

Strategic Management of Health Tourism in India: Opportunities and Challenges in Telangana

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Abstract:

Medical tourism is a strategic growth sector in India, with foreign visitors for treatment in 2025 at 507,244, and the market is expected to grow from USD 8.7 billion to USD 16.2 billion by 2030. With Hyderabad's recognized hospitals and exemplary aviation connectivity, Telangana, with its vision of creating a regional hub under the Telangana Tourism Policy 2025-30, has set its sights on becoming a regional hub. The study is qualitative with a secondary data design, and combines data on arrivals from the Bureau of Immigration presented in tables in the Lok Sabha, government and press releases, policy documents, and studies. The analysis is based on resource-based, value-chain, and stakeholder viewpoints, SWOT analysis, and comparison with Thailand, Türkiye, and Singapore. The findings reveal that the number of arrivals in India has returned to approximately 92 per cent of 2019 levels, but that the majority came from a single country – Bangladesh, which accounted for some three quarters of the total in 2024. The strengths of Telangana are clinical depth, affordability, and ecosystem integration, while weaknesses include fragmented facilitation, limited data at the state level, limited insurance portability, and lack of regulation of intermediaries. The paper suggests a multi-pillar strategic approach, including the following pillars: governance, quality assurance, market diversification, patient journey integration, and data-driven monitoring, and identifies the corresponding actions and performance indicators, which are broken down into phases. It states that the real difference between potential and advantage will be made by institutional co-ordination, rather than by building materially.

Keywords: medical value travel; health tourism; strategic management; Telangana; Hyderabad; Heal in India; destination competitiveness.

1. Introduction

Medical value travel (MVT) is now a well-established export industry, rather than a niche activity. The Government of India places the global MVT market at about USD 115.6 billion in 2022, rising to roughly USD 286.1 billion by 2030, and estimates India's own market at USD 8.7 billion in 2025 and USD 16.2 billion by 2030 (Indo-Asian News Service [IANS], 2026; Press Information Bureau [PIB], 2026). According to the PIB, India attracted 9.15 million foreign tourist arrivals (FTAs) in 2025, of which 507,244 were for medical treatment, accounting for approximately 5.5 percent of the total. India

is the 10th ranked country in the top 46 countries list of the Medical Tourism Index 2020-21 (IANS, 2026).

Health tourism is a broader concept than surgery abroad. In the light of this national framing, this paper considers it as two connected pillars: curative medical tourism and wellness tourism based on the AYUSH systems, like yoga and Ayurveda (PIB, 2026). Here, the focus is on the first, with an understanding that medical and wellness tourism is covered under the policy of Telangana.

Why Telangana? Development and promotion of tourist destinations, including medical tourism, is a primary responsibility of the State and Union Territory governments with the Ministry of Tourism complementing their efforts (Ministry of Tourism 2025). States, therefore, assume the responsibility of creating a national branding initiative like the 'Heal in India' initiative into a destination-level strategy. Telangana is a case of significance. According to officials, 89 hospitals in Hyderabad are accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and eight hospitals are accredited by Joint Commission International (JCI) making the city one of the top three MVT hospitals in the country (Siasat Daily, 2026a, 2026b). In March 2025, the state introduced a Tourism Policy for 2025–2030 that promises ₹15,000 crore of investment and three lakh jobs (United News of India [UNI], 2025). On 9 October 2026, the Chief Secretary issued instructions to the officials to draw up a strategic action plan to boost medical and wellness tourism (Siasat Daily, 2026b).

But an aspiration isn't a strategy. Official statements emphasize clinical quality and cost, but very little is said about the sequencing of investments, intermediaries, diversified source markets, and measures of results for the state. The data on arrivals is not released state-wise, and hence it is difficult to assess Telangana's performance against similar numbers in other states. The big public numbers are the government's projection to have just over 75,000 foreign patients in Telangana in 2014, and an estimate by the industry that the international patient market in Hyderabad is valued at ₹500 crore (The South First, 2025).

The present paper fills this gap. The goal of the study is to (a) describe the structure and the recent trend of the health tourism sector in India, (b) map the assets, policies and institutions in Telangana, (c) perform SWOT analysis and benchmarking in comparison to Thailand, Türkiye and Singapore, (d) identify the main problems and challenges, and (e) develop a strategic management framework with actions and indicators. The key point here is that the centre's argument is not a theoretical one that merely stands to reason, but an empirical one that relies on Telangana's governance and market decisions, rather than on its capacity to add more hospitals.

The paper is organized as follows. The literature review and conceptual frame are presented in Section 2. The method is explained in Section 3. The national evidence is presented in Section 4 and Telangana evidence in Section 5. Section 6 discusses the strategic position, Section 7 looks at challenges, Section 8 outlines the framework and Section 9 concludes.

