue (US\$17.73 billion, 48% of total revenue). Notably, the Ayush-based Wellness segment which includes Yoga centres alongside spas and resorts offering Ayush-based services, whose range of offerings

transcend beyond the conventional curative focus, is the fastest-growing component (21.29% CAGR). Homoeopathy contributed US\$7.35 billion in FY25, maintaining its position as a major pillar of the sector through its extensive patient reach. Unani recorded robust growth, expanding by 54.5 per cent over two years, largely supported by the rapid expansion of day-care services.



Ayush Revenue by System (US\$ Billion)

Ayush as a Driver of Jobs and Women's Empowerment.

The Ayush services sector directly supports 1.76 million jobs, making it one of India's largest healthcare employment ecosystems outside conventional medicine. Clinics alone employ more than 60 per cent of the workforce in Ayush services sector. Employment extends beyond practitioners to include therapists, nurses, educators, Ayush-based Wellness professionals, and

support staff. Importantly, the sector is emerging as a powerful platform for women's economic participation, particularly in hospitals, day care centres, educational institutions, and Ayush-based Wellness establishments. Women have a strong representation in Day Care centres (57%), Spas (60%+), Educational Institutions (58%), and Hospitals (53%). Overall, they constitute 43% of the total workforce across all segments.

Total Employment	Workforce in Clinics (as % of Total Employment)	Women Employees as % of Total Workforce			
		Day Care Centres	Ayurveda offering Spas	Educational Institute	Hospitals
1.76 Million	>60%	57%	60%+	58%	53%

A High-Value Growth Opportunity in Medical Value Travel (MVT). India's Traditional Medicine systems are advantageously placed in the rapidly growing global medical tourism market. The study estimates Ayush-related MVT at US\$1.77 billion in FY25. International patients contribute US\$1.77 billion, approximately five times more per patient than domestic patients, making MVT one of the sector's most strategic growth opportunities. This is despite them accounting for less than 1% of total patient volume.

Quality, Credibility and Visibility Drive Global Reach. The ability to attract international patients is shaped by visibility, quality, and treatment experience. Digital presence significantly improves international outreach, accreditation strengthens trust, and longer therapeutic programmes increase patient retention. The absence of multilingual, globally accessible platforms limits international visibility and reduces foreign patient engagement vis-à-vis greater reliance on domestic business portals. Conversely, websites, accreditation,

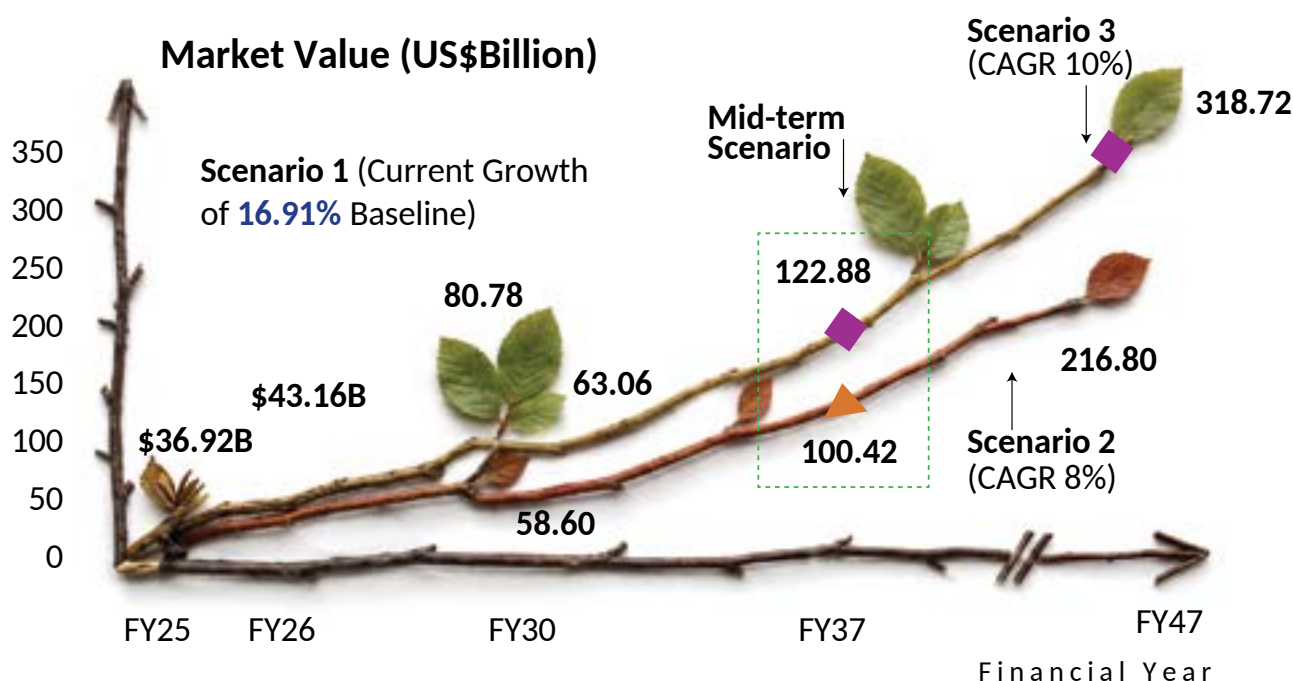
and longer therapeutic programmes (ALOS 5-11 days) show positive associations with international clientele appeal. These factors highlight the importance of quality assurance and digital transformation in expanding India's global footprint.

Determinants of Global Outreach (Positive Association)

1. Websites
2. Accreditation
3. Average Length of Stay (ALOS) (5-11 days)

Ayush as a US\$318 Billion Global Industry, Vision 2047. The Ayush services sector is poised for strong long-term growth, expanding from US\$36.92 billion

in FY25 to an anticipated US\$80.78 billion by FY30, and potentially reaching US\$216–318 billion by 2047. Under a baseline scenario (maintaining a conservative 8% CAGR), the sector would reach US\$216.80 billion by FY47. Under an accelerated scenario (10% CAGR, provided a thrust by Ayush-based Wellness tourism and MVT expansion), the sector could achieve US\$318.72 billion, positioning Ayush as a key contributor to Viksit Bharat@2047. Ayurveda is expected to remain the sector's largest pillar, while the Ayush-based Wellness segment is projected to be the fastest-growing driver of expansion. Accelerating global demand for preventive healthcare, wellness tourism, and integrative medicine are likely to drive the growth of MVT and wellness services, strengthening India's position in this domain.



Strategic Market Projections of the Ayush Services Sector, FY2025–FY2047

Apart from Ayurveda and Ayush-based Wellness, which are expected to remain the sector's primary growth engines, Homoeopathy and Unani are also expected to continue to perform well in markets where they enjoy established acceptance.

Strategic Roadmap for Accelerating the Ayush Services Economy. The findings of this study highlight a sector that has achieved considerable scale and momentum but continues to face challenges related to workforce development, quality assurance, digital adoption, regulatory harmonisation, and global market

integration. Addressing these constraints will be critical for sustaining growth, improving service quality, and enhancing international competitiveness. To unlock the sector's full potential and support its transition towards a US\$216–318 billion industry by 2047, the report proposes nine strategic recommendations. Together, these recommendations seek to strengthen institutional capacity, expand market access, foster innovation, and position India as a global hub for Traditional Medicine, Ayush-based Wellness services, and MVT.



Key Proposal (s)	Recommendation (s)	Strategic Objective (s)
1. Kalyāṇa Kośa & Punarnavā	Strengthen therapeutic Ayush-based Wellness as a distinct, clinically guided segment within the broader Ayush-based Wellness economy through relevant education pathways and by building on existing skilling, upskilling and Recognition of Prior Learning (RPL) mechanisms to address additional competency needs.	Develop the competencies required for clinically guided therapeutic wellness while creating wider professional opportunities for Ayush graduates and the existing Ayush-based Wellness workforce.
2. Nirīkṣaṇa	Establish a National Ayush Services Intelligence System by strengthening Ayush Grid and AHMIS, building on successive NSSO Surveys on Ayush for demand-side evidence, examining only non-duplicative Ayush indicators for other national surveys such as NFHS, where relevant, and institutionalising a periodic survey of Ayush service establishments.	Create a comprehensive and regular evidence base for policymaking, investment, sector monitoring and assessment of demand, employment, MVT and digital adoption.
3. Navaratna Mānaka	Widen adoption of the Ayush Quality Mark and support establishments through voluntary quality-readiness and self-assessment tools aligned with existing AQM requirements and recognised standards.	Improve consistency, safety and consumer confidence while strengthening the credibility and domestic and international competitiveness of Ayush services.
4. Dṛśya Setu	Strengthen establishment-level digital infrastructure through wider adoption of Ayush Grid and AHMIS, digital onboarding, electronic health records, teleconsultation, online booking, multilingual digital presence and integration with tourism and MVT platforms.	Improve service delivery, operational efficiency, digital discoverability and access to domestic and international patients.
5. Ārogya Sopāna	Explore wider financial protection for evidence-based therapeutic Ayush-based Wellness, rehabilitation and preventive Ayush services, based on defined clinical indications, treatment protocols, provider quality, costs and measurable outcomes.	Reduce out-of-pocket expenditure and create a credible pathway for extending financial protection to appropriate preventive and restorative Ayush services.
6. Sūtradhāra	Promote greater regulatory convergence across the Ayush services ecosystem through proportionate and non-duplicative frameworks, while respecting State-specific regulatory arrangements for Ayush-based Wellness services.	Reduce regulatory fragmentation and uncertainty while preserving State flexibility and creating a more consistent, transparent and investor-friendly environment.

Key Proposal (s)	Recommendation (s)	Strategic Objective (s)
7. Agraga	Develop integrated Ayush MVT clusters and Ayush-based Wellness corridors based on regional strengths, including Ayurveda, Yoga, Siddha and destination-based Ayush-based Wellness, while strengthening services-export promotion and access to international markets through different modes of service delivery.	Shift from institution-based promotion to destination-based service ecosystems and position India as a leading global destination for Traditional Medicine-based MVT and Ayush-based Wellness services.
8. Atirekhā	Strengthen the international readiness of Ayush MVT providers and facilitators by building on existing quality and certification systems and addressing additional requirements relating to clinical readiness, continuity of care, patient facilitation, communication, transparency, ethics and authenticity.	Build international patient confidence, improve MVT readiness and strengthen the credibility and export competitiveness of Indian Ayush services.
9. Prajñā Kauśalya	Promote the responsible use of artificial intelligence and digital technologies for quality assurance, traceability, clinical decision support, research and evidence generation, regulatory compliance and international market access, supported by appropriate digital skills and ethical safeguards.	Drive innovation, improve efficiency and evidence generation, strengthen regulatory and quality systems, and position India at the global frontier of technology-enabled Traditional Medicine.



INDIA'S AYUSH SERVICES SECTOR

SCALE • GROWTH • GLOBAL OPPORTUNITY

A TRADITIONAL STRENGTH. A GLOBAL FUTURE

GLOBAL CONTEXT

US\$605.6 Billion

Global Traditional Medicine Market in 2024

Global Wellness Institute

>US\$1

Trillion

Projected by 2029

Global Wellness Institute

US\$348 Billion

Traditional & Complementary Medicine (Services) Market in 2024

Global Wellness Institute

~12%

Global TM Services Industry Growth (2024–2029)

As per Global Wellness Institute Traditional & Complementary Medicine (Services) is the 2nd fastest-growing among 11 wellness sectors globally.

INDIA'S AYUSH SERVICES SECTOR AT A GLANCE (FY2024–25)



15,914

Establishments Surveyed Across all States & Union Territories



US\$36.92 Billion

Services Sector Revenue (FY25)
Up from US\$26.95 Billion in FY23



~17%

Revenue CAGR (FY23–FY25)
Well ahead of most conventional healthcare segments



1.76 Million

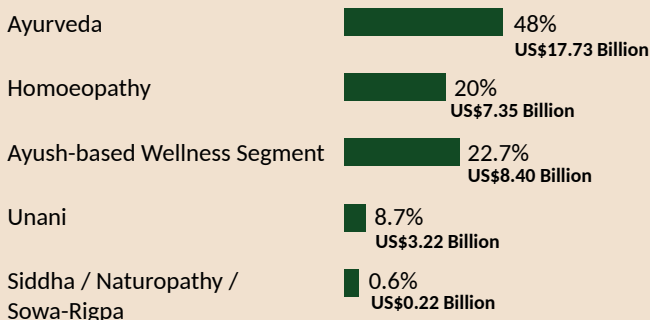
Direct Employment
1.06 million in clinics alone



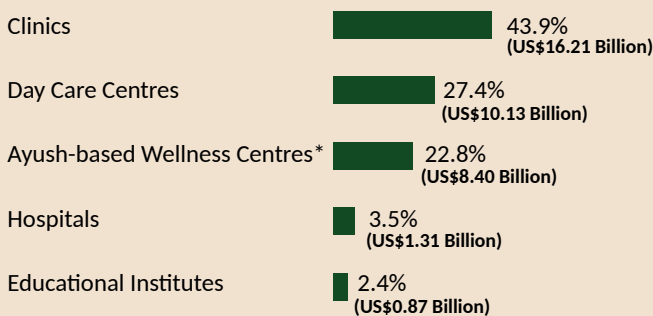
94%

Establishments with Healthy Gross Margins 20%–60%

REVENUE BY AYUSH SYSTEM (FY25)



REVENUE BY ESTABLISHMENT TYPE (FY25)



Fastest Growing Segment Ayush-based Wellness Centres 2-Year CAGR: 21.29%

*Ayush-based Wellness Centres include Yoga Centres and Spas & Resorts offering Ayush services.



CITIZENS' TRUST IN AYUSH (NSSO 79th Round, 2022–23)



46.3% RURAL
POPULATION used Ayush
in the preceding year.



52.9% URBAN
POPULATION used Ayush
in the preceding year.

Key Insight: Driven by trust and perceived effectiveness.

WOMEN'S SHARE IN AYUSH WORKFORCE

Share of Women in Workforce by Establishment Type



61% Ayush-based
Wellness Centres*



58% Educational Institutes



57% Day Care Centres



Predominantly
Male-led - Standalone
Clinics

Ayush is a strong engine of women's economic participation.

AYUSH MEDICAL VALUE TRAVEL (MVT)

US\$1.77 Billion

Ayush MVT Market in 2025 (estimated)

~1 Million

Foreign Patients Served Annually

Top Destinations

Kerala, Uttarakhand, Karnataka, Goa, Himachal Pradesh

70–90%

Lower Treatment Costs vs. Many Developed Countries

Recent Initiatives Strengthening Competitiveness: Ayush Visa available for 172 countries 5 new Regional Medical Hubs Adoption of ISO 22525 quality standards

STRATEGIC RECOMMENDATIONS (Four Pillars)

1. Knowledge Value Chain



- Build a certified therapeutic-wellness workforce & career pathway (*Kalyāṇa Kośa*).
- Conduct a quinquennial Ayush enterprise survey (*Nirīkṣaṇa*).

2. Enterprise Capability



- National quality & accreditation ladder covering Ayush-based Wellness Centres & day care, not just hospitals (*Navaratna Mānaka*).
- Strengthen digital infrastructure & online discoverability (*Drśya Setu*).
- Extend insurance protection for Ayush-based Wellness Centres & preventive care (*Ārogya Sopāna*).
- Harmonised regulation across states (*Sūtradhāra*).

3. Global Competitiveness



- Integrated Medical Value Travel (MVT) clusters & Ayush-based Wellness corridors based on regional strengths (*Agraga*).
- Dedicated, internationally aligned MVT quality certification (*Atirekhā*).

4. Innovation Dynamics



- Adopt AI & digital technologies for quality assurance, traceability & international market access (*Prajñā Kauśalya*).

OUR VISION: VIKSIT BHARAT @2047

Building a globally trusted, innovation-led, inclusive Ayush ecosystem that drives health, employment and economic growth.

Chapter 1
**India's Ayush Service
Economy**

शरीरे जर्जरीभूते व्याधिग्रस्ते कलेवरे ।
औषधं जाह्नवीतोयं वैद्यो नारायणो हरिः॥

*(Traditional Sanskrit subhāṣita; transmitted in Dhanvantaristotra
and extended Viṣṇusahasranāma recitation traditions)*

*When the body becomes decrepit and frail, and is afflicted by
disease, the medicine is treated as the sacred water of the
River Ganga, and the doctor is Lord Narayana (Hari) Himself*



1.1 Introduction

India has long been shaped by the Vedic intuition that truth wears many forms, a principle that evolved beyond philosophy into the everyday fabric of life. This civilisational trait fostered a natural medical pluralism where Ayurveda, Yoga, Siddha, Unani, folk remedies, and Homoeopathy coexisted, accommodated socially, if not always reconciled intellectually. Health was understood not as a mechanical absence of disease but as a dynamic balance between body, mind, and environment¹. In 1995, this deep-rooted ethos received formal institutional recognition with the establishment of the Department of Indian Systems of Medicine and Homoeopathy (ISM&H) which later on went on to be transformed into a full-fledged independent Ministry in 2014. This was more than just an administrative reorganisation, it was a state acknowledgment that Traditional Medicine systems sustained through centuries of community practice are vital pillars of the nation's healthcare identity².

While India's pluralistic heritage is ancient, its contemporary relevance is strikingly global. The modern world, burdened by chronic illness, ageing populations, and soaring costs, is increasingly searching for preventive and participatory care. It now discusses them in public policy and wellness economies. The World Health Organization (WHO)'s Global Traditional Medicine Strategy 2025–2034 recognises Traditional Medicine as an important component of people-centred healthcare, noting its use across all WHO regions³. The numbers reveal the scale: the Global Wellness Institute estimates the Traditional Medicine sector at \$605.6 billion in 2024

and projected to surpass \$1 trillion by 2029. The services part of this economy, covering clinics, wellness centres, and practitioners, is already worth US\$348 billion⁴. This is a trade not merely in remedies but in knowledge, trust, and long-term guidance.

Traditional Medicine systems in India nomenclatured as Ayush (encompassing Ayurveda, Yoga, Unani, Siddha, Sowa-Rigpa and Homoeopathy) stand at a pivotal juncture. The world is experiencing a powerful shift in consciousness about health wherein it is moving away from the exclusive dominance of pharmaceutical intervention towards prevention, holistic well-being, and natural medicine. The COVID-19 pandemic dramatically accelerated this shift. India is well poised to play a pivotal role in this transformation by offering its innate wisdom of holistic health consciousness, mental well-being, and harmonious existence.

This global resurgence of interest in holistic healthcare is mirrored by strong domestic adoption of Ayush in India, underscoring the sector's deep social roots and contemporary relevance. According to the 79th National Sample Survey Office (NSSO) Round (2022–23), Ayush has a substantial presence in India's healthcare landscape, with 46.3 per cent of rural and 52.9 per cent of urban residents reporting the use of Ayush systems during the preceding 365 days⁵. Utilisation is higher among females than males in both rural (48.8 per cent versus 43.9 per cent) and urban areas (55.4 per cent versus 50.5 per cent). Ayurveda remains the dominant Ayush system, used by 40.5 per cent of rural and 45.5 per cent of urban residents for the prevention or treatment of ailments,



while other Ayush systems (Yoga & Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy) account for 9.4 per cent and 12.8 per cent, respectively. These findings indicate the widespread acceptance of Ayush across India.

Among countries that have successfully transformed Traditional Medicine into a major health and economic sector, China represents the most prominent example. Over four decades, it has institutionalised Traditional Chinese Medicine (TCM) as a mainstream component of healthcare, education, research, and industrial policy. The TCM industry, products and services combined, is estimated at approximately US\$90 billion, with continued growth under the Healthy China 2030 strategy⁶.

The strength of China's model lies in deep institutional integration. The country operates 77,336 TCM facilities, including 5,715 hospitals, accounting for 16.9 per cent of diagnostic activity. TCM departments exist in 88.3 per cent of public hospitals, and over 98 per cent of community health centres provide TCM services, supported by approximately 732,000 practitioners, over 17 per cent of all licensed professionals⁷. TCM functions as an integrated component, not a parallel system.

China's experience shows that scale requires both demand and supply interventions. High-level coordination (via its State Council and Health Commission) gave TCM visibility; India's parallel efforts include creating a dedicated Ministry of Ayush (2014) and a WHO Traditional Medicine Centre in Jamnagar. China also underscores the need for data and metrics: it tracks

registered practitioners and TCM service use. Finally, China's model illustrates the synergy of integrating traditional practitioners into modern healthcare and ensuring their practices meet quality standards. While India's traditional systems and context are distinct, the broad principle holds: systematic support (regulatory, research, financing) is key to harnessing Traditional Medicine for universal health goals.

While China has successfully integrated TCM as a mainstream component of its healthcare system, India's approach has been to nurture multiple distinct systems through parallel institutional frameworks. This pluralistic model offers broader consumer choice but also presents challenges for standardisation, quality assurance, and insurance coverage. Bhasin (2007)⁸ defines this as functional coexistence - not mere juxtaposition but a genuine choice set where households may consult medical practitioners from different systems of medicine for different conditions, often within the same therapeutic episode. This civilisational foundation is central to understanding the economic character of the Ayush sector.

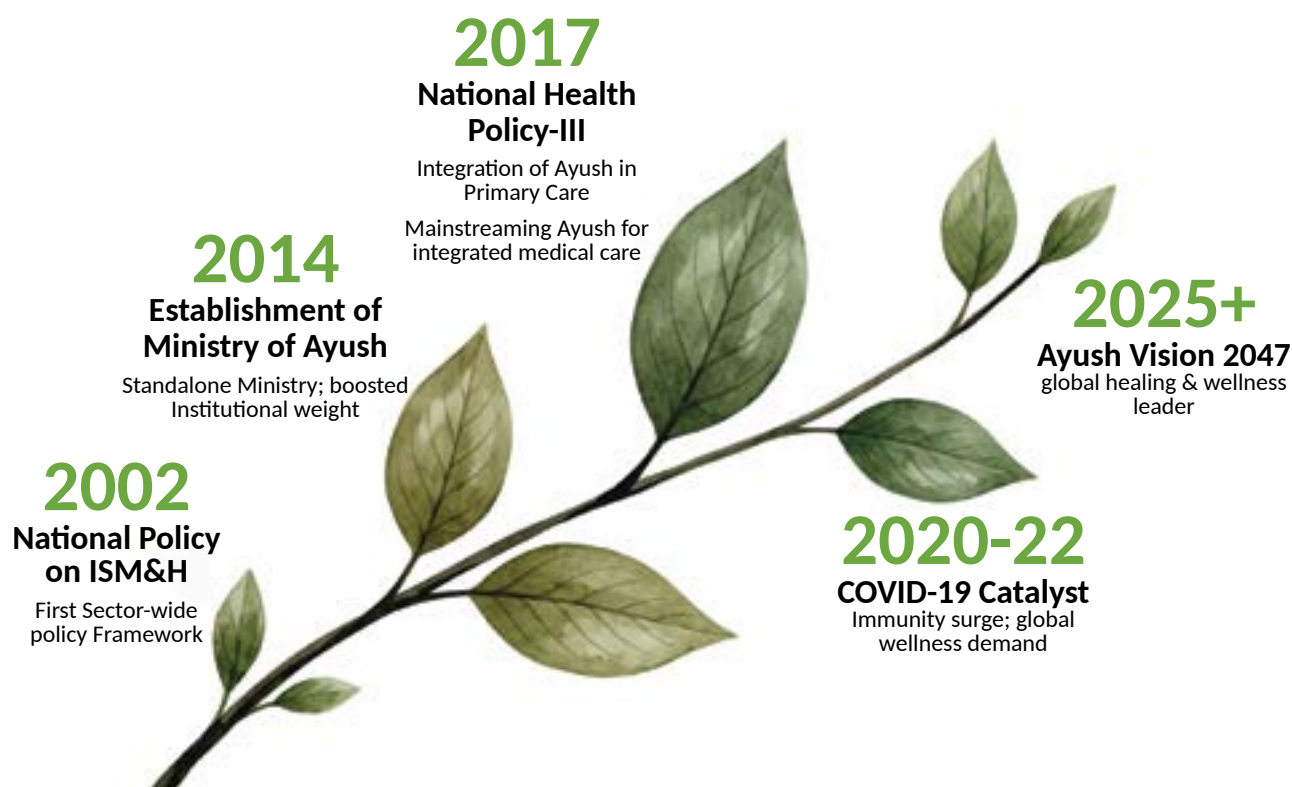
This pluralistic foundation has important economic consequences. Patients base healthcare decisions on affordability, accessibility, familiarity, and perceived effectiveness. In rural and semi-urban India, where time, distance, and cost heavily influence choices, Ayush systems offer trusted, readily available care. The sector's growth is sustained not by any single tradition's dominance but by the collective capacity of multiple systems to respond to diverse preferences. Its economic significance rests upon this civilisational inheritance, where knowledge diversity has become a source of social resilience and economic opportunity.



1.2 The Policy Imperative for Mapping Service Sector

The four phase evolution of India's Ayush sector is best understood as a long institutional transition toward an increasingly formalized, economically significant, and globally positioned health and wellness industry.

Figure 1.1: Phase-wise determinants of Ayush sector development



Source: Based on Policy documents and public access data

1.2.1 Phase 1: The Policy Architecture (2002)

The 2002 National Policy on Indian Systems of Medicine and Homoeopathy (ISM&H) marked the first coherent national vision for India's Traditional Medicine systems, which until then functioned through parallel arrangements with varying oversight. It prioritized education standardization, professional regulation, research, and preventive healthcare. This framework laid the foundations for Ayush's subsequent expansion, formalization, and mainstreaming within national development and public health strategies⁹.

1.2.2 Phase 2: Structural and Administrative Empowerment (2014)

A second and more consequential transition occurred in 2014 with the establishment of the Ministry of Ayush. The creation of a standalone Ministry, from a Department under the Ministry of Health and Family Welfare (MoHFW) significantly elevated the sector's institutional status within the Indian State, providing dedicated administrative authority, expanded budgetary support, and accelerated investment in research councils, pharmacopoeial standards, digital platforms, educational infrastructure, and international cooperation.

1.2.3 Phase 3: Systemic Mainstreaming (2017)

The National Health Policy - III (NHP - III) 2017 marked another important phase in the sector's evolution by re-augmenting Ayush's position within India's broader healthcare delivery strategy, picking up from the mainstreaming efforts initiated over a decade ago¹⁰. The policy explicitly emphasized the integration of Ayush into primary healthcare systems, especially in preventive and promotive care. This was a shift driven by the rising burden of non-communicable diseases and the need for pro-active lifestyle-oriented health interventions. The policy repositioned Ayush as a potentially integrated component of Universal Health Coverage (UHC). These mainstreaming efforts set the stage for further strengthening the institutionalisation of Ayush and its subsequent significant health interventions during the COVID-19 pandemic.

1.2.4 Phase 4: The Demand Shock and Market Maturity (2020–2025+)

The COVID-19 pandemic acted as a powerful catalyst for the Ayush sector, accelerating global demand for preventive healthcare, Ayush-based Wellness, and self-care solutions. As noted earlier, the COVID-19 crisis heightened consumer awareness of health and immunity, leading to a significant increase in interest in holistic and natural approaches to well-being. The global health crisis sharply increased demand for immunity enhancement, mental wellness, preventive healthcare, yoga, herbal products, and holistic therapies. Internationally, the pandemic expanded awareness of integrative and non-pharmaceutical approaches to health management; domestically, it drove unprecedented visibility for Ayush systems. The period also accelerated digital adoption, teleconsultation platforms, and interest in Ayush-based Wellness -oriented Medical Value Travel (MVT). The sector has now entered what we term the Ayush Vision 2047 phase, an aspirational period in which India aims to leverage its Traditional Medicine heritage to capture a significant share of the global wellness market while strengthening domestic public health through Ayush

integration. This dual mandate distinguishes Ayush from most other Traditional Medicine systems globally. China's TCM sector offers the closest parallel, but even there the institutional architecture and degree of state-directed industrialisation are structurally different in ways that matter for policy.

Estimation of the Ayush sector is important for strategic planning towards realizing the 2047 roadmap. The manufacturing segment of the Ayush sector has been estimated to be around 23 billion US dollars in 2022 according to a study done by RIS¹¹. However, an overall assessment of this sector would warrant an estimation of the services segment as well.

1.3 Completing the Picture: Understanding the Ayush Service Economy

While the 79th NSSO Round (2022–23) provides compelling evidence of the widespread use and acceptance of Ayush across India, its economic contribution has yet to be fully mapped. Despite robust demand-side estimates, reliable and comprehensive assessments of the sector's service-side overall economic footprint remain limited. One immediate reason may be the absence of a formal, agreed-upon definition of what constitutes the Ayush services sector. The field encompasses a wide array of providers: ranging from small clinics to large hospitals, luxury resorts, and spas, reflecting both its diversity and fragmentation. Consequently, existing studies have adopted varying definitions, making consistent measurement and analysis challenging.

A 2018 CII study defined Ayurveda services to include medical manpower, hospitals, dispensaries, pharmacies, ICT, education, and Ayush-based Wellness.¹² It estimated Ayurveda hospitals at Rs. 1,000 crore and clinics at Rs. 5,000 crore but offered no figure for the Ayush-based Wellness dimension associated with it. FICCI's 2019 study similarly examined Ayush-based Wellness but did not estimate alternative therapies within that segment.¹³ Sector-specific estimates remain fragmented: a 2020 report valued the global Yoga industry at US\$84 billion;¹⁴



Grand View Research (2025) estimates the Indian Yoga market at US\$5.06 billion;¹⁵ and IMARC (2025) values the India spa market at US\$1,354 million, projected to reach US\$3,188 million by 2034.¹⁶ No comprehensive survey covers Ayush across healthcare, Wellness, and education. Since 2014, the Ministry of Ayush has captured only public data, with no baseline on private units. Given the private sector's critical role, rigorous estimation of Ayush services is essential for strategic policy.

This report seeks to address a critical evidence gap by transforming the Ayush services sector from a largely unmeasured ecosystem into a transparent, measurable, and policy-relevant component of India's healthcare economy. It presents the first nationally scaled, establishment-level survey of India's Ayush service economy, covering 15,914 establishments across FY2022–23 to FY2024–25, transforming a partially visible ecosystem into a measurable economic sector.

The significance of this exercise extends beyond statistical measurement. As Ayush evolves from a decentralized network of practitioners and Ayush-based Wellness providers into a nationally important health and economic sector, the absence of reliable supply-side data poses growing challenges for policy design, resource allocation, and system integration. Ambitious national objectives, including preventive healthcare, UHC, digital health infrastructure, and MVT, require a clear understanding of the sector's institutional architecture.

The NSSO data confirm robust demand for Ayush, but demand alone is insufficient for system-wide preparedness. Achieving UHC through Ayush requires parallel evidence that supply-side infrastructure, namely, clinics, hospitals, trained practitioners, digital health records, and accredited facilities, is expanding in step with patient uptake. This study addresses precisely that

supply-side evidence gap. There is growing evidence that Ayush demand is both real and substantial. The important task ahead is to not focus on proving its relevance, but to better understand and strengthen the infrastructure and economic systems needed to support its future growth.

1.4 Scope and Definitional Boundary of the Ayush Services Sector

A critical first definitional task is establishing what this report means by the Ayush service sector. The Ayush service sector is a knowledge-delivery economy. Its enterprises are clinics, day care centres, hospitals, spa and luxury resorts, yoga establishments, and educational institutions attached with their teaching hospitals. An elaborate note on the different service establishments is provided in Annexure I.

This report is exclusively concerned with the service sector as defined above. The primary survey enumerated service establishments as above. Wherever an Ayush enterprise derives revenue from both product sales and service delivery, the analysis focuses on its service revenue and activities. For this study, the Yoga, Spa, and Resort facilities offering Ayush-based services together have been grouped under the Ayush-based Wellness segment, acknowledging their role in providing services that are beyond mere clinical care. Additionally, MVT revenue has been analysed separately from data captured within the hospital and Ayush-based Wellness segments to understand its contribution and growth drivers.

The Ayush systems covered are not a homogeneous industry. They differ fundamentally in their knowledge bases, therapeutic modalities, practitioner qualification requirements, regulatory frameworks, geographical



concentrations, and patient demographics. Ayurveda accounts for the largest share of establishments pan-India and has the strongest commercial presence in both therapeutic and Ayush-based Wellness markets. Yoga and Naturopathy, while grouped under a single Ministry designation, span practices from rigorous therapeutic yoga to the lighter fitness market. Unani has a strong base in North India; Siddha is prominent in Tamil Nadu and present in Kerala; Homoeopathy has the widest geographical spread, with strong penetration in West Bengal, Maharashtra, and Andhra Pradesh.

This report looks at the Ayush services sector as a whole as well as its individual subsystems. It estimates the sector's overall size, employment, and revenue, while highlighting the distinct characteristics and growth trends of different subsystems.

Box 1.1 The Ayush Systems: A Definitional Primer

Ayurveda is India's oldest codified medical system, drawing on the Ashtanga Sangraha, Charaka Samhita and Sushruta Samhita as foundational texts. It employs a holistic approach to health and healing through lifestyle, herbal, and dietary interventions. Ayurveda has the largest practitioner base of any Ayush system and the strongest commercial presence in both therapeutic and Ayush-based Wellness markets across India and is the primary system around which India's medical-value-travel strategy is necessarily built.

Yoga and Naturopathy encompass the therapeutic application of yogic practices (*āsana*, *prāṇāyāma*, meditation) and the drugless, nature-cure system of naturopathy. The global wellness and fitness dimensions of Yoga have driven explosive demand, and Yoga-based enterprises account for a disproportionately high share of the sector's gross margin.

Unani is rooted in the Graeco-Arabic tradition of Hippocrates and Ibn Sina, transmitted to the subcontinent through the Mughal period. Its institutional base is strongest in the populations in North India and pockets of South India.

Siddha is a Tamil classical medical system with a theoretical framework distinct from Ayurveda, concentrated in Tamil Nadu and Kerala, with a substantial diaspora market.

Homoeopathy, introduced to India in the nineteenth century, has achieved a large geographical spread, particularly strong in West Bengal, Maharashtra, and Andhra Pradesh, operating on the principle of like cures like using highly diluted preparations.

Sowa-Rigpa (the Trans- Himalayan medical tradition) is concentrated in a small number of high-altitude districts and practiced principally in Ladakh, Himachal Pradesh, Sikkim, and Arunachal Pradesh.



1.5 The Analytical Architecture: Design and Coverage of the Primary Survey

The report's analytical architecture for the Ayush sector rests on four analytical lenses, detailed further in Chapter 2. The foundational framework is the Service Value Chain (SVC), which tracks value creation and loss across three distinct nodes: upstream (knowledge, inputs, and research), midstream (enterprise-level service delivery), and downstream (outcomes, consumer markets, and social outcomes). Interlocking with this is the informality-formalisation continuum, which maps enterprises across informal, semi-formal, and formal tiers to show that formalisation builds vital economic capability rather than mere regulatory compliance.

The empirical foundation of this report is a dual-track primary survey specifically designed to generate robust, scalable data on Ayush service establishments across India. The survey enumerated a total of 15,914 Ayush service establishments, making it the most comprehensive systematic enumeration of the sector to date.

The survey design addresses a fundamental challenge in enumerating the Ayush sector: its enterprises are extremely heterogeneous in their concentration, highly clustered in specific states with long traditions of particular systems yet broadly distributed in others. The Southern region, for instance, is the most mature market for Ayush services. Kerala has for long been a leading state in Ayurvedic wellness tourism; Tamil Nadu is the hub for Siddha; and Karnataka is a major centre for Yoga education and naturopathy. A single-mode sampling approach would either over-invest in sparse regions to achieve representativeness, or under-represent the concentrated, high-density states where the sector's economic character is most distinctly defined.

The survey therefore used a two-pronged strategy: Track 1 focused on a wide enumeration in states known for high concentrations of specific Ayush subsystems, while Track 2 applied a stratified multi-stage probability sampling design across the remaining states and all union territories.

Annexure II provides a full technical account of the survey methodology, estimation procedures, and data limitations. The key parameters are: reference period FY2022-23 to FY2024-25; 15,914 establishments; coverage of all Ayush subsystems; and collection of data on revenue, employment, cost structure, digital adoption, and foreign patient receipts.



1.6 Study Objectives

This report seeks to answer four key strategic questions that are central to understanding the current performance and future potential of the Ayush services sector, and that are of direct relevance to policymakers, researchers, and practitioners.

