

AI in Healthcare

From instinct to inference

May 2026

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Way Forward

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Mr. Debarshi Duttagupta

Chairman, ASSOCHAM Health Council West Bengal



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India stands at a defining moment in the evolution of its healthcare system. Over the past decade, the country has made remarkable strides in expanding healthcare access, strengthening public health infrastructure, and improving key health indicators. Yet the scale and complexity of India's healthcare challenges continue to demand solutions that are not only ambitious, but deeply systemic and future-oriented.

The eastern region of India is emerging as a promising frontier for AI-driven healthcare transformation, with states such as West Bengal, Assam, Odisha, Bihar, Jharkhand, and the North-East increasingly adopting AI-powered diagnostics, telemedicine, robotic surgery, predictive analytics, and digital health platforms to bridge longstanding gaps in healthcare access and specialist availability. As India aspires toward universal health coverage and a digitally empowered society, the integration of AI and digital health systems offers an unprecedented opportunity to improve outcomes at scale. However, this transformation must remain guided by the principles of inclusion, accountability, ethics, and public trust.

This report, *AI in Healthcare – From Instinct to Inference*, arrives at a critical juncture in that journey. It examines how digitization and artificial intelligence are no longer peripheral innovations, but central pillars in shaping a more accessible, equitable, and resilient healthcare ecosystem for India.

The report thoughtfully captures the duality of India's healthcare landscape: extraordinary progress alongside persistent structural gaps. While Ayushman Bharat, ABDM, eSanjeevani, and other public digital infrastructure initiatives have laid a strong foundation, issues of affordability, interoperability, workforce shortages, and inequitable access remain pressing realities. At the same time, AI-enabled tools in diagnostics, disease surveillance, insurance, telemedicine, and community health delivery are demonstrating transformative potential across the healthcare continuum. The recommendations presented here are practical, phased, and grounded in institutional realities.

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Mr. Sombrata Roy

Co-Chairman, ASSOCHAM Health Council West Bengal



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Healthcare systems across the world are being reshaped by digital innovation, and India is emerging as one of the most important laboratories for this transformation. With its scale, diversity, and rapidly expanding digital public infrastructure, India possesses a unique opportunity to demonstrate how technology can strengthen healthcare delivery for millions.

India's healthcare transformation will not be driven by technology alone, but by the thoughtful integration of technology into human systems of care. The path forward demands collaboration between government, healthcare institutions, academia, innovators, civil society, and frontline workers.

This report, AI in Healthcare – From Instinct to Inference, provides a timely and comprehensive examination of how artificial intelligence and digitization are beginning to redefine the healthcare ecosystem in India. It highlights both the immense promise and the complex challenges that accompany this transition.

One of the report's greatest strengths lies in its grounded approach. Rather than viewing AI as a futuristic abstraction, it examines real deployments already impacting public health systems — from AI-assisted tuberculosis detection and diabetic retinopathy screening to telemedicine platforms and AI-enabled support for ASHA workers. These examples demonstrate that innovation in healthcare is no longer confined to pilot projects or urban institutions; it is increasingly reaching district hospitals, rural communities, and frontline care delivery. I commend the contributors to this report for producing a comprehensive and timely analysis of one of the most important transitions underway in Indian healthcare.

”

Mr. Devroop Dhar

Co-founder and CEO Primus Partners



“

Think about the last time you were not feeling well.

Perhaps it was a persistent headache, a rash that appeared overnight, or a cough that simply would not subside. What was the very first thing you did?

For most of us, even before we called a doctor, we reached for our phones and typed our symptoms into a search engine, or asked an AI tool for answers or reassurance. That quiet, instinctive act is more significant than it appears.