2. Literature Review and Conceptual Framework

2.1 Medical tourism as an export service

In early scholarship, medical tourism is viewed as a product of globalisation, whereby patients from high-cost/high-capacity systems look for treatment in low-cost systems (Connell, 2006; Turner, 2007). Heung et al. (2010) proposed a conceptual model that represents the interaction between the traveller's motivation, the destination attributes and the service process, and claimed that destinations need to be

managed simultaneously from a clinical and a hospitality perspective. According to a scoping review by OECD, the global estimates of the number of travellers were very broad ranging from approximately 60000 to 50 million, and cardiac surgery was identified as one area in which India excelled (Lunt et al., 2011). As mentioned, it was later found that medical travel does not only occur based on price but also through networks, language, and historical connections (Hanefeld et al., 2015). This is why India's imports come mostly from adjoining and related markets.

Indian literature emphasises both promise and trade-offs. Chanda (2013) placed Indian medical value travel in a context of the medical system characterized by relatively low public spending and high unmet domestic demand for hospital beds, thus posing questions of justice in redirecting this capacity. Johnston et al. (2010) found that the evidence base concerning the impacts of medical tourism on destination and departure countries is limited, especially when it comes to impacts on the access of local citizens to medical services. Later, it was observed that experienced workers migrate to private premises providing services to rich domestic or foreign clients, and that public health premises are understaffed (Arora, 2025).

2.2 Strategic management lenses

There are three developed lenses through which the analysis is conducted. The resource-based view is based on the premise that sustained advantage is gained by resources that are valuable, rare, hard to imitate, and well organised (Barney, 1991). In the case of Telangana, these are the clustering of accredited hospitals, specialist clinicians, and a cluster of health, hospitality and aviation services that it will be hard for other regions to replicate in a short span of time.

The value chain (Porter, 1985) breaks down value-creating activities. Patient inquiry and tele-consultation, visa and travel, treatment, recovery, and follow-up are the main activities, and support activities are accreditation, finance, technology, and workforce in health tourism. If any of its links is weak, including unreliable visa facilitation or lack of follow up care, then the value generated at the clinical core can be undermined.

Stakeholder theory (Freeman, 1984) focuses on the numerous stakeholders whose cooperation makes a difference: airlines, hotels, regulators, insurers, hospitals, facilitators, and the source country governments, as well as domestic patients whose access should not be affected. The core resources, supporting factors, destination management and policy and planning are all fundamentally related to destination performance, as outlined in destination competitiveness research (Ritchie & Crouch, 2003).

2.3 Conceptual framework

These lenses produce an analytic frame of four parts when combined. Resources and capabilities question: What does Telangana have? Positioning and markets question: whom and where they compete. How does the patient journey is delivered is a question asked by value-chain integration. In governance and learning, the question is: who coordinates, regulates and measures? The parts are based on the pillars of the strategic framework proposed in section 8.

3. Methodology

The study is qualitative and descriptive, totally secondary with simple quantitative description of arrival series. Four sources were used, in groups. First, governmental parliamentary replies (Lok Sabha

Unstarred Question 4136 of 18 August 2025), which outline the data available for the Bureau of Immigration for FTAs for medical purposes from 2019 to 2024 and the first four months of 2025 (Ministry of Tourism, 2025), and the Press Information Bureau's backgrounder (PIB, 2026) for 2026. Second, the announcements made by the Telangana government and reporting by news agencies and Hyderabad dailies in 2024, 2025, and 2026. Third, a policy brief by the Centre for Economic and Social Studies (CESS, 2023) titled 'International patients in Hyderabad '. Fourth, literature from and peer-reviewed articles from medical tourism institutions and literature.

Four steps were taken to carry out the analysis. Shares and growth rates were computed from the published figures. The evidence of assets, constraints, and policy signals was used to create a SWOT matrix. Three countries were used for benchmarking in this study: Telangana, Thailand, and Türkiye, Singapore. Lastly, the value chain was mapped with identified gaps to get the strategic framework.

Five limitations apply. The Telangana state level series of i) Bureau of Immigration does not exist and some patients enter into the state under other visa categories (CESS, 2023). (ii) There are inconsistencies in the definitions used by both official and press statements: while an October 2026 official report states that there are eight NABH and eight JCI hospitals, a February 2026 report claims there are more than 50 hospitals with NABH or JCI accreditation. (iii) The cost benchmarks have been compiled from 2007-08 and from trade websites, so are dated. In the Lok Sabha table, the values for Somalia and Uzbekistan are the same in 2020 and in 2021, indicating possible transcription errors; thus, the cells are treated with caution. (v) There was no initial survey. The findings are a strategic assessment, NOT a causal test.

4. Women's health tourism

4.1 Market size and positioning

According to the government, the market for MVT in India is projected to grow to USD 8.7 billion by 2025 and USD 16.2 billion by 2030 (IANS, 2026). There are also big variations in other estimates. According to trade press, the market had reached USD 6 billion in 2022, though there are conflicting reports of the market size, and a report on Telangana indicated that the market would reach USD 20.4 billion by 2026 and USD 25 to 28 billion by 2030 (BW Healthcare World, n.d.). It is therefore advisable for planners to make use of arrival numbers in immigration records, rather than values, when making decisions on headline values.