1. **Economic Scale and Growth Size:** What is the current total size of the Ayush services economy in terms of revenue, how is revenue distributed across systems and facility types, how fast is it growing, and what factors are driving its growth trajectory?
2. **Employment Dynamics:** How many people are employed in the Ayush services sector, and what is the gender composition of this workforce?
3. **Medical Value Travel (MVT):** How much revenue does the Ayush sector generate through medical value travel, and which institutional, operational, and market factors determine its ability to attract and serve patients?
4. **Vision 2047:** What could be the size of the Ayush services sector by 2047 under different strategic growth scenarios, and what institutional reforms, investments, and policy interventions are required to realise its highest-potential trajectory?



1.7 Report Organization

The remainder of the report proceeds as follows. Chapter 2 presents the analytical framework applied to the Ayush services sector of India. Chapters 3 and 4 address the study objectives in sequence. Chapter 5 presents voices from the ground, drawing on stakeholder feedback gathered during the field survey, synthesizes findings through the value chain lens, and translates analytical findings into a tiered policy agenda spanning three-time horizons. Chapter 6 discusses the Ayush services sector in the light of Viksit Bharat 2047 and enumerates upon the roadmap that can help to achieve it. Annexure I discusses Ayush service establishments considering their evolution and regulatory landscape in India. Annexure II is a technical note that provides a full technical account of the survey methodology, estimation procedures, and data limitations. Annexure III is a glossary of the Sanskrit terms used in this report, giving the meaning of each term and the context in which it is used, and should be read alongside the note on transliteration and diacritics in the front matter.



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Chapter 2

Analytical Framework

सर्वे भवन्तु सुखिनः। सर्वे सन्तु निरामयाः।
सर्वे भद्राणि पश्यन्तु। मा कश्चिद् दुःखभाग्भवेत् ॥

*(Traditional Sanskrit prayer for universal well-being
(precise textual provenance uncertain.)*

*May all beings be happy; may all be free from illness. May all
see what is auspicious, may no one suffer from sorrow.*



2.1 A Distinct Analytical Framework for Ayush

The Ayush services sector occupies a unique position within the Indian economy. Unlike most service sectors, its primary productive asset is not physical infrastructure or financial capital but accumulated knowledge. The sector draws upon codified medical traditions, practitioner expertise, community trust, and institutional systems that have evolved over centuries. At the same time, it operates within modern markets, competes for patients and consumers, generates employment and revenue, and increasingly participates in international trade through medical value travel and wellness services.

Three characteristics make the sector challenging to analyse through conventional economic frameworks alone.

First, the sector is inherently multi-dimensional. A single Ayush establishment may simultaneously provide healthcare services, train practitioners, support Ayush-based Wellness tourism, contribute to research, and generate employment. These activities span multiple economic categories and cannot be fully captured through a single-sector lens.

Second, the sector is fundamentally knowledge-intensive. The creation, preservation, transmission, validation, and application of knowledge lie at the centre

of value creation. Understanding the sector therefore requires attention not only to markets and enterprises, but also to knowledge systems and institutions.

Third, the sector exhibits substantial heterogeneity. It includes individual practitioners, small clinics, Ayush-based Wellness units, teaching institutions, hospitals, digital platforms, and internationally recognised Medical Value Travel (MVT) providers. These establishments differ considerably in scale, capability, market reach, and organisational maturity.

Given these characteristics, this report adopts an analytical framework that combines contemporary economic approaches with concepts drawn from the Indian knowledge traditions that underpin the Ayush systems themselves. The objective is not to replace modern economic analysis, but to complement it with conceptual tools better suited to understanding a traditional knowledge-based service economy.

The framework is organised around four analytical pillars - value creation, institutional capability, global competitiveness, and innovation. Together, these pillars provide the structure through which the empirical findings of the report are subsequently analysed.

Figure 2.1: Analytical pillars supporting Ayush sector assessment, aligned with Viksit Bharat@2047 horizon



2.2 The Four Analytical Pillars

Each pillar pairs a contemporary analytical question with a concept from the Indian knowledge tradition, and traces a three-stage progression of increasing maturity.

2.2.1 Pillar I · Knowledge Value Chain

Jñāna → *Vijñāna* → *Lokasaṅgraha*

The first pillar views the Ayush sector as a knowledge-based value chain, examining how knowledge is created, applied, and translated into economic and social outcomes. Drawing on *Jñāna* (knowledge), *Vijñāna* (applied knowledge), and *Lokasaṅgraha* (collective welfare), the framework distinguishes three interconnected stages within the ecosystem.

Jñāna represents the knowledge foundations i.e. educational institutions, research organisations, traditional knowledge repositories, and regulatory frameworks. *Vijñāna* represents the application of this knowledge through service delivery: clinics, hospitals, Ayush-based Wellness centres, teleconsultation platforms, and educational establishments. *Lokasaṅgraha* represents the broader outcomes i.e. health improvements, employment, entrepreneurship, Ayush-based Wellness tourism, medical value travel, and other societal benefits.

Figure 2.2: The *Jñāna*→*Vijñāna*→*Lokasaṅgraha* value chain: from knowledge creation to societal outcomes

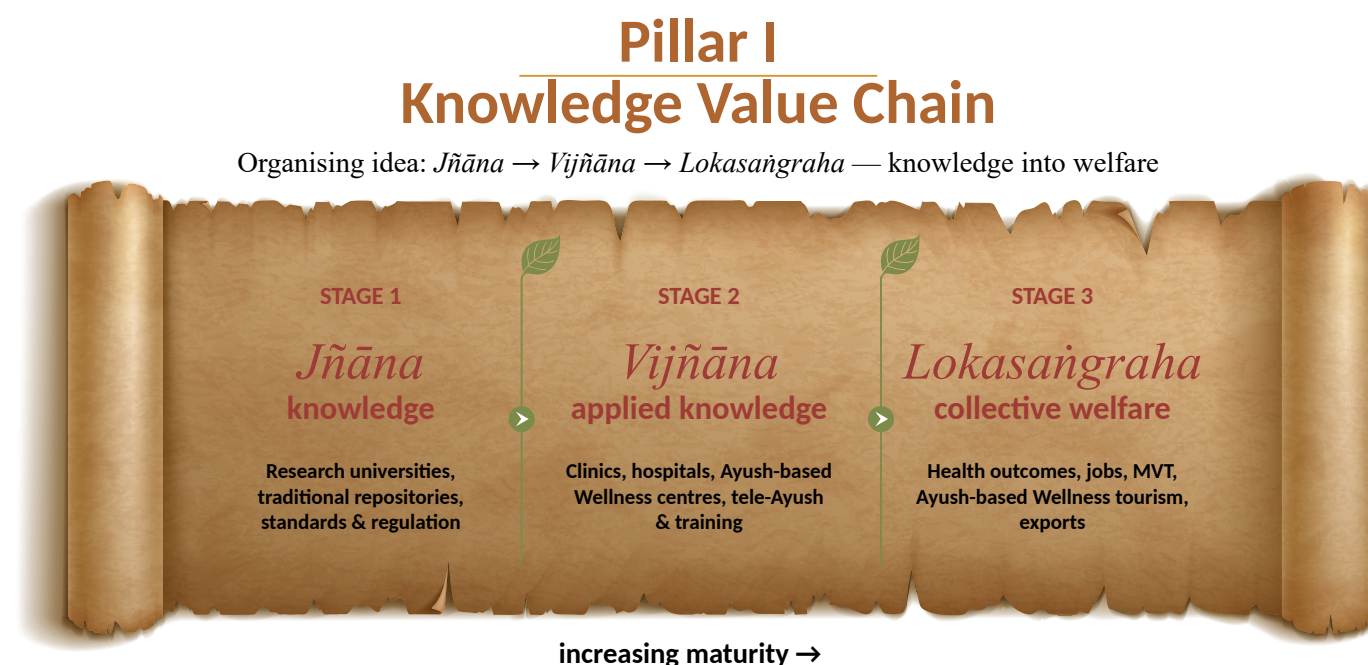


Table 2.1: *Jñāna*→*Vijñāna*→*Lokasaṅgraha* value chain

Stage	Segment	Illustrative Components
<i>Jñāna</i>	Knowledge Infrastructure	Research institutions, universities, traditional knowledge systems, standards, regulation
<i>Vijñāna</i>	Service Delivery	Clinics, hospitals, Ayush-based Wellness centres, tele-Ayush platforms, educational institutions
<i>Lokasaṅgraha</i>	Outcomes	Health outcomes, employment, entrepreneurship, MVT, Ayush-based Wellness tourism, exports

2.2.2 Pillar II · Enterprise Capability

Prārambha → *Vikāsa* → *Utkarṣa*

The second pillar focuses on institutional capability and organisational maturity. Ayush establishments differ considerably in scale, governance, quality systems, digital adoption, accreditation, and operational sophistication. Rather than a simple formal-informal distinction, the report analyses them along a capability continuum.

Prārambha represents primary establishments with limited institutional infrastructure. *Vikāsa* represents developing establishments adopting formal management systems and quality processes. *Utkarṣa* represents advanced establishments characterised by higher organisational capability, accreditation, integration, and service sophistication.

Figure 2.3: The *Prārambha*→*Vikāsa*→*Utkarṣa* capability continuum: from basic to advanced enterprises

Pillar II Enterprise Capability

Organising idea: *Prārambha* → *Vikāsa* → *Utkarṣa* — a capability continuum



Table 2.2: *Prārambha*→*Vikāsa*→*Utkarṣa* capability continuum

Stage	Description
<i>Prārambha</i>	Primary capability - limited institutional infrastructure
<i>Vikāsa</i>	Developing capability - adopting formal management and quality systems
<i>Utkarṣa</i>	Advanced capability - accreditation, integration and sophistication





2.2.3 Pillar III · Global Competitiveness

Sthānīya → *Pramāṇita* → *Vaiśvika*

The third pillar examines the extent to which establishments participate in regional, national, and international markets. Its organising concept is *Pramāṇa* which means validated and trusted knowledge. In contemporary healthcare and wellness markets, trust is expressed through standards, accreditation, quality assurance, and institutional credibility.

Sthānīya represents establishments serving local or regional markets. *Pramāṇita* represents those validated through recognised quality-assurance systems and institutional trust. *Vaiśvika* represents establishments capable of participating in international markets through medical value travel, Ayush-based Wellness tourism, cross-border partnerships, and service exports.

Figure 2.4: The *Sthānīya*→*Pramāṇita*→*Vaiśvika* continuum: from local to global market participation

Pillar III Global Competitiveness

Organising idea: *Sthānīya* → *Pramāṇita* → *Vaiśvika* — trust through *Pramāṇa*

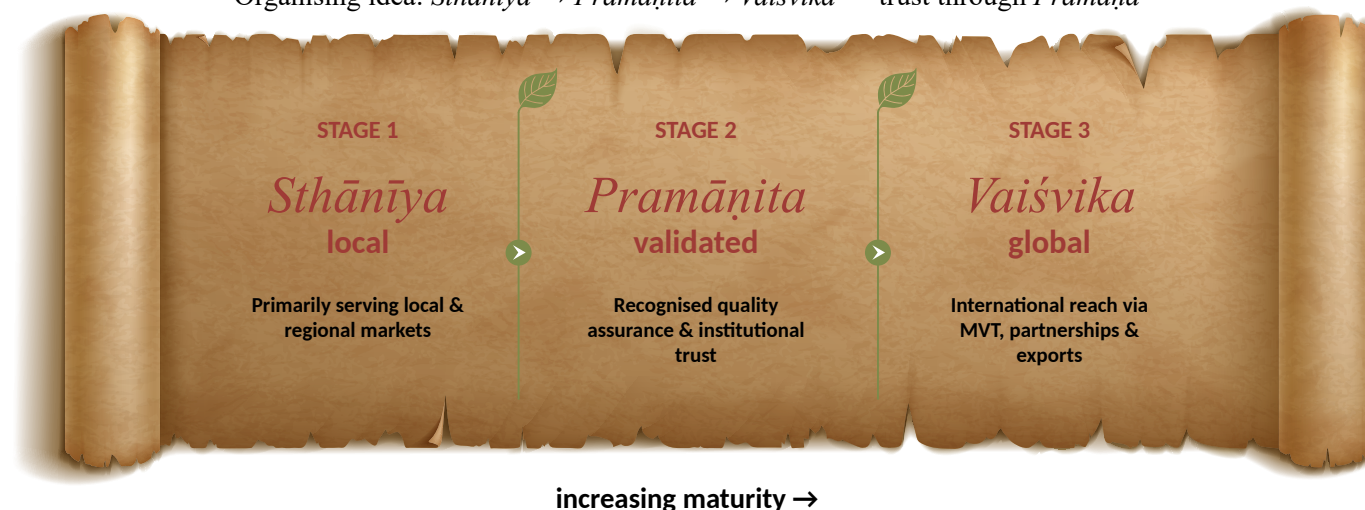


Table 2.3: *Sthānīya*→*Pramāṇita*→*Vaiśvika* continuum

Stage	Market Orientation
<i>Sthānīya</i>	Local and regional markets
<i>Pramāṇita</i>	National market integration through validated quality
<i>Vaiśvika</i>	International market participation



2.2.4 Pillar IV · Innovation Dynamics

Anukaraṇa → *Yukti* → *Navonmeṣa*

The fourth pillar focuses on innovation, adaptation, and learning. Within traditional knowledge systems, innovation often differs from that of conventional technology sectors; occurring through adaptation, refinement, practical experimentation, and cumulative learning rather than discrete breakthroughs alone.

Drawing on *Yukti*, the thoughtful, context-sensitive application of knowledge, the pillar distinguishes establishments that replicate existing practices (*Anukaraṇa*), those that adapt and improve existing approaches (*Yukti*), and those that contribute new service models, protocols, or institutional practices (*Navonmeṣa*).

Figure 2.5: The *Anukaraṇa*→*Yukti*→*Navonmeṣa* innovation continuum: from replication to innovation

Pillar IV Innovation Dynamics

Organising idea: *Anukaraṇa* → *Yukti* → *Navonmeṣa* — thoughtful application

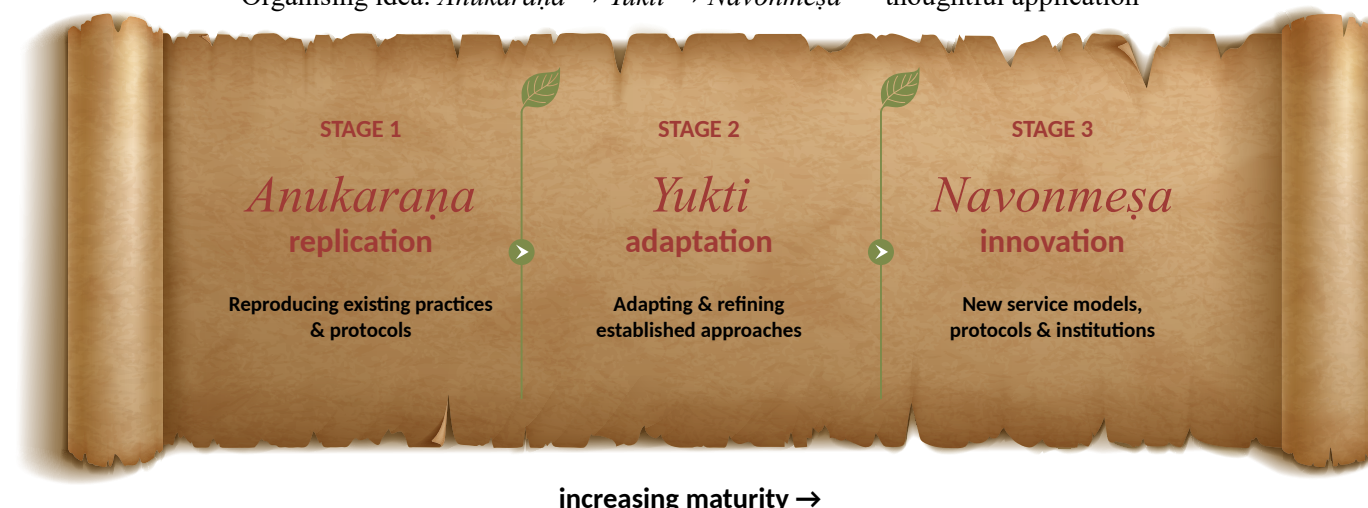


Table 2. 4: *Anukaraṇa*→*Yukti*→*Navonmeṣa* innovation continuum

Stage	Innovation Characteristic
<i>Anukaraṇa</i>	Replication of existing practices and protocols
<i>Yukti</i>	Adaptation and refinement of established approaches
<i>Navonmeṣa</i>	Innovation - new service models, protocols and institutions

2.3 Viksit Bharat@2047 as the Long-Term Horizon

The four pillars are tools for understanding the present structure and future trajectory of the Ayush services sector, and for assessing how it contributes to India's broader development aspirations.

The vision of Viksit Bharat@2047 envisages India as a developed, prosperous, innovative, and globally influential nation by the centenary of independence. Achieving it will require the growth of knowledge-intensive sectors capable of generating employment, creating globally competitive enterprises, expanding exports, and producing sustained economic value.

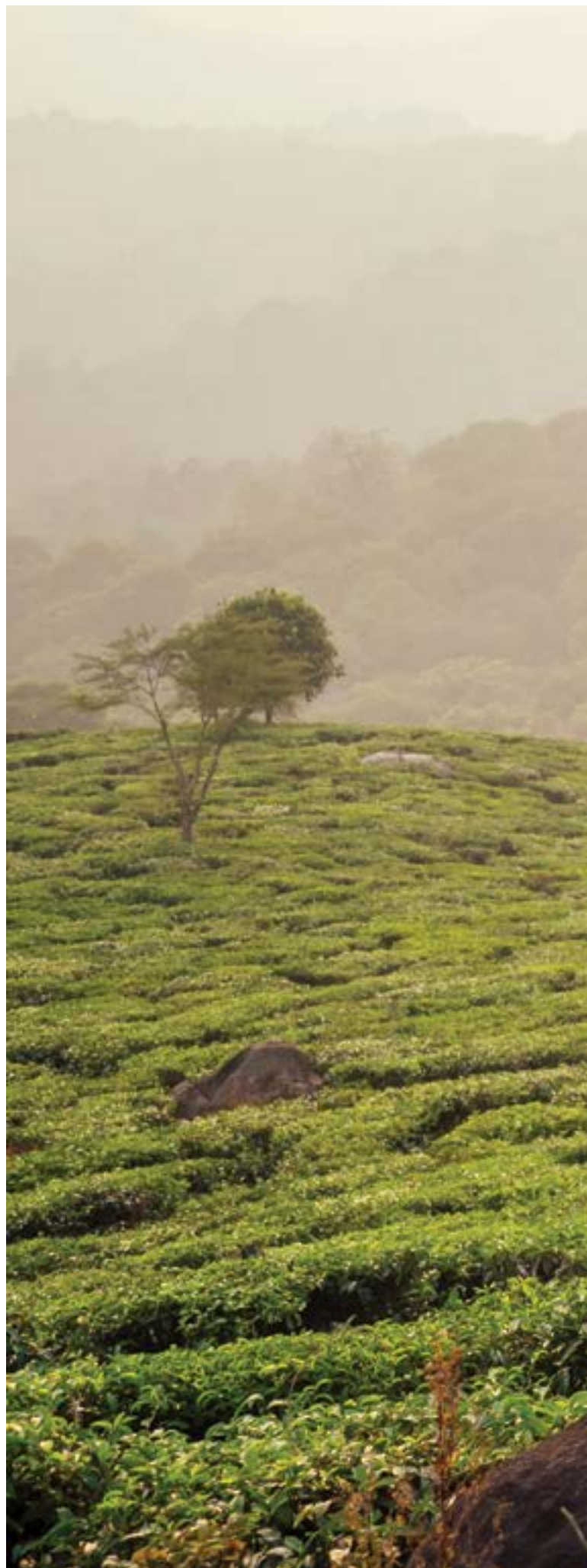
The Ayush services sector is particularly relevant to this objective: it is rooted in India's traditional knowledge systems, generates employment across urban and rural areas, contributes to healthcare and Ayush-based Wellness, and possesses growing international appeal. The four pillars provide a framework for examining these contributions systematically.

Accordingly, Viksit Bharat@2047 is treated not as a separate analytical lens but as the long-term horizon against which the sector's economic contribution, institutional development, global competitiveness, and innovation capacity are assessed.

2.4 Chapter Summary

This chapter has developed the analytical framework that guides the remainder of the report. Four pillars have been introduced: the *Jñāna*→*Vijñāna*→*Lokasaṅgraha* value chain, the *Prārambha*→*Vikāsa*→*Utkarṣa* capability continuum, the *Sthānīya*→*Pramāṇita*→*Vaiśvika* competitiveness continuum, and the *Anukaraṇa*→*Yukti*→*Navonmeṣa* innovation continuum. While presented separately for analytical clarity, the four pillars are interconnected in practice. Establishments with higher institutional capability (*Utkarṣa*) are more likely to achieve global competitiveness (*Vaiśvika*), as accreditation and quality systems facilitate international market access. Similarly, innovation (*Navonmeṣa*) often emerges from deeper integration into the knowledge value chain (*Jñāna*→*Vijñāna*→*Lokasaṅgraha*).

The chapters that follow apply these pillars to evidence collected from 15,914 Ayush service establishments across India, examining the size, structure, employment contribution, medical value travel potential, and future growth trajectory of the sector. The final chapter returns to these four pillars to synthesise the findings and develop a roadmap for strengthening the Ayush services sector as a contributor to Viksit Bharat@2047.





Chapter 3

The Economic Profile

क्वचिद् धर्मः क्वचिन्मैत्रि क्वचिदर्थः क्वचिद्यशः।
कर्माभ्यासः क्वचिच्चेति चिकित्सा नास्ति निष्फला ॥

(Bhāvaprakāśa, Pūrvakhaṇḍa, Miśra-prakaraṇa, verse 32.)

Medical Service is rewarding in several ways: sometimes it bestows spiritual merit (Dharma), sometimes it bestows loyal/influential friendships (Maitri), sometimes it bestows prolific livelihood (Artha), and sometimes it bestows respect and reputation (Yasha). Even if none of these material or social gains happen, the act of treating a patient always yields clinical experience and wisdom (Karmabhyasa).



3.1 Introduction

The previous chapter introduced the analytical framework used in this report to understand the Ayush services sector as a traditional knowledge service economy. This chapter begins the empirical application of that framework by examining the sector's economic architecture using data from 15,914 Ayush service establishments across India.

The objective of this chapter is to establish a baseline understanding of the size, structure, and characteristics of the sector. In doing so, it provides the empirical foundation for the subsequent analysis of Medical Value Travel (MVT), long-term growth projections, and policy recommendations. The chapter addresses five interrelated questions.

First, how large is the Ayush services economy, and how rapidly is it growing? This provides an estimate of the sector's overall economic scale and growth trajectory.

Second, how is the sector structured across different facility types and Ayush systems? Understanding this architecture helps identify where economic activity is concentrated and how different segments contribute to overall sector performance.

Third, what does the distribution of gross margins reveal about the economic health of Ayush establishments? Gross margins provide insights into enterprise profitability and operational efficiency.

Fourth, how digitally prepared are Ayush establishments? Digital infrastructure increasingly shapes service delivery, patient outreach, and participation in national and international markets.

Fifth, what is the scale and composition of employment generated by the sector? Understanding workforce characteristics is essential for assessing the sector's contribution to job creation and human capital development.

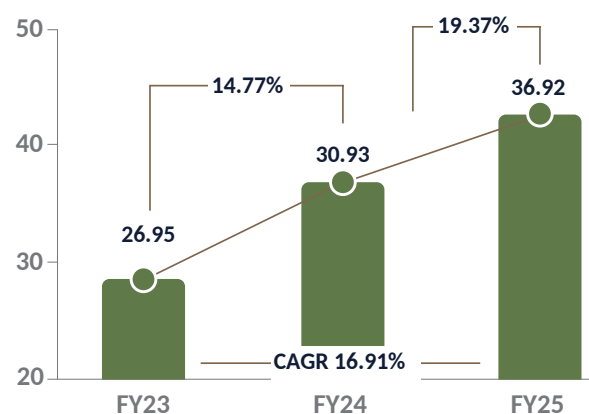
3.2 Scale, Growth and Geographical Footprint of the Ayush Services Economy

This section deals with the scale, growth, and geographical footprint of the Ayush services economy. It highlights revenue trends between FY23 and FY25, the distribution of revenue across establishments, and the regional spread of economic activity. This section also explores the geographical distribution of revenue as well as patient volume, offering insights into patterns of healthcare utilisation and the reach of Ayush services across India.

3.2.1 Revenue Scale and Growth Dynamics

The Ayush services sector recorded strong growth during the study period. The estimated size of the sector increased from US\$26.95 billion in FY23 to US\$36.92 billion in FY25, with Compound Annual Growth Rate (CAGR)¹ of 16.91 per cent (Figure 3.1). Overall, the sector expanded by approximately 37 per cent between FY23 and FY25, making it one of the fastest-growing segments of India's healthcare and wellness economy. This reflects growing consumer demand and adoption of traditional and preventive healthcare services.

Figure 3.1: Revenue Performance of the Ayush Service Sector



Source: RIS estimation based on field survey

While aggregate growth provides an indication of the sector's overall performance, it does not reveal change in revenue pattern over the study period. Understanding these shifts is important, as changes in the revenue distribution can reveal whether growth has been broadly shared or concentrated among a smaller group of establishments. To examine these underlying dynamics, we employ kernel density distribution (Figure 3.2).

The kernel density plot shows a clear upward shift in the revenue distribution of Ayush establishments over the three-year period. In FY23 (blue solid line), the largest concentration of enterprises is clustered around lower revenue levels, reflected in the primary peak located on the left side of the distribution. In FY24 (red dash-dot line), this peak shifts noticeably to the right, indicating an increase in the revenue levels at which most establishments operate. The trend continues in FY25 (magenta solid line), where the peak moves further right and becomes more pronounced.

This progressive rightward movement of the blue, red, and magenta curves suggests that the typical enterprise generated higher revenues in each successive year.

At the same time, the increasing height of the FY25 peak indicates a greater concentration of establishments around these higher revenue levels, suggesting that growth was experienced across a broad segment of the sector rather than being confined to a small number of enterprises.

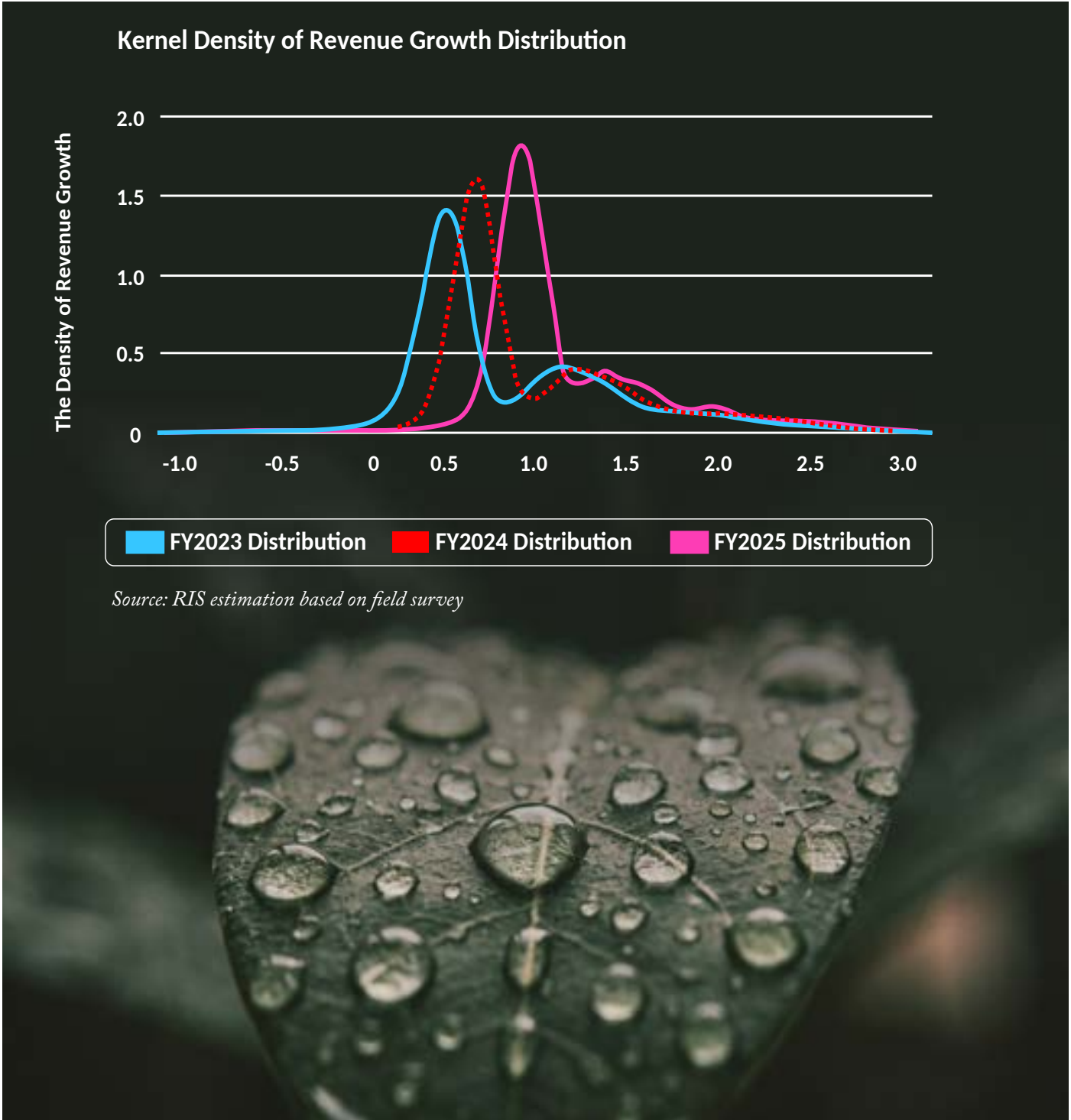
The secondary humps of the three distributions remain closely aligned, suggesting that the revenue position of the highest-earning establishments changed less dramatically than that of enterprises in the lower segments of the distribution.

This pattern indicates that much of the growth during

the study period occurred among establishments clustered around the primary peak, resulting in a larger concentration of enterprises at higher revenue levels. At the same time, the relative position of the highest-revenue establishments remained broadly stable, highlighting the continued presence of distinct enterprise segments within the sector.

Viewed through the *Prārambha–Vikāsa–Utkarṣa* capability continuum, this pattern may indicate that a growing number of establishments are progressing beyond the primary stage and acquiring the scale necessary for institutional development.

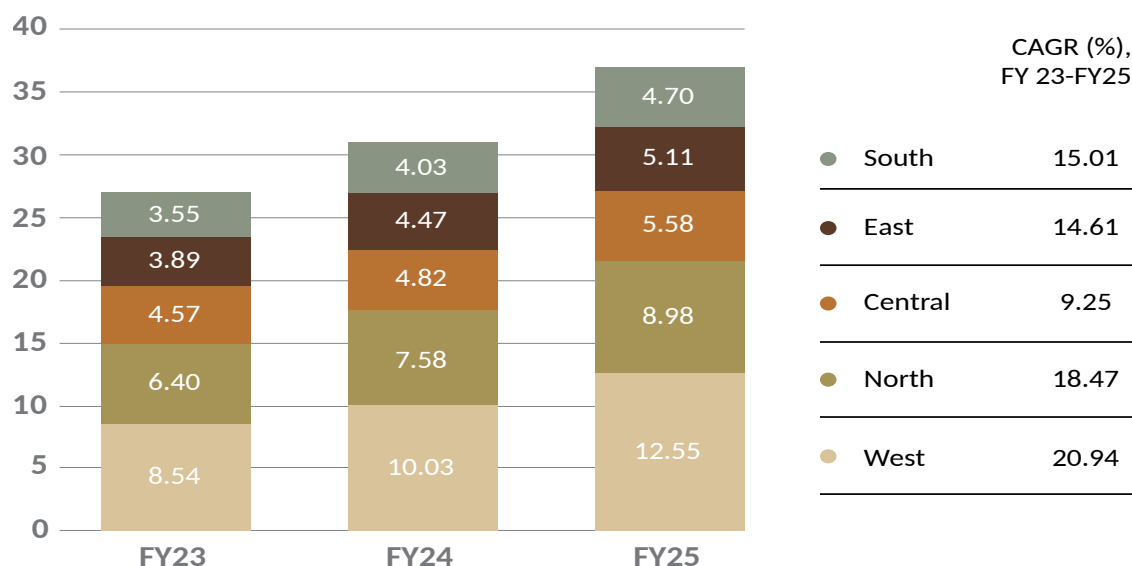
Figure 3.2: The Kernel Density of Revenue Growth Trend for FY23-FY25



3.2.2 The Regional Dimension

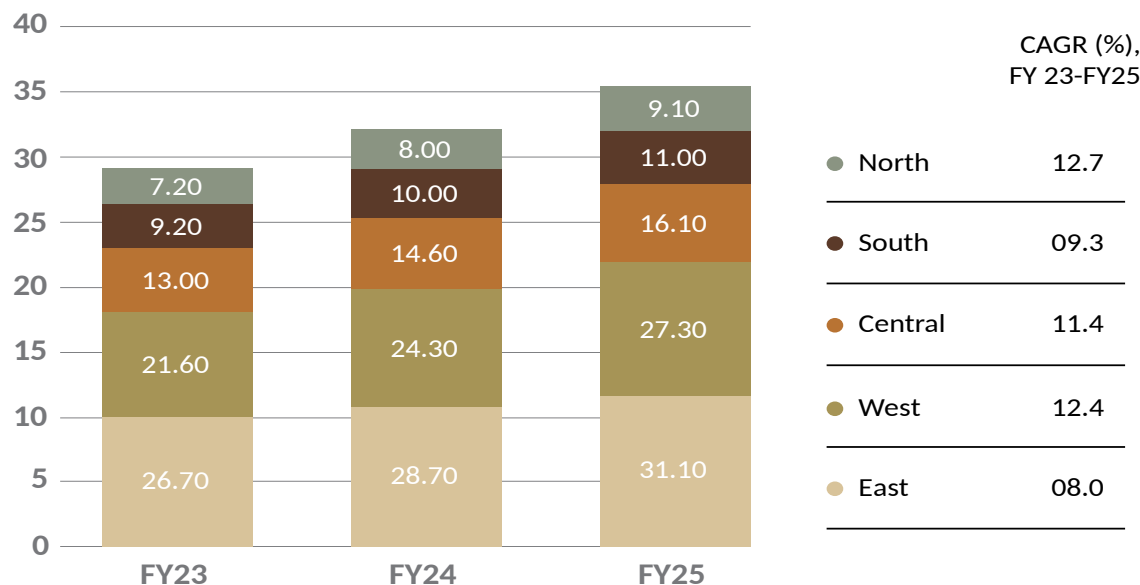
While national-level trends provide an overall picture of sector performance, regional analysis offers a deeper understanding of how Ayush services are distributed across India. Such analysis provides insights into differences in service utilization and revenue patterns. The figures 3.3 and 3.4 represent the revenue generation and patient volume, respectively across five regions of India.

Figure 3.3: Geographical Footprint of Revenue generation through Ayush Services (US\$ Billion)



Source: RIS estimation based on field survey

Figure 3.4: Geographical Footprint of Patients Receiving Ayush Services (Crores)



Source: RIS estimation based on field survey

The West region serves as the primary economic powerhouse, consistently leading in total revenue and reaching US\$12.55 billion in FY25, 33.99 per cent of national Ayush revenue, from a patient base of 27.3 Crore.

The South functions as a stable revenue contributor and the sector's primary international reputation anchor. The Central region represents an emerging growth opportunity whose realisation depends substantially on infrastructure investment and healthcare worker deployment. In contrast, the North region despite having

one of the smallest patient bases (9.1 Crore), generates a high revenue of US\$8.98 billion, potentially indicative of a higher-concentration of premium service providers or a more affluent demographic.

The Eastern region presents an interesting contrast, while it accounts for the highest patient volume at 31.1 crore, it ranks fourth in total revenue. This divergence indicates that the region generates relatively lower revenue per patient, highlighting untapped potential for expanding higher-value Ayush services and strengthening the sector's economic footprint.

