

Bridging the Care Divide: Regional Approaches to Expanding Hospital Access in Small-Town India

**Tapping Tier 2 & 3 Markets: A Region-Specific
Strategy for Bharat's Healthcare Boom**



Approximately 66% of India's population lives outside of the major metropolitan cities, according to the World Bank and other sources. This means that most Indians live in smaller cities, towns, and rural areas. While urbanization is increasing, with about 34% of the population living in urban areas, the majority of the country's population remains in non-metro locations.

As India's infrastructure grows and new highways reduce travel times, Tier 2 and 3 cities are becoming the next frontier for healthcare expansion. These cities serve their own populations and surrounding towns, where rising disposable incomes and declining trust in government hospitals are driving demand for improved healthcare services.

But one truth is becoming increasingly clear: each region behaves differently. So, the reasons for setting up a certain type of hospital in one district of Himachal may not translate in Madhya Pradesh. A model that succeeds in a coastal region of Maharashtra might fail in a landlocked northern town. And the market dynamics in Northeast of India are completely different.

In India, consumer behaviour changes from one district to another leave alone one state from another.

Our food changes, our lifestyle change, therefore it is very difficult to say that if a specific strategy worked in Madhya Pradesh, it would work in Chennai.

A Professor in leading MBA institute

To succeed, healthcare players must approach each market with a deep understanding of its unique socio-economic, geographic, and current healthcare behavioural fabric.

This write-up has been built based on the work that Kraftland has done for multiple clients on healthcare systems in tier 2 and tier 3 cities. It showcases that though penetration is happening, the gestation periods are longer; 5 years and beyond. Though patients come, they are not ready to pay the same rates that they will pay in a metro and as soon as they believe that the patient is serious, they will run to metro, driven by the thought process and trust that I will get quality care across everything in one place.

India's Tier 2 and 3 cities are undergoing a quiet yet significant healthcare transformation. From growing access to specialty care to strategic forays by leading hospital chains, the momentum is clearly shifting beyond metropolitan centres. Today, even smaller districts—whether it's Rewa in Madhya Pradesh or a remote town like Chirala in Andhra Pradesh—are home to facilities like Apollo Spectra, underscoring the depth of this emerging trend.

However, these cities aren't a monolith. Regional context—from road infrastructure to insurance penetration—can define the success or failure of a healthcare model. Improved roads make travel easier, but they also pull patients into bigger centres unless local trust is built.

Doctors: The Bedrock of Localized Trust

One encouraging trend is the return of super-specialists—often retired government doctors or private practitioners—who are setting up hospitals or diagnostics in their hometowns. Their local credibility helps fill care gaps left by public systems.

In Jaunpur (UP), one of the leading private practitioners is a retired government doctor. In Raigad (Alibag), for instance, a retired general surgeon runs a hospital that hosts a visiting laparoscopic surgeon from Mumbai. Similarly, an orthopaedic specialist established a local clinic and brought in metro-based spine experts for periodic visits. **Routine procedures stay local; complex surgeries are referred.** The success of this model hinges on the doctors' local roots and trust—a dynamic that varies from district to district.

Meanwhile, visiting super-specialists from metros—though helpful—often lead to fragmented care and referrals back to urban hospitals, especially in specialties like oncology, cardiology, and orthopaedics. This model suits areas close to urban centres but falters in more remote geographies where continuity of care is vital.

In cities like Kangra, Himachal Pradesh, local cardiologists returning from metros have set up Cath labs—there are six today. Even Satna in Madhya Pradesh has one, and Dibrugarh in Assam has at least two.

Small towns such as Hapur in Uttar Pradesh, Miraj in Maharashtra, and Srinivasnagar and Tumkur in Karnataka now have access to radiotherapy services, reflecting a significant shift in cancer care accessibility beyond metro cities. These **towns, once dependent on distant tertiary centres for such advanced treatments, are increasingly equipped with linear accelerators and trained oncology teams.**

But building trust is time consuming, and only few brands are making strides.

Despite significantly lower costs, patients often prefer metro hospitals, citing the need for second opinions. This behavioural pattern is often influenced by family members settled in cities, who bring elderly relatives for treatment.