4.2 Arrivals trend

The figures are from the Bureau of Immigration as displayed in Table 1. Medical arrivals reached 697,453 in 2019, collapsed by 73.8 percent in 2020, and then recovered strongly, rising 38.9 percent in 2023 to 659,356. The 2024 total of 644,387 was 2.3 percent lower than in 2023 and about 92 percent of the 2019 peak. The drop in overall tourism, not an increase in medical tourism, is responsible for this 21.2 percent share in 2021.

Table 1

Foreign Tourist Arrivals (FTAs) in India and Arrivals for Medical Purposes, 2019–2025

Year	Total FTAs	FTAs for medical purposes	Share of total (%)	Change in medical FTAs (%)
2019	10,930,355	697,453	6.38	—

Year	Total FTAs	FTAs for medical purposes	Share of total (%)	Change in medical FTAs (%)
2020	2,744,766	182,945	6.67	-73.8
2021	1,527,114	323,748	21.20	+77.0
2022	6,437,467	474,798	7.38	+46.7
2023	9,520,928	659,356	6.93	+38.9
2024	9,951,722	644,387	6.48	-2.3
2025	9,150,000 (approx.)	507,244	5.5	-21.3

Note. Data for 2019–2024 are from Bureau of Immigration figures in the Ministry of Tourism (2025). The 2025 figures are from PIB (2026) and may not be on an identical basis; percentage changes were calculated by the author.

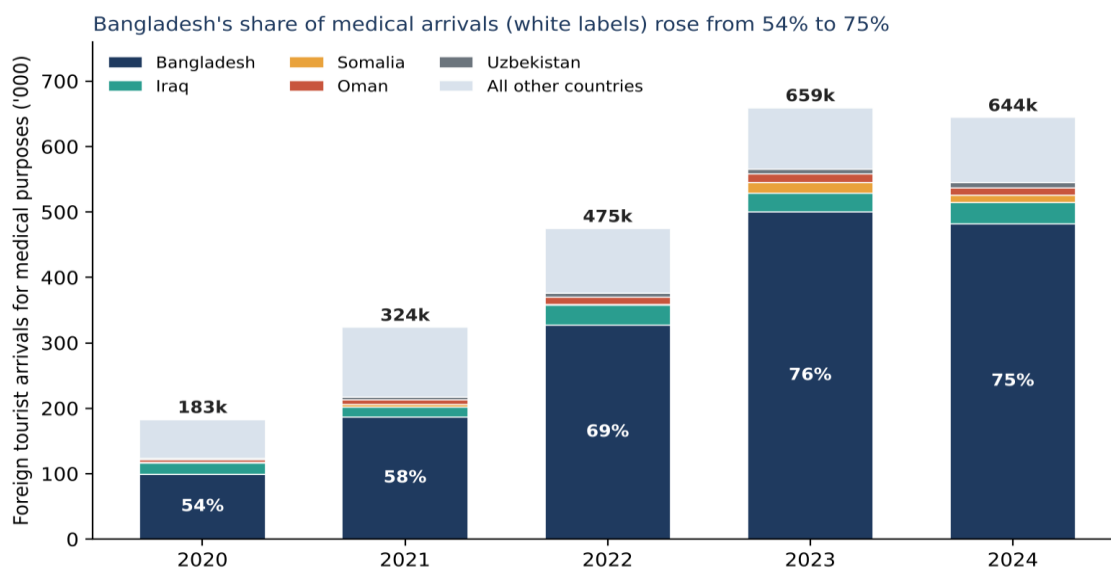
If similar to 2024, this would show a decline of approximately 21 percent in 2025. The majority of the decline is expected to be due to Bangladesh, as the number of medical arrivals fell from 482,336 in 2024 to 325,127 in 2025 (Ministry of Tourism, 2025; PIB, 2026). Excluding Bangladesh, the number of arrivals grew by around 12 per cent from approximately 162,000 to approximately 182,000. The reasons for the decline in Bangladesh are not explained by the sources reviewed, and bilateral or visa conditions are possible, but not yet tested explanations here. All the same, the pattern indicates that there is already a certain level of diversification and reliance on a single market is a significant risk.

4.3 Source markets

Figure 1 shows the composition of arrivals. The proportion of Bangladesh increased from 54 per cent in 2020 to 76 per cent in 2023 and to 75 per cent in 2024. In 2024, Iraq ranks second in the number of visitors, with 32,008, followed by Somalia, Oman and Uzbekistan (Ministry of Tourism, 2025). For 2025, the government lists Bangladesh (325,127), Iraq (30,989), Uzbekistan (13,699), Somalia (11,506), Turkmenistan (10,231), Oman (9,738), and Kenya (9,357) (IANS, 2026).

Central Asian and African markets are therefore emerging alongside the established West Asian ones.

Figure 1
Medical Arrivals to India by Source Country, 2020–2024



Source: Ministry of Tourism (2025), Lok Sabha Unstarred Question 4136; 'All other countries' computed as residual.