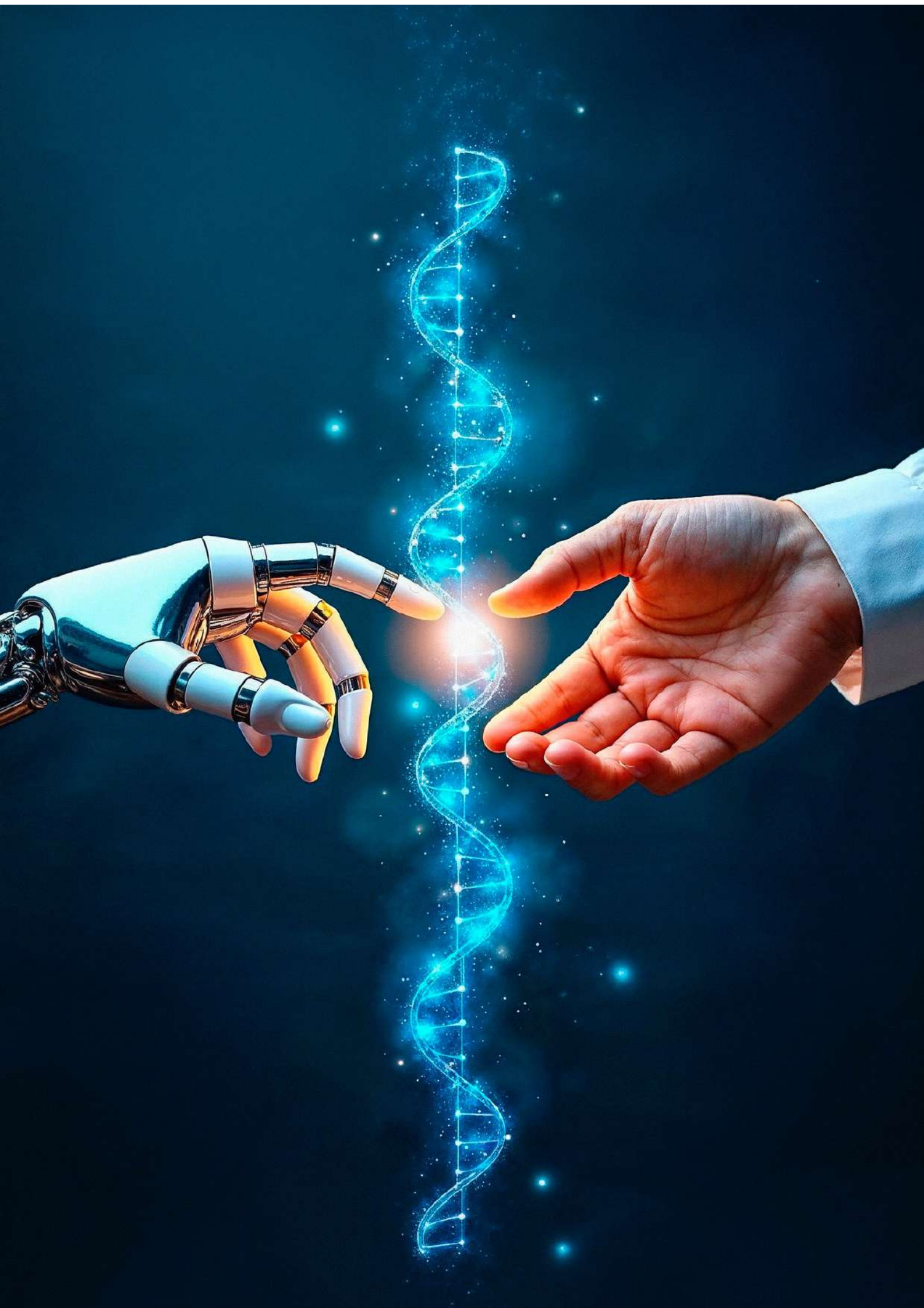
We are all already, in a way, part of the AI-enabled healthcare ecosystem. You may not have used that phrase to describe it. But that is precisely what it is.

This matters enormously in the Indian context. India has approximately 1.2 doctors for every 1,000 people. For hundreds of millions of citizens, access to a qualified physician remains constrained by chronic shortages, geographic barriers, and a fragmented continuum of care. On the other hand, according to the Comprehensive Modular Survey on Telecom 2025, over 97 percent of Indians aged 15 to 29 have access to a mobile phone. That single data point represents something more profound: the infrastructural readiness for a healthcare transformation in the hands of the people who need it most.

The question before us, therefore, is not whether AI can transform healthcare in India. That question has already been answered by digital records, AI diagnostic apps, and the daily habits of millions of people who reach for their phones before reaching for a prescription. The real question is how we take this informal, deeply human behavior and build something rigorous, equitable, and truly transformative around it. How do we move an entire healthcare system from instinct to inference, and from reactive, fragmented responses to proactive, data-driven care that reaches every Indian, regardless of where they live or what they can afford.

That is the ambition this report represents. And it is an ambition I believe India is uniquely positioned to realize.