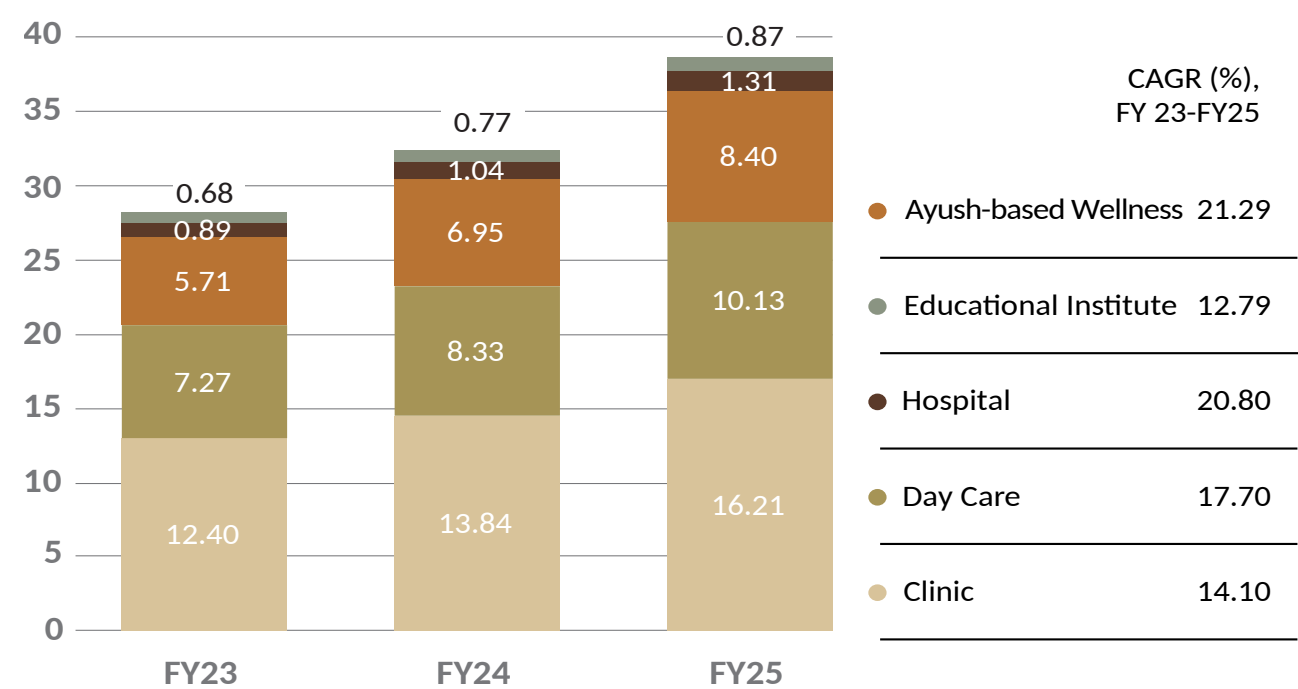
3.3 Revenue Distribution within the Ayush Services Sector

While the previous section examined the overall size and growth of the Ayush service economy, this section focuses on the distribution of service revenue across different Ayush systems and across different Ayush facilities. Analyzing the revenue composition by system and facility highlights their relative economic contribution and roles in shaping the Ayush service economy. The following sub-sections first assess revenue patterns across facilities, followed by the distribution of revenue across Ayush systems

3.3.1 Revenue by Facility Type

In present study, the Ayush services economy has been estimated from the major facility types- Clinic, Day care centre, Hospital, Educational Institute, Yoga centre, Spas, and Resorts offering Ayush-based services. The analysis however, has chosen to distinguish between facilities that primarily have a clinical focus, have a training and capacity-building focus and those whose services extend beyond therapy to a larger focus of well-being. Therefore, the above enlisted facility types have been regrouped into overall five segments viz., Clinic, Day care centre, Hospital, Educational Institute and Ayush-based Wellness (inclusive of Yoga Centre, Spa and Resort).

Figure 3.5: Ayush Revenue by Facility type (US\$ Billion)



Source: RIS estimation based on field survey

Figure 3.5 presents the revenue contribution of each facility type between FY23 and FY25. With a contribution of 43.91 per cent to total sector revenue, clinic emerged as the largest segment, generating an estimated revenue of US\$16.21 billion in FY25. As the most widespread form of Ayush service delivery, Clinic constitutes the primary interface between practitioners and patients and form the backbone of the sector’s outpatient care ecosystem.

Day care centre represents the second-largest segment, generating US\$10.13 billion and accounting for 27.44 per cent of total sector revenue. Together, Clinic and Day care centre contribute more than 71 per cent of the sector’s total revenue, highlighting the dominant role of ambulatory and non-residential care within the Ayush services economy.

The Ayush-based Wellness segment contributes US\$8.40 billion, accounting for approximately 23 per cent of the total Ayush services revenue. Its strong contribution

reflects the growing demand for preventive healthcare, holistic well-being, and Ayush-based Wellness tourism, making it a key driver of sectoral growth.

Ayush hospitals and educational institutes account for a relatively smaller share of total revenue but remain essential to the sector. Hospitals provide specialised clinical and therapeutic services, while educational institutes support human resource development, research, and the long-term sustainability of the Ayush ecosystem.

All five facility categories recorded positive growth between FY23 and FY25, indicating that expansion was not confined to a single segment. However, growth rates varied across facility types. The Ayush-based Wellness segment recorded the fastest growth, expanding by 47.11 per cent during the study period, followed closely by Hospital, which grew by 46.70 per cent. This suggests increasing demand for organised Ayush-based Wellness services and more intensive forms of Ayush-based care.

Box 3.1: The Wellness Premium: faster growth, different product. Among all facility types, the facilities collectively representing Ayush-based Wellness (Yoga centre, Spa, and Resort) recorded the fastest growth during the study period. The Ayush-based Wellness segment expanded by US\$2.69 billion between FY23 and FY25, registering a CAGR of 21.29 per cent, compared with the overall sector growth rate of 16.91 per cent. Within the Ayush-based Wellness segment, Yoga Centres recorded the strongest growth, with a CAGR of 32.46 per cent, highlighting the increasing popularity of yoga-based wellness offerings and their growing contribution to the sector's overall expansion.

Unlike Clinic or Hospital, Ayush-based Wellness facility primarily caters to preventive healthcare, lifestyle management, rejuvenation, Yoga, mindfulness, and holistic Ayush-based Wellness experiences. These services are closely aligned with the preferences of both domestic Ayush-based Wellness seekers and international visitors.

The rapid expansion of this segment indicates growing demand for wellness-oriented Ayush services and highlights its increasing importance within the broader Ayush economy. Given its strong orientation towards experiential and destination-based care, the Ayush-based Wellness segment is also likely to play an important role in the future growth of MVT, a theme examined in greater detail in Chapter 5.

Box 3.2: Day Care Centre: The Emerging Middle Tier. Day Care centre has emerged as one of the fastest-growing segments of the Ayush services economy. With an estimated revenue of US\$10.13 billion in FY25 and a CAGR of 17.70 per cent during the study period, they are the second-largest and second-fastest-growing facility type.

Positioned between outpatient Clinic and inpatient Hospitals, Day Care centre provides therapies that require multiple sessions or extended treatment without overnight admission. These procedures are more intensive than a routine consultation but do not require hospitalisation.

The rapid expansion of this segment suggests that the Ayush services sector is developing a distinct intermediate tier of service delivery. This broadens the range of treatment options available to patients and reflects increasing demand for structured therapeutic interventions beyond conventional outpatient care. Such facilities are also well suited to Ayush-based Wellness visitors and short-duration treatment programmes, making them a potentially important component of India's growing MVT ecosystem.



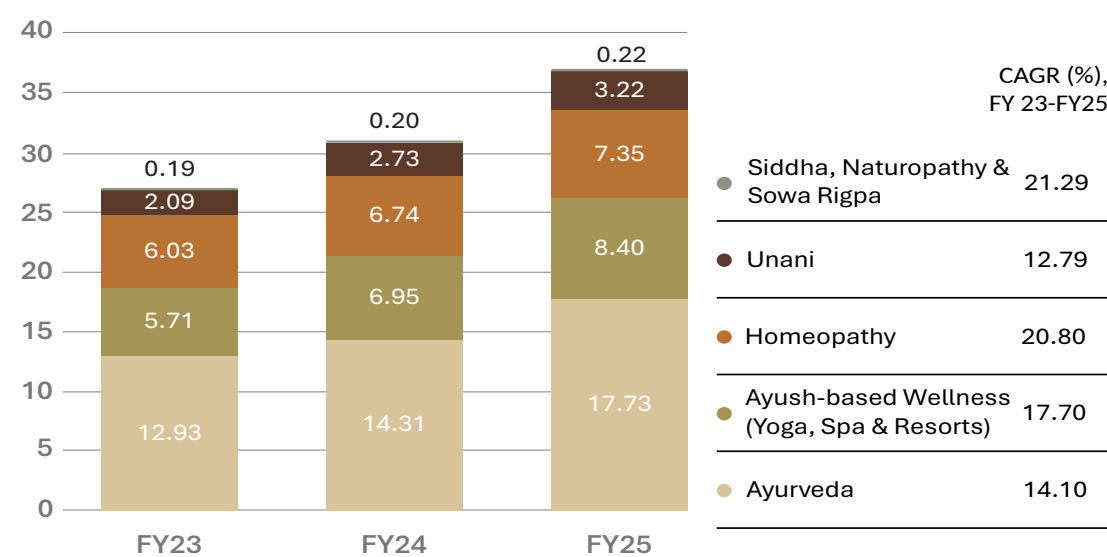
3.3.2 Revenue Architecture by System

The Ayush services comprise of the following systems: Ayurveda, Homoeopathy, Unani, Siddha, Yoga & Naturopathy and Sowa Rigpa. Each characterised by different service model, patient profile, institutional structure, and growth trajectory. As mentioned earlier, this study has defined a Ayush-based Wellness segment driven by service offerings from Ayurveda, Yoga and other Ayush systems. This segment has been retained as such for the entire set of analysis that has been carried out under this study. In the present study, owing to the relatively minimal coverage of Naturopathy and Sowa-Rigpa establishments, as well as the presence of Siddha establishments predominantly in one state (Tamil Nadu), data from these three systems have been represented as a unified group. In lieu of the above

classification, examining them separately, provides a clearer understanding of the diversity within the Ayush economy.

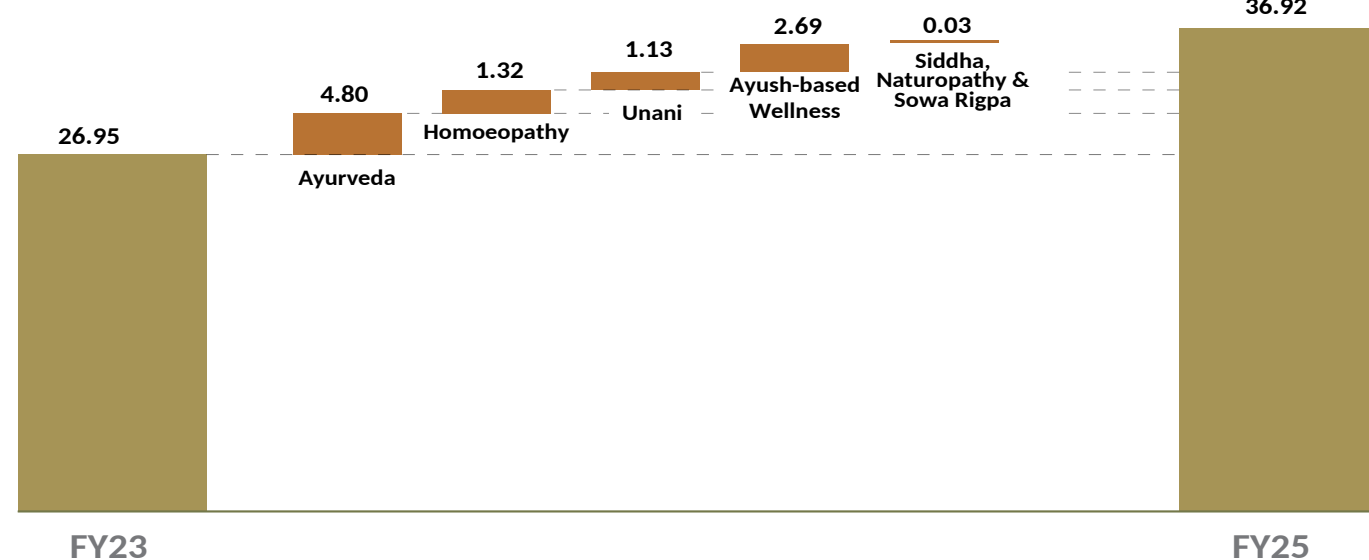
Though, overall sector has shown an impressive growth, but not uniform across systems. Ayurveda remained the dominant component, accounting for 48.02 per cent of total revenue in FY25. It also recorded the largest absolute increase in revenue during the study period, reflecting its central position within India's Traditional Medicine ecosystem. (Figure 3.6). Unani also recorded strong growth during the study period, while Homoeopathy, despite remaining the second-largest system with a 19.91 per cent share of total revenue, grew at a comparatively slower pace, suggesting a more mature market relative to other segments.

Figure 3.6: Ayush Revenue by System (US\$ Billion)



Source: RIS estimation based on field survey

Figure 3.7: Unpacking Topline Expansion of Ayush Economy (US\$ Billion)



Source: RIS estimation based on field survey

Note: The first bar in the figure depicts the size of the Ayush economy in FY2023 and serves as the baseline. The subsequent bars illustrate the incremental contribution of each individual Ayush system to the overall expansion of the Ayush economy during the following two financial years.

Figure 3.7 presents the increase in revenue recorded across various systems over the study period. While Ayurveda contributed the largest share of incremental revenue in absolute terms, the combined contribution of Homoeopathy, Unani, Ayush-based Wellness, and the Siddha-Naturopathy-Sowa Rigpa grouping also represented a substantial source of growth. This indicates that growth is increasingly being supported by

multiple systems rather than by a single segment alone.

3.3.2.1 Ayurveda: The Dominant System

Table 3.1 shows the distribution of Ayurveda revenue across different facility types between FY23 and FY25. Ayurveda generated an estimated US\$17.73 billion in FY25, up from US\$12.93 billion in FY23, representing a growth of 37.12 per cent over the study period.

Table 3.1: Ayurveda Revenue by Facility type (US\$ Billion)

Facility	FY23	FY24	FY25	2-yr Growth (%)	FY25 Share (%)
Clinic	6.08	6.69	8.43	38.65	47.55
Day Care	5.74	6.32	7.68	33.80	43.31
Hospital	0.71	0.83	1.08	52.11	6.09
Educational Institute	0.40	0.47	0.54	35.00	3.05

Source: RIS estimation based on field survey

A notable feature of the Ayurveda economy is the balanced contribution of Clinic and Day care centre. Clinic accounted for 47.55 per cent of system revenue in FY25, while Day care centre contributed 43.31 per cent. Together, these two facility types generated more than 90 per cent of total Ayurveda revenue, indicating that the system is built around two complementary modes of service delivery. Clinic primarily provides outpatient consultations and routine healthcare services, whereas Day care centre offer structured therapeutic procedures that require multiple sessions without overnight admission.

Although Hospital accounted for only 6.09 per cent of Ayurveda revenue in FY25, they recorded the fastest growth among all facility types, expanding by 52.11 per cent during the study period. This suggests increasing demand for institution-based Ayurveda services, even

though hospitals currently represent a relatively small share of the overall Ayurveda economy.

3.3.2.2 Homoeopathy: A Clinic-Dominant System

Table 3.2 presents the distribution of Homoeopathy revenue across different facility types between FY23 and FY25. Homoeopathy generated an estimated US\$7.35 billion in FY25, increasing from US\$6.03 billion in FY23, representing a growth of 21.89 per cent over the study period.

The most striking feature of the Homoeopathy services economy is its overwhelming reliance on Clinic, which accounted for 91.84 per cent of total system revenue in FY25. This indicates that Homoeopathy service delivery in India is primarily organised around outpatient consultations, with relatively limited dependence on institutional or residential modes of care.

Table 3.2: Homoeopathy Revenue by Facility type (US\$ Billion)

Facility	FY23	FY24	FY25	2-yr Growth (%)	FY25 Share (%)
Clinic	5.52	6.20	6.75	22.28	91.84
Day Care	0.09	0.07	0.09	0.00	1.22
Hospital	0.14	0.17	0.18	28.57	2.45
Educational Institute	0.28	0.30	0.33	17.86	4.49

Source: RIS estimation based on field survey

In contrast, Day care centre contributed only 1.22 per cent of total revenue and recorded virtually no growth during the study period. Hospital accounted for 2.45 per cent of revenue, while Educational institute contributed 4.49 per cent, reflecting the continued importance of education and training within the Homoeopathy ecosystem.

3.3.2.3 Unani: A Day Care Centre Oriented System

Table 3.3 presents the distribution of Unani revenue across different facility types between FY23 and FY25. Unani generated an estimated US\$3.22 billion in FY25, increasing from US\$2.09 billion in FY23, representing a growth of 54.07 per cent over the study period.

Table 3.3: Unani Revenue by Facility type (US\$ Billion)

Facility	FY23	FY24	FY25	2-yr Growth (%)	FY25 Share (%)
Clinic	0.71	0.86	0.93	30.99	28.88
Day Care	1.34	1.83	2.24	66.42	69.57
Hospital	0.04	0.04	0.05	25.0	1.55
Educational Institute	0.00	0.00	0.00	n/a	0.00

Source: RIS estimation based on field survey

Note: Educational institutes in the Unani system do not generate significant service revenue; they are primarily training institutions.

A distinguishing feature of the Unani services economy is the dominant role of Day care centre, which accounted for 69.57 per cent of total system revenue in FY25. Revenue from Day care centre increased from US\$1.34 billion in FY23 to US\$2.24 billion in FY25, recording a growth of 66.42 per cent, the highest among all facility-system combinations in the dataset.

In comparison, Clinic contributed 28.88 per cent of total revenue, while Hospital accounted for 1.55 per cent. This indicates that Unani service delivery is concentrated around therapeutic procedures that are delivered through structured, non-residential care rather than conventional

outpatient consultations or inpatient treatment.

3.3.2.4 Ayush-based Wellness : A High-Growth Segment

Table 3.4 presents the revenue distribution of the Ayush-based Wellness segment across Yoga centre, Spa, and Resort between FY23 and FY25. The Ayush-based Wellness segment generated an estimated US\$8.40 billion in FY25, increasing from US\$5.71 billion in FY23, representing a growth of 47.11 per cent over the study period. This makes Ayush-based Wellness the fastest-growing segment of the Ayush services economy.

Table 3.4: Ayush-based Wellness Segment Revenue by Facility type (US\$ Billion)

Facility	FY23	FY24	FY25	2-yr Growth (%)	FY25 Share (%)
Yoga	2.24	2.93	3.93	75.45	46.79
Spa	1.34	1.65	2.06	53.73	24.52
Resort	2.13	2.37	2.41	13.15	28.69

Source: RIS estimation based on field survey

Among the three facility types within Ayush-based Wellness, Yoga centre accounted for the largest share of revenue, contributing US\$3.93 billion in FY25 and recording the highest growth rate of 75.45 per cent over the study period. This reflects the increasing acceptance of Yoga as an integral part of preventive healthcare, fitness, and holistic well-being, supported by growing domestic participation as well as expanding international recognition.

In comparison, Resort grew more moderately, from US\$2.13 billion to US\$2.41 billion, recording a growth of 13.15 per cent. Although the Resort segment expanded at a slower pace than Yoga centre and Spa, it continues to represent an important component of destination Ayush-based wellness services.

Spa increased from US\$1.34 billion in FY23 to US\$2.06 billion in FY25, representing a growth of 54.73 per cent. The sustained expansion of this segment suggests increasing demand for Ayush-based Wellness therapies and rejuvenation services, primarily led by Ayurveda.

3.4 Financial Health: the Gross Margin

Revenue and growth provide an indication of the size and expansion of the Ayush services economy. Gross margins offer a complementary perspective by illustrating the operating performance of different facility types. While gross margins do not capture the full financial position of an enterprise, they provide a useful indicator of the relationship between revenues and the direct costs of service delivery.

3.4.1 Gross Margin Distribution by Facility Type

Table 3.5 presents the distribution of gross margins across different facility types. The sector is grouped into four margin bands, ranging from less than 20 per cent to more than 60 per cent, allowing comparison of the operating characteristics of different service models.

Table 3.5: Gross Margin Distribution by Facility type

Margin	Clinic (%)	Day Care (%)	Hospital (%)	Educational Institute (%)	Spa (%)	Resort(%)	Yoga Centre (%)	Total (%)
< 20%	—	—	20.38	15.30	0.60	14.77	0.10	0.65
20%–40%	71.19	73.88	59.24	21.86	44.10	83.22	18.00	63.87
40%–60%	28.81	26.10	17.54	46.45	22.60	2.01	49.00	30.35
> 60%	—	—	2.84	16.39	32.70	—	32.90	5.13

Source: RIS estimation based on field survey

Note: (—) denotes zero

Overall, the sector demonstrates a relatively stable margin profile. Nearly 64 per cent of establishments reported gross margins between 20 and 40 per cent, making this the most common operating range across the Ayush services economy. A further 30.35 per cent of establishments achieved margins between 40 and 60 per cent, indicating that a substantial proportion of enterprises operate with comparatively strong gross margins.

Only 0.65 per cent of establishments reported margins below 20 per cent, while 5.13 per cent recorded margins above 60 per cent. Together, these findings suggest that extremely low or exceptionally high margins are relatively uncommon, with most enterprises concentrated within the middle ranges.

The distribution varies considerably across facility types. Clinic and Day care centre are predominantly concentrated in the 20–40 per cent margin band, reflecting relatively consistent operating models. Hospital display a broader distribution, with a greater proportion of establishments reporting lower margins, consistent with the higher operating costs associated with inpatient care and specialised clinical infrastructure.

In contrast, Yoga centres and Spa exhibit a larger concentration of establishments in the higher margin categories. Nearly half of Yoga centre reported margins between 40 and 60 per cent, while almost one-third exceeded 60 per cent. A similar pattern is observed among Spa, indicating that Ayush-based Wellness-oriented services often operate under different cost structures from conventional clinical facilities.

Box 3.3: High Gross Margins Reflect a Commercially Viable Sector

The gross margin profile of the Ayush services sector indicates that most establishments operate with healthy operating margins. Nearly 94.22 per cent of surveyed establishments reported gross margins between 20 and 60 per cent, while only 0.65 per cent reported margins below 20 per cent.

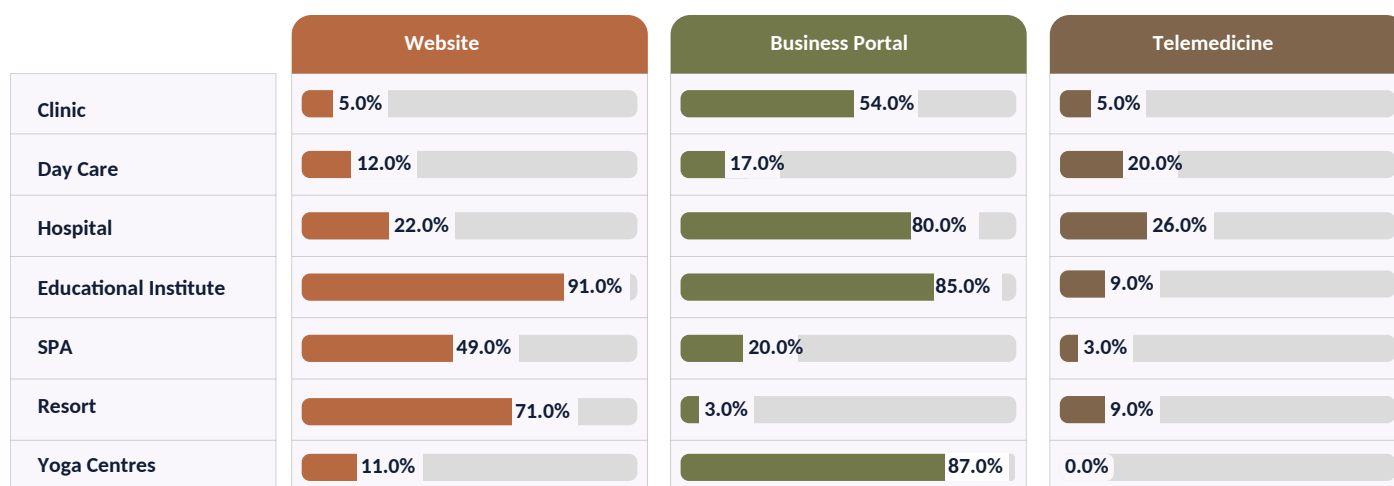
Within Ayush-based Wellness Segment, strongest performance is observed among Yoga centre and Spa. Yoga centre, the fastest-growing facility type within the Ayush-based Wellness segment, where 32.90 per cent of establishments reported gross margins exceeding 60 per cent. Similarly, a significant proportion of Spa, also operated within higher margin bands.

These findings suggest that the Ayush services sector is not characterised by uniformly low-margin enterprises. Instead, many establishments demonstrate commercially sustainable operating models, although profitability varies across facility types depending on their cost structures, infrastructure requirements, and service mix. The relationship between financial performance, institutional capability, and future growth opportunities is explored further in the concluding chapter.

3.5 Digital Readiness

Digital infrastructure has become an increasingly important component of healthcare and Ayush-based Wellness service delivery. For the Ayush services sector, digital readiness extends beyond operational efficiency; it determines how establishments are discovered, evaluated, and accessed by patients. Website presence, business portal adoption, and telemedicine capability therefore provide useful indicators of an enterprise's ability to participate in increasingly digital healthcare markets.

Figure 3.8: Digital Adoption Rate by Facility type



Source: RIS estimation based on field survey

The findings reveal considerable variation in digital readiness across the Ayush ecosystem.

First, website ownership differs substantially across facility types (Figure 3.8). Educational Institutes demonstrate the strongest digital presence, with 91 per cent maintaining dedicated websites, followed by Resort (71%) and Spa (49%). In contrast, website penetration remains low among Hospital (22%), Day care centre (12%), Yoga centre (11%), and Clinic (5%). Given that Clinic account for the largest share of service delivery within the sector, their limited independent online presence represents an important feature of the current digital landscape.

Second, business portal adoption is considerably higher than website ownership for several facility types. Yoga centre record the highest adoption rate at 87 per cent, followed by Educational Institute (85%) and Hospital (80%), while Clinic also show relatively high participation at 54 per cent. This suggests that many establishments have embraced digital platforms for business visibility and domestic outreach even where they have not developed dedicated institutional websites.

Third, telemedicine adoption remains comparatively limited across the sector. Hospital report the highest level of telemedicine capability at 26 per cent, followed by Day care centre (20%). Adoption is considerably lower among Educational Institute and Resort (9% each), Clinic (5%), and Spa (3%), while Yoga centre reported virtually no telemedicine capability. The findings indicate that although digital marketing and business networking are becoming more common, the use of digital technologies for clinical consultation and continuity of care remains at an early stage.

Resorts have a high website penetration (71 per cent), indicating that destination-based Ayush wellness services are particularly proactive in establishing online visibility. Yoga centres reported 87 per cent business

portal adoption, which is the highest of any facility type and reflects a trend towards booking-platform Yoga scheduling.

Taken together, these findings suggest that different facility types have adopted different digital strategies. Educational Institution have developed strong institutional visibility, Yoga centre rely heavily on digital business platforms, Hospital have made greater progress in telemedicine, while Clinic, the largest component of the sector, continue to exhibit good levels of business portal adoption.

Viewed through the *Sthānīya–Pramāṇita–Vaiśvika* framework introduced in Chapter 2, digital readiness represents an important dimension of enterprise capability. Establishments with stronger digital visibility and telemedicine capability are better positioned to reach patients beyond their immediate geographic markets and to participate in wider national and international service networks. The role of digital capability in supporting MVT and international market integration is examined in greater detail in Chapter 5. Beyond digital capability, the sector's human capital is equally critical. The following section examines the employment architecture of the Ayush services economy, highlighting its scale, composition, and gender dynamics.

3.6 Employment: The Human Capital Dimension

The Ayush services sector directly employs more than 1.76 million people across Clinic, Hospital, Educational institutions, Resort, Yoga centre and Spa. As a knowledge-intensive service sector, its workforce represents one of its most valuable assets. Ayush services depend on skilled practitioners, therapists, instructors, researchers, and support personnel who together drive healthcare delivery and Ayush-based Wellness services across the country. This section examines the employment

architecture of the sector across facility types, systems of medicine, and gender. Together, these indicators provide insights into the labour intensity, workforce composition, and employment potential of the Ayush services economy.

3.6.1 Workforce Distribution across Facilities and Systems

The distribution of the workforce across different facility types and systems of medicine can be seen in Figures 3.9 and 3.10. Employment is concentrated primarily in Clinic, which employ approximately 1.06 million people, accounting for more than 60 per cent of the total workforce. This reflects the widespread presence of outpatient care and reinforces the central role of

clinic within the Ayush ecosystem. The Ayush-based Wellness and Day care segments constitute the next largest employers, supporting approximately 305.6 thousand and 281.5 thousand workers respectively. Together, these two segments account for more than one-third of total employment, highlighting the growing importance of Ayush-based Wellness and procedure-based therapeutic services within the sector.

Educational Institution employ approximately 89.4 thousand people, while Hospital account for around 23 thousand workers. Although Hospital relatively represent the smallest share of total employment, they are the critical units in specialised and institution-based healthcare delivery.

Figure 3.9: Workforce Engagement in the Ayush Services across Facility

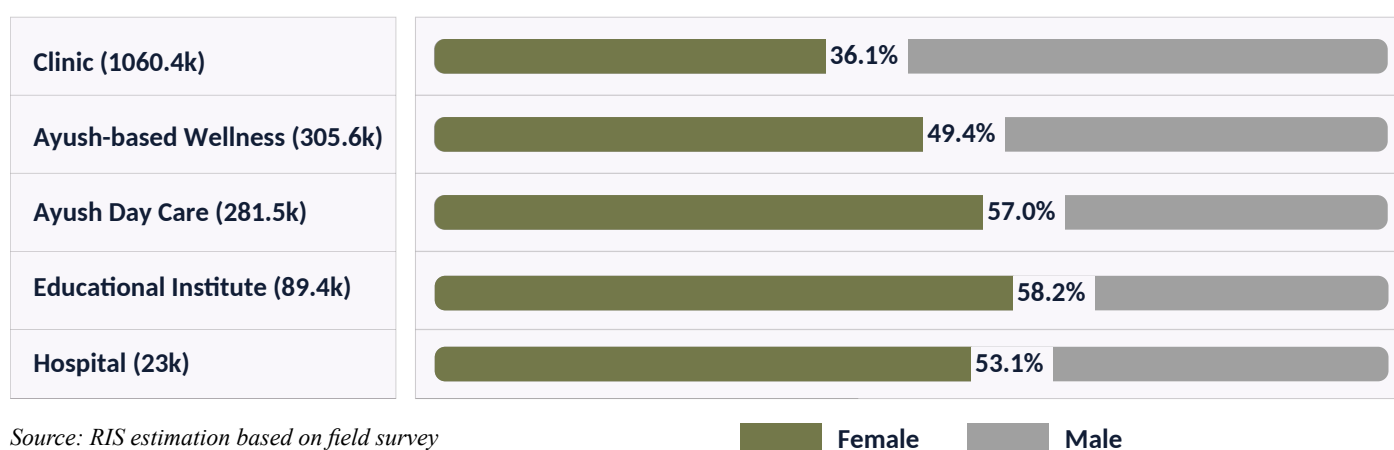
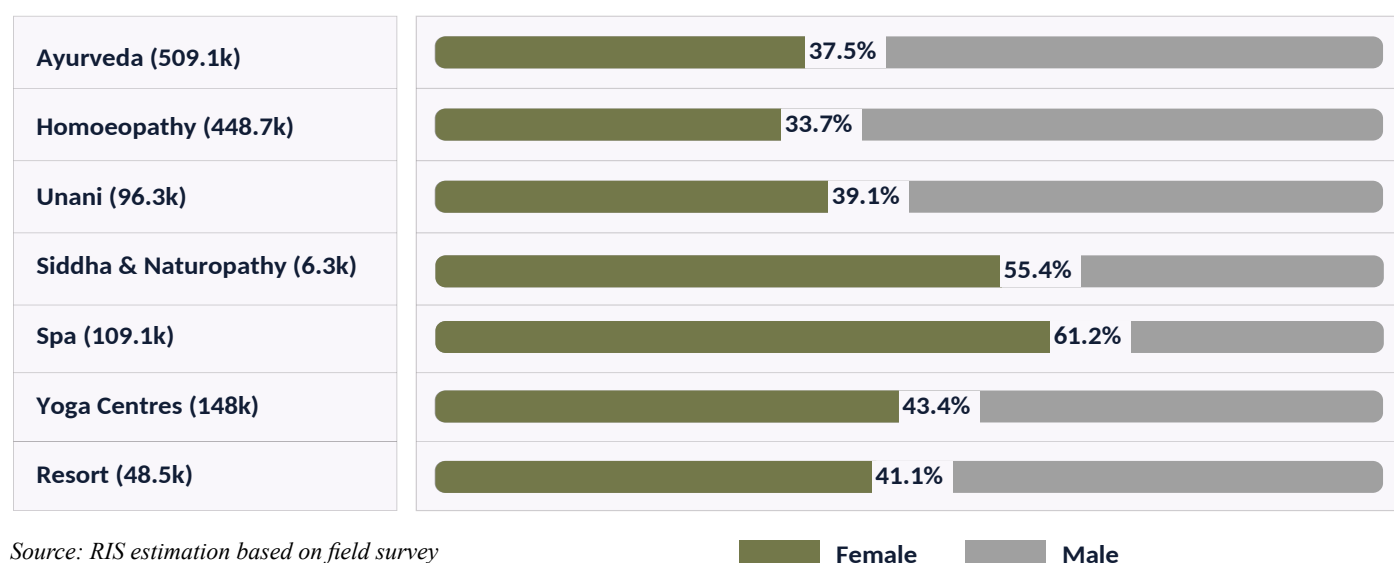


Figure 3.10: Workforce Engagement in the Ayush Services across System



The employment distribution broadly mirrors the revenue architecture discussed earlier, although clinic account for a larger share of employment than revenue, reflecting the labour-intensive nature of outpatient service delivery.

3.6.2 Core Labour Dynamics & Structural Insights

A. Hyper-Concentration in Outpatient Care (Clinic): Standing at 1.06 million workers, individual and group Ayush clinic represent above 60% of total sectoral employment. Within this category, Ayurveda (509,123 employees) and Homoeopathy (448,700 employees) account for 90.3 per cent of clinic-based employment. This indicates an extensively decentralized, retail-oriented service delivery model. The workforce comprises primarily of solo practitioners or micro-establishments, representative of relative low capital intensity but excellent grassroots physical penetration across both rural and urban areas.

B. Gender-Inclusive Phenomenon across Formats: The data highlights a fascinating shift in gender ratios as we move across different care delivery formats. For instance, in traditional standalone clinics, men constitute 64% of the workforce. Across the entire Ayush services sector, however, women comprise approximately 43% of the workforce, with particularly strong representation in institutional settings such as Day Care centres (57%), Hospitals (53%), and Educational institutes (58%). Institutionalized formats (hospital and formal day-care settings) act as far more potent engines for formal female labour force participation (FLFP) than traditional private practices. Expanding secondary and tertiary institutional care frameworks directly advances gender-inclusive employment goals.



3.6.3 Granular Deep-Dive: The Ayush-based Wellness Segment

The Ayush-based Wellness segment, employing over 305 thousand people, represents one of the most dynamic sources of employment within the Ayush services economy. While the overall segment exhibits near gender parity, its workforce composition varies considerably across different facility types.

Yoga centre, the largest employer within the Ayush-based Wellness segment, have a relatively higher proportion of male employees, with women accounting for 43.4 per cent of the workforce. In contrast, Spa exhibit the highest female workforce participation among all facility types, with women accounting for 61.2 per cent of employees.

Resort display a different employment profile, with women accounting for 41.1 per cent of the workforce. Compared with Yoga centre and Spa, Resorts combine therapeutic services with hospitality, premium Ayush-based Wellness services, resulting in a more diverse occupational structure.

These findings indicate that the Ayush-based Wellness economy is not a homogeneous labour market but comprises multiple employment models, each requiring different skills and workforce compositions.