4.4 National policy architecture

The Ministry of Tourism's National Strategy and Roadmap for Medical and Wellness Tourism rests on five pillars: building a destination brand, strengthening the ecosystem, digitalisation through an online MVT portal, improved accessibility, and wellness promotion (Ministry of Tourism, 2023). The Ministry of Health and Family Welfare launched the Heal in India portal for international patients (Ministry of Tourism, 2024). The e-Medical Visa and e-Medical Attendant Visa have been extended to nationals of 171 countries (IANS, 2025), and a dedicated AYUSH visa was introduced on 27 July 2023 (OpenGov Asia, 2026). The Union Budget 2026–27 proposed five regional medical hubs combining clinical, educational, and research facilities (IANS, 2026). These measures create the national enabling environment; converting them into a state-level advantage is the task of the states.

5. Telangana's Health Tourism Ecosystem

5.1 Clinical and infrastructural base

Hyderabad is the state's health tourism core. Table 2 collects the main public indicators. Officials describe 89 NABH-accredited and eight JCI-accredited hospitals (Siasat Daily, 2026b), and participants at a February 2026 roundtable cited approximately 12,000 hospital beds and an international airport handling more than 31 million passengers a year (Siasat Daily, 2026a). The same roundtable claimed that international patient inflows to the city have more than doubled over the past decade (Siasat Daily, 2026a). Such claims are plausible but unaudited, which underlines the data gap discussed in Section 7.

Table 2

Public Indicators of Hyderabad's Health Tourism Capacity

Indicator	Value	Source
Foreign patients visiting Telangana, 2014	Just over 75,000	The South First (2025)
Estimated value of Hyderabad's international patient market	₹500 crore	The South First (2025)
NABH-accredited hospitals in Hyderabad	89	Siasat Daily (2026b)

Indicator	Value	Source
JCI-accredited hospitals in Hyderabad	8	Siasat Daily (2026b)
Hospitals with NABH or JCI accreditation (earlier count)	More than 50	Siasat Daily (2026a)
Hospital beds	Approx. 12,000	Siasat Daily (2026a)
Airport passengers per year	More than 31 million	Siasat Daily (2026a)
Beds earmarked for foreign patients at TIMS	50	Deccan Chronicle (n.d.)
International patients at one leading private hospital: pre-pandemic year / 2020	About 4,000 / 1,200	IMTJ (n.d.)

Note. Figures are as reported by the cited sources and are not independently verified. The accreditation counts differ in definition and date.

5.2 Patient profile and source markets

Patients are sent to Hyderabad from the African countries and the Arab world. The CESS (2023) study of international patients revealed that among the other cities studied, Hyderabad had a higher proportion of African patients. Patients are referred to private hospitals in Uganda, Rwanda, Zambia, Nigeria, Ethiopia, Kenya, Cameroon, Tanzania, Somalia and Sudan and there are also some cross-border referrals from Bangladesh, Uzbekistan and Myanmar, primarily for oncology, neurology and treatment of the brain and spine (IMTJ, n.d.). The mix of Telangana is thus not similar to the national trend in which Bangladesh is the largest player. This is a good strategy, as it reduces risk, but also places Telangana in markets such as Africa and West Asia in which currency, visa and payment conditions can change rapidly.

5.3 Exposure to shocks

During the pandemic, the sector was exposed to its vulnerability. A single Hyderabad hospital indicated that it had seen a 60–70 per cent drop in overseas patients, from an average of 4,000 patients per year, to 1,200 patients in 2020, and another 1,500 patients were seeking consultation through online channels (IMTJ, n.d.). The strategic framework picks up on this in the online consultations, where it is explained that tele-consultation can continue to drive demand and the subsequent in-person travel.

5.4 Policy and institutional build-up

Since 2024, the policy response in Telangana has been stepped up. Table 3 summarises the main steps. This pattern is a shift from announcement to institution; from coordinating society to a hub proposal, to a government and hospital pilot, to a single-window portal.

Table 3
Timeline of Telangana Health Tourism Policy Measures, 2024–2026

Date	Measure	Source
March 2024	Chief Minister announces a forthcoming Health Tourism Policy and an ambition to serve	UNI (2024)

Date	Measure	Source
	patients from other countries.	
March 2025	Tourism Policy 2025–30 introduced: ₹15,000 crore investment target, three lakh jobs, 27 Special Tourism Areas, medical tourism among promoted segments	UNI (2025); TBO Academy (2025)
May 2025	Miss World pageant used to showcase Hyderabad's hospitals	The South First (2025)
20 February 2026	Roundtable proposes a Telangana State Medical Tourism Society and a greenfield MVT hub under a public–private partnership.	Siasat Daily (2026a); Chattopadhyay (2026)
7 June 2026	Committee formed to introduce international medical tourism in government hospitals, including a dedicated block at TIMS, package rates, and patient support services	Siasat Daily (2026c)
9 October 2026	Chief Secretary orders a strategic action plan, project reports before the Telangana Global Summit, a Single Window Portal, and streamlined organ transplantation procedures within applicable regulations	Siasat Daily (2026b); Deccan Chronicle (2026)

Note. Compiled by the author from the cited reports.