This leads to poor utilization and financial pressure on high-investment facilities in Tier 2/3 markets—especially if regional trust and referral networks are not established.

Tale of Two Contrasting doctors

In one district where our team was doing a feasibility analysis the senior doctors who had retired from Army were very happy that they could live the life like in the past as the houses were big and the army cantonment was nearby from where they could enjoy their army liberties. But in the same district we have another doctor who was comparatively younger who despite having a 50-bed hospital set-up with latest equipment for him was not happy as he did not see opportunity for growth and was not motivated to continue. And this tale we saw unfolding in multiple district. Therefore, choosing the right doctor who has a strong long-term reason to be in that city is very important.

Infrastructure alone doesn't prevent patient migration. Emotional trust, perceived comprehensiveness, and social proof drive decision-making.

“Trust anchors,” are required for secondary expansions in diagnostics, preventive care, or more complex therapies.

Similarly, diagnostic services have expanded through teleradiology models. Hindlabs, run by HLL Lifecare, is a success story in this regard. But many local doctors remain hesitant to accept digital reports, especially in regions where face-to-face interactions are still the norm. Physician confidence in remote diagnostics remains a challenge shaped by generational and geographic nuances.

Given these complexities, capital-efficient, single-specialty centres are gaining ground—especially in areas where a focused need exists and regional behaviour supports adoption.

Indira IVF has built over 100 centres using a protocol-driven model, many in Tier 2/3 towns. Its success is rooted in tapping underserved but high-demand areas with affordable, standardized services. Other examples include:

- Motherkraft in Kangra, specializing in maternal and childcare.
- Navneet Urology in Una, offering comprehensive local services tailored to the needs of the region.
- Apex Kidney Care providing comprehensive kidney services (mainly dialysis) in 11 states with 200+ centers

These models thrive where services are sharply focused, community trust is built over time, and infrastructure matches local affordability and demand.

Even in oncology, chemotherapy-only centers could meet immediate needs in regions where patients currently travel for routine infusions. Radiation oncology, being cost-heavy and compliance-intensive, can be phased in once trust and volume are established.

Public-Private Partnerships (PPP), could it be a possible option, but it is a Double-Edged Sword

Partnerships between private players and government hospitals offer another route—especially in areas where public infrastructure is present but under-resourced. For example, Krsnaa Diagnostics in Himachal Pradesh has successfully partnered with public hospitals to deliver radiology and pathology services.

For private healthcare providers operating in the Northeast, working through the existing PHC/CHC and ASHA network is essential to ensure last-mile access. Leveraging ASHAs for community outreach and integrating

PPP models must be operationally agile, not bureaucratically idealistic. Success lies in last-mile execution, not just MOU signing.

services into government-led programs and health camps offers a practical and scalable model. This helps private players navigate geographic challenges while aligning with public health efforts to reach underserved populations.

However, such collaborations are heavily dependent on operational alignment. In regions where administrative bandwidth is limited or where doctors distrust private involvement, these models struggle despite infrastructure readiness.

As the trust factor is in the process of being built, Bharat patients still have a continued preference for urban hospitals for major treatments. Also, as many of these patients have close family working in metros, it becomes a double win for them – they get better care and also, they can meet their relatives. For older parents, going to metros/bigger

cities also help them bond with their grandkids and also gives their children the satisfaction that they are giving their best medical care to their parents.

In summary, "Bharat is not waiting for healthcare—it is evolving its own blueprint. The question is: Are we ready to listen?" We believe these are the 6 points that we need to listen to:

One India, Many Markets: Regional disparities in healthcare behaviour, economics, and trust demand tailored models, not template-based replication from metros.

Trust Trumps Infrastructure: Even with upgraded facilities, patients often migrate to metros—unless regional credibility is established.

Doctors Are Market Makers: The availability and alignment of doctors—especially those with local roots—are critical to success.

Focused Models Win: Capital-efficient, single-specialty formats outperform large multispecialty models in early stages.

Public-Private Partnerships (PPP) can bridge access gaps but demand operational agility and trust with local institutions.