Box 3.4: Institutional Care Supports Greater Female Workforce Participation

Female workforce participation varies considerably across different modes of service delivery. Women constitute the majority of employees in Educational Institution (58.2 per cent), Day care centre (57.0 per cent), Hospital (53.1 per cent), and Spa (61.2 per cent). In contrast, women account for only 36.1 per cent of employment in Clinics. The findings suggest that institutional and organised models of Ayush service delivery act as strategic levers for gender empowerment in the professional workforce.

3.7 Key Insights

This chapter points out to the Ayush services sector evolving into a large, diverse, and rapidly expanding component of India's healthcare and economy. The findings from this study articulate that the sector has moved beyond a grouping of isolated Traditional Medicine practices and now comprises multiple service models, each serving different patient needs, generating different economic outcomes, and contributing differently to employment and healthcare delivery.

Key insights emerge from the analysis.

1. The Ayush services economy has both scale and value. Clinic remain the foundation of the sector,

accounting for the largest share of employment and providing widespread access to healthcare. At the same time, hospital and Ayush-based Wellness, generate higher-value services and are emerging as important drivers of future growth.

2. Growth is broad-based across the sector. Revenue has increased across all major systems of medicine and facility types, demonstrating that expansion is not confined to a single segment but reflects a rising demand for Ayush services more generally.
3. The structure of the sector is becoming increasingly diversified. Alongside traditional clinic-based practice, Day care centre, Resort, Yoga centre, and Spa are assuming a larger role within the Ayush economy. This diversification broadens the range of services available to patients while creating new avenues for growth.
4. The sector has strong commercial fundamentals. Most establishments operate within healthy gross margin range, while several high-growth segments, such as Ayush-based Wellness, combine rapid expansion with sustainable operating performance. These findings point out that the sector possesses a sound economic foundation for future investment and expansion.
5. Digital capability remains uneven across the sector. Although business portal adoption is widespread among several facility types, website ownership and telemedicine adoption remain limited, particularly among clinics. As patient engagement increasingly moves towards digital platforms, strengthening digital capability will become an important determinant of future competitiveness.
6. The Ayush services sector is also emerging as an important source of skilled employment. Beyond generating more than 1.76 million jobs, the sector supports diverse professional opportunities across clinical care, Ayush-based Wellness, education, and allied health services. The increasing participation of women in institutional and Ayush wellness-based settings highlights its contribution to inclusive employment.

Ayush represents a sectoral economy that is expanding in size and in complexity. The following chapters build upon this empirical foundation to examine the sector's international potential, future growth trajectory, and the policy interventions required to realise its full contribution to India's healthcare and economic development.





Endnote

1. In the report, Compound Annual Growth Rate (CAGR) has been calculated using geometric mean.

Chapter 4

Medical Value Travel and Global Integration

अयं बन्धुरयं नेति गणना लघुचेतसाम् ।
उदारचरितानां तु वसुधैव कुटुम्बकम् ॥

(Mahopaniṣad , Chapter VI, verse 71.)

"This is mine and that is a stranger" is the thought of narrow-minded people. For those with a generous and noble heart, the entire world is one big family.



4.1 Integrating the Ayush Services Economy into Global Markets

The previous chapter established the size, structure, and economic characteristics of India's Ayush services sector. It showed that the sector has evolved into a US\$36.92 billion services economy supporting more than 1.76 million jobs across clinics, daycare, hospitals, educational institutions, and Ayush-based Wellness segments. While this reflects the domestic strength of the sector, its long-term growth will increasingly depend on its ability to connect with international markets.

For service industries, international trade takes place through four modes of supply defined under the General Agreement on Trade in Services (GATS)¹: Mode 1 (Cross-border Supply), where services are delivered remotely across borders; Mode 2 (Consumption Abroad), where consumers travel to another country to receive services; Mode 3 (Commercial Presence), where firms establish operations in foreign markets; and Mode 4 (Movement of Natural Persons), involving the temporary movement of professionals to provide services abroad. In the healthcare sector, all four modes play a role in global integration through telemedicine and digital health services (Mode 1), international patient travel or Medical Value Travel (MVT) (Mode 2), overseas healthcare investments and hospital networks (Mode 3), and the cross-border movement of doctors, therapists, and other healthcare professionals (Mode 4). Among these, MVT has emerged as one of the most visible channels of healthcare service exports, generating foreign exchange earnings while strengthening a country's position in the global healthcare market.

For the Ayush services sector, MVT represents more than international patient inflows. It provides a pathway through which India's traditional systems of medicine participate in the global healthcare and Ayush-based Wellness economy. Unlike many conventional medical tourism destinations that compete primarily on the basis of cost, India through its Ayush systems offers a distinct value proposition built around preventive healthcare, chronic disease management, holistic therapies, Yoga, Panchakarma, and Ayush-based Wellness programmes. These services are closely aligned with growing global demand for integrative, preventive, and lifestyle-based healthcare.

India possesses several advantages in this regard. It is home to well-established systems of Traditional Medicine, a large network of trained practitioners, internationally recognised Yoga traditions, and specialised Ayush-based Wellness institutions. Government initiatives such as 'Heal in India, Heal by India', Ayush Visa, and the establishment of the WHO Global Traditional Medicine Centre at Jamnagar have further strengthened India's

position as an emerging destination for Traditional Medicine and Ayush-based Wellness services.

Despite these advantages, relatively little empirical evidence exists on the scale and characteristics of Ayush-based MVT. Most existing studies focus on India's overall medical tourism industry, with limited information on international patients seeking Ayurveda, Yoga, Unani, Siddha, Homoeopathy, and other Ayush services. Questions relating to the size of this market, the revenue it generates, the characteristics of international patients, and the factors influencing their choice of healthcare providers remain largely unanswered.

This chapter addresses these questions using evidence from the national establishment survey. It estimates the contribution of international patients to the Ayush services economy, examines the characteristics of establishments participating in MVT, and identifies the factors associated with attracting international patients. In doing so, the chapter highlights how the Ayush services sector is beginning to integrate with global healthcare markets and the opportunities this presents for the future growth of the sector.



4.2 The Global Opportunity for Ayush Services

MVT has emerged as one of the most important segments of the global healthcare economy. The global medical tourism market was valued at approximately US\$115.6 billion in 2022 and is projected to reach US\$286.1 billion by 2030, representing a CAGR of 10.8 per cent². Growth has traditionally been driven by patients seeking affordable treatment and shorter waiting times abroad, but increasingly reflects rising demand for preventive healthcare, rehabilitation, and wellness-oriented services.

This trend is reinforced by the rapid expansion of the global wellness economy. According to the Global Wellness Institute³, the wellness economy reached US\$6.8 trillion in 2024 and is projected to grow to US\$9.8 trillion by 2029. Within this broader market, Traditional and Complementary Medicine (T&CM) is expected to be the second-fastest-growing of the eleven wellness sectors, expanding at around 10.8 per cent annually and exceeding US\$1 trillion by 2029. Together, these trends point to a gradual shift in global healthcare demand away from episodic treatment towards prevention, longevity, and holistic well-being, areas where India's Traditional Medicine systems possess a natural comparative advantage.

India has begun to benefit from these developments. The country's medical tourism market is estimated at US\$8.7 billion in 2025⁴ and is projected to reach US\$16.2 billion by 2030, accounting for approximately five per cent of the global market. As per the present study, the Ayush Medical Tourism segment is estimated at US\$1.77 billion in FY2025 catering to around 1.04 million foreign nationals, represents roughly 20 per cent of India's medical tourism market. International demand for Ayush services remains concentrated in a small number of established ecosystems, particularly Kerala, Uttarakhand, Karnataka, Goa, Tamil Nadu and Himachal Pradesh, where Ayurveda, Yoga, and Ayush-based Wellness services have developed these states into internationally popular destinations. The international competitive landscape provides useful perspective. Countries such as Thailand, Mexico, Turkey, and South Korea have established strong positions within different segments of the medical tourism market⁵.

India enjoys a substantial cost advantage, with treatment costs generally estimated to be 70–90 per cent lower than those in many developed countries⁶. However, evidence suggests that cost alone is insufficient to sustain





international competitiveness. In interviews with fifteen senior medical tourism providers across six Indian cities, Medhekar et al. (2020) found that healthcare providers ranked treatment cost only seventh among nine supply-side determinants of competitiveness, placing greater importance on accreditation, staff expertise, waiting time, and patient safety. These findings suggest that the future growth of Ayush MVT will depend increasingly on institutional quality, international credibility, and service differentiation rather than price competition alone.

Recognising this opportunity, the Government of India has introduced several initiatives to strengthen the country's position in global healthcare markets. The Union Budget 2026–27 announced the development of five integrated Regional Medical Hubs incorporating dedicated MVT and Ayush centres, the establishment of three new All India Institutes of Ayurveda, and further support for the WHO Global Traditional Medicine Centre as part of the broader Heal in India initiative⁷. Complementing these measures, the Ayush Visa, introduced in 2023 and now available to nationals of 172 countries⁸ under the e-visa category, provides a dedicated facilitation pathway for international patients seeking Ayush treatment. The adoption of International Organization for Standardisation (ISO) 22525 by the Bureau of Indian Standards (BIS), the introduction of the Ayush Quality Mark Certification and the growing availability of insurance products covering Ayush treatments further strengthen the institutional environment supporting international patient mobility. An important gap, however, remains in financial protection for inbound patients. While insurance coverage for Ayush treatment has expanded within India, there is currently no comparable India-based insurance mechanism specifically designed to cover planned treatment costs of foreign nationals travelling to India for MVT, leaving such patients dependent largely on self-payment or coverage arranged in their country of origin. Despite this favourable policy environment and the expanding global market, empirical evidence on Ayush MVT remains limited. Existing studies primarily focus on India's overall medical tourism industry and provide relatively little information on the characteristics of establishments delivering Ayush services to international patients.

The following sections address this evidence gap using establishment-level survey data to examine the scale of Ayush MVT, the characteristics of Ayush MVT, and the factors associated with attracting international patients.



4.3 Structural Characteristics of Ayush MVT

The survey findings indicate that participation in Ayush MVT is shaped by a combination of clinical, institutional, and digital factors rather than any single characteristic. Four factors emerge consistently from the descriptive evidence: therapeutic depth, institutional capacity, digital readiness, and quality signalling. Together, these determine how effectively establishments participate in international healthcare markets. These characteristics are discussed below.

4.3.1 Ayush MVT is a Long Stay Economy⁹

Among all indicators examined, the characteristics of clinical service delivery appear to have the strongest association with international patient participation. Average Length of Stay (ALOS) across the surveyed hospitals was 8.6 days in FY2022–23, increasing to 8.8 days in FY2023–24. Considerable variation exists across systems of medicine. Ayurveda hospitals recorded an ALOS of around 9 days, while Kerala's specialised Ayurveda hospitals averaged 10.9 days, reflecting their concentration in Panchakarma and residential therapeutic programmes. Homoeopathy, by comparison, recorded an average stay of 5.2 days¹⁰.

These figures suggest that Ayush MVT is centred on extended therapeutic programmes ranging from 5-11 days. Ayush therapies commonly involve a sequence of consultations, therapeutic procedures, Yoga, dietary interventions, and lifestyle modification delivered over several days or weeks.

Service utilisation indicators further reinforce this finding. Average bed occupancy across the surveyed hospitals was 57 per cent, indicating that approximately 43 per cent of existing bed capacity remained unutilised during the study period. This suggests that the principal constraint on expanding MVT is unlikely to be physical infrastructure. Similarly, an Out Patient Department (OPD)-to- Inpatient Department (IPD) conversion rate of 21.5 per cent indicates that approximately one in five outpatient consultations progresses to inpatient care, highlighting the importance of residential treatment within the Ayush care pathway.

4.3.2 MVT is Relatively Small in Volume, Disproportionately Large in Value

Foreign patients account for approximately 4.7–5.5 per cent of total Ayush patient volume across the surveyed hospitals. Yet the estimated revenue contribution of MVT is in the range of 15–25 per cent of hospital segment revenue, indicating that international patients generate substantially higher revenue per visit than domestic patients. MVT is not a volume story. It is a value and margin story: every additional foreign inpatient enrolled in a residential Ayush-based Wellness package

contributes far more to establishment revenue than domestic patients. This structural asymmetry has direct implications for resource allocation, pricing strategy, and policy prioritisation.

4.3.3 Digital Readiness

The survey also highlights the growing importance of digital infrastructure in attracting international patients. Although 90 per cent of surveyed hospitals were listed on domestic health or business portals, only 66.8 per cent maintained a functional website and just 20.9 per cent offered telemedicine services (Table 4.1).

Table 4.1: Digital presence indicators, surveyed Ayush hospitals, FY2024–25.

Digital indicator	Share (%)	Quality assessment
Listed on health/business portal (Justdial, Practo, etc.)	90.0%	Primarily passive directory
Has a functioning website	66.8%	Active digital presence
Offers telemedicine services	20.9%	Variable integration depth

Source: RIS estimation based on field survey



These figures suggest that while digital adoption is widespread, much of it remains oriented towards domestic patient acquisition. Business directories facilitate local discovery but provide limited support for international patient engagement, multilingual web-portal, or pre-arrival clinical consultation. Dedicated websites and telemedicine services are more closely aligned with the information requirements of overseas patients, who typically rely on digital channels to identify providers, evaluate treatment options, and communicate with clinicians before travelling.

The survey also found extremely limited post-treatment telemedicine engagement. The median share of patients continuing teleconsultation after their initial visit was only 0.34 per cent, indicating that digital platforms are rarely integrated into long-term clinical care. Given that many Ayush treatments for chronic conditions require continued follow-up, integrating telemedicine into post-treatment care pathways could significantly enhance patient retention, referrals, and long-term revenue from international patients. This represents a low-cost, high-impact area for future investment.

4.3.4 Quality Signalling

Institutional credibility represents a third important factor influencing MVT. Approximately 51 per cent of surveyed hospitals reported holding at least one recognised accreditation, with National Accreditation Board for Hospitals & Healthcare Providers (NABH) being the most common certification. Accredited hospitals charged only a modest premium for outpatient consultations compared with non-accredited establishments, suggesting that accreditation currently functions as a limited pricing signal in the domestic market.

Its significance is likely to be much greater in international markets. Medhekar et al. (2020) also highlighted that accreditation as the most important supply-side determinant of medical tourism competitiveness, ranking it above treatment cost and hospital facilities. The introduction of the Ayush Quality Mark Certification Scheme creates a robust accreditation environment for Ayush service providers. For international patients, the Ayush Quality Mark serves as a signal of institutional quality and patient safety rather than as a mechanism for increasing domestic prices.

4.4 Regression Analysis: Validating the Drivers of Ayush MVT

In this section, a binary logistic regression model was employed to examine the factors influencing the likelihood of a healthcare facility attracting foreign patients, and the estimated effects are presented as odds ratios. Foreign patient uptake was specified as the dependent variable, while website ownership, ALOS, business portal listing, and accreditation status were included as explanatory variables. The analysis aims to identify the factors that significantly influence international patient inflows and to evaluate the extent to which institutional capabilities and market presence contribute to participation in cross-border healthcare services. These variables were selected on the basis of both the descriptive findings presented earlier in this chapter and the supply-side framework proposed by Medhekar et al. (2020).

The model is highly statistically significant (LR $\chi^2(4) = 263.16$; $p < 0.001$), indicating that the selected institutional characteristics collectively explain a substantial share of the variation in foreign patient participation across the surveyed hospitals. The regression results provide strong statistical support for the patterns identified in the preceding analysis (Table 4.2). Website ownership emerges as the strongest predictor of foreign patient uptake, with establishments maintaining a dedicated website being associated with 3.6 times higher odds of attracting international patients. This reinforces the importance of digital visibility as a prerequisite for participation in international healthcare markets. ALOS is the most precisely estimated predictor in the model¹¹. Each additional day of stay increases the odds of attracting foreign patients by approximately 85 per cent, confirming that international demand is closely associated with longer-duration, residential therapeutic programmes rather than short outpatient consultations. When interpreting the results, it is important to note that the ALOS variable was observed within a range of 5 to 11 days. Therefore, the predicted effects on foreign patient uptake are most reliable within this range and should not be extrapolated beyond the observed values.



Table 4.2: Logistic Regression Results – Determinants of Foreign Patient Uptake



Predictor	Odds Ratio	Std. Err.	p-Value	Remark
Website ownership (1 = has website)	3.6269***	1.3709	0.001	Positive predictor
Average Length of Stay (days)	1.8547***	0.1122	0.000	Positive predictor
Business portal listing (1 = listed)	0.3554***	0.1308	0.005	Negative predictor
Accreditation status (1 = accredited)	2.0058*	0.7461	0.061	Positive predictor
Intercept	0.0405***	0.0246	0.000	-

Source: RIS estimation based on field survey.

Note: *** and * denoted the significance at 1 per cent and 10 per cent level, respectively.

Accreditation also appears to enhance a facility's ability to attract foreign patients, approximately doubling the odds of foreign patient uptake; however, its statistical significance remains relatively modest. The modest statistical significance of accreditation ($p = 0.061$) may reflect the aggregation of different accreditation systems, such as NABH, ISO, and other certifications, into a single binary variable. Future research with more granular data on accreditation type, scope, and recency would strengthen the analysis. However, the positive direction of the relationship is consistent with earlier evidence highlighting accreditation as an important determinant of international patient confidence.

Finally, the analysis shows that establishments relying primarily on domestic business portals significantly

decreases odds of attracting foreign patients. This finding suggests that while such platforms remain effective for domestic patient acquisition, they are less effective in facilitating international patient engagement, where dedicated websites, referrals, and institutional reputation play a more important role.

Overall, the regression strengthens the conclusions drawn from the descriptive analysis. It demonstrates that the characteristics identified in the previous section are supported not only by descriptive patterns in the survey data but also by multivariate regression analysis. Taken together, these findings provide a robust empirical foundation for understanding the factors shaping Ayush MVT in India.



4.5 Conclusion

The analysis presented in this chapter demonstrates that MVT has emerged as an identifiable and economically significant component of India's Ayush services economy. Although international patients account for a relatively small proportion of total patient volume, they are present across a significant share of surveyed hospitals, indicating broad geographic and institutional participation in MVT. The evidence suggests that Ayush MVT should therefore be understood not as a niche tourism activity but as an emerging export segment within India's broader healthcare and Ayush-based Wellness economy.

The survey also shows that Ayush MVT is uniquely positioned for medical tourism. Rather than being driven by high-value surgical procedures or price arbitrage alone, its comparative advantage lies in integrated

therapeutic experiences combining clinical consultation, traditional therapies, Yoga, dietary interventions, and lifestyle management. The analysis further indicates that participation in international markets is shaped less by treatment costs than by institutional characteristics such as digital visibility, therapeutic depth, and quality assurance. These findings are reinforced by the regression analysis, which identifies website ownership, longer ALOS, and accreditation as significant determinants of foreign patient participation. These findings align with the *Sthānīya–Pramāṇita–Vaiśvika* framework introduced in Chapter 2. Establishments with dedicated websites (digital visibility), longer ALOS (therapeutic depth), and accreditation (quality trust) are more likely to transition from local/regional (*Sthānīya*) to national (*Pramāṇita*) and international (*Vaiśvika*) market participation.





Endnotes

1. The General Agreement on Trade in Services: objectives, coverage and disciplines https://www.wto.org/english/tratop_e/serv_e/GATSqa_e.htm
2. Medical and Wellness Tourism in India, PIB, 02 May 2026, <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2257447®=3&lang=2>
3. 2025 Global Wellness Economy Monitor. <https://globalwellnessinstitute.org/industry-research/2025-global-wellness-economy-monitor/>
4. India's medical tourism market to nearly double by 2030. <https://tvbrics.com/en/news/india-s-medical-tourism-market-to-nearly-double-by-2030/>
5. KPMG-FHRAI 'Heal in India' Report (2025)
6. Medhekar, A., Wong, H.Y. and Hall, J.E. (2020), 'Health-care providers perspective on value in medical travel to India,' Tourism Review.
7. Government to establish Regional Medical Hubs to boost Medical Value Tourism, PIB, 01 February 2026; <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2221485®=48&lang=2>
8. <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2152493®=48&lang=2>
9. Note: While the survey did not collect patient-level revenue data, the aggregate patterns, 4.7%–5.5% of patient volume generating 15%–25% of hospital revenue, indicate that foreign patients contribute significantly more per visit than domestic patients.
10. Note: ALOS data for Unani, Siddha, and Yoga & Naturopathy were not consistently reported across establishments and are therefore not presented here.
11. While the regression analysis identifies a strong positive association between ALOS and foreign patient uptake, the cross-sectional nature of the survey data does not permit causal inference. It is possible that establishments attracting foreign patients adapt their service offerings to include longer programmes, rather than longer programmes simply attracting foreign patients. Future longitudinal research would be valuable to establish the direction of causality.

Chapter 5

Voices from the Field: Our Reflections

(Qualitative field evidence and institutional case studies on how India's Ayush enterprises operate, adapt, and confront institutional constraints on the ground.)

भिषजां साधुवृत्तानां भद्रमागमशालिनाम् ।
अभ्यस्तकर्मणां भद्रं भद्रं भद्राभिलाषिणाम् ।

(Aṣṭāṅgahrdaya, Uttarasthāna, Chapter 40, verse 77.)

Let prosperity and well-being be to the physicians of noble conduct, to those who are well-versed in the scriptures, to those who are experienced in practical application, and to those who desire the welfare of all living beings



5.1 Introduction

Aggregate data on India's Ayush sector, such as the number of enterprises, revenue growth, and overall market trends, provide an essential starting point for understanding the sector. Numbers can trace the arc of growth but cannot adequately capture the institutional frictions, practitioner dilemmas, and governance challenges that shape everyday service delivery on the ground. This chapter primary insights for filling in that gap through a qualitative case study approach, drawing on structured field visits at Ayush facilities across selected places. It is further complemented by secondary institutional analysis of Ayush organisations at different scales and with distinct operational logics.

The technical note related with qualitative methodology, including the research design and analytical procedure, used in the study is presented in the annexure of the report.

5.2 Findings from Field Sites

The field findings presented below illustrate the four analytical pillars introduced in Chapter 2. The regulatory and quality challenges reflect the need to strengthen the *Jñāna* (knowledge infrastructure) stage of the value chain. The case studies of Arya Vaidya Sala Kottakkal and Apollo AyurVAID demonstrate the *Prārambha–Vikāsa–Utkarṣa* continuum, showing how institutions can progress from basic capability to advanced, accredited, globally competitive enterprises.

5.2.1 Theme I - Regulatory Capacity and Quality Assurance

One of the most consistent themes emerging from the field visits was the need to strengthen quality governance across the Ayush services sector. While practitioners acknowledged the growing demand for Ayush services, they also emphasised that the pace of sectoral expansion has not always been matched by the development of uniform standards, certification systems, and regulatory oversight. The nature of these challenges varied across systems and facility types, but together they pointed to the importance of a stronger and more coherent quality assurance framework.

Among Ayurveda clinics and Panchakarma centres, particularly those visited in Punjab, some practitioners highlighted concerns regarding the absence of standardised certification for therapies and consistency in the quality of Ayurvedic medicines available from different sources. They also highlighted consumer confusion between Ayurvedic medicines and other health and Ayush-based Wellness products using Ayurveda-

related terminology. According to practitioners, this makes it difficult for patients to distinguish between clinically grounded Ayurvedic practice and commercially marketed Ayush-based Wellness products, potentially affecting public confidence in the wider sector.

Nutraceutical companies run advertisements claiming Ayurvedic efficacy but operate entirely outside Ayush oversight. Patients cannot distinguish - and this damages credibility for those of us practising authentically.

- Ayurveda Clinic Practitioner, Punjab."

For context, it is being further added here that this issue needs to be understood against the backdrop of India's evolving regulatory framework. Ayurvedic medicines and products such as nutraceuticals and Ayurveda Aahara are placed under distinct regulatory pathways, with separate requirements governing composition, labelling and permissible claims. A greater clarity around these distinctions, appropriate use of health and therapeutic claims, stronger consumer awareness and closer coordination between the Ministry of Ayush, FSSAI and other relevant regulators will help reduce confusion while also protecting consumer interests and the credibility of authentic Ayush products and services.



Field visits to Yoga centres revealed a different but related challenge. Most respondents recognised the Yoga Certification Board (YCB) as the principal public institution responsible for maintaining standards and preserving the authenticity of Yoga instruction. However, several practitioners observed that certification through the YCB was perceived to be more time-consuming than

private certification systems such as Yoga Alliance. As a result, many centres either sought private certification or operated without formal accreditation. Practitioners also noted increasing demand for contemporary formats such as chair yoga and aerial yoga, which are not presently covered within the existing certification framework.

Figure 5.1: FITM field team in conversation with a Yoga practitioner at Yog Mandir, Jaipur, during the establishment survey.



Source: FITM at RIS

Ayurveda spas presented another dimension of the regulatory landscape. Despite the rapid expansion of Ayush-based Wellness tourism and preventive healthcare services, respondents indicated that therapist qualifications, treatment protocols, and service standards vary considerably across establishments. During the field survey, therapy prices ranged from ₹1,500 to ₹4,000 for a 60–90-minute session, reflecting the commercial growth of the sector.

In Homoeopathy, the concerns raised by practitioners related less to clinical standards and more to institutional recognition. Respondents noted that, unlike many allopathic healthcare providers, Homoeopathy clinics often remain outside major insurance reimbursement systems and government support schemes. The absence of such institutional mechanisms was viewed as a constraint on the expansion and formalisation of the sector.

Taken together, the field evidence suggests that the regulatory challenges facing the Ayush services sector are not uniform but differ across systems and service models. While Ayurveda practitioners emphasised product quality and therapeutic standards, Yoga centres highlighted certification processes, Ayush-based

Wellness establishments pointed to the absence of service standards, and Homoeopathy practitioners underscored the need for stronger institutional integration. Despite these differences, a common message emerged from the field: as the Ayush services sector continues to grow, strengthening quality governance, improving regulatory clarity, and enhancing public confidence will be important for supporting its long-term development.

5.2.2 Theme II - Supply Chain Constraints and Cost Pressures

Another recurring theme across the field visits was the importance of resilient supply chains in sustaining the growth of the Ayush services sector. The nature of these challenges varied considerably across different systems of medicine, reflecting the diversity of their production processes.

Among Ayurveda establishments, practitioners consistently identified the availability and quality of medicinal plants as a major operational concern. Many establishments depend on herbs and medicinal raw materials sourced from different states and ecological regions, making them vulnerable to fluctuations with

respect to their cultivation, seasonal availability, transportation, and market supply. Respondents noted that shortages of certain medicinal plants had become a recurring operational challenge rather than isolated disruptions.

Figure 5.2: FITM field team documenting operational constraints at a Panchakarma centre in Ludhiana, Punjab.



Source: FITM at RIS

Field visits indicated that these supply-side constraints have direct implications for service delivery. Higher raw material costs increase the cost of in-house medicine preparation and procurement, which in turn raises the overall cost of treatment. Practitioners observed that this creates a particular challenge for patients from lower-income groups, for whom affordability remains an important consideration when choosing between different healthcare options.

A hospital administrator at a mid-sized private Ayurveda hospital in Kerala observed: “We want to offer Ayurveda to everyone, but when the cost of a course of treatment rivals allopathic hospitalisation, patients make rational choices. Supply is the hidden variable driving our affordability problem”.

- Hospital Administrator, Ayurveda Hospital

The experience of the Yoga sector presented a contrasting picture. Respondents across Yoga centres reported strong post-pandemic growth in enrolment and business activity, but identified relatively few supply-side constraints. Yoga is a service model that depends primarily on trained instructors rather than physical inputs such as medicinal plants or therapeutic products.

As a result, its expansion has been considerably less affected by fluctuations in material availability or input prices.

This contrast illustrates an important characteristic of the Ayush services economy. While Ayurveda operates through relatively complex supply chains, Yoga functions as a knowledge- and skill-intensive service with limited dependence on physical inputs. The operational challenges faced by different Ayush systems are therefore not uniform, underscoring the need to understand the sector as a collection of distinct service models rather than a single homogeneous industry.

Across the field sites, Ayurveda practitioners also highlighted concerns regarding the quality and traceability of medicinal raw materials. Several respondents observed that differences in sourcing practices and product quality create uncertainty for healthcare providers and increase the importance of reliable procurement channels. Collectively, these observations suggest that strengthening supply chain resilience and ensuring consistent quality of medicinal inputs will remain important considerations as the Ayush services sector continues to expand.

5.2.3 Theme III - Human Resource Constraints and Skill Ecosystem Gaps

The field visits highlighted that the continued expansion of the Ayush services sector depends not only on infrastructure and demand but also on the availability of appropriately trained human resources. Across systems and facility types, respondents pointed to gaps between the skills required in practice and those currently available in the labour market.

Among Ayurveda hospitals and Panchakarma centres, the shortage of qualified Panchakarma therapists emerged as one of the most frequently reported operational challenges. Practitioners observed that while trained personnel were available in the market, the quality of therapeutic skills varied considerably across institutions. In many cases, therapists acquired practical competencies through employer-specific, on-the-job training rather than through standardised professional education, resulting in differences in treatment quality and patient experience across establishments.

In the Yoga sector, respondents highlighted a different challenge. Although demand for Yoga services has increased significantly in recent years, many practitioners observed that public perceptions continue to associate Yoga with free or community-based instruction. This affects the willingness of clients to pay professional fees, making employment less stable for certified instructors despite growing demand for Yoga and Ayush-based Wellness services.

Field visits to Ayurveda hospitals also demonstrated the close relationship between workforce availability and institutional quality. Several respondents noted that maintaining qualified clinical and support staff in accordance with accreditation standards increases operating costs, particularly for hospitals seeking to provide comprehensive and high-quality care.

Cross-Cutting Observation: The field evidence suggests that the human resource challenge in the Ayush services sector extends beyond the availability of practitioners. Across different service models, respondents consistently pointed to a mismatch between formal training and the practical skills required for contemporary service delivery. The findings indicate that workforce development is as much a question of skills, clinical exposure, and professional competency as it is of expanding the number of trained personnel entering the sector.

5.2.4 Theme IV - Demand-Side Barriers and Mainstreaming Challenges

The field visits indicated that demand for Ayush services is influenced not only by patient preferences but also by the institutional environment within which healthcare services are delivered. Across different systems of medicine, practitioners observed that demand for Ayush continues to grow, yet several structural factors limit its wider adoption as a mainstream healthcare option.

An issue consistently highlighted across hospitals was the limited integration of Ayush services within insurance and reimbursement systems. While schemes such as the Central Government Health Scheme (CGHS) and the Rajasthan Government Health Scheme (RGHS) provide reimbursement for eligible beneficiaries, respondents noted that such coverage is largely confined to government employees. For the majority of patients covered by private health insurance, reimbursement for Ayush treatment remains limited and challenging. Practitioners also reported delays in claim settlements under existing government schemes, affecting cash flow and operational planning for healthcare institutions.

Field visits further suggested that the affordability of Ayush care is often determined not only by treatment costs but also by access to reimbursement mechanisms. As a result, similar treatments may be financially accessible to one group of patients while remaining out-of-pocket expenditures for others.

Respondents across several systems also expressed the view that the demand for Ayush by patients has progressively increased, with many patients seeking treatment after conventional therapies have proved ineffective or prohibitively expensive. Homoeopathy practitioners, in particular, observed that patient numbers have increased steadily over the past five to six years, driven by affordability, perceived safety, and growing public awareness. However, they noted that this growth has largely been market-led rather than resulting from formal integration within healthcare delivery pathways.

Taken together, the field evidence suggests that demand for Ayush services is not constrained by public interest alone. Rather, utilisation is shaped by broader institutional factors, including treatment pathways, reimbursement arrangements, and patterns of healthcare access. As the sector continues to expand, these institutional factors are likely to play an increasingly important role in determining the scale and composition of demand across different Ayush systems and service models. The insurance coverage gap identified in the field reinforces Recommendation 5 (*Ārogya Sopāna*) of this report: expanding insurance coverage for therapeutic wellness,



preventive care, Panchakarma, and day-care services would reduce out-of-pocket expenditure, promote preventive healthcare, and support the sector's formalisation.

People come to us after two years of failed allopathic treatment. By then the disease has progressed. If we were the first call, outcomes would be entirely different.” - Senior Homoeopathy Practitioner

5.3 Institutional Case Studies

5.3.1 Case Study 1 : Isha Foundation - Isha Health Solutions, Coimbatore, Tamil Nadu

Organisational Background

Founded in 1992 by Sadhguru Jaggi Vasudev near Coimbatore, Tamil Nadu, the Isha Foundation is a non-profit spiritual organisation that has evolved into one of India's most institutionally sophisticated integrated Ayush-based Wellness platforms. Headquartered at the Isha Yoga Center at the foothills of the Velliangiri Mountains, it operates globally offering Yoga programs, health services, ecological initiatives, and rural outreach, supported by an estimated 11 million volunteers worldwide. Its US chapter alone reported revenues of US\$ 40 million in 2022, and its flagship Inner Engineering program is offered in major cities globally.

The Integrated Health Model: Isha Health Solutions

Isha Health Solutions, located within the Isha Yoga Center campus, represents the foundation's structured health delivery architecture. It offers integrated medical consultations by doctors trained across Allopathy, Ayurveda, Siddha, and Hatha Yoga, an intentional pluralism that positions it outside any single Ayush modality. The service offering spans residential inpatient programmes targeting chronic and lifestyle-related conditions, non-residential day programmes including Ayurvedic therapies, online medical consultation (accessible to those unable to travel to Coimbatore), and Isha Arogya community health centres established in Tamil Nadu cities (Salem, Chennai, with Trichy and Coimbatore planned), offering free consultation with integrated pharmacy access.

Programmes combine Yogic science, Ayurveda and Siddha medicines, dietary and lifestyle recommendations, Panchakarma therapies, and meditative practices. The residential programmes target chronic ailments where Ayurvedic and integrative approaches have documented efficacy and patient acceptance. Patient testimonials document reduction in diabetic medication dependence and improvements in chronic pain conditions, providing an outcomes narrative that supports demand generation.

The Volunteer-Capital Business Model

The analytically distinctive feature of the Isha Foundation model is its systematic leveraging of volunteer capital

as a structural substitute for paid labour. With over 11 million volunteers globally, and programmes described as “almost entirely volunteer-run,” the foundation dramatically compresses its labour cost base. Volunteers are drawn from the community of Inner Engineering programme completers - individuals who have undergone the foundation’s flagship Yoga initiation and who contribute time as an expression of practice commitment rather than for financial compensation.

This volunteer architecture creates a cross-subsidy mechanism with significant implications for the health services arm. Revenue generated from premium-priced programmes, namely Inner Engineering online courses, residential Ayush-based Wellness programmes, health leadership programmes priced at US\$ 6,500 per participant, and product sales (Yoga equipment, personal care, accessories), subsidises community-facing health services including free OPD consultation at Isha Arogya centres. The Isha Yoga Center campus itself, as a pilgrimage and Ayush-based Wellness destination drawing thousands of visitors weekly, generates both direct revenue and a sustained pipeline of engaged health-service users.

Analytical Note: The Volunteer-Capital Model as Ayush Governance Innovation The Isha Foundation’s ability to operate high-quality integrated health services at subsidised or zero cost to end-users, while maintaining institutional financial sustainability, rests on a labour market mechanism unavailable to commercial or government Ayush providers: the conversion of spiritual/practice commitment into voluntary service contribution. This is not replicable at sector scale, but it points to the value of mission-alignment in reducing transaction costs in Ayush service delivery, and offers a partial template for civil society organisations and NGOs seeking to operate Ayush services in underserved populations.

Supply Chain Advantage: In-House Formulation

Isha Health Solutions lay an emphasis on careful, direct procurement. This in-house or closely supervised supply chain reduces dependence on the fragmented external herbal supply market that constrains commercial Ayush clinics and hospitals, and projects quality consistency as a brand attribute rather than an operational aspiration. The Isha example illustrates how vertical integration in the supply chain - feasible for organisations of sufficient institutional scale - can resolve the quality-cost tensions that characterise the sector’s supply-side challenge.

5.3.2 Case Study 2 : Arya Vaidya Sala Kottakkal (AVS), Kottakkal, Kerala

Historical and Institutional Context

Established in 1902 at Kottakkal, Malappuram district, Kerala, by the physician-philanthropist Vaidyaratnam P.S. Varier, Arya Vaidya Sala Kottakkal (AVS) is among the most significant institutional achievements in modern Ayurveda. What began as a village clinic has grown, over twelve decades, into a multi-unit, multi-dimensional, multi-national charitable organisation whose global patient footprint exceeds 800,000 individuals annually. AVS operates Ayurvedic hospitals at Kottakkal, Delhi, Kochi, and Chennai; manufactures over 550 classical Ayurvedic formulations across three production facilities; maintains more than 1,600 authorised dealers; and operates 27 branch clinics across India.