5.5 The public-sector pilot

The public-sector pilot deserves attention. The Dr. MCR Telangana Institute of Medical Sciences and Research (TIMS) earmarked 50 beds for foreign patients, set up a Medical Tourism Promotion Committee, and began negotiating agreements with African and Arab countries covering insurance and related issues, targeting specialities such as organ transplantation, cardiac surgery, cancer, neurology, orthopaedics, urology, nephrology, and pulmonology (Deccan Chronicle, n.d.). Free care for the poor under Aarogyasri is to continue (Deccan Chronicle, n.d.). The June 2026 committee is tasked with package rates, translators, customised diets, and attendant facilities, and with coordination with a Telangana Medical and Wellness Tourism Promotion Board (Siasat Daily, 2026c). If designed well, fee income from international patients can cross-subsidise public services; if designed poorly, it can crowd out local patients.

6. Strategic Analysis

6.1 SWOT assessment

Table 4 organises the evidence into a SWOT matrix. The balance is favourable on assets and opportunities but exposes governance and information gaps that rivals with mature systems have already closed.

Table 4
SWOT Assessment of Telangana's Health Tourism Position

Dimension	Factors supported by the evidence
Strengths	Dense accredited hospital base (89 NABH, 8 JCI); approximately

Dimension	Factors supported by the evidence
	12,000 beds and tertiary-care depth; cost advantage over Western systems; international airport with more than 31 million passengers a year; diversified African and West Asian patient base; high-level political attention; public-sector capacity at TIMS and NIMS
Weaknesses	No published state-level arrivals series; coordinating body still at proposal stage; fragmented facilitation and weak licensing of intermediaries; inconsistent accreditation counts; limited insurance portability; dependence on word-of-mouth networks in a few markets
Opportunities	Union Budget 2026–27 provision for five regional medical hubs; Heal in India branding and e-Medical Visa access for 171 countries; emerging Central Asian and African markets; PPP-based integrated MVT hub; tele-consultation and AYUSH-based recovery packages; government-to-government agreements
Threats	Competition from Türkiye, Thailand, and Singapore, and from other Indian hubs such as Chennai and Delhi; shocks to a few source markets; reputational damage from malpractice or unscrupulous brokers; ethical scrutiny of organ transplantation; public backlash if local access suffers

Note. Compiled by the author from Chattopadhyay (2026), IANS (2025, 2026), Siasat Daily (2026a, 2026b), and Deccan Chronicle (n.d.).

6.2 International benchmarking

India is pitted against three big rivals in Table 5. The rankings are indicative only and do not represent exact values due to the fact that the countries use different counting methods. In terms of medical tourists, an estimated 2.5 million people visited Thailand in 2018, 450,000 visited Singapore, and in 2024, an estimated two million traveled to Türkiye for health care (Global Healthcare Accreditation, n.d.; Republic of Türkiye Directorate of Communications, n.d.). The scale of a coordinated national effort can be swift — Türkiye's volume went from over 670,000 in 2021 to over 1.8 million in 2023 (Republic of Türkiye Directorate of Communications, n.d.).

Table 5
Benchmark Destinations: Volume and Specialisation

Destination	International patients	Year	Typical specialisations	Source
Thailand	2,500,000	2018	Cosmetic surgery, dental care, orthopaedics	Global Healthcare Accreditation (n.d.)
Türkiye	About 2,000,000 (revenue about USD 3 billion)	2024	Hair transplant, cosmetic surgery, cancer, organ transplants	Republic of Türkiye Directorate of Communications (n.d.)
Singapore	450,000	2018	Cardiology, oncology,	Global Healthcare

Destination	International patients	Year	Typical specialisations	Source
			orthopaedics	Accreditation (n.d.)
India	644,387	2024	Cardiology, cancer treatment, orthopaedics	Ministry of Tourism (2025); Global Healthcare Accreditation (n.d.)

Note. Volumes use each country's own definitions and are not strictly comparable.

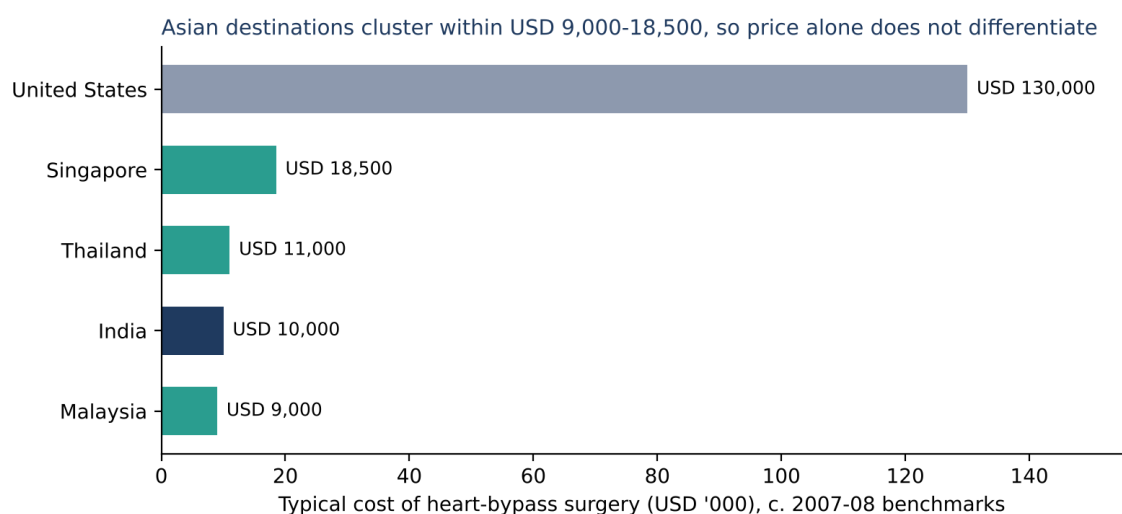
Two lessons follow. First, the revenue per visitor in Türkiye is approximately USD 1,500, indicating high treatment volume of cosmetic and dental treatments. The profile of Telangana, focused on oncology, neurology, transplantation and cardiac care, suggests that there are fewer patients but that these are of much higher value, and that there is much more reliance on trust in clinical outcomes. Second, the leaders combine clinical skills with national coordination, branding and facilitation – the very things Telangana is suggesting.