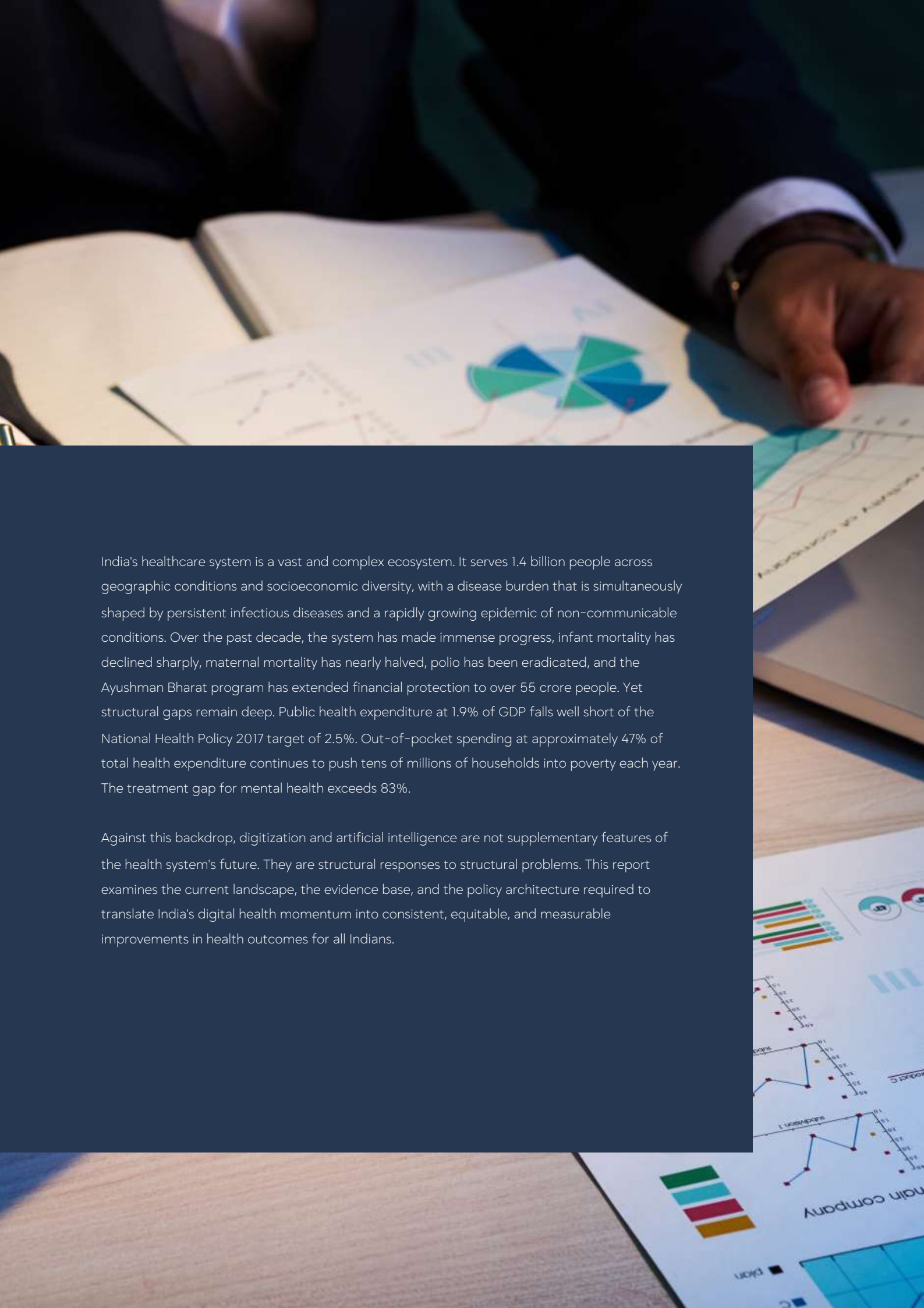
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01

Executive Summary

A close-up photograph of a person in a dark suit and white shirt, with a watch on their left wrist, pointing their right index finger at a document. The document is open on a desk and features several charts and graphs, including a pie chart and line graphs. The background is slightly blurred, showing more of the desk and the person's arm.

India's healthcare system is a vast and complex ecosystem. It serves 1.4 billion people across geographic conditions and socioeconomic diversity, with a disease burden that is simultaneously shaped by persistent infectious diseases and a rapidly growing epidemic of non-communicable conditions. Over the past decade, the system has made immense progress, infant mortality has declined sharply, maternal mortality has nearly halved, polio has been eradicated, and the Ayushman Bharat program has extended financial protection to over 55 crore people. Yet structural gaps remain deep. Public health expenditure at 1.9% of GDP falls well short of the National Health Policy 2017 target of 2.5%. Out-of-pocket spending at approximately 47% of total health expenditure continues to push tens of millions of households into poverty each year. The treatment gap for mental health exceeds 83%.

Against this backdrop, digitization and artificial intelligence are not supplementary features of the health system's future. They are structural responses to structural problems. This report examines the current landscape, the evidence base, and the policy architecture required to translate India's digital health momentum into consistent, equitable, and measurable improvements in health outcomes for all Indians.