The Ethics-Based Reinvestment Architecture

The foundational governance innovation of AVS is its profit-distribution model, codified in its Trust deed. Fifty-five percent of institutional profits are directed to charitable activities: free outpatient consultation, free inpatient treatment for economically weaker sections,



support for an affiliated Ayurveda college, research, seminars, publications, herbal garden cultivation, and a classical theatre academy. The remaining 45 percent is reinvested for institutional development. This architecture, which predates contemporary ESG frameworks by decades, creates a sustainability structure in which commercial success directly funds service access for populations unable to pay.

The Delhi hospital exemplifies the tiered access model in practice. The 49-bed facility offers Deluxe Rooms, Standard AC Rooms, Private AC Rooms, Non-AC Rooms, General Ward, and a Free Ward explicitly reserved for Economically Weaker Section patients. Treatment protocols, including classical Panchakarma and Kerala speciality therapies, are identical across ward categories; the differentiation is in accommodation quality and pricing. This tiered structure allows AVS to serve an economically diverse patient population within a single institutional framework without compromising clinical standards.

Supply Chain Integration: Centre for Medicinal Plants Research

AVS's internal resolution of the supply chain fragility challenge is institutionally instructive. The Centre for Medicinal Plants Research (CMPR), established at Kottakkal in 2003 and recognised as a Centre of Excellence by the erstwhile Department of Ayush, Government of India, undertakes research in medicinal plant cultivation, quality, and formulation. Manufacturing facilities at Kottakkal, Kanjikode, and Nanjangud produce the full range of classical formulations from internally quality-controlled inputs, reducing exposure to the external market supply disruptions that constrain smaller facilities.

5.3.3 Case Study 3 : Patanjali Ayurved, Haridwar, Uttarakhand

Organisational Profile

Founded in 2006 by Baba Ramdev and Acharya Balkrishna, Patanjali Ayurved represents one of the most disruptive business-model innovations in Indian consumer healthcare over the past two decades. Beginning as a Yoga phenomenon, the organisation rapidly converted audience trust into product demand, scaling to total income of Rs. 9,335 crore in FY2024 and a group revenue of Rs. 31,961 crore inclusive of its subsidiaries (Business Standard, 24 November 2024). With over 5,000 exclusive retail outlets, a presence in more than 20 countries, and a portfolio of over 1,000 product lines spanning food, personal care, healthcare, and home care, Patanjali has fundamentally altered the competitive landscape for FMCG, Ayurvedic medicines, and natural health products in India.

These figures relate primarily to Patanjali's manufacturing, FMCG and product businesses and are not estimates of its healthcare-services revenue. They are included here only to provide the institutional context within which its Ayush service activities have developed; the discussion that follows distinguishes these product-side capabilities from their relevance to healthcare and Ayush-based Wellness service delivery.

Product and Manufacturing Ecosystem: Institutional Context

Patanjali's manufacturing and product businesses lie outside the service-sector boundary of this study. They are nevertheless relevant to the case because they reflect the wider institutional ecosystem supporting its healthcare and Ayush-based Wellness activities,



particularly through medicine supply, quality control, distribution and brand reach.

Patanjali's core strategic logic is cost leadership grounded in three structural advantages: direct herb sourcing from farming communities (bypassing multiple intermediary layers), in-house production at the Haridwar facility (with production capacity of Rs. 35,000 crore being expanded to Rs. 60,000 crore), and mass-volume scale that generates marginal cost advantages unavailable to smaller Ayush producers. Products are priced competitively vis-a-vis comparable offerings from established FMCG brands, creating mass-market accessibility that aligns with its Swadeshi (self-reliance) brand identity. This pricing model has influenced multinational FMCG competitors to reconsider their strategies and launch competing natural product lines, fundamentally reshaping market dynamics.

The Divya Pharmacy division addresses the healthcare segment specifically, offering Ayurvedic formulations for a wide spectrum of conditions. Revenue from operations stood at Rs. 6,460 crore in FY24 (following the transfer of food business to Patanjali Foods in 2022), with the five-fold jump in profit to Rs. 2,901 crore in FY24 reflecting improved operating leverage.

Rural Penetration and Farmer Integration

Patanjali's supply chain model is analytically significant for the Ayush sector precisely because it inverts the fragility pattern observed in our field visits. Rather than

depending on a fragmented external herbal market, Patanjali works directly with farming communities for the sustainable cultivation of key medicinal herbs and plants, creating livelihood opportunities while securing supply chains. This farmer-partnership model - at the scale Patanjali operates - achieves input cost stability, traceable quality, and rural development co-benefits simultaneously. The omnichannel distribution architecture (exclusive Arogya Kendras, traditional retail, supermarkets, e-commerce) ensures that this cost advantage reaches end-consumers across geographies.

5.3.4 Case Study 4 : Apollo AyurVAID Hospitals

Organisational Profile

Founded in 2005 by Rajiv Vasudevan, an alumnus of IIM Calcutta, AyurVAID was conceived to bring scientific rigour and clinical precision to one of the world's oldest systems of medicine. Today, as Apollo AyurVAID, it is the largest chain of Ayurveda hospitals in India, offering high-quality, insurance-approved, NABH-accredited in-patient services through a countrywide network of physicians. The chain currently operates eleven hospitals across Bengaluru, Delhi, Chennai, Almora, and Kochi, with a capacity of around 200 beds, and additional hospitals at Hyderabad and Navi Mumbai are planned. It also operates several centres in a "hospital-in-hospital" format, embedded within quaternary-care hospitals.

Figure 5.3: Apollo AyurVAID - among India's most awarded NABH-accredited Ayurveda hospital networks.



Source: Apollo AyurVAID Hospitals



The institution's clinical approach, termed Precision Ayurveda, is a highly personalised, protocol-driven model focused on diagnosing and treating the root cause of serious diseases in a manner consistent with classical Ayurveda principles. It addresses complex conditions across major specialties, including neurology, oncology, nephrology, metabolic and gastrointestinal health, and gynaecology, and monitors over 500 clinical data points at every stage of care to support safe, effective, and real-time patient management. The chain is accredited by leading medical insurers and the CGHS for cashless Ayurveda care, and reports industry-leading patient-experience benchmarks, including an 88 per cent Net Promoter Score and 98.6 per cent overall customer satisfaction.

From Accreditation to Credibility

AyurVAID's trajectory illustrates how quality certification can be converted into institutional credibility. In 2010, AyurVAID Domlur became the first Ayurveda hospital in India to earn NABH accreditation, and its Ramamurthy Nagar facility later became the first to receive NABH accreditation for para-surgical procedures. In 2012, the organisation won the QCI-DL Shah National Quality Award, the first such award to any Ayurveda organisation, and in 2019 it became the first and only Ayurveda centre to be audited under JCI globally. This record was extended in 2025, when Apollo AyurVAID became the first organisation in the Ayurveda and Ayush sector to receive the IMC Ramkrishna Bajaj National Quality Award (RBNQA) for Performance Excellence in Healthcare - one of India's most rigorous quality honours, evaluated against the internationally recognised Malcolm Baldrige performance-excellence criteria. The RBNQA is the chain's second national quality award after the 2012 recognition, and together these milestones mark the progressive entry of Ayurveda into the mainstream quality-assurance frameworks that govern modern healthcare. This sustained investment in accreditation directly addresses the central tension identified in the field studies: that quality compliance carries cost, but, when paired with insurance integration and brand-building, it becomes a source of competitive advantage rather than a burden.

Integration with Modern Medicine and Scale

A defining feature of the model is its deliberate integration with mainstream healthcare. In 2022, Apollo Hospitals Enterprises Ltd., India's largest integrated healthcare enterprise, acquired a majority stake in AyurVAID, creating the present Apollo AyurVAID entity and pairing classical Ayurvedic practice with the reach and clinical infrastructure of a major hospital group. The chain pursues evidence-building through research collaborations with institutions such as Monash

University, Australia, and the Open Health Systems Laboratory, USA, and has extended into a “Tested Safe” Ayurveda products range. Its embrace of digital therapeutics, including the Panini cloud-based patient-care platform and, during the pandemic, the C-ARM immunity programme selected by the EU-sponsored COVID-X accelerator, demonstrates how technology can reinforce, rather than dilute, classical practice.

AI-Enabled Innovation: The D-RISK Diabetes-Screening Framework

Apollo AyurVAID’s engagement with technology has moved beyond record-keeping toward clinical innovation. Its AyurVAID D-RISK framework, a non-invasive, self-administered screening and triage tool for detecting individuals at risk of undiagnosed diabetes, was selected for inclusion in the World Health Organization and IndiaAI Foundation’s Compendium on the Real-World Impact of AI in Health, chosen from submissions across twelve countries and unveiled at the India AI Impact Summit in New Delhi in February 2026. The tool addresses a substantial public-health gap: a

large share of Indian diabetics remain undiagnosed, and the undiagnosed population is projected to rise sharply worldwide over the coming decades.

What makes D-RISK analytically significant for this report is its method. The framework combines conventional demographic, anthropometric, lifestyle, and symptom indicators with features derived from classical Ayurveda descriptions of early metabolic imbalance, fed into an automated machine-learning model developed on a cohort of roughly 12,000 individuals. It is designed as a screening and triage aid that prioritises individuals for confirmatory laboratory testing, rather than as a diagnostic instrument; its reported performance reflects model-development validation, and planned next steps include prospective blinded validation against gold-standard biomarkers and multi-region pilots. D-RISK is a concrete illustration of the report’s broader thesis: that the codified observational knowledge embedded in Ayurveda is a genuine economic and scientific asset, which - when paired with modern data methods and appropriate clinical governance - can generate globally relevant, exportable health innovation.



Analytical Note: Apollo AyurVAID and the Medical Value Travel Pathway: Apollo AyurVAID is the field counterpart to the report's central thesis on medical value travel. A corporate, NABH- and JCI-benchmarked, insurance-integrated chain that already draws patients from over 90 countries embodies precisely the supply-side position the international wellness market is seeking - clinically credible, digitally visible, and quality-assured. The Apollo AyurVAID case shows how accreditation can become a revenue-enabling asset once it is coupled with insurance integration, scale, and international reach. Apollo AyurVAID's ability to attract patients from over 90 countries directly validates the findings of Chapter 4: accreditation, website presence, and longer therapeutic programmes are empirically associated with international patient uptake. The chain's NABH accreditation and JCI benchmarking provide the institutional credibility that international patients seek, while its structured residential programmes offer the therapeutic depth that supports longer average lengths of stay.

Synthesis and Policy Implications

The findings from the field visits converge on a common diagnosis. The Ayush services sector is experiencing sustained growth in patient demand, service diversification, and public acceptance. However, this expansion is taking place within an institutional ecosystem that remains unevenly developed. Across facility types and systems, the areas highlighted for further strengthening were quality assurance, supply chain reliability, skilled human resources, insurance coverage, and regulatory support. The sector's growth at scale should be driven by quality, accessibility, and international competitiveness.

The institutional case studies provide important insights into how some organisations have responded to these challenges. Although their organisational models differ, they collectively demonstrate that long-term success in the Ayush sector depends on building institutions striving for benchmark service delivery.

First, the case studies underline the importance of institutional quality and governance. Whether through formal accreditation, standardised clinical protocols, or trust-based governance structures, successful institutions have invested in systems that build credibility and patient confidence. Quality assurance therefore emerges not only as a regulatory requirement but also as a strategic asset for long-term growth.

Second, the cases demonstrate the value of institutional integration. Organisations such as Arya Vaidya Sala Kottakkal and Patanjali have reduced operational risks by integrating medicinal plant cultivation, pharmaceutical manufacturing, quality assurance, and healthcare delivery within a single ecosystem. Such vertical

integration improves quality consistency, enhances resilience against supply chain disruptions, and strengthens institutional sustainability. Schemes like the NMPB-QCI Voluntary Certification Scheme for Medicinal Plant Produce (VCSMPP) enhance the credibility of sourcing for medicinal plants.

For a services-sector analysis, the importance of this vertical integration lies not in the scale of manufacturing revenue alone, but also in the institutional capabilities it can provide to service delivery greater control over medicine supply and quality, reduced exposure to supply disruptions, and the ability to connect healthcare and Ayush-based Wellness services with a wider organisational ecosystem.

Third, the case studies illustrate that financial sustainability and social responsibility are not mutually exclusive. AVS Kottakkal reinvests institutional surpluses into education, research, and charitable healthcare, while the Isha Foundation combines volunteer participation with cross-subsidisation to expand access to community health services. Although these models have evolved under different institutional contexts, they demonstrate that sustainable financing mechanisms can coexist with broader public health objectives. While the challenges facing different Ayush systems vary, the field evidence also suggests opportunities for cross-system learning and integration. The Isha Foundation's model of combining Ayurveda, Siddha, Yoga, and Allopathy demonstrates that pluralistic service delivery can enhance patient outcomes and institutional credibility. Exploring such integrated models at scale could strengthen the sector's overall competitiveness.

Finally, the field visits suggest that the future of the Ayush services sector will depend on much more than expanding the number of practitioners or healthcare facilities. As the sector grows, equal attention will need to be given to the institutions that support service delivery. Stronger governance, a skilled workforce, consistent quality standards, research, digital systems, and reliable supply chains will all play an important role in ensuring that the sector can meet growing domestic demand while also strengthening its position in international healthcare and wellness markets.

Chapter 6
**Road to
Viksit Bharat 2047**

असतो मा सद्गमय ।
तमसो मा ज्योतिर्गमय ।
मृत्योर्मा मृतं गमय ।
शान्तिः शान्तिः शान्तिः ॥

(Bṛhadāraṇyaka Upaniṣad 1.3.28)

*From the unreal, lead me to the Real;
From darkness, lead me into Light;
From the realm of death, lead me to Immortality.*



6.1 Introduction

The findings presented in this report point to a sector with enormous untapped potential. While the previous chapters describe where India's Ayush services sector stands today, the next question is where it could be by 2047 and what will be needed to get there.

The second part sets out a practical roadmap for achieving that growth. Building upon the findings of this study, it focuses on four areas that will shape the future of the sector - strengthening the knowledge and

When viewed together, the projections and the roadmap highlight both the scale of the opportunity and the steps needed to realise it. With the right policy support, institutional strengthening and private sector participation, the Ayush services sector can play a much larger role in creating jobs, expanding service exports, strengthening healthcare and contributing to India's journey towards Viksit Bharat@2047.

6.2 Strategic Projections to 2047

The preceding chapters established the current economic profile of India's Ayush services sector, its contribution to employment, its emerging role in MVT, and the institutional factors influencing its growth. Building on this evidence, this section examines the sector's long-term growth potential up to 2047.

Rather than presenting a single forecast, the analysis adopts a scenario-based approach. Long-term projections over a twenty-year horizon are inherently sensitive to changes in technology, public policy, consumer preferences, and global healthcare markets. Accordingly, the scenarios presented here should be interpreted as alternative growth pathways rather than precise predictions. Their purpose is to illustrate the range of outcomes that could emerge under different rates of institutional development and market expansion.



6.2.1 Projection Scenarios

All the projections are made using FY2024–25 as the base year, when the Ayush services sector was estimated at US\$36.92 billion. Future market size is projected under three alternative scenarios. The scenarios reflect different assumptions regarding the pace of sectoral expansion and institutional development while maintaining a common analytical framework.

- **Scenario I: High-Growth Scenario (16.91% - Aspirational Case)** assumes that the sector broadly sustains its recent growth momentum, through FY 2030, supported by continued expansion in domestic demand, Ayush-based Wellness services, and MVT.
- **Scenario II: Moderate Growth Scenario (8% Growth – Conservative/Base Case)** assumes that growth continues but gradually moderates as structural constraints limit the pace of expansion.
- **Scenario III: Accelerated Growth Scenario (10% - Growth Case)** assumes that institutional

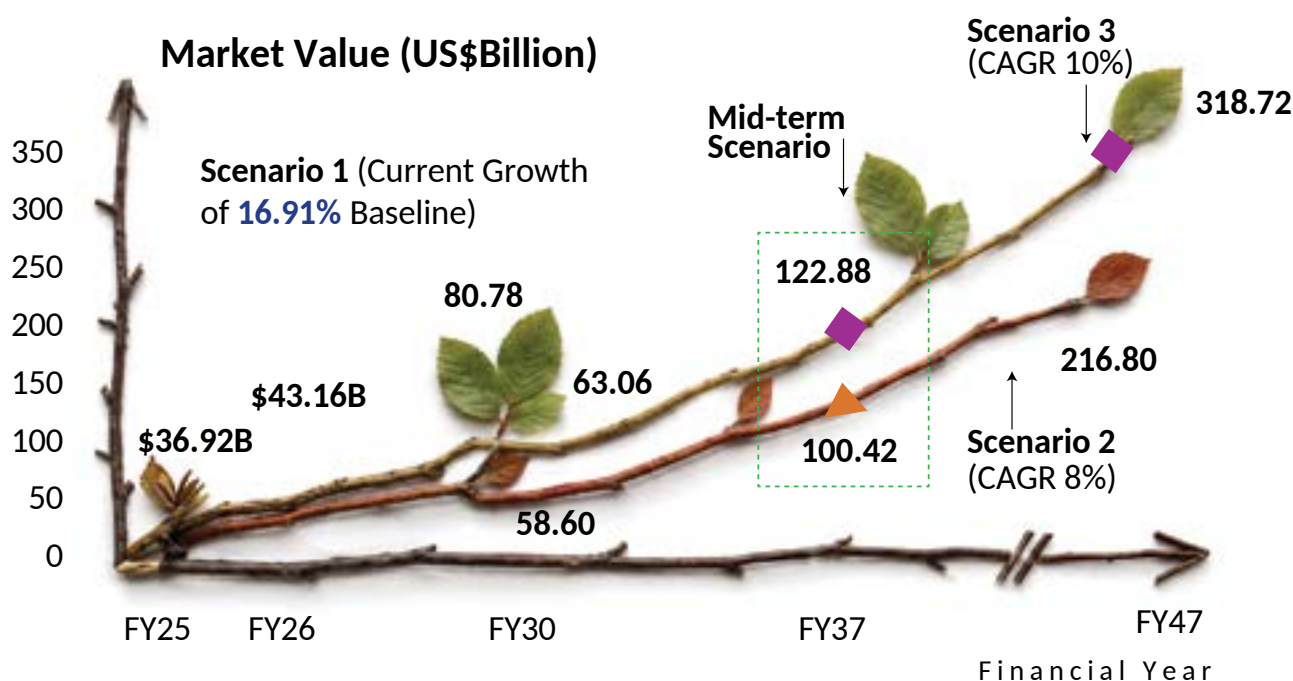
reforms, stronger global integration, technological adoption, and productivity improvements enable the sector to grow at a faster and more sustained pace.

Together, these scenarios provide a planning framework for assessing the possible size and contribution of the Ayush services sector under different development pathways.

6.2.2 Market Projections

The projections indicate that the Ayush services sector is poised for robust long-term expansion under all three growth scenarios (Figure 6.1). Starting from a base value of US\$36.92 billion in FY2025, the sector is projected to reach approximately US\$80.78 billion, US\$63.06 billion, and US\$58.60 billion by FY2030 under the high-growth (16.91%), accelerated-growth (10%), and moderate-growth scenarios (8 %), respectively. The relatively modest differences during the initial years reflect the sector's existing growth momentum.

Figure 6.1: Strategic Market Projections of the Ayush Services Sector, FY2025–FY2047



Source: RIS estimation based on field survey

(Note: Projected trajectory under the moderate (8% CAGR) and accelerated (10% CAGR) long-run scenarios, from a FY2025 base of US\$36.92 billion.)

Over the longer term, however, the growth trajectories diverge substantially. By FY2047, the sector is projected to attain a market size of US\$318.72 billion under the accelerated-growth scenario and US\$216.80 billion under the moderate-growth scenario. These projections demonstrate that sustained policy support,

institutional strengthening, innovation, and greater global integration could significantly influence the future size of the Ayush services economy. Even under the moderate-growth pathway, the sector is expected to expand to nearly five times its FY2025 size, highlighting its strong long-term growth potential.

6.2.3 Growth Across Major Segments

Growth across the Ayush services economy is expected to be uneven, with individual systems expanding at different rates depending on healthcare demand, consumer preferences, technological adoption, and opportunities in domestic and international markets. The projections suggest that while all Ayush systems are expected to grow over the long term, Ayurveda and the Ayush-based Wellness segment will remain the principal drivers of sectoral expansion (Table 6.1).

Ayurveda is projected to retain its dominant position throughout the projection period. Its market size is expected to increase from US\$17.73 billion in FY2025 to US\$37.21 billion by FY2030 under the current growth scenario and further to US\$152.17 billion by FY2047 under 10 per cent growth. Even under the more conservative 8 per cent growth scenario, Ayurveda is projected to reach US\$103.51 billion by FY2047. This sustained growth reflects Ayurveda's strong domestic demand, expanding role in preventive and integrative healthcare, increasing global acceptance, and its central role in MVT.

Table 6.1: Projected Growth by Major Ayush System (US\$ billion)

System	FY25	FY2026	FY2030	FY2030	FY2047	FY2047
	Base	Current CAGR		10% CAGR	8% CAGR	10% CAGR
Ayurveda	17.73	20.56	37.21	30.11	103.51	152.17
Homoeopathy	7.35	8.11	12.02	11.87	40.82	60.01
Unani	3.22	3.97	9.20	5.82	20.00	29.40
Siddha, Naturopathy & Sowa Rigpa	0.22	0.24	0.31	0.35	1.19	1.75
Ayush-based Wellness (Yoga/SPA/Resort)	8.40	10.19	22.05	14.92	51.28	75.39
Total	36.92	43.07	80.78	63.06	216.80	318.72

Source: RIS estimation based on field survey

(Note: The 16.91% figure is the sector's current CAGR carried forward; the 8% and 10% columns correspond to the moderate and accelerated long-run scenarios respectively.)

The Ayush-based Wellness segment is projected to remain the second largest contributor and one of the fastest-growing components of the Ayush services economy. The market is expected to expand from US\$8.40 billion in FY2025 to US\$75.39 billion by FY2047 under the 10 per cent CAGR scenario. Even under the conservative growth scenario, the Ayush-based Wellness market is projected to increase to US\$51.28 billion. The strong outlook reflects rising demand for preventive healthcare, healthy ageing, stress management, holistic wellness, and the growing popularity of wellness tourism among both domestic and international consumers.

In comparison, Homoeopathy is projected to grow steadily from US\$7.35 billion in FY2025 to US\$60.01 billion by FY2047 under the 10 per cent CAGR scenario, while reaching US\$40.82 billion under the

conservative scenario. The sustained growth reflects continued domestic demand and the expanding role of homeopathic healthcare services.

Unani, and Siddha, Naturopathy & Sowa Rigpa are also projected to record steady growth, although their contribution to the overall market is expected to remain relatively smaller. Their expansion will depend on continued institutional support, greater public awareness, improved service delivery, and wider market penetration. Together, these projections indicate that future growth of the Ayush services economy will be led primarily by Ayurveda and Ayush-based Wellness services, with other systems making complementary contributions to the sector's overall expansion.

Table 6.2: Projected Growth by Facility Type (US\$ billion)

System	FY25	FY2026	FY2030	FY2030	FY2047	FY2047
	<i>Base</i>	<i>Current CAGR</i>	<i>10% CAGR</i>	<i>8% CAGR</i>	<i>10% CAGR</i>	
Clinic	16.21	18.39	37.21	26.93	92.58	136.10
Day Care Centre	10.13	11.92	12.02	17.46	60.02	88.24
Hospital	1.31	1.58	9.20	2.32	7.98	11.73
Institute	0.87	0.98	0.31	1.44	4.94	7.26
Ayush-based Wellness	8.40	10.19	22.05	14.92	51.28	75.39
Total	36.92	43.07	80.78	63.06	216.80	318.72

Source: RIS estimation based on field survey



Across facility types (Table 6.2), clinics are projected to remain the largest contributor to the Ayush services economy, expanding from US\$16.21 billion in FY2025 to US\$136.10 billion by FY2047 under the 10 per cent CAGR scenario. Day care centres are also expected to witness substantial growth, increasing from US\$10.13 billion to US\$88.24 billion over the same period, reflecting the growing preference for outpatient and short-duration Ayush treatments. The Ayush-based Wellness segment is projected to remain one of the fastest-growing categories, rising from US\$8.40 billion in FY2025 to US\$75.39 billion by FY2047, driven by increasing demand for preventive healthcare, wellness tourism, and holistic lifestyle services. In comparison, hospitals and educational institutes are also expected to grow steadily, although their contribution to the overall market will remain relatively smaller.

6.2.4 What the Projections Mean

The projections presented above illustrate the scale of the opportunity before the Ayush services sector. Under all three scenarios, the sector is expected to expand substantially by 2047, confirming that Traditional Medicine services are an emerging knowledge-intensive service industry capable of generating employment, exports, and long-term economic value.

Four broad observations emerge from the projections.

1. **Ayurveda-led multi-system growth of the Ayush services economy, as observed during the study period.** Throughout the projection period, Ayurveda is projected to account for the largest share of sectoral revenue and employment. However, Homoeopathy demonstrates steady growth, Unani shows promise in specific regions and Ayush-based Wellness emerging as the fastest growing segment. Each system has distinct strengths and market opportunities that contribute to the sector's overall growth and resilience.
2. **Ayush-based Wellness and MVT will become the fastest-growing segments of the sector.** The projections suggest that future growth would increasingly be driven by residential wellness programmes, Yoga-based preventive healthcare, Panchakarma, and integrated therapeutic services rather than conventional outpatient consultations alone. Rising global demand for preventive health, healthy ageing, stress management, and holistic healthcare is likely to accelerate this transition, making Ayush-based Wellness services and MVT important engines of export growth.

3. **The difference between the three growth scenarios highlights the importance of institutional transformation.** The gap between the Base Case, Growth Case, and Aspirational Case pathways widens considerably over time, illustrating the compounding impact of sustained institutional reforms to be taken over the next two decades. Relatively small differences in annual growth rates produce dramatically different economic outcomes by 2047, demonstrating that the long-term trajectory of the sector would depend on institutional capability to meet growing market demand.

4. **The Ayush economy is predicted to evolve into a diversified knowledge-based services ecosystem.** The evidence presented throughout this report shows that the sector is no longer defined solely by healthcare delivery. Today it encompasses wellness, MVT, education, research, digital health, and international knowledge exchange. This diversification would strengthen the sector's resilience, expand its contribution to employment and exports, and enhance its strategic relevance within India's broader services economy.

These projections should not be interpreted as predetermined outcomes. They represent alternative development pathways whose realisation will depend upon the institutional choices made over the coming two decades. Achieving the higher-growth scenarios will require strengthening the foundations of the Ayush ecosystem from knowledge generation and institutional capability to global competitiveness and innovation. The following part of this chapter therefore turns from the opportunity potential to the strategy required to realise it, presenting a roadmap for the Ayush services sector organised around the analytical framework introduced in Chapter 2.

Part 2 : The Strategic Roadmap

Applying the four analytical pillars of Chapter 2 viz., the Knowledge Value Chain, Enterprise Capability, Global Competitiveness, and Innovation Dynamics, to identify the changes that will strengthen each part of the Ayush services ecosystem.

Pillar I : Knowledge Value Chain

Jñāna → Vijñāna → Lokasaṅgraha

Chapter 2 had introduced the first analytical pillar as a Knowledge Value Chain, as a progression from *Jñāna* (the knowledge base created through education, research, traditional knowledge and standards) to *Vijñāna* (where this knowledge is put into practice through service delivery), and ultimately to *Lokasaṅgraha* (where it creates wider value through better health, employment, entrepreneurship and exports).

When applied to the findings of the study, this lens reveals that the sector's *Jñāna* foundations (its education, workforce and data systems) needs to keep pace with the rapid changes taking place in *Vijñāna*, the service-delivery layer. Preventive healthcare, holistic wellness and therapeutic wellness are reshaping demand, but education and workforce ecosystem remain largely oriented towards clinical practice rather than the emerging Ayush-based Wellness economy. The Sector currently lacks a comprehensive data ecosystem to guide evidence-based policy and planning. Strengthening these knowledge foundations is essential to secure the *Lokasaṅgraha* outcomes the sector is capable of generating. The changes that can strengthen this pillar are set out below.

Recommendation 1: *Kalyāṇa Kośa and Punarnavā* - Strengthening Therapeutic Wellness as a distinct, clinical segment within the Ayush-based Wellness economy

Rationale

The Ayush-based Wellness segment has emerged as one of the important areas of growth within the Ayush services economy. The Ayush-based Wellness establishments covered by this study span a wide range of wellness offerings, from Yoga and general wellbeing services to Ayurveda-based programmes offered through Ayush-based Wellness centres, spas and resorts. These services cater to different needs and collectively contribute to the growing demand for preventive health, wellbeing and Ayush-based Wellness. Within this broad and diverse space, it would be important to explore the scope to strengthen a more acknowledged segment of **therapeutic wellness**, where wellness services are clinically guided and delivered within an appropriate framework of professional oversight, quality and safety.

The **Ayush Quality Mark Certification framework for Ayush Wellness Centres** gives this distinction greater clarity. It recognises a space between general Ayush-based Wellness and clinical care, where services draw on Ayurveda, Yoga and other Ayush systems but are offered

with a therapeutic intent requiring a different set of professional and clinical safeguards. Thus we would have two **distinct and complementary dimensions of the wider Ayush-based Wellness sector**, serving different needs and requiring standards appropriate to the nature of the service being provided.

This study has examined the broader Ayush-based Wellness segment and has not measured therapeutic wellness separately. The findings nevertheless show the scale, growth and employment potential of the Ayush-based Wellness services. Within this larger market, therapeutic wellness could be developed as a more clearly defined segment, with appropriate standards for clinical oversight, quality and professional competence. Over time, this could also strengthen its relevance for MVT and, where supported by evidence and the regulatory framework, healthcare financing.

Despite this potential, the current education and workforce ecosystem has not adequately evolved to this changing nature of Ayush service delivery. The National Commission for Indian System of Medicine (NCISM) and National Commission for Homoeopathy (NCH) have made sincere efforts to strengthen the Ayush education framework in India to a competency-based one for national Public Health roles. However, the therapeutic wellness sector increasingly demands specific competencies that cater to a global audience with respect to preventive healthcare, lifestyle counselling, wellness operations, digital service delivery, quality management, entrepreneurship and international patient management. Consequently, much of the workforce continues to acquire these skills through informal, on-the-job training, resulting in variability in service quality and limiting the sector's capacity to scale.



Action Point(s)

The Ministry of Ayush may consider further strengthening therapeutic wellness as a clearly defined segment within the broader Ayush-based Wellness space, leveraging upon the service and quality requirements that have been identified under the Ayush Quality Mark scheme. As part of this, the scope of therapeutic wellness, the clinical and workforce requirements associated with it, and the competencies needed across different categories of personnel could be clearly defined. Towards this end:

- **The National Commission for Indian System of Medicine (NCISM) and the National Commission for Homoeopathy (NCH)** may consider incorporating structured modules on therapeutic wellness, preventive and lifestyle medicine, Panchakarma in Ayush-based Wellness settings, Ayush-based Wellness programme design, digital health, patient communication, entrepreneurship and MVT within undergraduate and postgraduate education (*Kalyāṇa Kośa module*). Further, greater integration of healthcare management, nutrition, tourism, rehabilitation sciences and digital technologies could be explored within Ayush education, that would enable graduates to pursue diverse professional pathways across the therapeutic wellness value chain.
- **The Ministry of Ayush, in collaboration with the Apex Institutions of Ayurveda, State Ayush Universities and other academic institutions,** may develop specialised certificate and diploma programmes for different cadre such as Ayush therapists, Yoga instructors, Ayush-based Wellness managers etc., creating nationally recognised competency pathways for careers in therapeutic wellness.
- **The Ministry of Ayush, together with the Ministry of Skill Development and Entrepreneurship and the Healthcare Sector Skill Council (HSSC),** may build upon the existing Ayush skilling, reskilling, upskilling and Recognition of Prior Learning (RPL) architecture. Existing Qualification Packs and competency pathways could be reviewed against the additional requirements of therapeutic wellness, particularly clinical supervision, quality assurance, digital skills, patient communication and international patient services. Where gaps are identified, appropriate bridge modules or additional competencies could be incorporated within the existing NSQF/NCVT framework (*Kalyāṇa Kośa - Punarnavā*).

- **Ayush educational institutions could explore partnerships with wellness providers, hospitals, MVT establishments and industry associations** to promote internships, apprenticeships, faculty exchanges and industry-led curriculum development, ensuring that graduates acquire practical skills aligned with market requirements.

Box 6.1 The workforce measures above can be carried under a single identity, *Kalyāṇa Kośa* - a certified therapeutic wellness education module, delivered in two complementary layers:

Layer	Focus
<i>Kalyāṇa Kośa</i>	New entrants - an elective stream within BAMS/BHMS/ BUMS/BSMS/BSRS and a stand-alone certification for Yoga instructors, spa therapists and Ayush-based Wellness-resort staff.
<i>Kalyāṇa Kośa – Punarnavā (renewal)</i>	Existing workforce - building on HSSC's existing skilling, upskilling and RPL pathways, with additional bridge competencies introduced where required for therapeutic-wellness settings.

Expected Outcomes

A clearer policy framework for therapeutic wellness would help in distinguishing clinically guided services from the wider Ayush-based Wellness market and provide establishments with a roadmap towards higher standards of professional oversight, quality and safety. When education and workforce development are aligned with an emerging market demand, therapeutic wellness can evolve into one of the principal engines driving the next phase of growth of the Ayush services sector, with impeccable relevance for preventive care, rehabilitation and Medical Value Travel.

Recommendation 2: A National Ayush Services Intelligence System for Evidence-Based Policymaking (*Nirīkṣaṇa*)

Rationale

One of the biggest challenges facing the Ayush services sector is that it is still not measured well enough. The Ministry of Ayush has built important digital platforms, including Ayush Grid, AHMIS, the NAMASTE Portal and its integration with the Ayushman Bharat Digital Mission,

that have greatly improved the availability of clinical and administrative data. However, they provide only a partial picture of the sector. Information on revenues, employment, Medical Value Travel, workforce, quality certification, digital readiness and service utilisation remains scattered and is not updated in a consistent manner.

The NSSO's dedicated Survey on Ayush has considerably strengthened demand-side evidence on awareness, utilisation and expenditure. A corresponding gap remains on the supply side, where nationally comparable information on service establishments, revenues, employment, workforce composition, quality certification, digital readiness and Medical Value Travel remains limited.

A stronger national data base for Ayush services could be built by expanding the use of existing digital infrastructure and linking it more closely with national statistical systems. Better data will help shape policy, guide investments, monitor progress and ensure that the Ayush services sector continues to grow in a balanced, evidence-informed and sustainable manner.

Action Point(s)

The Ministry of Ayush may strengthen the national data ecosystem for the Ayush services sector by building upon existing digital infrastructure and enhancing convergence with national statistical systems, towards establishing a National Ayush Services Intelligence System (*Nirīkṣaṇa*). Towards this end:

- **The Ministry of Ayush could consider expanding the scope of existing digital platforms, including Ayush Grid and the Ayush Hospital Management Information System (AHMIS),** to capture service-sector indicators such as employment, patient volumes, Medical Value Travel, workforce composition, accreditation status, digital adoption and other operational indicators, thereby creating a comprehensive evidence base for policymaking.
- **The Ministry of Ayush may work with MoSPI/ NSSO and, where relevant, the Ministry of Health and Family Welfare and IIPS** to strengthen demand-side measurement of Ayush without duplicating existing national surveys. Future rounds of the dedicated NSSO Survey on Ayush may provide the principal platform for tracking household awareness, utilisation, expenditure and related Ayush indicators. Before proposing any Ayush-related additions to the NFHS, the domains covered under the NSSO Ayush schedule could be mapped against the NFHS questionnaire, with only those indicators that

address a clearly identified information gap and add value to the NFHS's health and demographic framework considered for inclusion.