6.3 Cost and the value proposition

Cost advantage is still India's entry ticket but it is no longer a differentiator. At USD 10,000, heart-bypass surgery in India is compared to USD 11,000 in Thailand, USD 9,000 in Malaysia, USD 18,500 in Singapore, and USD 130,000 or more in the United States (Foreign Policy, 2008). Consider the following. Figure 2 shows the Asian destinations are confined to one narrow band. It has been suggested that there is an improvement in India's position with current quotes ranging from USD 4,500 – 8,000 for bypass surgery (Medical Tourism Association, n.d.), but price-led competition is a race that rivals can also run. Telangana's value proposition must be based on outcomes, transparency, and the overall patient experience.

Figure 2

Heart-Bypass Surgery Cost Benchmarks, circa 2007–08



Source: Foreign Policy (2008), citing 2007-08 data. Dated benchmark; recent Indian quotes: USD 4,500-8,000 (Medical Tourism Association, n.d.).

Note. Figures are dated benchmarks from Foreign Policy (2008); recent Indian quotes of USD 4,500–8,000 are given in the text (Medical Tourism Association, n.d.).

6.4 Strategic options

There are three big possibilities to support the evidence. In higher volume, less complex procedures, a cost-led volume strategy would be competitive based on price. It is the least appealing for Telangana as both Türkiye and Thailand are well established in the region and there are not that many price differences between the Asian destinations. A niche leadership strategy would focus on complex tertiary care such as oncology, neurosciences, transplantation, cardiac care and orthopaedics, as the clinical depth of Hyderabad and on-going patient profile already indicate. A more holistic strategy would involve adding the surrounding ecosystem, which includes the proposed greenfield MVT hub, and would include tele-consultation, recovery and wellness.

The latter two answers are not mutually exclusive. Niche leadership is the clinical reputation that brings patients and the integrated hub is the conversion of that reputation into a unique and replicable experience that patients are unlikely to find elsewhere. Thus, the governance, data, and equity safeguards are the conditions that ensure the credibility of the two options in the framework in Section 8.

7. Challenges

7.1 Fragmented governance and facilitation

Fragmentation is the most common fault mentioned. The division of medical providers and travel and accommodation service delivery can give patients very different experiences and make people lose faith in the brand, warns an Apollo Hospitals executive (BW Healthcare World, n.d.). In the February 2026 roundtable, industry participants requested a unified body to coordinate promotion activities across the globe, regulate the ethical standards, provide a grievance mechanism and oversee the licensing of facilitators (Chattopadhyay, 2026). Hyderabad, India: The CESS (2023) note also mentions that there are problems in acquiring medical visas for some foreign patients and for them, visas and passports are arranged by intermediaries. One bad experience with a broker can harm the reputation of all hospitals if it remains unlicensed and without a code of conduct.

7.2 Market concentration and shocks

Bangladesh is the country that provided approximately three-quarters of medical arrivals in 2023 and 2024 on a national level (Ministry of Tourism, 2025). The African and the West Asian base in Telangana is also much more diversified yet is dependent on a few corridors. The surge and the sudden drop of the inflow of Bangladeshi nationals in 2025 (IMTJ, n.d.) and the sudden closure of hospitals in Hyderabad during Covid-19 pandemic (PIB, 2026) both reflect how demand can disappear rapidly due to changes in a border, currency or politics.

7.3 Data deficit

Strategy needs measurement. India does not publish arrivals by purpose or by nationality, but does publish arrivals by destination state, and Telangana does not publish figures regularly and they are rounded. The key public indicators are: The 2014 number of foreign patients is just over 75,000; and The estimated market size is ₹500 crore (The South First, 2025). Reporting at the hospital level is lacking for both the number of patients and the specialties serviced, length of stay, revenue, and outcomes. The state lacks reporting at the hospital level on the number of patient encounters, hospital

specialties, length of stay, hospital revenue, and hospital outcomes, which prevents the state from setting targets, evaluating incentives, and credibly marketing results.