India's healthcare system carries an extraordinary paradox. This can be listed as:



The infrastructure foundation is in place, but adoption remains uneven.

ABDM has registered more than 88 crore accounts and linked over 98 crore health records, establishing India as a global leader in digital health architecture. The Ayushman Bharat Health Account (ABHA), the Healthcare Professionals Registry (HPR), the Health Facility Registry (HFR), and the Unified Health Interface (UHI) together constitute a federated, consent-based digital health ecosystem of genuine sophistication. Yet the gap between IDs created and records actively used reflects the persistent challenge of converting infrastructure into adoption. ABDM participation remains largely voluntary for private providers, and the clinical continuity that the system promises is not yet a consistent reality.



AI is already in clinical practice, but governance has not kept pace.

AI diagnostic tools like Qure.ai, Niramai, Khushi Baby are operating at the district hospital level and below, demonstrating clinical performance comparable to specialists in tasks ranging from tuberculosis detection on chest X-rays to diabetic retinopathy screening, breast cancer detection, ECG analysis, and pathology. They are live deployments, many of them in public health settings. What is absent is the regulatory architecture, mandatory post-market surveillance, and a clear accountability framework when AI contributes to a clinical error.



The digital divide is real and must be designed against, not designed around.

Over 820 million Indians use the internet, but digital health literacy is materially lower than digital access. The ability to create an ABHA ID, navigate a teleconsultation, or interpret a digital prescription report requires capabilities that remain uneven across rural, elderly, low-income, and female populations. Inclusive design is not a cosmetic consideration in India's context. It determines whether the digital health system serves the population it is built for.



Community health workers are the most critical last-mile asset, and the most under-digitized.

India's 10 lakh ASHAs represent a trusted, geographically distributed health workforce of unmatched reach. They are currently operating with minimal digital tools, paper registers, and manual reporting systems that lose granularity and delay response. Tablet-based clinical decision support, ABHA-linked visit records, AI-assisted risk flagging, and real-time reporting capability are all technically available. Deploying them at scale to the ASHA workforce is arguably the highest-return-on-investment digital health intervention India can make, because ASHA workers reach the last mile.