- **A five-yearly National Survey of Ayush Service Establishments (Quinquennial Survey):** Complementing the household-level NSSO Survey on Ayush, a periodic National Survey of Ayush Service Establishments may be considered to generate the supply-side economics and institutional information that household surveys cannot capture. The Ministry of Ayush may consider institutionalising a quinquennial (once in 5 years) enterprise survey of the Ayush service sector, with a nationally representative sample adequate for system, establishment and region-level analysis. The survey instrument should capture: foreign patient nationality and source-market data; revenue disaggregated by patient type (domestic OPD, domestic inpatient, foreign OPD, foreign inpatient); therapist-to-physician ratios; and digital platform utilisation beyond binary presence indicators. A quinquennial cadence would allow policymakers to track MVT market share, occupancy trends, and digital adoption rates at the establishment level, providing establishment-level information for policy and investment decisions
- **Linking sector data with evidence on outcomes and value.** Clinical and real-world outcome data, including patient-reported outcomes, may be considered as a progressive complement to the proposed Ayush services data system. For priority interventions being considered for public financing or insurance coverage, engagement with the Department of Health Research and HTAI may be explored to assess effectiveness, safety and economic value.

Box 6.2 : These measures can be institutionalised as *Nirīkṣaṇa* - the National Ayush Services Intelligence System. A standing service-economy layer added to the existing Ayush Grid, capturing establishment-level revenue, employment, digital readiness, accreditation and MVT share, to support the sector's measurement by observation.

Expected Outcomes

A strengthened data intelligence ecosystem would help governments make better decisions. It will make it easier to monitor the growth of the Ayush services sector, plan investments, strengthen the workforce and support MVT. Bringing together information from digital platforms, establishment surveys and national household surveys

will also provide a more complete picture of both the supply of and demand for Ayush services across the country.

Pillar 2 - Enterprise Capability

Prārambha → Vikāsa → Utkarṣa

Chapter 2 introduced Enterprise Capability, as a way of understanding how Ayush service establishments can develop over time. The framework describes three broad stages viz., *Prārambha* stage (representing establishments with basic organisational capacity and limited institutional infrastructure), the *Vikāsa* stage (where more formal management, digital and quality systems begin to take place), and the *Utkarṣa* stage (representing more mature establishments with stronger quality assurance, accreditation, integration and service sophistication). These stages are intended as an analytical framework rather than a formal classification or ranking of the establishments surveyed. They help identify the factors that enables an establishment to move up this continuum through quality systems, digital adoption, financial integration and regulatory maturity.

The survey findings point to several characteristics associated with the earlier stages of this continuum, particularly among smaller establishments: uneven adoption of quality standards, limited digital capability,

weak insurance linkages and differences in regulatory coverage. The recommendations below focus on four areas that can strengthen institutional capability viz., quality, digital systems, financial protection and regulatory convergence.

Recommendation 3: Strengthen and Scale the Ayush Quality Mark as the National Quality Framework for Ayush Services Sector :

Navaratna Mānaka - A Progressive Quality Pathway for Ayush Services

Rationale

Quality assurance in Ayush services has entered an important new phase with the launch of the **Ayush Quality Mark (AQM)** in December 2025. Implemented through AYUSHEXCIL, the Mark provides a common quality identity for Ayush products and services and already covers **Ayush hospitals, clinics, day-care centres, wellness centres and MVT Facilitators**. For service establishments, recognition is linked to established accreditation or certification systems and additional requirements prescribed under the programme. This is an important step towards addressing a long-standing challenge in the Ayush services sector.

Ayush-based Wellness services offering institutions (Yoga centres, resorts, and Spas) and therapeutic day-care centres, often tend to become first point-of-contact



for many people, especially those seeking preventive care, wellness or MVT. Differences in infrastructure, practitioner qualifications, treatment protocols, hygiene, safety and service quality can affect affects consumer confidence and the sector's ability to scale, integrate with insurance systems and compete internationally.

India has already laid down a strong foundation for quality standardisation on which the AQM can build. The Bureau of Indian Standards (BIS) has established a dedicated Ayush vertical and has developed standards relevant to different parts of the Ayush and its wellness ecosystem, including service requirements for Yoga centres.. At the international level, India has assumed an important leadership role in standardisation through the establishment of a dedicated ISO subcommittee on Ayurveda and Yoga (ISO/TC 249/SC 2 - Ayurveda and Yoga), with the Bureau of Indian Standards serving as its secretariat. The scope of this committee extends beyond products to include health and Ayush-based Wellness service requirements, rejuvenation procedures and Yoga practices, creating an unprecedented opportunity for India to shape global standards for Ayush services. BIS should leverage upon this by taking forward its Indian Standards to ISO for international adoption/recognition.

Moving forward, it would be pertinent to deepen the reach and usefulness of the Ayush Quality Mark. This would be most helpful for establishments of different sizes and levels of maturity to enter the quality system, progressively improve their standards and ultimately meet nationally and internationally recognised benchmarks.

Action Point(s)

- **Supporting quality readiness among smaller establishments.** The Ayush Quality Mark already specifies the applicable accreditation/certification and additional requirements for recognition. For smaller clinics, Yoga centres, Panchakarma facilities and Ayush-based Wellness establishments that may require support in reaching these standards, *Navaratna Mānaka* could function as a voluntary readiness and gap-assessment tool aligned with the existing AQM criteria. It would not constitute a separate certification, accreditation or eligibility route for the Ayush Quality Mark. Instead it could help establishments identify areas requiring improvement before undertaking the prescribed self-assessment, accreditation or certification process under AQM.
- **Creating linkages between Ayush Quality Mark and defined market benefits.** AQM recognition should increasingly carry practical value for service

providers. Recognised establishments could be given greater visibility on official Ayush and MVT platforms and considered, where appropriate, within government-supported international promotion, insurance and purchaser networks. This would give providers a stronger reason to invest in quality.

- **Providing practical support for establishments seeking the Mark.** State Ayush departments and relevant professional institutions could support periodic orientation and quality-improvement programmes, for smaller providers aided by the development of simple self-assessment tools, model SOPs, checklists and short training modules explaining what establishments need to do to meet AQM requirements.
- **Track the uptake and impact of the Ayush Quality Mark.** AYUSHEXCIL and the Ministry could take an active lead in periodically publishing information on the number and type of service establishments receiving the Mark, their geographical distribution, renewals and other appropriate indicators of uptake. Linking this information with the proposed Ayush services data system would additionally help identify regions where adoption remains low and whether the Mark is improving quality, patient confidence and market access over time.
- **Strengthen the workforce component of quality assurance** The Ministry of Ayush in collaboration with the relevant statutory and professional bodies, including NCISM, NCH, the Yoga Certification Board and, where appropriate, the Ayurveda Training Accreditation Board (ATAB), could work together to strengthen competency, training and continuing skill-development standards for personnel delivering Ayush and therapeutic-wellness services. These requirements can strengthen the **Workforce & Service Competency** dimension of *Navaratna Mānaka* and complement it.

Box 6.3 : Navaratna Mānaka (the nine-gem standard) may be used as a voluntary quality-readiness framework covering nine areas relevant to Ayush service establishments. It is intended as an improvement and self-assessment aid aligned with existing AQM and recognised certification requirements. It does not replace or alter the prescribed process for obtaining the Ayush Quality Mark.

Gem Standard	Facet assessed
<i>Gomedaka</i>	Compliance with applicable legal and regulatory requirements, infrastructure and essential facility requirements*
<i>Pravāla</i>	Hygiene, sanitation and infection prevention
<i>Vaidūrya</i>	Practitioner and therapist competency, documentation and adherence to recognised service protocols
<i>Muktā</i>	Environmental sustainability, waste management and sustainable use of resources
<i>Puṣyarāga</i>	Nutrition, lifestyle counselling and holistic Ayush-based Wellness programme design
<i>Māṇikya</i>	Digital readiness, booking and information transparency, health-record management and data protection
<i>Marakata</i>	Patient safety, emergency preparedness and referral systems
<i>Indranīla</i>	Informed consent, grievance redressal and consumer protection
<i>Vajra</i>	Consistency, quality and authenticity of traditional practice

*For Gomedaka, legal and regulatory compliance refers only to requirements applicable to the establishment according to its nature, services offered and the law in force in the concerned State/UT. Where no specific statutory framework applies to a category of wellness establishment, the assessment would consider applicable general and local regulatory requirements together with relevant recognised quality and service standards.

Expected Outcomes

Strengthening the progression towards the Ayush Quality Mark across the services sector establishments will make Ayush services safer, more consistent and more reliable. It will give patients greater confidence in the services they receive, encourage more providers to adopt recognised quality standards and support the continued professionalisation of the sector. Better quality assurance will also strengthen the reputation of Indian Ayush services, making them more competitive in domestic and international markets and also help

India shape the next generation of global standards for Traditional Medicine and Ayush-based Wellness.

Recommendation 4: Strengthening Digital Infrastructure to Enhance Service Delivery and Global Visibility – *Drśya Setu* (the bridge of visibility)

Rationale

In today's healthcare landscape, a provider who cannot be found online is increasingly at a competitive disadvantage. Patients increasingly rely on digital platforms to discover healthcare providers, compare services, access information, schedule consultations and continue follow-up care after treatment. For international patients in particular, an establishment's digital presence often serves as the first point of engagement and significantly influences healthcare choices.

The findings of this study clearly demonstrate that digital readiness is positively associated with the ability of Ayush establishments to attract both domestic and international patients. Establishments with dedicated websites, online booking facilities, teleconsultation services, digital patient management systems and active online engagement consistently reported higher patient footfall and stronger participation in Medical Value Travel. Conversely, a significant proportion of establishments surveyed continue to have limited or no digital presence, restricting their visibility, accessibility and ability to participate in the rapidly expanding digital health ecosystem.

The Government has already established a strong foundation for digital transformation through initiatives such as the Ayush Grid, Ayush Hospital Management Information System (AHMIS) and integration with the Ayushman Bharat Digital Mission (ABDM). AHMIS is now ABDM-compliant and supports electronic health records, digital service delivery and integration with ABHA IDs. The Ministry has also initiated digital readiness assessments of Ayush facilities and is undertaking phased onboarding and capacity-building programmes to improve digital adoption.

While these initiatives have significantly strengthened the digital backbone of the sector, the survey findings suggest that these digital platforms need to translate into wider adoption at the establishment level. This is particularly important for smaller providers, many of whom still lack the digital tools needed to manage patients, deliver follow-up care and compete effectively in an increasingly digital healthcare market.

Action Point(s)

Further digital acceleration of the Ayush services sector may be pursued through the following measures :

- **The adoption of Ayush Grid and the Ayush Hospital Management Information System (AHMIS) may be expanded** across all categories of Ayush establishments, including clinics, hospitals, Panchakarma centres and Ayush-based Wellness facilities, enabling electronic health records, digital patient management, appointment scheduling, inventory management and interoperability with the Ayushman Bharat Digital Mission.
- **The digital onboarding of Ayush service providers (akin to e-Sushrut),** could be targeted particularly to small and medium-sized establishments, by facilitating the development of multilingual websites, online appointment systems, teleconsultation facilities, digital payment solutions and search engine visibility. Such interventions would improve patient access and enable establishments to reach wider domestic and international audiences.
- **Large hospitals and Medical Value Travel-ready institutions** may be encouraged to adopt comprehensive digital platforms incorporating multilingual information, online consultations, package booking and post-treatment follow-up. Smaller clinics and Ayush-based Wellness centres may be supported through simplified digital solutions, including government-supported clinic management software, verified online profiles and integration with national health platforms.
- **Digital literacy and capacity building programs could further be strengthened** by expanding training programmes for practitioners and healthcare administrators on electronic health records, telemedicine, cybersecurity, digital marketing, patient engagement and utilisation of digital public infrastructure.
- **States/UTs may consider dedicated budgetary support for strengthening Ayush service delivery, with an identified component for digital infrastructure and capacity building,** including digital onboarding of facilities, adoption of electronic health records & patient-management systems, connectivity, basic digital infrastructure and training of personnel. Such support could focus on smaller public facilities and service providers that may otherwise be disadvantaged by virtue of financial or technical

barriers to digital adoption.

- **Digital platforms may be leveraged to improve transparency and consumer confidence** by enabling establishments to publicly display accreditation status, quality certifications, practitioner credentials and service offerings in a standardised format, thereby assisting patients in making informed choices.
- **State Governments could explore integration of Ayush establishments with state tourism, wellness and healthcare portals,** improving digital discoverability and facilitating linkages between healthcare, wellness and tourism ecosystems, particularly in states with significant Ayush infrastructure.

Box 6.4 : The digital measures can be unified under a single mechanism, *Dṛśya Setu*, with three independent tracks for how an establishment actually reaches patients:

Track	Best-fit establishments & mechanism
<i>Setu Mūla</i> (Basic Digital Track)	Clinics and small domestic-facing Day Care centre that are bridged via subsidised eSushrut-style software for a verifiable national listing via subsidised clinic software. No dedicated-website requirement.
<i>Setu Viśva</i> (International Visibility Track)	Hospitals and MVT-facing establishments that are bridged via multilingual websites, package pricing, direct booking and telemedicine, listed on the MVT Portal.
<i>Setu Saṃyoga</i> (Tourism and Ayush-based Wellness Integration Track)	Day Care centre and Therapeutic Wellness that are bridged via package-based booking integrated with hospitality and tourism discovery channels.

Expected Outcomes

Strengthening digital infrastructure will improve the visibility, accessibility and operational efficiency of Ayush establishments while enhancing patient experience and continuity of care. Greater digital integration will

support wider adoption of electronic health records, strengthen participation in the Ayushman Bharat Digital Mission, improve access to teleconsultation and digital health services, and generate valuable real-time data for evidence-based policymaking. Most importantly, enhanced digital readiness will enable Ayush establishments to reach larger domestic and international markets, strengthening the competitiveness and long-term growth of India's Ayush services sector.

Recommendation 5: Exploring Wider Financial Protection for Evidence-based Therapeutic Wellness and Preventive Ayush Services – *Ārogya Sopāna*

Rationale

Financial protection through health insurance is a critical determinant of healthcare utilisation and plays an important role in improving access to quality healthcare services. Insurance coverage for Ayush has widened in recent years, but much of it continues to be associated with hospital-based treatment. The survey findings also indicate that insurance penetration across the wider Ayush services sector remains limited, leaving households to meet a large share of expenditure directly.

At the same time, the way Ayush services are delivered is changing. A range of interventions including rehabilitation, chronic-disease management and clinically guided therapeutic-wellness services may be delivered through day-care or other structured settings independent of conventional inpatient care. Their suitability for financial protection would need to take account of the evidence for the intervention, clinical indication, treatment protocol, provider qualifications, quality standards, costs and measurable outcomes.

The Government has taken important steps to improve financial protection through the enabling of complete coverage for Ayush treatments under IRDAI regulations. Building upon this initiative, there is an opportunity to progressively widen financial protection to evidence-based Ayush services including therapeutic wellness services, thereby encouraging a growing consumer shift to preventive and restorative care.

Action Point(s)

Further options for widening financial protection may be examined jointly by the Ministry of Ayush, Ministry of Health and Family Welfare, NHA and IRDAI, particularly for evidence-based therapeutic wellness and preventive Ayush services. Towards this end:

- **The Ministry of Ayush and IRDAI may develop standardised treatment protocols and reimbursement pathways for evidence-based**



therapeutic wellness interventions, including physician-supervised rehabilitative therapies, structured lifestyle management programmes and protocol-based day-care services. Clear standards will make it easier for insurers to recognise and reimburse these services.

- **As part of the ongoing consideration of Ayush services under AB-PMJAY**, the Ministry of Ayush may work with the Ministry of Health and Family Welfare and the National Health Authority (NHA) to examine the feasibility of including selected evidence-based Ayush interventions, particularly those delivered through inpatient and day-care settings. Any future inclusion should be supported by clearly defined treatment protocols, package costs, provider standards and mechanisms for monitoring quality and outcomes.
- **Expansion of insurance coverage could be linked with recognised quality and accreditation frameworks**, ensuring that reimbursable services are delivered by establishments meeting nationally recognised standards. This should improve patient safety, strengthen confidence among insurers and create additional incentives for service providers to adopt quality certification.

- **Data generated through insurance claims and utilisation patterns could be integrated with the proposed Ayush data intelligence ecosystem**, enabling policymakers to evaluate the effectiveness, cost-efficiency and health outcomes of Ayush interventions and support future evidence-based expansion of insurance coverage.
- **The Ministry of Ayush may undertake targeted engagement with insurers, employers and healthcare providers** to improve awareness of existing Ayush insurance provisions, encourage wider utilisation of covered services and promote innovative insurance products supporting preventive and wellness-oriented healthcare.

Box 6.5: *Ārogya Sopāna* provides an illustrative way of considering how different Ayush services may relate to financial protection. It does not classify services simply as “curative”, “preventive” or “wellness”. It looks at the purpose of care, clinical indication, strength of the treatment protocol, professional oversight, evidence, quality assurance and measurability of outcomes. The framework does not determine insurance eligibility. It indicates the level of evidence and service structure that may be required before different forms of financial protection can be considered.



Step	Nature of care	Requisites	Possible approach to financial protection
<i>Cikitsā</i> (Curative)	Clinically indicated treatment for a diagnosed condition, delivered through an appropriate clinical setting	Defined indication and treatment protocol; qualified provider; recognised quality requirements; documented outcomes and costs	Currently insurable, per IRDAI's 2016 mandate and 2024 full-sum-insured circular, but restricted to accredited/recognised institutions and a minimum inpatient stay.
<i>Saṅjīvanī</i> (Restorative)	Physician-prescribed rehabilitation and chronic-disease management, including day-care delivery	Physician oversight; defined protocol and duration; evidence of benefit; quality-assured provider; measurable outcomes and package costs	May be considered for wider financial protection where evidence, quality and reimbursement requirements are met
<i>Rakṣā</i> (Preventive)	Structured, protocol-based preventive care for at-risk (not yet diagnosed) individuals and those with defined preventive needs.	Clearly identified target group; evidence-supported intervention; professional oversight appropriate to the service; defined outcomes and costs	Financing options may be explored selectively, including insurance, public programmes or employer-supported models, depending on evidence and policy feasibility
<i>Kalyāṇa</i> (Promotive)	Services primarily directed towards wellbeing, relaxation, general fitness or lifestyle enhancement without a defined clinical indication	Appropriate service quality, safety, professional competence and consumer protection	Currently outside conventional health reimbursement; other purchaser- or consumer-financing models may be more appropriate

Expected Outcomes

A clearer basis for widening financial protection will help in identifying Ayush services for which reimbursement is clinically justified, supported by evidence and feasible from a financing perspective. This will help reduce out-of-pocket expenditure for eligible services for patients. It will also provide clearer requirements on treatment protocols, provider quality, costs and outcomes for insurers and public purchasers. Above all, it would allow therapeutic wellness and preventive services to be considered on their clinical and economic merits, and not being excluded merely on the grounds of them falling outside conventional inpatient care.

Recommendation 6: Strengthening Regulatory Harmonisation across the Ayush Services Ecosystem - *Sūtradhāra* (A Threaded Route to Regulatory Harmonisation)

Rationale

The findings of this study highlight that the regulatory architecture governing the Ayush services sector remains fragmented across states. While health is a State subject under the Constitution and states have developed their own regulatory frameworks reflecting local priorities and healthcare systems, this has also resulted in significant variations in the regulation, registration and oversight of Ayush establishments.

The regulatory landscape differs considerably across states with respect to registration requirements, licensing procedures, institutional oversight, quality standards and enforcement mechanisms. While some states have established dedicated Ayush Directorates and well-developed regulatory systems, others continue to regulate Ayush through broader health departments with varying administrative capacities. Similarly, although

the Clinical Establishments (Registration and Regulation) Act, 2010 provides a framework for regulating clinical establishments, its adoption remains uneven across states. Moreover, a large segment of the Ayush services ecosystem, including Yoga centres, Panchakarma centres and therapeutic wellness establishments, falls outside a uniform regulatory framework.

This diversity reflects India's federal structure and should continue to allow states the flexibility to innovate and respond to local needs. However, as India aspires to define itself as a global leader in Traditional Medicine and Ayush-based Wellness services, greater regulatory convergence would help improve consistency in service quality, facilitate investment, strengthen consumer confidence and project a coherent international identity for the Ayush sector.

Greater regulatory convergence would not require uniform legislation across all states. A common set of minimum standards and principles can coexist with state-specific approaches to implementation.

Action Point(s)

The Ministry of Ayush and State Governments may explore greater regulatory convergence within the flexibility provided by India's federal structure. Towards this end:

- **In consultation with State Governments and the National Council for Clinical Establishments,** efforts may focus on wider adoption of uniform minimum standards for Ayush clinical establishments under the Clinical Establishments (Registration and Regulation) Act, 2010, while encouraging states that have not adopted the Act to incorporate equivalent standards within their own regulatory frameworks.
- **A clearer regulatory architecture for Ayush-based Wellness services may be explored in consultation with State Governments, recognising Ayush-based Wellness as an important service category in its own right.** A substantial part of the Ayush wellness ecosystem comprises Yoga centres, spas and resorts offering Ayush-based wellbeing services that may not involve diagnosis, treatment or regular clinical supervision and, therefore, may not fall within the conventional scope of regulation applicable to clinical establishments. At the same time, these establishments form an important and growing part of the Ayush services economy and require an appropriate framework for quality, safety, professional competence, consumer protection and permissible service claims.

- **A national model framework, or the feasibility of a Model Wellness Act, may therefore be examined,** providing a common classification of wellness establishments and distinguishing between general wellness, Ayush-based Wellness and clinically supervised therapeutic wellness according to the nature and purpose of services offered and the level of professional oversight involved. Such a framework could define the scope of services, minimum requirements for personnel, infrastructure, hygiene and safety, permissible health and therapeutic claims, consumer protection, referral arrangements and the circumstances under which clinical supervision or registration under the applicable clinical-establishment framework becomes necessary. Existing quality-assurance mechanisms, particularly the Ayush Quality Mark for Ayush-based Wellness Centres, could complement this regulatory architecture.

Any such framework would need to remain proportionate to the nature and risk profile of the services offered and avoid duplication with existing State, local and quality-certification requirements.

- **Existing national quality initiatives, including the Ayush Quality Mark, BIS standards and other nationally recognised certification systems,** could be aligned or referenced with the above-mentioned regulatory frameworks, wherever appropriate, to promote greater consistency in quality assurance across the country while reducing duplication of compliance requirements.
- **Periodic consultation mechanisms between the Ministry of Ayush and State Governments** could provide a forum to facilitate exchange of best practices, harmonise regulatory approaches and periodically review emerging challenges in the regulation of the rapidly evolving Ayush services sector.

Box 6.6 : Regulatory convergence can take the form of *Sutradhara* - the thread-holder - a model code offering states three independently adoptable threads rather than one all-or-nothing Act, respecting health as a State subject:

Thread	What a state adopts
Accountability Thread	Clear assignment of responsibility within each state for registration, oversight, inspection and grievance redressal relating to Ayush service establishments.
Standards Thread	Use of the notified minimum standards for Ayush clinical establishments under the Clinical Establishments Act, or equivalent standards within state regulatory arrangements.
Wellness Thread	A common reference framework for registration and minimum standards applicable to Ayush-based Wellness and Yoga establishments, adaptable to State regulatory arrangements.

Expected Outcomes

Greater regulatory convergence would improve consistency in service quality across states while preserving the flexibility inherent in India's federal structure. It would reduce regulatory uncertainty for service providers and investors, strengthen consumer confidence, facilitate implementation of national quality standards and enable India to present a more coherent and credible Ayush services framework to domestic and international patients, investors and other stakeholders.



Pillar 3 - Global Competitiveness

Sthānīya → *Pramāṇita* → *Vaiśvika*

Chapter 2 defined the third pillar as Global Competitiveness, built on the concept of *Pramāṇa* (validated and trusted knowledge). It traces a progression from *Sthānīya* establishments serving local and regional markets, to *Pramāṇita* establishments validated through recognised quality-assurance systems and institutional trust, and finally to *Vaiśvika* establishments capable of participating in international markets through e travel, wellness tourism and service exports. The framework makes clear that the path to global markets runs through validated quality. For Ayush establishments, movement from domestic to international markets depends heavily on recognised standards, accreditation and patient trust.

Applying this framework to the findings indicates that India's comparative advantage in Traditional Medicine remains largely *Sthānīya*, anchored in strong regional ecosystems such as Ayurveda in Kerala, Yoga in Uttarakhand and Siddha in Tamil Nadu, but has yet to be consistently converted into *Pramāṇita* credibility and *Vaiśvika* reach. Greater international reach will depend on stronger destination-based service networks and quality systems that are recognised and understood by international patients and partners. The following recommendations set out the changes required to move Ayush establishments along this continuum towards genuine global competitiveness.

Recommendation 7: Developing Ayush MVT Clusters and Ayush-based Wellness Corridors to Promote Services Exports - *Agraga* (An Ayurveda-Led, Multi-System MVT Vanguard)

Rationale

The findings of this study demonstrate that India's comparative advantage in MVT extends beyond Ayush Hospitals or Ayush-based Wellness centres. International patients increasingly seek integrated treatment journeys that combine clinical care, therapeutic wellness, accommodation, tourism, rehabilitation and post-treatment support. Developing geographically integrated clusters can therefore create stronger value propositions than isolated institutions.

The survey also reveals distinct regional specialisations across the country. Kerala has emerged as the leading destination for classical Ayurveda and Panchakarma; Uttarakhand has developed strengths in Yoga and spiritual wellness; Goa and coastal Karnataka combine therapeutic wellness with leisure tourism; while Rajasthan and the Himalayan states offer heritage and nature-based wellness experiences. Rather than

creating entirely new ecosystems, these existing strengths provide a strong foundation for developing internationally recognised Ayush MVT clusters.

Recognising this opportunity, the Union Budget 2026–27 announced the establishment of five Regional Medical Hubs in partnership with State Governments and the private sector. These hubs are envisaged as integrated healthcare complexes comprising modern healthcare facilities, Ayush centres, MVT Facilitation Centres, diagnostics, rehabilitation, education and research infrastructure.

The Government has also introduced important enabling initiatives such as the Ayush Visa, expansion of the Heal in India initiative and greater emphasis on MVT as a priority services export sector. Our survey provides grounds for further recommendation of the development of destination-based Ayurveda MVT Zones integrating accredited providers, transparent pricing, multilingual services and bundled treatment packages.

These initiatives provide an important opportunity to position Ayush not merely as a healthcare offering but as a globally competitive exportable service ecosystem.

Action Point(s)

Integrated Ayush MVT clusters may be developed through coordinated action by the Ministry of Ayush, Ministry of Health and Family Welfare, Ministry of Tourism, Ministry of Commerce & Industry, State Governments and industry. Towards this end:

- **The proposed Regional Medical Hubs could incorporate integrated Ayush MVT ecosystems**, bringing together Ayush hospitals, therapeutic wellness centres, Panchakarma facilities, Yoga institutions, rehabilitation services, accommodation, diagnostics and MVT facilitation services within a single destination. This would create seamless patient journeys while enhancing the overall value proposition for international visitors.
- **State Governments may identify and develop region-specific Ayush clusters based on their comparative strengths**, building upon existing ecosystems such as Ayurveda and Panchakarma in Kerala, Yoga and spiritual wellness in Uttarakhand, Siddha in Tamil Nadu, coastal wellness destinations in Goa and Karnataka, and heritage wellness circuits in Rajasthan and the Himalayan region. Such place-based approaches would strengthen regional branding while avoiding duplication of investments.
- **Ayush Wellness Corridors** may link healthcare services with tourism circuits, cultural heritage, hospitality, local cuisine, medicinal plant gardens and wellness experiences. This would encourage longer patient stays, improve visitor experience and generate wider economic benefits for local communities.
- **Services export promotion initiatives, could give greater visibility to Ayush MVT as a strategic services export sector** and facilitate greater participation of Ayush service providers in international trade promotion, investment promotion, buyer-seller engagements and global branding initiatives. This would strengthen India's presence in the rapidly expanding global wellness and healthcare services market.
- **Integrated treatment packages** may combine pre-arrival teleconsultations, visa facilitation, treatment protocols, accommodation, rehabilitation and post-treatment follow-up, thereby providing international patients with predictable, transparent and end-to-end care pathways.
- **Digital platforms supporting the Heal in India initiative and Ayush Visa may be strengthened** to provide multilingual information on accredited establishments, treatment options, pricing, travel logistics and follow-up care, enabling international patients to access reliable information through a single interface.
- **Cluster development may also involve** participation of MSMEs, Ayush-based Wellness service providers, hospitality enterprises, traditional artisans, medicinal plant cultivators and local communities so that the benefits of MVT extend across the wider services economy.
- **Greater integration of Ayush services within India's ongoing and future trade negotiations may be pursued in coordination with the Department of Commerce.** Building on provisions emerging in recent trade agreements, focus can extend beyond MVT to the full range of services trade opportunities, that includes digitally delivered consultations and Ayush-based Wellness services, commercial establishment of Ayush clinics and Ayush-based Wellness centres overseas, and temporary movement of qualified practitioners. Recognition of professional qualifications, transparent licensing requirements and reduction of avoidable market-access barriers may additionally form part of this engagement.

Box 6.7 : Cluster development can be framed as *Agraga*, the vanguard, formally replicating four cluster model that already work, rather than assigning specialisations administratively:

Cluster model	Proven model	Best-fit hub states
Clinical-Panchakarma	Kerala	Kerala; states building comparable clinical depth
Yoga-Spiritual Wellness	Uttarakhand	Uttarakhand
Leisure-Clinical Combination	Goa, coastal Karnataka	Goa, coastal Karnataka
Luxury Heritage Ayush-based Wellness	Rajasthan, Himachal Pradesh	Rajasthan, Himachal Pradesh

Within this vanguard, Ayurveda is anticipated to be the champion sub-sector, while Unani, Siddha and Homoeopathy retain their own parallel pathways.



Expected Outcomes

Developing integrated Ayush MVT clusters and wellness corridors would strengthen India's competitiveness in the global healthcare and wellness economy by shifting from institution-based promotion to destination-based service ecosystems. It would improve patient experience through integrated care pathways, increase the average duration of stay and expenditure of international visitors, strengthen India's services exports, generate high-quality employment across healthcare, tourism and hospitality sectors, and create globally recognisable regional brands for Ayush. By leveraging the natural strengths of different states while aligning them within a coherent national strategy, India can position itself as the world's leading destination for Traditional Medicine-based MVT. A stronger trade-policy integration would further widen the export opportunities available to Ayush beyond inbound MVT by supporting greater international mobility of practitioners, overseas establishment of Ayush service providers, digitally delivered services and improved access to priority markets.

Recommendation 8: International Readiness for Ayush MVT - *Atirekhā*

Rationale

Quality assurance takes on added importance in MVT. International patients make decisions from a distance, often with limited familiarity with the provider, the system of medicine or the regulatory environment in India. Their experience also moves beyond treatment itself to pre-arrival information, facilitation, communication, payments, accommodation, continuity of care and post-treatment follow-up.

NABH provides accreditation pathways for healthcare establishments, while the SEPC, in partnership with the Association of Healthcare Providers (India) (AHPI), has developed certification schemes for Ayush-based Wellness Centres and MVT Facilitators by adapting internationally recognised standards such as ISO 22525 for MVT and integrating additional requirements under the Ayush Quality Mark Programme. This represents an important step towards harmonising Indian certification systems with international quality benchmarks.

In parallel, India has demonstrated a growing role in international standard-setting through the establishment of ISO/TC 249/SC 2 on Ayurveda and Yoga, with the BIS serving as the secretariat. The committee's mandate extends beyond products to include health and wellness service requirements, rejuvenation procedures and Yoga practices, providing India with a unique opportunity to shape the future international standards governing Traditional Medicine services.



It is important to make better use of these existing mechanisms and address the additional requirements that arise when services are offered to international patients. These include reliable pre-arrival information, language and communication support, transparent service and pricing information, appropriate facilitation, continuity of care, grievance redressal and verifiable quality credentials.

Action Point(s)

Further strengthening of quality assurance for Ayush MVT may build on the Ayush Quality Mark, recognised accreditation and certification systems, and relevant national and international standards. Particular attention may be given to the additional requirements associated with international patient care. Towards this end:

- **Wider adoption of the Ayush Quality Mark and other recognised accreditation or certification systems may be encouraged among establishments and facilitators participating in MVT.** Particular focus could be given to hospitals, therapeutic wellness centres and MVT Facilitators seeking to serve international patients.
- **A common set of MVT-readiness parameters may be identified within or alongside existing quality systems.** These could cover pre-arrival information, communication support, pricing transparency, patient facilitation, emergency arrangements, continuity of care, grievance redressal and post-treatment follow-up.
- **India's engagement with relevant international standard-setting processes may continue through BIS and other competent institutions,** with experience from Ayush MVT informing the development and review of standards relating to traditional-medicine and Ayush-based Wellness services based on the same.
- **Verified information on accreditation, certification and MVT readiness could be made more visible through relevant national digital platforms,** including Heal in India and Ayush-related platforms, helping international patients identify providers and facilitators with recognised quality credentials.
- **International promotion of Ayush MVT may give greater visibility to providers and facilitators holding recognised quality credentials and demonstrating readiness for international patient care.** Coordination with the Ministry of Commerce & Industry and Ministry of Tourism could help connect quality assurance with services-export and destination-promotion initiatives.

Box 6.8: *Atirekhā* provides an illustrative framework for the additional capabilities that become important when an Ayush establishment serves international patients. It complements existing quality and accreditation systems by drawing attention to aspects of service delivery that are particularly relevant to MVT.

Atirekhā dimension

Clinical readiness and safety - Appropriate clinical oversight for the services offered; qualified professionals; documented treatment protocols; emergency and referral arrangements; adverse-event reporting and patient-safety procedures.

Continuity of care - Pre-arrival clinical communication where required, clear treatment planning, discharge information and arrangements for appropriate post-treatment follow-up after the patient returns home.

Demonstrated service capability - Documented experience in delivering the relevant services, with records on patient outcomes, complaints and service quality available for review through applicable quality-assurance mechanisms.

Communication and patient facilitation - Clear information in languages appropriate to target markets; transparent pricing and service information; support for payments, documentation, travel and other facilitation needs relevant to international patients.

Quality, ethics and authenticity- Compliance with recognised quality requirements; appropriate infrastructure; ethical promotion and claims; traceability of therapeutic materials where relevant; and delivery consistent with the principles and standards of the Ayush system concerned.

Expected Outcomes

Greater use of recognised quality systems, together with clearer MVT-readiness requirements, could give international patients better information on the quality and capabilities of Ayush providers and facilitators. It could also improve consistency in areas such as patient communication, transparency, safety, facilitation and continuity of care.

Clearer expectations would make it easier for service providers to prepare for international patients and demonstrate their capabilities to overseas partners,

insurers and facilitators. Over time, closer alignment between quality assurance, international standards, trade agreements and MVT promotion could strengthen confidence in Indian Ayush services in priority international markets.

Pillar 4 - Innovation Dynamics

Anukaraṇa → *Yukti* → *Navonmeṣa*

Chapter 2 described Innovation Dynamics through three stages: *Anukaraṇa*, where established practices are followed; *Yukti*, where they are adapted to changing needs; and *Navonmeṣa*, where new approaches emerge. Applying this lens to the findings shows that much of the Ayush services ecosystem still operates at the *Anukaraṇa* stage, replicating established practices, while emerging digital technologies and artificial intelligence offer a pathway towards *Yukti* and *Navonmeṣa* (adapting service delivery and creating new models for quality assurance, traceability, clinical support, research and international market access). These technologies should augment the knowledge and judgement of qualified Ayush practitioners. The recommendation that follows sets out how the sector can harness innovation to strengthen its competitiveness.

Recommendation 9: Responsible leveraging of Artificial Intelligence and Digital Technologies to Strengthen the Ayush Services Ecosystem - *Prajñā Kauśalya* (Wisdom-in-execution)

Rationale

The survey highlights several challenges across the Ayush services ecosystem that can be effectively addressed through the adoption of emerging digital technologies and artificial intelligence. These include uneven quality assurance, fragmented patient records, limited digital visibility of establishments, inadequate evidence for policymaking, variability in treatment documentation, supply-chain traceability challenges and increasing international expectations regarding quality, transparency and digital service delivery.

At the same time, India's expanding digital public infrastructure, including the Ayush Grid, Ayushman Bharat Digital Mission and related digital health initiatives, provides a strong foundation for integrating innovative technologies within the Ayush ecosystem. There is an opportunity therefore to not only digitise existing processes, but also for harnessing technology to improve service delivery, strengthen research, support practitioners and enhance the international competitiveness of India's Traditional Medicine sector.