7.4 Quality assurance and regulation

Accreditation is a tangible quality signal, but the number of counts in the officials' statements varies (as Section 3 points out). According to an earlier FICCI and Ernst & Young report, India is a weaker performer with respect to regulation, does not have any government-government institutional arrangements with source countries and requires to improve post-operative care (WION, n.d.). The second gap (Deccan Chronicle, n.d.) is addressed by the TIMS plan to negotiate agreements with African and Arab countries. Organ transplantation, particularly, is very sensitive: When the October 2026 directive to streamline the organ transplantation procedures emphasises compliance with relevant regulations (Deccan Chronicle, 2026), any sense of lax oversight would have serious reputational implications.

7.5 Insurance, payments and continuity of care

The insurance for treatment in India is still limited, and the problem is recognized in the TIMS plans for negotiations with insurance in source countries (Deccan Chronicle n.d.). Analysts have recommended insurance policy changes that include coverage for pre-existing conditions, surgeries, and travel expenses, in order to help improve the patient journey and build trust (Arora, 2025). Continuity following the patient's discharge to home, via tele-follow-up and connection with home-country clinicians, is also poorly developed.

7.6 Equity and domestic health system pressures

The distribution issues with public sector participation. Reading Arora (2025), it seems that more professional workers are attracted to private services that cater to the more affluent domestic or foreign clients, thereby minimizing the workload of the public health centres. The Telangana government's pledge to continue free care under Aarogyasri and the international block TIMS (Deccan Chronicle, n.d.) is thus both ethical and political – public legitimacy is essential for continued policy support.

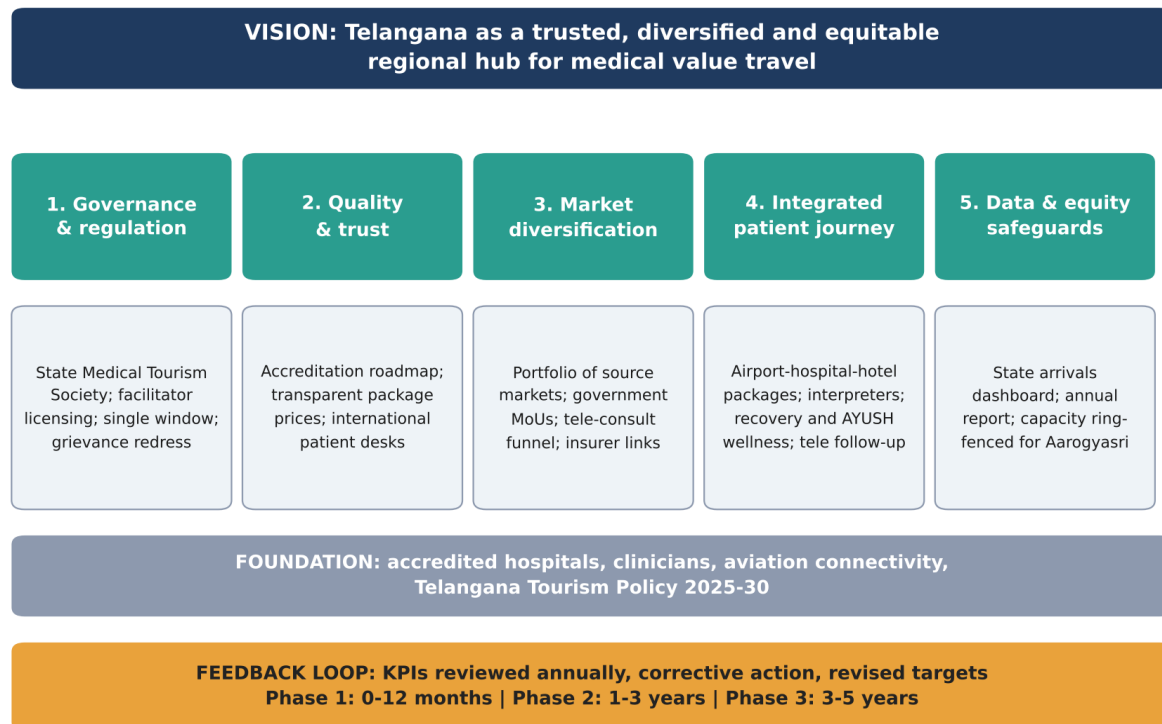
8. A Strategic Management Framework for Telangana

8.1 Design logic

The framework addresses the above gaps in the following four parts of Section 2. It builds on the existing base of resources that Telangana already has and introduces five pillars, as illustrated in Figure 3. The pillars are presented in the order in which they are important; namely that governance and data are the foundations for quality assurance, marketing, and integration.

Figure 3

Strategic Framework for Health Tourism in Telangana



Note. Framework developed by the author from the analysis in Sections 4–7.

8.2 The five pillars

Governance and regulation: The proposed Telangana State Medical Tourism Society should be formed with a clear statute or registration and consist of hospitals, tourism and health departments, airlines, and patients, and should have the authority to register the facilitators, lay down a code of conduct, and have a grievance system in place to address the grievances (Chattopadhyay, 2026). It is likely that the Single Window Portal that was ordered in October 2026 will form the front end of its operations.