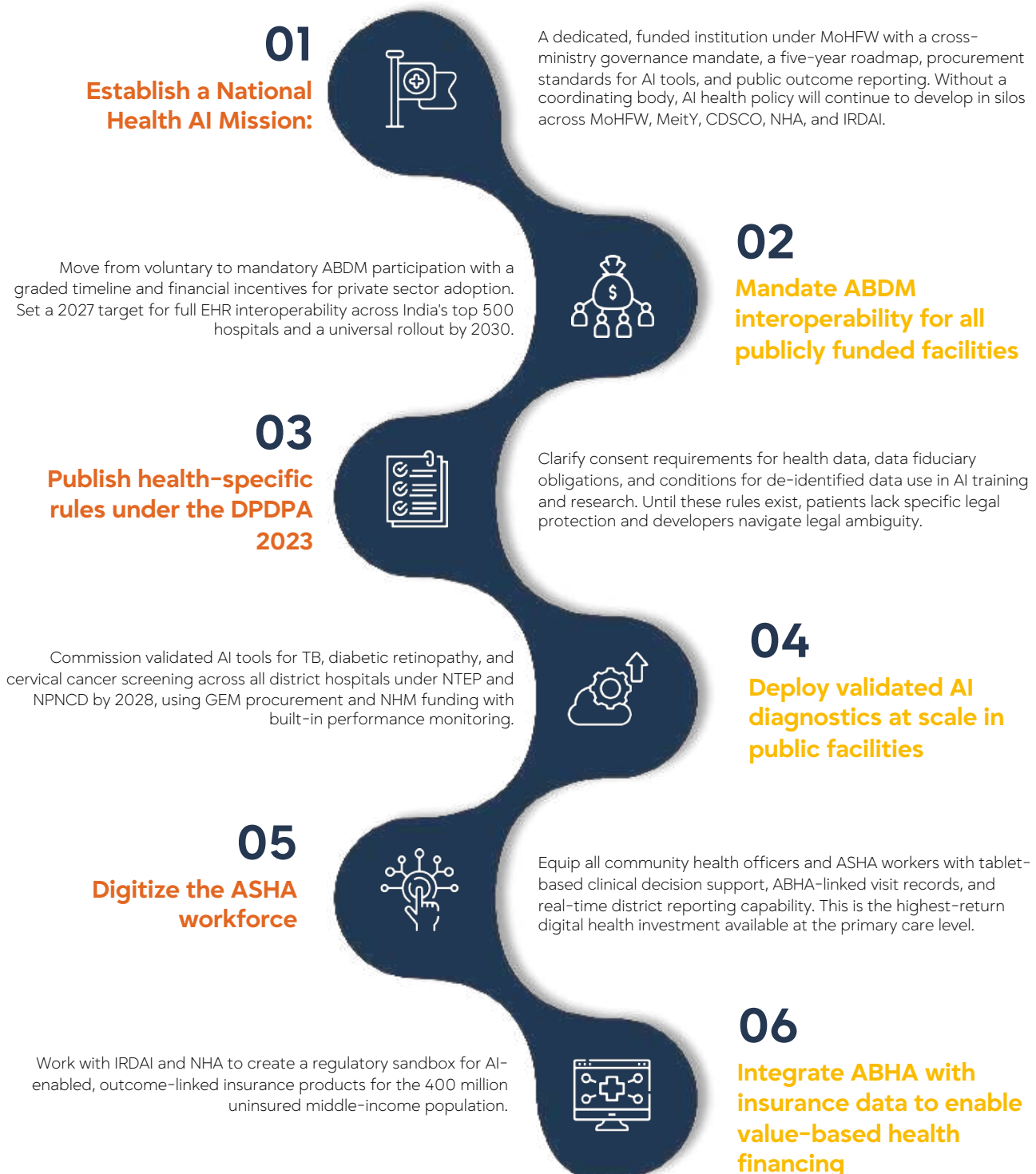


The pharmaceutical and insurance ecosystems are undergoing AI-driven transformation with uneven governance.

The National Health Claims Exchange (NHCX) is creating a unified digital claims infrastructure connecting hospitals with nearly 50 insurance providers, it is a structural improvement in the transparency and efficiency of health financing. AI is being used for claims processing, fraud detection, underwriting, and risk profiling across India's health insurance sector. However, the integration of insurance data with ABHA health records, which would enable genuine value-based, outcome-linked insurance products, is still in its nascent stages, and the regulatory framework for AI in insurance decisions remains underdeveloped.

Strategic Recommendations

The report advances six strategic recommendations. Together, they represent a phased, institutionally grounded pathway from India's health system transformation, where digitization and AI operate as reliable, equity-enhancing instruments of public health





02

Understanding Healthcare in India

India's healthcare system is evolving, shaped by demographic transitions, economic changes, and technological advancements, and it comprises a complex system that integrates public, private, and traditional medicine sectors. This report provides a comprehensive, evidence-based overview of India's healthcare system, analyzing its scale and achievements, identifying structural challenges, and assessing the role of AI and digitization in reshaping the healthcare sector across the pillars of infrastructure, diagnosis, patient support, outreach, and insurance. In recent years, India has successfully woven AI and digitization into its overall health care matrix, and they are no longer seen as futuristic add-ons. They are woven into every matrix of intervention.

The last decade has seen significant development of the healthcare ecosystem. As of now, there are 13,86,150 registered allopathic doctors. The Ministry of AYUSH has informed that there are 7,51,768 registered practitioners in the AYUSH system of medicine. Assuming that 80% of registered practitioners in both the allopathic and AYUSH systems are available, the doctor-population ratio in the country is estimated at 1:811, which aligns with the World Health Organization (WHO) recommendation of 1:1000. There has been an increase in Medical Colleges from 387 to 818; UG seats from 51,348 to 1,28,875; and PG seats from 31,185 to 82,059 from 2014 to date.



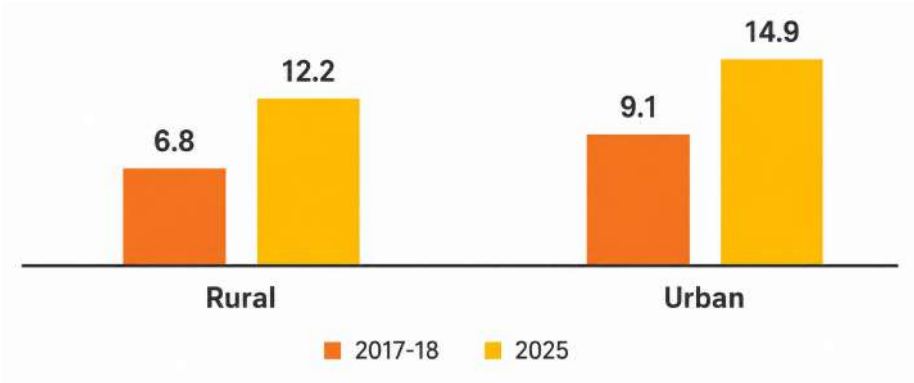
As informed by the Indian Nursing Council (INC), there are 42.94 lakh nursing personnel registered in the country as of 31st March, 2025. There are 5,253 nursing institutions, including 809 government and 4,444 private institutions, producing nearly 3.87 lakh nursing personnel annually to meet the country's nursing personnel requirements. Some of the major health parameters are mapped alongside the global benchmarking/scenario, which establishes India's growth trajectory over the past decade.