Action Point(s)

The use of AI and other digital technologies may be explored in areas where they address clearly identified service, research or regulatory needs.: Towards this end:

- **Artificial intelligence could be integrated within quality assurance systems** to support quality inspections, automate documentation, detect inconsistencies in service delivery, strengthen compliance monitoring and assist in identifying adulteration and quality deviations in medicinal products. This would complement existing quality and accreditation initiatives while improving regulatory efficiency.
- **Digital technologies should be leveraged to strengthen traceability across the Ayush value chain**, including the use of blockchain, QR-based authentication, digital product passports and geospatial technologies to enable end-to-end tracking of medicinal plants, raw materials, formulations and therapeutic products. Such systems would enhance transparency, authenticity and consumer confidence while facilitating compliance with international quality requirements.
- **AI-enabled and validated clinical support tools may be encouraged** to assist practitioners in areas such as Prakriti assessment, clinical documentation, treatment planning, pharmacovigilance, adverse event reporting and



longitudinal patient follow-up. Such tools should be developed with appropriate clinical oversight and serve as decision-support systems that complement professional judgement rather than replace it.

- **Artificial intelligence may be responsibly utilized to strengthen research and evidence generation** by enabling large-scale analysis of clinical outcomes, classical literature, treatment protocols and patient data. This would support real-world evidence generation, facilitate clinical research and strengthen the scientific basis of Ayush interventions.
- **Innovation through greater collaboration between academic institutions, research organisations, technology developers, startups and industry**, may be encouraged, supporting the development of indigenous digital solutions for diagnostics, digital therapeutics, quality management, telehealth and patient engagement tailored to the needs of Traditional Medicine.
- **Digital technologies can be leveraged to improve regulatory compliance and international market access** by developing digital knowledge repositories, regulatory intelligence tools and automated compliance support systems that enable Ayush service providers to better understand country-specific regulatory requirements, certification pathways and international quality standards.
- **Capacity building programmes could be further strengthened** to equip Ayush practitioners and service providers with digital skills required for the effective adoption of emerging technologies, ensuring that innovation is accompanied by appropriate training, ethical safeguards and responsible use of artificial intelligence.

Expected Outcomes

The strategic adoption of artificial intelligence and digital technologies would strengthen quality assurance, improve service delivery, enhance operational efficiency and accelerate evidence generation across the Ayush services ecosystem. It would also improve traceability, support regulatory compliance, facilitate international market access and create new opportunities for innovation-led entrepreneurship. By embedding digital technologies across the value chain, India can strengthen the global competitiveness of its Ayush services sector while positioning itself as a leader in technology-enabled Traditional Medicine.



Part 3 - Implementation Framework

A consolidated view of the recommendations, the institutions responsible, and an indicative phased roadmap to 2047

Summary of Recommendations

Table 6.3: Recommendations with core thrust

No.	Recommendation	Core Thrust
1	Strengthening Therapeutic Wellness as a distinct, clinical segment within the Ayush-based Wellness Economy • <i>Kalyāṇa Kośa and Punarnavā</i>	Develop the therapeutic-Ayush-based Wellness workforce by strengthening relevant education pathways and building on existing HSSC skilling, upskilling and RPL mechanisms to address additional competency needs.
2	Strengthening Data Intelligence for Evidence-Based Policymaking • <i>Nirīkṣaṇa</i>	Strengthen the Ayush data ecosystem through existing digital platforms, build on the NSSO Survey on Ayush for demand-side evidence, and carry out a quinquennial periodic establishment-level data capture on the economic and service dimensions of the sector.
3	Strengthening and Scaling the Ayush Quality Mark as the National Quality Framework for Ayush Services Sector • <i>Navaratna Mānaka</i>	Widen adoption of the Ayush Quality Mark and support establishments of different sizes and levels of maturity through voluntary quality-readiness and self-assessment tools aligned with existing AQM requirements and recognised standards.
4	Strengthening Digital Infrastructure to Enhance Service Delivery and Global Visibility • <i>Dṛśya Setu</i>	Strengthen establishment-level digital infrastructure and online visibility, with closer links to the national digital health ecosystem.
5	Exploring Wider Financial Protection for Evidence-based Therapeutic Wellness and Preventive Ayush Services • <i>Ārogya Sopāna</i>	Progressively extend insurance and financial protection to therapeutic wellness and preventive services, based on clinical need, evidence, defined protocols, provider quality, costs and measurable outcomes..
6	Strengthening Regulatory Harmonisation across the Ayush Services Ecosystem • <i>Sūtradhāra</i>	Promote regulatory convergence through proportionate and non-duplicative frameworks for clinical and wellness establishments, while respecting the federal structure and State-specific regulatory arrangements.
7	Developing Ayush MVT Clusters and Ayush-based Wellness Corridors to Promote Services Exports • <i>Agraga</i>	Strengthen destination-based MVT networks and expand international market access for Ayush services, including through trade agreements and different modes of services delivery.
8	International Readiness for Ayush MVT • <i>Atirekhā</i>	Build on existing quality and certification systems while addressing the additional requirements of international patient care and MVT.
9	Responsible use of Artificial Intelligence and Digital Technologies to Strengthen the Ayush Services Ecosystem • <i>Prajñā Kauśalya</i>	Explore appropriate uses of AI and digital tools for quality assurance, traceability, clinical support, research and market access.

Implementation of Recommendations: A Whole-of-Government Approach

Across the recommendations, the Ministry of Ayush serves as the anchor institution. Delivery, however, depends on coordinated action by other Union ministries, regulators, standards and accreditation bodies and State Governments.

A Whole-of-Government approach would be very critical for the next phase of growth of the Ayush services sector. Workforce development would involve engagement with the skill-development ecosystem. Similarly, digital integration and financial protection would require

coordination with the Ministry of Health and Family Welfare and the National Health Authority. Additionally, MVT would require closer engagement with Tourism and Commerce. Quality, standards and international market access would require continued collaboration with BIS, QCI, AYUSHXCIL and other relevant institutions. States and UTs will remain central to implementation across all these areas.

The following table maps each recommendation to the principal Ministries, departments and other bodies whose participation would be required for each area of intervention.

Table 6.4: Focus areas with lead anchor and supporting Ministries

No.	Focus Area	Lead / Anchor	Supporting Ministries, Regulators & Bodies
1	Therapeutic wellness & workforce	Ministry of Ayush	NCISM, NCH, Apex Institutions of Ayurveda, State Ayush Universities; Ministry of Skill Development & Entrepreneurship, Healthcare Sector Skill Council (HSSC), industry & Ayush-based Wellness providers
2	Data intelligence	Ministry of Ayush	National Sample Survey Office (NSSO), Ministry of Health & Family Welfare, International Institute for Population Sciences (IIPS / NFHS)
3	Quality & accreditation	Ministry of Ayush	Bureau of Indian Standards (BIS), Quality Council of India (QCI), NCISM, NCH, Yoga Certification Board, State Governments, ISO
4	Digital infrastructure	Ministry of Ayush	National Health Authority (ABDM), State Governments (tourism, wellness & health portals)
5	Financial protection	Ministry of Ayush	Ministry of Health & Family Welfare, National Health Authority (AB-PMJAY), IRDAI, insurers & employers
6	Regulatory harmonisation	Ministry of Ayush	State Governments, National Council for Clinical Establishments
7	MVT clusters & corridors	Ministry of Ayush	Ministry of Health & Family Welfare, Ministry of Tourism, Ministry of Commerce & Industry, State Governments; MSMEs & industry
8	MVT quality & certification	Ministry of Ayush	AYUSHXCIL, Services Export Promotion Council (SEPC); AHPI; QCI; BIS (ISO/TC 249/SC 2), NABH, Ministry of Commerce & Industry, Ministry of Tourism
9	AI & digital innovation	Ministry of Ayush	Academic & research institutions, technology developers, startups, industry

Indicative Implementation Roadmap to 2047

The roadmap below sequences the recommendations across three horizons - a near-term foundation phase (by 2030), a scale-up and integration phase (by 2037), and a global-leadership phase (by 2047). The horizons are indicative, intended to structure sequencing and priority rather than to prescribe fixed deadlines.

Table 6.5: Recommendations across three horizons

No.	Recommendation	By 2030 - Foundation	By 2037 - Scale-up	By 2047 - Global Leadership
1	Therapeutic wellness & workforce	Strengthen NCISM/ NCH curricula; develop relevant certificate & diploma programmes; build on existing HSSC skilling, upskilling and RPL pathways	Nationwide competency pathways; industry-linked internships; digital & MVT competencies embedded	Future-ready workforce sustaining India as a global wellness leader
2	Data intelligence	Expand Ayush Grid/ AHMIS to service-sector indicators; design the quinquennial enterprise survey	First quinquennial Ayush service-establishment survey; successive NSSO Surveys on Ayush strengthened; non-duplicative NFHS indicators considered, where relevant	Regular five-yearly survey cycle informing strategic investment decisions
3	Quality & accreditation	Widen Ayush Quality Mark adoption; voluntary quality-readiness support for smaller establishments; strengthen relevant BIS standards	Wider adoption of recognised quality and certification systems across establishment categories; competency standards strengthened	India benchmarking and shaping global traditional-medicine standards
4	Digital infrastructure	Onboard establishments to AHMIS & ABDM; support SME digital presence	Tailored digital platforms by establishment scale; transparency features	Fully digital, globally discoverable Ayush service ecosystem
5	Financial protection	Standardised protocols & reimbursement pathways; pilot models	Selected evidence-based preventive and promotive Ayush interventions considered for wider coverage, including under AB-PMJAY; quality-linked coverage	Evidence-based financial protection progressively extended to appropriate therapeutic, restorative and preventive Ayush services
6	Regulatory harmonisation	Explore model regulatory framework for Ayush-based Wellness; wider adoption of CEA minimum standards or equivalent State standards	Risk-proportionate state frameworks; simplified and non-duplicative compliance; integration with recognised quality systems.	More coherent and credible Ayush services framework across States while preserving State flexibility

No.	Recommendation	By 2030 - Foundation	By 2037 - Scale-up	By 2047 - Global Leadership
7	MVT clusters & corridors	Develop Regional Medical Hubs; identify region-specific clusters	Ayush Wellness Corridors; integrated treatment packages; export recognition	India as the world's leading traditional-medicine MVT destination
8	MVT quality & certification	Widen adoption of Ayush Quality Mark and recognised MVT certification systems; identify additional MVT-readiness parameters	MVT-readiness parameters integrated with existing quality systems; recognised providers given greater visibility in global promotion	Globally recognised quality architecture underpinning MVT growth
9	AI & digital innovation	AI in quality assurance & traceability; digital-skilling of practitioners	AI clinical-support tools; research & evidence generation; startup collaboration	Technology-enabled Traditional Medicine at global competitive frontier

When taken together, the projections in Part 1 and the roadmap in Parts 2–3 present both the scale of the opportunity and the institutional pathway to realise it by positioning the Ayush services sector as a major contributor to healthcare, employment, exports and India's aspiration of becoming a developed nation by 2047.



Annexure I: A Note on the Establishment Categories of the Sector

Definitions, Evolution and Regulatory Landscape

AI.1 Introduction and Scope

This report measures the size of India's Ayush services sector - the value created when the knowledge of the Ayush systems is delivered to people as a service, beyond a packaged product such as medicine. Given the diversity of the sector, the survey classifies establishments according to the principal setting in which Ayush services are delivered. This allows different forms of service delivery to be counted and compared while recognising differences in their purpose, business model, workforce, clientele and regulatory requirements. The survey is built around five establishment categories:

- **Day care centres and clinics** - the primary, outpatient front line of Ayush care;
- **Hospitals** - facilities with beds that admit patients for inpatient treatment;
- **Educational institutes** - colleges and their attached teaching hospitals that train Ayush practitioners;
- **Yoga centres** - establishments that teach and therapeutically apply yoga; and
- **Spas and resorts offering Ayush services** - commercial establishments set within a hospitality or relaxation setting offering high value Ayush experience.

Five Categories

Each category is a distinct type of establishment and the service it delivers

Day care centres & clinics

Outpatient consultation, medicines and short day-care therapies - no overnight stay.

Hospitals

Inpatient care with beds - medical, surgical and para-surgical treatment over a stay.

Educational institutes

Colleges with teaching hospitals that train and qualify the practitioner workforce.

Yoga centres

Teaching and therapeutic application of yoga, with certified instruction.

Spas & resorts offering Ayush services

Wellness, rejuvenation and relaxation set within a hospitality experience.



The same Ayush therapy can appear in any pillar; the setting defines how it is run, paid for and measured.



AI.2 Ayush Day Care Centres and Clinics

AI.2.1 What they are

Ayush clinics and day-care centres are the primary and most accessible unit of Ayush care: an outpatient-focused facility where a person receives consultation, medicines and short therapeutic procedures under one of the Ayush systems, but is not admitted to stay overnight. In regulatory practice this is a broad family. It includes standalone clinics and polyclinics, government dispensaries, and the Ayush units co-located at Primary Health Centres (PHCs) and Community Health Centres (CHCs) - any centre, in other words, that offers Ayush therapies without requiring inpatient admission.¹

These centres provide clinical consultation services along with day care involving classical Ayush therapies and certain Panchakarma procedures (which may be intensive but do not need an overnight stay). The patient comes in, undergoes a supervised procedure, rests, and goes home the same day. This same-day pattern is what defines the category, and it sits between an ordinary outpatient consultation and a full hospital admission.

AI. 2.2 Evolution

The clinic-and-dispensary layer is the oldest and most widespread form of organised Ayush care in India. For decades, government dispensaries were the backbone of public Ayush services, offering free consultation and medicines close to where people lived. After independence, states built dense dispensary networks, and over time the National Ayush Mission (NAM) financed their upgradation and the placement of Ayush units inside mainstream PHCs and CHCs.²

An important recent development has been the Ayushman Arogya Mandir (Ayush) programme - earlier known as Ayush Health & Wellness Centres, under which existing Ayush dispensaries and sub-health centres are being upgraded into Ayush-based wellness-oriented primary care centres. The aim is to shift the everyday clinic from a purely curative dispensary towards a holistic model that also promotes prevention and self-care in the community.³

A second change of this evolution is increasing integration of Ayush services within the wider public health system. Rather than running entirely in parallel to the conventional health system, Ayush units have increasingly been co-located within mainstream PHCs, CHCs and district hospitals, so that a patient can access Ayush options at the same facilities they already visit. This co-location ensured that the dispensary was no longer a standalone facility but part of the primary care network.

On the private side, rising public interest in preventive, lifestyle and chronic-care services has driven a wave of standalone Ayurveda and Panchakarma clinics, as well as branded Ayush-based wellness clinics in towns and cities. In 2019, NABH introduced the Entry Level Ayush Centre standards for smaller clinics and dispensaries for which full hospital accreditation may not be appropriate.⁴

AI. 2.3 Regulatory landscape

No single law governs Ayush clinics on their own. They sit at the meeting point of three things: health-sector regulation, professional registration of the practitioner, and local (municipal) licensing. Where it has been adopted by a state, the Clinical Establishments (Registration and Regulation) Act, 2010 brings clinics under “any recognised system of medicine” within its registration-and-minimum-standards regime.⁵ The practitioner in charge must be registered with the relevant Ayush council or board, and a clinic offering commercial services must also satisfy local trade and health-licensing rules, which vary from city to city.

Beyond mandatory registration, clinics may voluntarily seek the NABH Entry Level Ayush Centre certification, which represents consistent practices in areas such as medicine dispensing, treatment planning and infection control, and helps a centre qualify for insurance tie-ups.⁶

Table AI.1: Key instruments shaping Ayush clinics and day-care centres.

Instrument / Authority	Level	What it does for clinics and day-care centres
Clinical Establishments (Registration and Regulation) Act, 2010	Central (adopted by states)	Brings clinics under any recognised system of medicine into a registration and minimum-standards regime, where the Act is in force.
State clinical / private medical establishment laws	State / UT	Register and regulate clinics in states that have their own legislation in place of, or alongside, the central Act.
NABH Entry Level Ayush Centre Certification	Voluntary (national)	Introductory quality certification tailored to small clinics, polyclinics, dispensaries, PHCs and CHCs offering Ayush therapies.
Ayush council / Board registration	Central / State	Requires the practitioner running the clinic to hold valid registration in the relevant Ayush system.

AI.3 Ayush Hospitals

AI.3.1 What they are

An Ayush hospital is a healthcare facility that provides inpatient services under one of the Ayush systems. It is run by qualified Ayush practitioners, has dedicated therapy sections, and typically operates with a minimum of about five beds, offering medical, surgical or para-surgical treatment.⁷ Hospitals are usually registered through state-level Ayush directorates and regulated under the applicable clinical establishment laws, and they deliver curative, preventive, rehabilitative and wellness-oriented care.

AI.3.2 Evolution

The institutional history of Ayush hospitals reaches back to pre-colonial times, when several princely states - Travancore and Mysore important among them - patronised Ayurveda and Siddha and set up hospitals that mirrored the structure of modern biomedicine facilities. Post-independence, a combination of strong practitioner lineages, cultural demand and educational networks drove the steady expansion of the public Ayush hospital footprint.

The private hospital sector grew on the back of varied market demand viz., wellness, chronic care, elective therapies and medical value travel - and through large brands and college-attached hospitals. Public sector financing has been led by the National Ayush Mission, which supports 10-, 30- and 50-bedded integrated Ayush hospitals and the upgradation of existing facilities.⁸

The growth of corporate participation has also influenced the organisation of Ayush hospital services. This has contributed to the growth of larger inpatient facilities with more formal systems of governance, staffing, clinical protocols, performance monitoring and financial management. Corporate hospitals were also early adopters of accreditation, notably the NABH Ayush Hospitals Accreditation Programme, which they used to build credibility, support insurance partnerships and attract international patients.

Hospitals also support several parts of the wider Ayush services ecosystem. They generate demand for medicines, equipment and trained personnel, provide referral and inpatient services, and have important linkages with wellness and Medical Value Travel.

AI.3.3 Regulatory landscape

At the apex sits the Clinical Establishments (Registration and Regulation) Act, 2010, a central law that provides a statutory basis for registering and regulating establishments offering services in “any recognised system of medicine” - thereby formally bringing Ayush hospitals within its scope wherever the Act has been adopted. It requires registration, compliance with prescribed minimum standards, maintenance of records, emergency stabilisation duties and inspection. As a complement, the Ministry of Health and Family Welfare has notified minimum standards for specific facility types, such as hospitals up to ten beds under the Ayush stream.⁹ Because “Public Health and Hospitals” falls within the State List of the Constitution, many states run their own clinical or private medical establishment laws, several of which explicitly name the recognised

Ayush systems. Notable examples include the Karnataka Private Medical Establishments Act, the Tamil Nadu clinical establishments legislation, and the Delhi Nursing Homes Registration Act. Alongside statutory regulation, the voluntary NABH Ayush Hospitals Accreditation Programme sets benchmarks for patient safety, infection prevention, biomedical waste management and governance.¹⁰

Table AI.2: Principal regulations governing Ayush hospitals in India.

Instrument	Level	Relevance to Ayush hospitals
Clinical Establishments (Registration and Regulation) Act, 2010	Central (adopted by states)	Registration, minimum standards, record-keeping, inspection and emergency duties for hospitals under any recognised system of medicine.
NABH Ayush Hospitals Accreditation Programme	Voluntary (national)	Quality benchmarks for infection control, waste management, patient safety and clinical governance.
Karnataka Private Medical Establishments Act, 2007	State	Explicitly covers Ayurveda, Unani, Siddha, Homoeopathy, Yoga and Naturopathy; sets registration and oversight, including a Director of Ayush.
Tamil Nadu Clinical Establishments (Regulation) Act, 1997	State	Registers and regulates establishments under any recognised system of medicine and constitutes a State Council.
Delhi Nursing Homes Registration Act, 1953	State / UT	Applies to Ayush hospitals that fall within the definition of a nursing home; sets registration and bed-wise fee norms.
J&K norms for Ayush nursing homes / private hospitals	State / UT	Administrative registration and licensing norms specific to Ayush private facilities, including waste-disposal permissions.

Footnote references for the state instruments above: Karnataka¹¹; Tamil Nadu¹²; Delhi¹³; and Jammu & Kashmir

AI.4 Ayush Educational Institutes

AI.4.1 What they are

An Ayush educational institute is a college together with its attached teaching hospital that delivers structured, curriculum-based undergraduate and postgraduate degree and doctoral programmes in the Ayush systems. A defining requirement is the attached hospital: a college cannot train clinicians without a hospital in which students gain supervised clinical exposure.

Educational institutions supply much of the professional workforce employed across the other establishment categories covered by the study.¹⁴

AI.4.2 Evolution

Ayush education has gradually moved from traditional modes of knowledge transmission to a formal system of institutional education and statutory regulation. The decisive step towards central regulation came with the Indian Medicine Central Council Act, 1970, which created the Central Council of Indian Medicine (CCIM) and a pan-India framework for recognising qualifications, prescribing minimum standards and approving new colleges and courses in Ayurveda, Siddha and Unani.¹⁵ Homoeopathy education was governed in a similar way through the Homoeopathy

Central Council Act, 1973 and the Central Council of Homoeopathy (CCH).¹⁶

Governance was further consolidated with the creation of the Department of Indian Systems of Medicine & Homoeopathy in 1995, later renamed the Department of Ayush in 2003, which strengthened the policy framework for education, national institutes and workforce development.¹⁷ As the sector expanded quickly, concerns grew about quality, infrastructure and the accountability of private institutions - setting the stage for major reform.

In 2020, Parliament enacted two landmark laws. The National Commission for Indian System of Medicine (NCISM) Act, 2020 superseded the 1970 Act, dissolved the CCIM and created the NCISM,¹⁸ while the National Commission for Homoeopathy (NCH) Act, 2020 repealed the 1973 Act and created the NCH as the apex regulator for Homoeopathy education.¹⁹ The new regime shifted approval from a one-time, somewhat subjective recommendation towards an objective Minimum Essential Standards backed by continuous assessment and rating. The commissions work through specialised boards - the Board of Ayurveda (BOA); the Board of Unani, Siddha and Sowa-Rigpa (BUSS); the Medical Assessment and Rating Board for Indian Systems of Medicine (MARB-ISM); and the Board of Ethics and Registration for Indian Systems of Medicine (BERISM).

Under the present framework, establishment of a new college involves a staged approval process covering land and infrastructure, the attached teaching hospital, State-level permissions, university affiliation and prior approval from the relevant assessment board. Compliance is subsequently subject to continuing assessment rather than being confined to the point of initial approval.

More recent reforms have reframed the purpose of Ayush education around access to quality and affordable training, the supply of competent professionals, and a community-health perspective - in step with the National Education Policy 2020's emphasis on globally relevant curricula. Initiatives to embed research culture, and the growing role of Ayush in primary care through the Ayushman Arogya Mandirs, have reinforced the move from a purely classical orientation towards demonstrable clinical competence.

AI.4.3 Regulatory landscape

Today, education is regulated by system: the NCISM oversees Ayurveda, Siddha, Unani and Sowa-Rigpa, while the NCH oversees Homoeopathy. Establishing a new college, opening a higher course or increasing student intake is now tied to objective benchmarks and to prior permission from the assessment board, rather than a single approval. The Minimum Essential Standards regulations of 2024 set the requirements for land, built-up space, the attached hospital, faculty and departments, while curriculum regulations such as the 2022 standards modernise course content while preserving classical foundations.²⁰

Quality assurance now combines statutory assessment with independent accreditation. MARB-ISM conducts structured assessment and rating of Ayurveda, Siddha and Unani colleges, and independent third-party accreditation (for example through bodies under the Quality Council of India) provides an additional layer of external quality assurance.²¹



Table AI.3: Regulatory framework for Ayush medical education, by discipline.

Discipline	Regulator	Backbone of the regulatory framework
Ayurveda	NCISM	Minimum Essential Standards, Assessment & Rating Regulations, 2024 (establishment and hospital standards); Minimum Standard of UG Education Regulations, 2022 (curriculum).
Siddha	NCISM	Equivalent NCISM Minimum Essential Standards, Assessment & Rating Regulations, 2024; shared UG education curriculum regulations, 2022.
Unani	NCISM	Equivalent NCISM Minimum Essential Standards, Assessment & Rating Regulations, 2024; shared UG education curriculum regulations, 2022.
Homoeopathy	NCH	Establishment of New Homoeopathic Medical Institution Regulations, 2024; Minimum Essential Standards for Homoeopathic Colleges & Attached Hospitals, 2024; BHMS course regulations, 2022.

AI.5 Yoga Centres

AI.5.1 What they are

A Yoga centre is an establishment whose primary service is the structured teaching and therapeutic application of Yoga - the practice of asana (postures), pranayama (breath regulation), meditation and yoga therapy - delivered to the public through classes, courses or therapy sessions. The category spans a range of forms: urban yoga studios, teacher-training schools, ashrams that offer instruction, and dedicated yoga-therapy or yoga-and-naturopathy centres.

A Yoga centre is distinct from a Yoga retreat or resort. A centre is primarily about teaching and practice - people come to learn or to receive therapy, and usually go home afterwards. A residential retreat or resort, by contrast, packages yoga inside a hospitality and accommodation experience; those establishments are treated under the spas-and-resorts pillar. Within Ayush, Yoga is paired as a formal professional degree program with Naturopathy, and Yoga centres straddle education, Ayush-based wellness and health promotion.

AI.5.2 Evolution

The organisation of Yoga as a formal service has evolved alongside its movement from the traditional guru-shishya and ashram settings towards institutionalised teaching, training and professional practice.

The growing global popularity of Yoga significantly expanded demand for organised Yoga services, reinforced by the International Day of Yoga observed each year since 2015, turned a primary informal activity into a sought-after service at home and abroad. Government institutions such as the Morarji Desai National Institute

of Yoga support training, therapy and research in the field, and efforts to standardise what is taught through a common, widely promoted yoga protocol - helped move the practice towards a consistent, teachable form.²²

An important institutional development was the establishment of the Yoga Certification Board (YCB) in March 2018 under the Ministry of Ayush. The YCB set out to professionalise and standardise a field that had until then been treated as an unorganised career, by certifying Yoga professionals and by accrediting Yoga institutions. This brought, a recognised national benchmark for the quality of teaching and practice.²³

AI.5.3 Regulatory landscape

There is no single statute that regulates Yoga centres as such. Their governance is largely voluntary and standards-based, centred on the Yoga Certification Board. The YCB works along two tracks: it certifies Yoga professionals across a series of levels, ranging from a basic protocol instructor up to yoga therapist and yoga master, and it accredits Yoga institutions, centres, schools and ashrams across four levels, based on their scale, experience and years of operation.²⁴

Where a centre offers clinical Yoga therapy for the management of disease, it may come within the ambit of clinical establishment regulation; where it operates as a commercial business, it is subject to local municipal and trade licensing. Centres that provide broader Ayush-based wellness services may also pursue NABH wellness-centre standards. The regulatory framework therefore continues to rely largely on voluntary certification and accreditation, supplemented by clinical-establishment and local licensing requirements where applicable.

Table AI.4: Instruments shaping the governance of Yoga centres.

Instrument / Authority	Level	Role for yoga centres
Yoga Certification Board (YCB), Ministry of Ayush	Central (voluntary scheme)	Certifies Yoga professionals across multiple levels and accredits yoga institutions, centres, schools and ashrams across four levels.
Clinical establishment laws (central / state)	Central / State	May apply where a centre delivers clinical Yoga therapy for the treatment of disease.
Local municipal and trade licensing	Local	Governs the commercial operation of a centre (premises, trade licence, safety) and varies between cities.
NABH standards for Ayush Treatment and Wellness Centres	Voluntary (national)	Optional quality benchmarks for centres offering broader Ayush-based wellness services.

AI.6 Ayush Spas and Resorts

AI.6.1 What they are

Ayush spas and resorts are commercial Ayush-based wellness establishments that deliver Ayush therapies - most prominently Ayurveda, frequently combined with Yoga and Naturopathy - within a hospitality, beauty or relaxation experience. A spa is broadly understood as a place devoted to wellbeing through professional services that renew mind, body and spirit.²⁵ For the purposes of this study, these establishments broadly fall into two groups:

- **Hotel and day spas** - where Ayurveda treatments such as Abhyanga or Shirodhara form part of a wider spa menu, accessed by hotel guests or by local clientele on a non-residential basis.
- **Ayush-based wellness resorts and retreats** - which offer immersive, often residential, Ayurveda and Yoga programmes, typically with consultation by an Ayurvedic physician, customised plans and on-site stay over several days.

Their distinction from hospitals and clinics lies principally in purpose and setting: spas and resorts that offer Ayush-based services place wellness and hospitality at the centre of the experience, whereas hospitals are organised primarily around clinical care.

AI.6.2 Evolution

From the 1990s onwards, Ayurveda became increasingly associated with India's emerging wellness-tourism market, particularly in Kerala. Kerala, with its deep

Ayurvedic lineage, was the first state to nurture an Ayurveda-based resort industry, and is often called the "Mecca of Ayurveda". Somatheeram, founded in 1985 near Thiruvananthapuram, is among the early examples of a dedicated Ayurveda resort offering hospital-style Ayurveda services within a resort ambience - a model that then spread across Kerala and the rest of the country.²⁶

Operationally, three models emerged: Ayush units embedded within hospitality resorts (where the luxury experience leads and Ayush-based wellness is an amenity); resorts run by Ayurveda institutions (where authentic therapeutic protocols lead, set within comfortable accommodation); and integrated destination retreats (which blend two or more disciplines - Ayurveda, Yoga, Naturopathy, mindfulness, nature immersion - for a holistic effect).

Ayush-based wellness establishments also differ in the intensity and duration of the services they provide. Some cater to visitors seeking longer residential programmes, including multi-day Ayurveda and Panchakarma programmes, while others primarily offer shorter wellness or spa services. The category therefore covers a broad spectrum, ranging from general relaxation and wellbeing to more structured, practitioner-guided therapeutic-wellness programmes.

Growth has been propelled by the worldwide rise of wellness tourism and by policy support. The "Heal in India" agenda, the dedicated e-Ayush visa launched in 2023 for non-surgical Ayurveda, yoga and naturopathy stays,²⁷ and the integration of Ayurveda spas by major luxury hotel chains have all added momentum. In parallel,

urban day spas have expanded rapidly in metropolitan cities, driven by rising incomes, work-related stress and growing Ayush-based wellness awareness. A useful way to read the segment is along a spectrum from holistic Ayush-based wellness (relaxation and rejuvenation) to therapeutic wellness (physician-led, condition-focused programmes).

AI.6.3 Regulatory landscape

There is no single law that governs Ayush spas and resorts. Depending on how an establishment is classified and what it offers, it falls across healthcare, tourism and local-licensing regulation. Where a spa or resort offers clinical services, the Clinical Establishments (Registration & Regulation) Act, 2010 - and the corresponding state clinical establishment laws - can apply in states where they are in force.²⁸

This distinction becomes particularly relevant for regulation. An establishment providing clinically supervised therapeutic services may come within the applicable clinical-establishment framework, depending on the nature of the services and the law in force in the State. An Ayush wellness establishment offering non-clinical Ayush-based services, however, may fall primarily within tourism, municipal, trade and other local regulatory requirements. The result is a regulatory landscape in which establishments operating within the wider Ayush-based wellness segment may be subject to

different requirements depending on the nature of their services and the State in which they operate. the tourism side, the Ministry of Tourism's National Strategy and Roadmap for Medical and Ayush-based wellness Tourism leverages Ayurveda, Yoga and Naturopathy for medical value travel and promotes the accreditation of Ayush-based wellness centres within resorts,²⁹ while the hotel star-classification guidelines provide a voluntary route to recognition for properties seeking tourism incentives.³⁰ Several states define Ayush-based resorts within their tourism policies - Uttarakhand, for instance, creates specific investment categories for Yoga, Ayurveda and Naturopathy resorts.³¹

Quality assurance is also increasingly being addressed through voluntary standards and certification. Existing mechanisms include the NABH Accreditation Standards for Treatment and Wellness Centres, as well as the Ministry of Ayush's Ayush Quality Mark framework.³² At the municipal level, cities regulate operation directly, for example through the Guidelines for Operation of Spa/Massage Centres in Delhi, which define permitted personnel and services and set licensing conditions.³³

Table AI.5: Instruments shaping the governance of Ayush spas and resorts.

Domain	Instrument / Authority	Scope for spas and resorts
Healthcare	Clinical Establishments Act, 2010 and state clinical establishment laws	Apply to spas / resorts that offer clinical services, in states where the relevant law is in force.
Tourism strategy	National Strategy and Roadmap for Medical and Wellness Tourism, 2022	Promotes Ayush for medical value travel and the accreditation of Ayush-based wellness centres within resorts.
Tourism classification	Hotel project approval and star-classification guidelines; state tourism policies	Voluntary recognition and investment categories; some states define Ayush resorts explicitly.
Quality standards	NABH Accreditation Standards for Ayush-based wellness Centres	Voluntary quality, safety and hygiene benchmarks for spas and Ayush-based wellness centres.
Municipal licensing	City-level spa / massage centre guidelines (e.g., Delhi, 2021)	Define permitted personnel and services and set licensing conditions for urban spas.



AI.7 Reading the Five Categories Together

For the purposes of this study, Siddha, Naturopathy, and Sowa-Rigpa are grouped together in the analysis due to their relatively smaller sample sizes and geographic concentration. However, each system retains its distinct identity in the definitional framework above. Taken together, the five categories capture the principal institutional settings through which Ayush services are delivered: clinics and day-care centres for outpatient and same-day care; hospitals for inpatient services; educational institutions for teaching and clinical training; Yoga centres for Yoga instruction and related services; and spas and resorts offering Ayush services within wellness and hospitality settings.

Some features are common to all five categories. The Clinical Establishments (Registration and Regulation) Act, 2010 recurs wherever clinical services are offered, but its reach depends on state adoption. State-level variation is the norm rather than the exception, because public health is constitutionally a state subject. NABH provides voluntary quality benchmarks across hospitals, clinics, Ayush-based wellness centres and (through the YCB) Yoga institutions. Across these categories, regulatory arrangements vary considerably, although voluntary accreditation, certification and standard-setting have become increasingly important alongside statutory requirements. Defining each category by what it is, how it evolved and how it is governed gives the report a consistent lens through which to measure a diverse and fast-growing sector.



Endnotes

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22. Morarji Desai National Institute of Yoga (MDNIY), an autonomous body under the Ministry of Ayush.
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Annexure II: Technical Note - Survey Design and Data Analytical Framework

The methodological approaches described below underpin the empirical analyses presented in Chapters 3 (economic profile), 4 (Medical Value Travel), and 5 (qualitative field evidence).

The Indian knowledge tradition offers a richer and more fitting epistemological foundation. In the *Nyāya Sūtras* of Gotama, knowledge is organised around four *pramāṇas* - valid sources of knowing: *Pratyakṣa* (direct perception), *Anumāna* (inference), *Upamāna* (comparison and analogy), and *Āptopadeśa* (authoritative testimony). The epistemological architecture of this report maps, in a partial but meaningful way, onto this schema. Survey data provides *Pratyakṣa* - direct observation of enterprises as they are. Statistical inference provides *Anumāna* - reasoned conclusions drawn from observed patterns. Comparative analysis with global wellness economies provides *Upamāna*. And the accumulated textual, institutional, and practitioner knowledge of the Ayush tradition itself constitutes a form of *Āptopadeśa* - authoritative testimony - that cannot be reduced to, or replaced by, enterprise survey data.

AII.1 Survey Design: Heterogeneity and Concentration

The survey design addresses a fundamental challenge in enumerating the Ayush services sector. The sector's enterprises are extremely heterogeneous in their concentration - highly clustered in specific states with long traditions of systems yet broadly distributed in others. A single-mode sampling approach would either over-invest in sparse regions to achieve representativeness or under-represent the concentrated high-density states where the sector's economic character is most distinctly

defined.