Quality and trust: Hospitals wishing to join should agree to a published accreditation roadmap, published package pricing, and standard international patient desks. The government hospitals providing international blocks must also apply the same standards, and the mechanism of package rates that the committee of June 2026 is considering must be applied (Siasat Daily, 2026c).

Market diversification: Grouping source markets into a portfolio is the right approach for Telangana. It should cement existing African and West Asian routes, expand Central Asian markets like Uzbekistan and new African markets like Kenya (which already seem to be included in India's top sources – IANS, 2026), and leverage government-to-government solutions, as TIMS has just started to do, to solve insurance and referral issues.

Integrated patient journey: The proposed hub should be based on the entire trip from the tele-consultation, visa assistance, airport pickup, hospital treatment, recovery, optional wellness/Heritage tourism, and tele-follow-up. The healthcare–hospitality–aviation ecosystem is a unique asset of Hyderabad here (Siasat Daily, 2026a).

Data and equity protection measures: Patient numbers, length of stay, revenue and patient satisfaction by nationality and speciality should be reported on an annual basis in the Society's state report. It should

also fix the capacity and ensure that international income at public hospitals is channelled to the services provided to Aarogyasri patients.

8.3 Action Plan and Indicators

Table 6 outlines the phased actions and lead agencies and indicators for the pillars. The indicators are for discussion and will be calibrated with baseline data.

Table 6
Action Plan, Lead Agencies, and Proposed Indicators

Pillar	Priority actions	Lead	Phase	Proposed indicators
Governance and regulation	Register the Society; licence facilitators; launch Single Window Portal; create grievance mechanism	Tourism Department; Health Department	1 (0–12 months)	Facilitators licensed; grievances resolved within a set period
Quality and trust	Accreditation roadmap; published package prices; international patient desk standard	Society; hospital association	1–2	Share of participating hospitals accredited; share of packages with published prices
Market diversification	Market portfolio plan; country MoUs; tele-consultation funnel; insurer partnerships	Society; TGTDC; TIMS	2 (1–3 years)	Share of top source country; number of active MoUs
Integrated patient journey	Greenfield MVT hub via PPP; airport-to-hospital service; recovery and AYUSH packages; tele-follow-up	TGTDC; private partners	2–3	Patient satisfaction; average length of stay; follow-up completion
Data and equity safeguards	State arrivals dashboard; annual report; reinvestment rule for public hospitals	Society; Health Department	1 and ongoing	Annual report published; Aarogyasri access unchanged or improved

Note. Phase 1: 0–12 months; Phase 2: 1–3 years; Phase 3: 3–5 years. TGTDC = Telangana Tourism Development Corporation.

8.4 Implementation risks

There are 3 risks that need to be managed explicitly. Overlap in institutions between tourism and health and hospital associations may delay decisions; therefore, the mandate of the Society needs to be clear.

Excessive promotion before quality systems are in place may be detrimental to the brand. Last but not least, if there are no baseline data, there is a possibility that targets will be misguided.

9. Conclusion

Health tourism in India has bounced back from the pandemic but has yet to take off on an even footing. Although the government's 2025 prediction of 507,244 medical arrivals indicates a further decline (due to the reduction in Bangladesh arrivals), it still has space to accommodate the increases from other nations, which totalled approximately 12 per cent of the 2019 peak, with arrivals reaching 644,387 in 2024. The national narrative then is a strong policy push, increasing diversification, and the perilous reliance on a single corridor. Telangana has a head start in this scenario. The city of Hyderabad has a large number of accredited hospitals, specialists, an airport, a unique patient population from Africa and West Asia, and, since 2024, consistent political interest. From announcement to institution building, the measures of 2025 and 2026, such as the Tourism Policy, the proposed Medical Tourism Society, the MVT hub proposal, the TIMS international block and the Chief Secretary's October directive, are all signs of an administration that is slowly shifting gears.

In addition, the analysis reveals why this will not be a make-or-break situation for infrastructure. The cost factor is no longer the differentiator between India and Thailand, or Malaysia and Türkiye, where coordinated national effort has proved to be a game-changer in a few years. The issues facing Telangana are the lack of governance, information, and trust: fragmented facilitation, unlicensed intermediaries, inconsistent accreditation numbers, limited insurance coverage, and lack of state-level data. These are in the state's control to rectify.

The five-pillar framework provided here – on governance and regulation, quality and trust, market diversification, integrated patient journey and data with equity safeguards – should be implemented in stages, observed and agreed to in a politically defensible manner. Equity is a central tenet of its policy. Public support for health tourism is only sustainable if it is clearly demonstrated that the revenues generated by it are strengthening the ability to provide care to the residents of Telangana, instead of undermining it.

The following recommendations are made to further the development of the evidence base that is missing: hospital-level data for international patients, primary surveys of patient experience and facilitator practices, and comparative studies with other Indian hubs like Chennai and Delhi. The proposals here should be viewed as the structured beginning for the state's action plan, not a blueprint, until such data are available.

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