Table 1:
Snapshot of Health Parameters

Indicator	India	WHO/Global Benchmark
Doctors per 1,000 people	1.0 (0.7 in govt)	Min 1.0
Hospital beds per 1,000 people	1.3 (0.79 govt)	2.7 global avg / 3.0 NHP target
Public health expenditure (% GDP)	1.9% (FY26E)	5–6%
Out-of-pocket expenditure	~47% of total health spend	~18% OECD average
Health insurance coverage	~36% of population	Universal (policy target)
eSanjeevani teleconsultations	372 million+ (mid-2025)	—
ABHA health IDs created	74 crore+	—

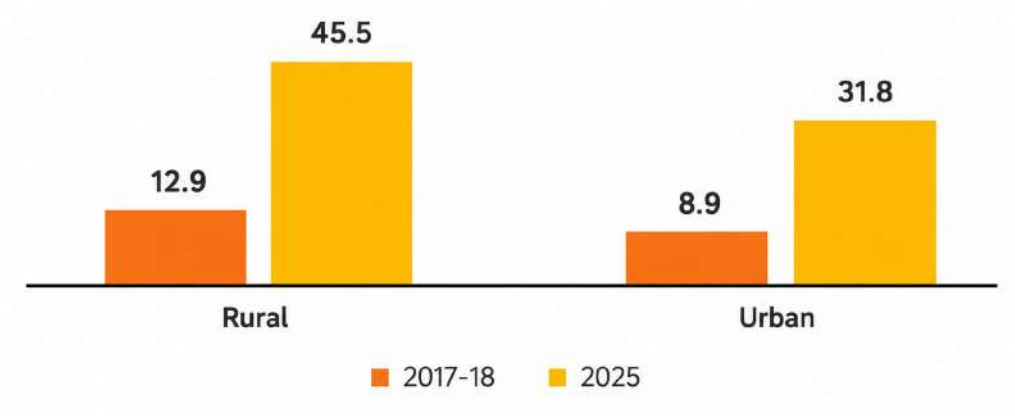


Table 2:
Proportion of population reported ailing



India has approximately 1.4 billion people, and the public health expenditure is at 1.9 percent of GDP. There have been significant gains in health outcomes owing to Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY) and other targeted Government interventions, which have enhanced access, reduced financial barriers, and strengthened trust in public healthcare systems.

Table 3:
Percentage of population covered through the Government Health Financed Schemes/Insurance (including PMJAY/ State Specific health insurance schemes, etc.)