The Southern region illustrates this challenge most clearly. It is the most mature market for Ayush services in India - not merely the densest but the most institutionally developed, the most internationally connected, and the most economically sophisticated. Kerala is the undisputed leader in Ayurvedic wellness tourism, characterised by a high density of NABH-accredited resorts and hospitals, a deeply embedded panchakarma tradition, and a practitioner pipeline that has been producing qualified Ayurveda physicians for centuries. Tamil Nadu is the hub for Siddha medicine and multi-specialty medical tourism, anchored in Chennai's institutional Siddha hospitals and the classical knowledge base of the Tamil medical tradition. Karnataka, particularly around Bangalore and Mysore, is a major centre for Yoga education and Naturopathy, combining India's technology-led urban professional Ayush-based wellness market with the ashram and teacher-training tradition of Mysore's classical Yoga lineage.

The concentration of economically significant Ayush activity in the South means that a uniform probability sample calibrated to the national enterprise density would produce state-level estimates for Kerala, Tamil Nadu, and Karnataka that are either prohibitively expensive to achieve with adequate precision, or too imprecise to be analytically useful. The dual-track design resolves this by treating high-concentration states as distinct sampling strata that receive wider enumeration, while applying probability sampling elsewhere. The Figure AII.1 details the two-track methodology used to estimate Ayush services sector metrics (revenue, employment, etc.) and the statistical safeguards used to ensure accuracy.



Figure AII.1: Dual Track Primary Survey Architecture

Sampling Strategy: Sample Survey Primary Objective: Generate state-level estimates for the Ayush sector (Revenue, Employment, Service Uptake, etc.).	Methodology: Addressing Small Population Variance Primary Objective: Remaining states utilized sample-based methods to ensure statistical representativeness.
Approach 1: Census (Near-Complete Enumeration) Applied to: Karnataka, Tamil Nadu, and Kerala. Rationale: Permitted by field conditions and high data accessibility. Goal: Capture actual population parameters within the baseline frame.	The Challenge: Small sample sizes lead to high susceptibility to outliers, making means unrepresentative. The Solution: Implementation of Empirical Bayes (Bayesian Shrinkage) to stabilize estimates.
Approach 2: Sample Survey Applied to: All other states. Rationale: Necessary due to resource constraints, geographic spread, or access challenges. Goal: Statistically valid inference to allow for cross-state comparisons.	How it Works: States are not treated as isolated entities. - Observed averages from small samples are “shrunk” toward the global mean (the aggregate average of all states). - This balances specific state data against broader population trends.

AII.2 Bayesian Shrinkage

The dual-track design substantially improves estimation precision relative to a single-mode sample, but it does not fully solve a problem endemic to any survey of a heterogeneous sector distributed across states: the Small Population Variance problem, or small-sample bias.

AII.2.1 The Problem: Small Samples and Noisy Averages

When sample sizes are small, the central tendency statistics computed from them - means, medians, mode in a small-sample state can distort the state-level estimate substantially, producing an apparent state average that does not reflect the true underlying distribution. Large samples, by contrast, smooth out these anomalies: with 60 or 80 observations, a single outlier has limited leverage on the sample mean.

In the context of this survey, the problem manifests most acutely in Track 2 states with small Ayush enterprise populations - states where Siddha or Unani enterprises are sparse, or where the overall enterprise count is low relative to the state's population. If such a state happens to include a single large atypical enterprise in its sample - a well-funded Ayurveda hospital, for instance, in a state without a tradition of hospital-based Ayurveda - the state-level revenue-per-enterprise estimate will be substantially inflated relative to the true average. Reporting that inflated estimate as if it were reliable would produce misleading cross-state comparisons and distorted national aggregates.

Small samples do not merely produce imprecise estimates - they produce systematically biased ones. The direction of the bias is unpredictable: a small sample may overstate or understate the true state average depending on which enterprises happen to fall into it. Bayesian Shrinkage addresses this by anchoring sparse-state estimates to a well-estimated prior.

AII.2.2 The Solution: Bayesian Shrinkage (Empirical Bayes)

Bayesian Shrinkage adjusts state-level estimates by pulling them toward the national average when the state's sample size is small. This prevents a single outlier establishment from distorting the state's estimated revenue or employment figures. The methodological response to the Small Population Variance problem in this report is Bayesian Shrinkage, specifically the empirical Bayes variant, is a well-established and widely used method of addressing small-sample estimation challenges in multi-unit survey contexts. The core idea is conceptually elegant: instead of treating each state's estimate in isolation, which gives full weight to potentially noise-driven outliers, Bayesian Shrinkage pulls (shrinks) the averages of small-sample states toward the grand average of all states, with the degree of shrinkage determined by the reliability of the sample.

The reliability is quantified through a weight w , computed for each state as: $w = n / (n + C)$, where n is the state's sample size and C is a constant equal to the grand average sample size across all states in the survey.

This formula has the following properties that make it statistically principled:

- When n is very small ($n \ll C$): w approaches zero. The state estimate is given little weight and the shrunk estimate is pulled strongly toward the grand mean. The small, unreliable sample is not trusted to speak for the state's true population.
- When n equals C : $w = 0.5$. The state estimate and the grand mean receive equal weight. This represents the inflection point at which the sample is considered moderately reliable.
- When n is large ($n \gg C$): w approaches one. The shrunk estimate converges on the raw sample estimate. The large, reliable sample is trusted to represent the state accurately with minimal adjustment.

The shrunk estimate for any state is then computed as:

$$\text{Shrunk Estimate} = w \times (\text{State Sample Mean}) + (1 - w) \times (\text{Grand Mean})$$

This formula has a clear intuitive interpretation: the shrunk estimate is a weighted average of what the state-specific data say and what the national average says, where the weight assigned to the state-specific data increases with the reliability of that state's sample. States with large, reliable samples retain their own character; states with small, noisy samples are anchored to the national prior.

AII.2.3 Numerical Illustration

Table AII.1 illustrates the mechanics of Bayesian Shrinkage with a stylised example using five hypothetical states with different sample sizes, calibrated to the survey's actual sample size distribution. The constant C is set at 30, representing the grand average sample size in the survey. Revenue per establishment is used as the indicator for illustration, with a grand mean of ₹100 lakh.

Table AII.1: Bayesian Shrinkage: numerical illustration for five hypothetical states ($C = 30$, Grand Mean = ₹100 lakh)

State	Sample n	Constant C	Weight w	Raw Estimate	Shrunk Estimate	Remarks
State A (sparse)	8	30	0.21	₹142L	₹100L	Heavy pull toward grand mean; raw estimate unreliable.
State B (moderate)	20	30	0.4	₹118L	₹107L	Moderate shrinkage; estimate partially corrected.
State C (adequate)	45	30	0.6	₹108L	₹104L	Mild shrinkage; raw estimate mostly trusted.
State D (large)	80	30	0.73	₹96L	₹97L	Minimal shrinkage; large sample speaks for itself.
State E (dense)	120	30	0.8	₹102L	₹102L	Near-zero shrinkage; estimate unchanged by correction.
Grand Mean (μ)	-	-	-	₹100L	₹100L	The prior toward which all sparse-state estimates are pulled.

Note: Illustrative figures only. $C = 30$ represents the grand average sample size across all states. Raw estimates are synthetic; Shrunk Estimates = $w \times \text{Raw} + (1-w) \times \text{Grand Mean}$.

The critical insight from Table All.1 is the differential treatment of different states. State A, with only 8 observations, has a weight of 0.21 - meaning its raw estimate is reduced by nearly 80 per cent toward the grand mean. If State A's raw estimate is ₹142 lakh (an outlier driven by one large enterprise), the shrunk estimate of ₹100 lakh is substantially more defensible as a representation of the state's typical enterprise than the raw figure. State E, with 120 observations, has a weight of 0.80 - its raw estimate of ₹102 lakh is changed only marginally, to ₹102 lakh, because the large sample is trusted to accurately represent the state's enterprise universe.

One caveat about the shrinkage approach is important to acknowledge explicitly: Bayesian Shrinkage is not a magic correction that recovers missing information. It is a principled trade-off - reducing variance (and the risk of outlier-driven distortion) at the cost of introducing a shrinkage bias toward the grand mean. For genuinely

exceptional states - states whose Ayush economy is truly unusual relative to the national average - the shrunk estimate may understate the degree of that exceptionalism. Kerala's extraordinarily high enterprise density and premium revenue profile, for instance, would be slightly smoothed toward the national average by the correction applied to its smallest-sample subsystem cells, even though the underlying reality is genuinely atypical.

The Bayesian Shrinkage approach is the best available methodological response to the Small Population Variance problem - but it is a response, not a solution. The fundamental solution is a larger, more frequent enterprise census. The data investment required to achieve that is the most important methodological recommendation this report can make.



AII.3 Data Sources

AII.3.1 Primary Source: The Enterprise Schedule

The primary data source is the enterprise-level schedule of the dual-track survey, which collects information on: enterprise identity and registration status; principal Ayush subsystem; number and type of workers employed (by gender, employment status, and qualification); gross receipts from services and ancillary product sales; expenditure on intermediate inputs, wages, rent, utilities, and other operating costs; capital assets and investment; digital infrastructure (website, telemedicine, business portal); and the share of receipts attributable to foreign patients.

Access to enterprise-level unit data - as opposed to published tabulations - enables distribution analysis of gross margins, enterprise-level cross-tabulations of formality and revenue, and subsector-by-state breakdowns that illuminate spatial heterogeneity.

AII.3.2 Field Visit Observations and Data Challenges

As part of the study's qualitative validation strategy, field visits and stakeholder consultations were conducted across selected Ayush establishments. These interactions covered a diverse institutional landscape, including Clinics, Day Care centres, Hospitals, Ayush educational institutions, Yoga centres, Spas & Resorts providing Ayush based services. For this study Yoga services as well as Ayush based services offered in Spas and Resorts have been collectively encompassed under a larger Ayush-based wellness segment.

A major challenge encountered during the survey process was the highly heterogeneous nature of the Ayush service ecosystem. Considerable variation existed across establishments in terms of service models, treatment practices, pricing structures, staffing arrangements, record-keeping systems, and levels of formalization. This made it difficult to establish uniform reporting standards across enterprises, particularly when attempting to capture comparable information on revenue streams, employment patterns, patient volumes, and operational expenditures.

The field visits also highlighted the fragmented institutional structure of the sector. Many establishments operated without standardized accounting systems, digital records, or formal business documentation, creating substantial difficulties in obtaining reliable financial and operational data. Smaller clinics and Ayush-based wellness centres frequently relied

on informal bookkeeping practices or cash-based transactions, limiting the precision of reported income and expenditure figures.

Another important challenge was the absence of consistent regulatory and certification frameworks across states and subsectors. Variations in licensing norms, therapy classifications, practitioner credentials, and operational standards complicated the categorization of establishments during survey enumeration. In several cases, respondents themselves were uncertain regarding the formal classification of their institutions within the broader Ayush ecosystem.

Human resource-related issues also affected survey data capture. Several establishments reported shortages of qualified therapists, trained support staff, and formally certified practitioners. At the same time, workforce arrangements were often informal or part-time in nature, making it difficult to accurately classify employment categories, contractual status, and wage structures.

The survey additionally encountered challenges related to the absence of standardized treatment protocols and pricing mechanisms. Significant variation in therapy costs, treatment duration, and service packages across providers reduced comparability across establishments and complicated efforts to construct consistent economic aggregates.

More broadly, the field observations revealed that the Ayush sector is currently experiencing rapid demand expansion - particularly in preventive healthcare, chronic disease management, and wellness-oriented services - while the supporting institutional infrastructure remains unevenly developed. Gaps in regulation, workforce standardization, digitalization, supply-chain management, and quality assurance continue to affect not only sectoral growth, but also the reliability and consistency of establishment-level economic data.

These findings underscore a central methodological challenge of the study: measuring the Ayush economy requires engaging with a service sector that is simultaneously expanding, diversifying, and formalizing, but which still operates through highly uneven institutional and informational systems.



AII.4 Logistic Regression

This note outlines the theoretical framework for identifying the institutional and operational determinants that predict whether an Ayush (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy) establishment successfully attracts foreign patients. Utilizing cross-sectional data from the 2025 fiscal year (FY25), the methodology employs a Binary Logistic Regression (Logit) Model estimated via Maximum Likelihood Estimation (MLE).

AII.4.1 Research Design and Sample Segmentation

To analyze the factors driving medical tourism and foreign patient influx, Ayush establishments are classified into two mutually exclusive, dichotomous groups based on their operational outcomes in FY25:

Treatment Group ($Y = 1$): Ayush hospitals or Ayush-based wellness Centres that reported hosting at least one foreign patient during FY25.

Control Group ($Y = 0$): Ayush hospitals or Ayush-based wellness Centres that reported zero foreign patients during the same fiscal period.

AII.4.2 Mathematical Formulation of the Logit Model

Because the dependent variable (Y_i) is binary, standard Ordinary Least Squares (OLS) regression is inappropriate due to heteroscedasticity and the possibility of predicting probabilities outside the $[0, 1]$ range. Instead, a logistic regression model is constructed.

$$\ln\left(\frac{P_i}{1-P_i}\right) = \alpha + \beta X_i + \varepsilon_i$$

Where:

- $P_i = P_r(Y_i = 1 \vee X_i)$ denotes the conditional probability that establishment i attracts foreign patients,
- $\left(\frac{P_i}{1-P_i}\right)$ represents the **odds ratio** (the probability of success divided by the probability of failure),
- α is the intercept term, and
- β is a vector of parameters ($b_1, b_2, \dots, b_k$) to be estimated.
- X_i is a vector of observable institutional and operational characteristics,

The vector X_i captures critical supply-side drivers of medical tourism, including:

- Accreditation: Dummy variable (e.g., NABH/ certification vs. none).
- Digital Presence: Dummy variable indicating ownership of an official website.
- Market Visibility: Dummy variable indicating whether the center is listed on Generic Business Portals (e.g., Practo, Justdial).
- Operational Capacity: Continuous variable measuring the Average Length of Stay (ALOS) of patients.

AII.4.3 Probability Estimation

By taking the antilogarithm (exponentiating) of the logit equation on both sides, we isolate the cumulative logistic distribution function. This allows us to calculate the conditional probability (P) that a specific Ayush facility will attract foreign patients given its structural attributes ($\mathbf{X} = \mathbf{x}$):

$$P_i(X = x) = \frac{e^{\alpha + \beta x}}{1 + e^{\alpha + \beta x}} = \frac{1}{1 + e^{-(\alpha + \beta x)}}$$

This transformation ensures that the estimated probabilities strictly fall within the mathematically sound boundaries of $0 \leq P \leq 1$.

The parameters are estimated using the Maximum Likelihood Estimation (MLE) procedure. Letting $Y_i \in \{0,1\}$, the likelihood function is specified as:

$$L(\beta) = \prod_{i=1}^N P_i^{Y_i} (1 - P_i)^{(1-Y_i)}$$

The MLE approach yields consistent, asymptotically efficient, and asymptotically normal parameter estimates under standard regularity conditions. It functions by constructing a likelihood function that measures the probability of observing the given sample data as a function of the parameter values. It iteratively solves for parameter estimates that *maximize* this probability, yielding estimators that are asymptotically efficient, consistent, and normally distributed in large samples.

AII.4.4 Statistical Inference and Interpretation

Directionality of Coefficients (β)

The sign of the estimated coefficient (b) dictates the directional movement of the log-odds relative to the independent variable:

$b > 0$: An increase in the value of X (or the presence of attribute X if binary) is associated with an increase in the logit (and thus the probability) of attracting foreign patients.

$b < 0$: An increase in X is associated with a decrease in the logit of attracting foreign patients.

Hypothesis Testing

To evaluate the statistical relevance of the predictors, we apply inferential framework testing: Null Hypothesis (H_0): $\beta_i = 0$. There is no linear relationship between the operational characteristic X_i and the logit of Y in the population.

Alternative Hypothesis (H_0): $\beta_i \neq 0$. A significant linear relationship exists.

Conclusion Criterion: If the empirical p-value associated with the Wald statistic (or Likelihood Ratio test) is below the chosen significance threshold (e.g., $\alpha = 0.05$), the null hypothesis is rejected. This confirms that the specific institutional characteristic (such as digital presence or accreditation) is a statistically significant predictor of an Ayush establishment capacity to attract global healthcare consumers.

AII.5 Qualitative Methods

AII.5.1 Research Design and Approach

The qualitative case study design, consistent with Yin's (2014) canonical framework for case-based inquiry, used in the study investigates a contemporary phenomenon - the operational and governance landscape of Ayush service delivery - within its real-world context, in situations where the boundaries between phenomenon and context are not sharply delineated. The epistemological commitment is interpretivist, recognising that practitioner experiences and institutional actors' perceptions constitute analytically valid and substantively important forms of knowledge.

Thematic analysis (TA) was selected as the primary analytical method. Following Braun and Clarke's (2006) reflexive TA framework, the process involved iterative familiarisation with field notes and observation records, generation of initial codes, organisation of codes into candidate themes, review and refinement of themes against the data corpus, and final definition and naming. The analysis is primarily inductive - themes emerged from the data - though sensitised by the theoretical concerns of the broader study, particularly the relationship between institutional frameworks, supply chain dynamics, and service quality.

AII.5.2 Data Collection

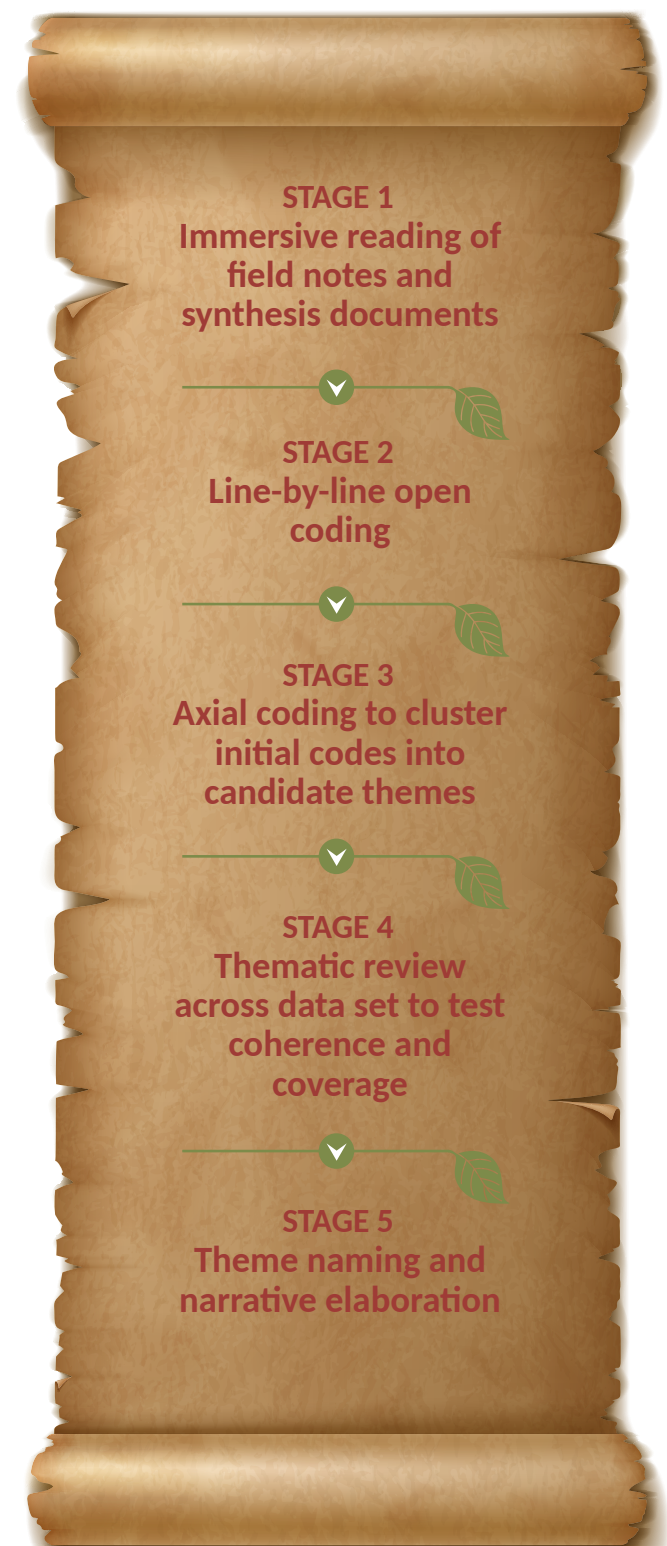
Primary data were collected through two principal instruments. First, structured field observations were conducted at each facility, documenting physical infrastructure, patient flow, staffing arrangements, medicine storage and dispensing, signage, and operational practices. Second, semi-structured key informant interviews (KIIs) and informal conversations were held with facility administrators, treating practitioners, and where possible, support staff. Informants were encouraged to elaborate on challenges, operational adaptations, and their assessments of the regulatory and policy environment.

Field notes were compiled immediately following each visit. No audio recording was used; instead, detailed contemporaneous notes were maintained. The observation and interview data were subsequently systematised into a structured synthesis document that forms the primary data corpus for the present chapter.

AII.5.3 Analytical Procedure

Thematic analysis proceeded in five stages:

Figure AII.2: Stages of Thematic Analysis



The Thematic Analysis exercise identified four overarching themes: (i) regulatory deficit and quality governance; (ii) supply chain fragility and cost pressure; (iii) human resource constraints and skill ecosystem gaps; and (iv) demand-side barriers and integration with mainstream healthcare.

Interested readers can access the data collection tool used for the field study at the following link - <https://fitm.ris.org.in/sites/fitm.ris.org.in/files/Publication/Field-Survey-Questionnaire.pdf>

Annexure III: Glossary of Sanskrit Terms

This glossary lists every Sanskrit term used in this report, its meaning, where it appears, and the context of its use. Terms are given in their correct IAST form; the transliteration convention followed is set out in the Note on Transliteration and Diacritical Marks in the front matter.

Pillar 1 - Knowledge Value Chain

Term	Meaning	Where it appears	Context of use
<i>Jñāna</i>	Knowledge foundations: educational institutions, research organisations, traditional-knowledge repositories, regulatory frameworks.	Ch. 2, 5, 6	<i>First stage of the knowledge value chain.</i>
<i>Vijñāna</i>	Application of knowledge through service delivery: clinics, hospitals, Ayush-based wellness centres, teleconsultation, education.	Ch. 2, 6	<i>Second stage of the same chain.</i>
<i>Lokasaṅgraha</i>	Broader societal outcomes: health improvements, employment, entrepreneurship, wellness tourism, medical value travel.	Ch. 2, 6	<i>Third stage of the same chain.</i>

Pillar 2 - Enterprise Capability Continuum

Term	Meaning	Where it appears	Context of use
<i>Prārambha</i>	Establishments with basic organisational capacity and limited institutional infrastructure.	Ch. 2, 3, 5, 6	<i>First stage of the capability continuum.</i>
<i>Vikāsa</i>	Developing establishments where more formal management, digital and quality systems begin to emerge.	Ch. 2, 3, 5, 6	<i>Second (middle) stage.</i>
<i>Utkarṣa</i>	Advanced establishments: higher organisational capability, accreditation, integration and service sophistication.	Ch. 2, 3, 5, 6	<i>Third (advanced) stage.</i>

Pillar 3 - Global Competitiveness Continuum

Term	Meaning	Where it appears	Context of use
<i>Pramāṇa</i>	Validated and trusted knowledge - the organising concept underlying this pillar.	Ch. 2, 6	<i>Governing concept of the pillar.</i>
<i>Sthānīya</i>	Establishments serving local or regional markets.	Ch. 2, 3, 4, 6	<i>First stage of the competitiveness continuum.</i>
<i>Pramāṇita</i>	Establishments validated through recognised quality-assurance systems and institutional trust.	Ch. 2, 3, 4, 6	<i>Second (middle) stage.</i>
<i>Vaiśvika</i>	Establishments capable of participating in international markets through medical value travel, wellness tourism, cross-border partnerships and service exports.	Ch. 2, 3, 4, 6	<i>Third (global) stage.</i>

Pillar 4 - Innovation Dynamics

Term	Meaning	Where it appears	Context of use
<i>Anukaraṇa</i>	Establishments that replicate existing practices.	Ch. 2, 6	<i>First stage of the innovation continuum.</i>
<i>Yukti</i>	The thoughtful, context-sensitive application of knowledge; establishments that adapt and improve existing approaches.	Ch. 2, 6	<i>Middle stage and organising concept of the pillar. Carries no diacritics in IAST.</i>
<i>Navonmeṣa</i>	Establishments contributing new service models, protocols or institutional practices.	Ch. 2, 6	<i>Third (innovation) stage.</i>

The nine Sanskrit-named recommendations (Chapter 6)

Term	Meaning	Where it appears	Context of use
<i>Kalyāṇa Kośa & Punarnavā</i>	Recommendation 1 - strengthening therapeutic wellness as a distinct clinical segment through education, skilling and workforce development.	Exec. Summary; Ch. 6	<i>Box 6.1. Kalyāṇa Kośa names the education stream; Punarnavā (“renewal”) the upskilling bridge. Kalyāṇa recurs as the fourth step of Ārogya Sopāna.</i>
<i>Nirīkṣaṇa</i>	Recommendation 2 - a National Ayush Services Intelligence System for evidence-based policymaking.	Exec. Summary; Ch. 6	<i>Recommendation 2 heading and Box 6.2.</i>
<i>Navaratna Mānaka</i>	Recommendation 3 - a nine-gem voluntary quality-readiness and self-assessment framework aligned with the Ayush Quality Mark.	Exec. Summary; Ch. 6	<i>Recommendation 3 heading and Box 6.3.</i>
<i>Dr̥śya Setu</i>	Recommendation 4 - “the bridge of visibility”; strengthening establishment-level digital infrastructure and online discoverability.	Exec. Summary; Ch. 6	<i>Recommendation 4 heading and Box 6.4.</i>
<i>Ārogya Sopāna</i>	Recommendation 5 - a graded pathway for extending financial protection to evidence-based therapeutic wellness and preventive services.	Exec. Summary; Ch. 6	<i>Recommendation 5 heading and Box 6.5.</i>
<i>Sūtradhāra</i>	Recommendation 6 - “a threaded route to regulatory convergence”; harmonisation across the Ayush services ecosystem.	Exec. Summary; Ch. 6	<i>Recommendation 6 heading and Box 6.6.</i>
<i>Agraga</i>	Recommendation 7 - “the vanguard”; developing Ayush MVT clusters and wellness corridors to promote services exports.	Exec. Summary; Ch. 6	<i>Recommendation 7 heading and Box 6.7. Carries no diacritics in IAST.</i>
<i>Atirekhā</i>	Recommendation 8 - international readiness of Ayush MVT providers and facilitators.	Exec. Summary; Ch. 6	<i>Recommendation 8 heading and Box 6.8.</i>
<i>Prajñā Kauśalya</i>	Recommendation 9 - “wisdom-in-execution”; responsible use of artificial intelligence and digital technologies.	Exec. Summary; Ch. 6	<i>Recommendation 9 heading.</i>

Sub-components of Dr̥śya Setu (Recommendation 4)

Term	Meaning	Where it appears	Context of use
<i>Setu Mūla</i>	Basic Digital Track - clinics and small domestic-facing day-care centres reached through subsidised clinic software and a verifiable national listing.	Ch. 6	<i>First of three tracks in Box 6.4.</i>
<i>Setu Viśva</i>	International Visibility Track - hospitals and MVT-facing establishments with multilingual websites, package pricing, direct booking and telemedicine.	Ch. 6	<i>Second track.</i>
<i>Setu Saṃyoga</i>	Tourism and Wellness Integration Track - package-based booking integrated with hospitality and tourism discovery channels.	Ch. 6	<i>Third track.</i>

The nine gem-standards of Navaratna Mānaka (Recommendation 3)

Term	Meaning	Where it appears	Context of use
<i>Gomedaka</i>	Compliance with applicable legal and regulatory requirements, infrastructure and essential facility requirements.	Ch. 6	<i>Box 6.3. Carries no diacritics in IAST.</i>
<i>Pravāla</i>	Hygiene, sanitation and infection prevention.	Ch. 6	<i>Box 6.3.</i>
<i>Vaidūrya</i>	Practitioner and therapist competency, documentation and adherence to recognised service protocols.	Ch. 6	<i>Box 6.3.</i>
<i>Muktā</i>	Environmental sustainability, waste management and sustainable use of resources.	Ch. 6	<i>Box 6.3.</i>
<i>Puṣyarāga</i>	Nutrition, lifestyle counselling and holistic Ayush-based Wellness programme design.	Ch. 6	<i>Box 6.3.</i>
<i>Māṇikya</i>	Digital readiness, booking and information transparency, health-record management and data protection.	Ch. 6	<i>Box 6.3.</i>
<i>Marakata</i>	Patient safety, emergency preparedness and referral systems.	Ch. 6	<i>Box 6.3. Carries no diacritics in IAST.</i>
<i>Indranīla</i>	Informed consent, grievance redressal and consumer protection.	Ch. 6	<i>Box 6.3.</i>
<i>Vajra</i>	Consistency, quality and authenticity of traditional practice.	Ch. 6	<i>Box 6.3. Carries no diacritics in IAST.</i>

The four steps of *Ārogya Sopāna* (Recommendation 5)

Term	Meaning	Where it appears	Context of use
<i>Cikitsā</i>	Curative - clinically indicated treatment for a diagnosed condition, delivered in an appropriate clinical setting.	Ch. 6	<i>First step in Box 6.5.</i>
<i>Saṅjīvanī</i>	Restorative - physician-prescribed rehabilitation and chronic-disease management, including day-care delivery.	Ch. 6	<i>Second step.</i>
<i>Rakṣā</i>	Preventive - structured, protocol-based preventive care for at-risk individuals not yet diagnosed.	Ch. 6	<i>Third step.</i>
<i>Kalyāṇa</i>	Promotive - services directed towards wellbeing, relaxation, fitness or lifestyle enhancement without a defined clinical indication.	Ch. 6	<i>Fourth step. Same word as in Kalyāṇa Kośa, used here in a distinct sense.</i>

Epistemological vocabulary (*Nyāya Sūtras* of Gotama)

Term	Meaning	Where it appears	Context of use
<i>Nyāya Sūtras</i>	Classical Indian logical and epistemological text of Gotama, providing the report's methodological frame.	Annexure II	<i>Opening of the Technical Note.</i>
<i>Pramāṇas</i>	Valid sources or means of knowing (plural), per Nyāya epistemology.	Annexure II	<i>Governing term for the four items below.</i>
<i>Pratyakṣa</i>	Direct perception.	Annexure II	<i>Mapped to primary survey data.</i>
<i>Anumāna</i>	Inference.	Annexure II	<i>Mapped to statistical inference.</i>
<i>Upamāna</i>	Comparison and analogy.	Annexure II	<i>Mapped to comparative analysis with global wellness economies.</i>
<i>āptopadeśa</i>	Authoritative testimony.	Annexure II	<i>Mapped to the accumulated textual, institutional and practitioner knowledge of the Ayush tradition.</i>

Classical texts cited in the chapter epigraphs

Term	Meaning	Where it appears	Context of use
<i>subhāṣita</i>	A classical Sanskrit aphorism or well-turned verse.	Ch. 1 epigraph	<i>Describes the genre of the opening verse.</i>
<i>Viṣṇusahasranāma</i>	The thousand names of Vishnu; a recitation tradition through which the Chapter 1 verse is transmitted.	Ch. 1 epigraph	<i>Cited alongside the Dhanvantarī-stotra.</i>

Term	Meaning	Where it appears	Context of use
<i>Bhāvaprakāśa</i>	A classical Ayurvedic compendium; source of the Chapter 3 epigraph.	Ch. 3 epigraph	<i>Cited with Pūrvakhaṇḍa, Miśra-prakaraṇa, verse 32.</i>
<i>Pūrvakhaṇḍa</i>	The first major division of the Bhāvaprakāśa.	Ch. 3 epigraph	<i>Part of the Chapter 3 citation.</i>
<i>Miśra-prakaraṇa</i>	A section within the Pūrvakhaṇḍa.	Ch. 3 epigraph	<i>Part of the Chapter 3 citation.</i>
<i>Mahopaniṣad</i>	The Upanishad from which the vasudhaiva kutumbakam verse of the Chapter 4 epigraph is drawn.	Ch. 4 epigraph	<i>Cited with Chapter VI, verse 71.</i>
<i>Aṣṭāṅgahṛdaya</i>	Vāgbhaṭa's classical Ayurvedic treatise; source of the Chapter 5 epigraph.	Ch. 5 epigraph	<i>Cited with Uttaraśthāna, verse 77.</i>
<i>Uttaraśthāna</i>	The final section of the Aṣṭāṅgahṛdaya.	Ch. 5 epigraph	<i>Part of the Chapter 5 citation.</i>
<i>Bṛhadāraṇyaka Upaniṣad</i>	One of the principal Upaniṣads; source of the Chapter 6 epigraph.	Ch. 6 epigraph	<i>Part of the Chapter 6 citation.</i>
<i>Dhanvantaristotra</i>	A devotional hymn associated with Dhanvantari; one of the recitation traditions through which the Chapter 1 verse is transmitted.	Ch. 1 epigraph	<i>Cited alongside the extended Viṣṇusahasranāma recitation tradition.</i>

Yoga-practice terms

Term	Meaning	Where it appears	Context of use
<i>āsana</i>	Physical posture; a component of Yoga practice.	Ch. 1; Annexure I	<i>Box 1.1 and the definition of a Yoga centre.</i>
<i>prāṇāyāma</i>	Breath regulation; a component of Yoga practice.	Ch. 1; Annexure I	<i>Same contexts as above.</i>





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RIS specialises in issues related to international economic development, trade, investment and technology. It is envisioned as a forum for fostering effective policy dialogue and capacity-building among developing countries on global and regional economic issues. The focus of the work programme of RIS is to promote South-South Cooperation and collaborate with developing countries in multilateral negotiations in various forums. Through its following centres/forums, RIS promotes policy dialogue and coherence on regional and international economic issues.



The word “DAKSHIN” (दक्षिण) is of Sanskrit origin, meaning “South.” The Hon’ble Prime Minister of India, Shri Narendra Modi, inaugurated DAKSHIN – Global South Centre of Excellence in November 2023. The initiative was inspired by the deliberations of Global South leaders during the Voice of the Global South Summits. DAKSHIN stands for Development and Knowledge Sharing Initiative. Hosted at the RIS, DAKSHIN has established linkages with leading think tanks and universities across the Global South and is building a dynamic network of scholars working on Global South issues.



AIC at RIS has been working to strengthen India’s strategic partnership with ASEAN in its realisation of the ASEAN Community. AIC at RIS undertakes research, policy advocacy and regular networking activities with relevant organisations and think-tanks in India and ASEAN countries, with the aim of providing policy inputs, up-to-date information, data resources and sustained interaction, for strengthening ASEAN-India partnership.



CMEC has been established at RIS under the aegis of the Ministry of Ports, Shipping and Waterways (MoPS&W), Government of India. CMEC is a collaboration between RIS and Indian Ports Association (IPA). It has been mandated to act as an advisory/technological arm of MoPSW to provide the analytical support on policies and their implementation.



FITM is a joint initiative by the Ministry of Ayush and RIS. It has been established with the objective of undertaking policy research on economy, intellectual property rights (IPRs) trade, sustainability and international cooperation in traditional medicines. FITM provides analytical support to the Ministry of Ayush on policy and strategy responses on emerging national and global developments.



BEF aims to serve as a dedicated platform for fostering dialogue on promoting the concept in the Indian Ocean and other regions. The forum focuses on conducting studies on the potential, prospects and challenges of blue economy; providing regular inputs to practitioners in the government and the private sectors; and promoting advocacy for its smooth adoption in national economic policies.



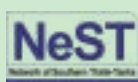
FIDC, has been engaged in exploring nuances of India’s development cooperation programme, keeping in view the wider perspective of South-South Cooperation in the backdrop of international development cooperation scenario. It is a tripartite initiative of the Development Partnership Administration (DPA) of the Ministry of External Affairs, Government of India, academia and civil society organisations.



FISD aims to harness the full potential and synergy between science and technology, diplomacy, foreign policy and development cooperation in order to meet India’s development and security needs. It is also engaged in strengthening India’s engagement with the international system and on key global issues involving science and technology.



As part of its work programme, RIS has been deeply involved in strengthening economic integration in the South Asia region. In this context, the role of the South Asia Centre for Policy Studies (SACEPS) is very important. SACEPS is a network organisation engaged in addressing regional issues of common concerns in South Asia.



Knowledge generated endogenously among the Southern partners can help in consolidation of stronger common issues at different global policy fora. The purpose of NeST is to provide a global platform for Southern Think-Tanks for collaboratively generating, systematising, consolidating and sharing knowledge on South South Cooperation approaches for international development.

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