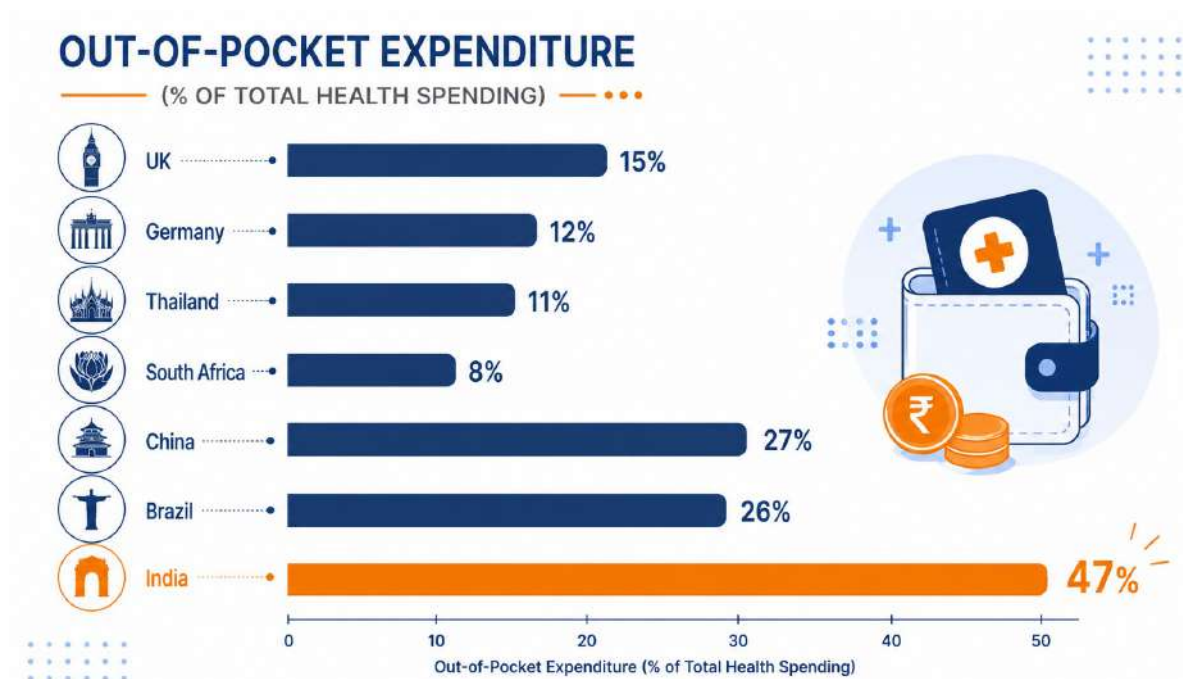
Encouragingly, this enhanced affordability has coincided with a substantial increase in healthcare demand. The Proportion of Population Reporting Ailments (PPRA) has nearly doubled from 6.8% to 12.2% in rural areas and 9.1% to 14.9% in urban areas, signaling improved awareness and a decisive shift towards proactive health-seeking behavior. In the past decade, infant mortality has fallen sharply, polio has been eradicated, maternal mortality has nearly halved, and the Ayushman Bharat program has provided financial protection to over 55 crore people. The digital health infrastructure that India has been strongly established through the ABHA health ID system and eSanjeevani teleconsultation.

2.1

Current Challenges

High out-of-pocket expenditure: Despite these gains, overall public health expenditure is at 1.9% of GDP, which falls short of the NHP 2017 target of 2.5%, and out-of-pocket health expenditure stands at roughly 47% of total health spending.





PMJAY has been transformative, with 41 crore Ayushman cards issued, 9.84 crore hospital admissions funded, benefits worth ₹1.4 lakh crore paid but it does not reach the vast 'missing middle': the salaried and self-employed population above the poverty line that earns too much for PMJAY but too little to absorb private insurance premiums comfortably.

Inequitable access across geographies, income groups, and gender: Despite progress in access to health care, inequalities by socioeconomic status, geography, and gender still exist. While metropolitan regions concentrate over 75% of the country's healthcare professionals, rural areas face a critical shortage of healthcare professionals. Primary Health Centers (PHCs) in rural India are overwhelmed, catering to around 36,049 people each which is far exceeding their capacity and **limiting access to quality healthcare**.

The **number of doctors at PHCs** decreased from 31,716 in 2021 to 30,640 in 2022, as reported in the *Rural Health Statistics 2021-22*. This shortfall significantly impacts rural communities' **access to timely and adequate medical care**, underscoring the urgent need for strategic improvements in healthcare staffing and resources in these areas.

Dual burden of communicable and non-communicable diseases: The burden of NCDs, including mental health conditions and chronic conditions such as diabetes, CVDs, chronic respiratory diseases, cancer, and other endocrine conditions, is rising at an alarming rate. These diseases exhibit a higher prevalence among vulnerable groups, including women, marginalized and underserved communities, and older adults.

2.2

Areas of Intervention

India's healthcare challenge is not simply a resource problem, but also essentially a distribution problem of trained staff, diagnostic tools, health information and preventive and curative action. The areas that need intervention can be categorized under:



Primary Care and Last-Mile Service Delivery:

Primary Care and Last-Mile Service Delivery: India has approximately 1.6 lakh Health and Wellness Centres (Ayushman Arogya Mandirs) operational as of 2024, reflecting significant infrastructural expansion in primary care. However, equitable distribution across rural, tribal, and hard-to-reach areas remains a core challenge, with persistent shortages of doctors, specialists, and diagnostic facilities limiting timely access to care in the communities that need it most.



Diagnostics and early disease detection :

Represent another major intervention area, especially as India faces a rapidly growing burden of non-communicable diseases such as diabetes, hypertension, cardiovascular diseases, and cancer. Delayed diagnosis continues to increase healthcare costs and affect patient outcomes.



Fragmentation in health records & patient data:

The healthcare system continues to face fragmentation in these records and data. Lack of interoperability between hospitals, laboratories, insurance companies, and public health systems often results in duplication, inefficiencies, and discontinuity of care.



Preventive and community healthcare:

Must become a larger policy focus as India simultaneously manages infectious diseases, malnutrition, and a rising burden of lifestyle disorders.

Together, these intervention areas establish the broader rationale for digitisation and AI adoption across the healthcare ecosystem and not merely as technology upgrades, but as critical pillars for improving healthcare access, efficiency, affordability, and outcomes at scale.

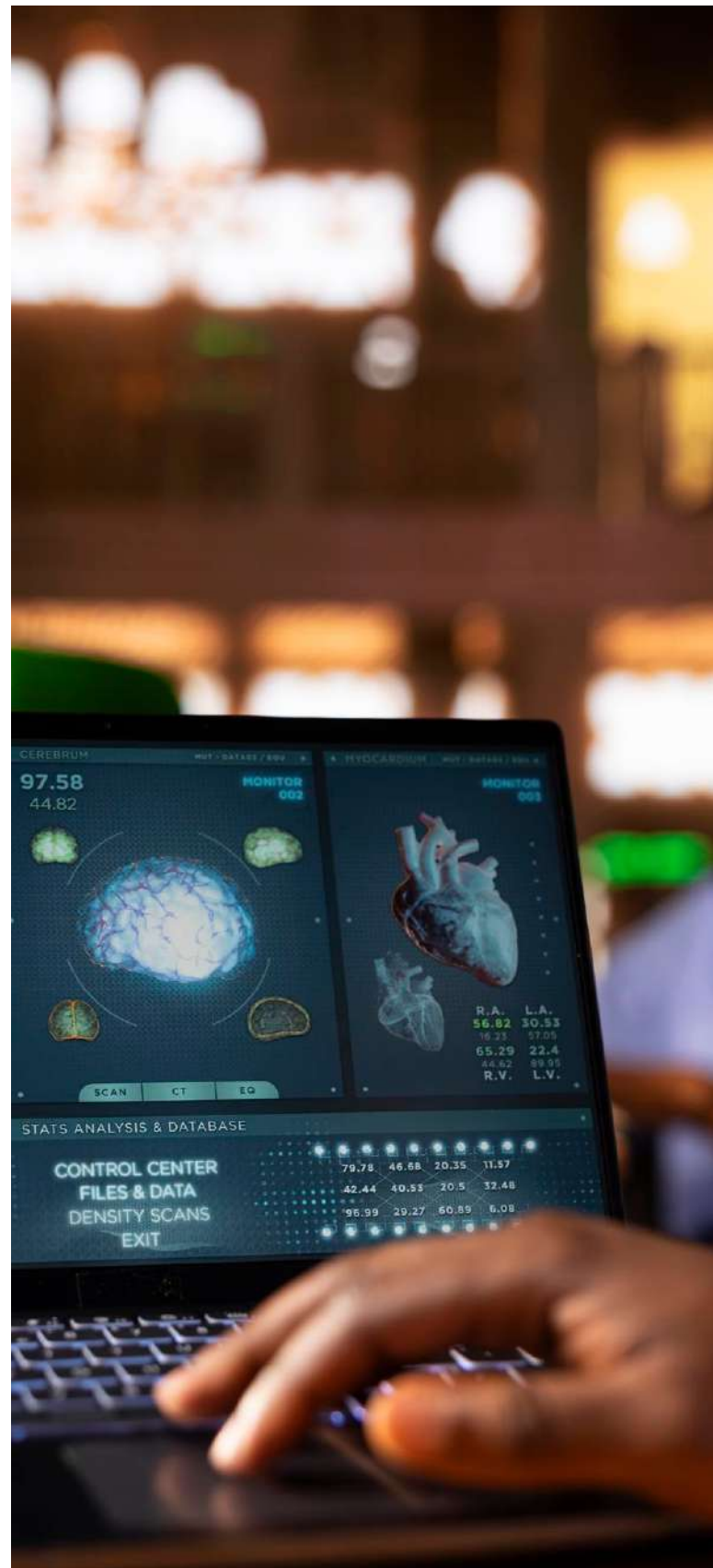


Role of Digital Health and Digitization of Health Services

India's healthcare system is undergoing a profound transformation, driven by the rapid digitization of health services and the emergence of AI as a core enabler of this shift. For a country of India's scale and complexity, which is marked by vast geographic spread, deep socioeconomic diversity, and a dual burden of communicable and non-communicable diseases, digitization is not a convenience but a necessity. The move from paper-based, fragmented systems to connected, data-driven platforms is laying the groundwork for a health system that is more equitable, efficient, and responsive. As India scales this infrastructure, it is creating the conditions for AI to move from isolated pilots to a transformative, system-wide impact.

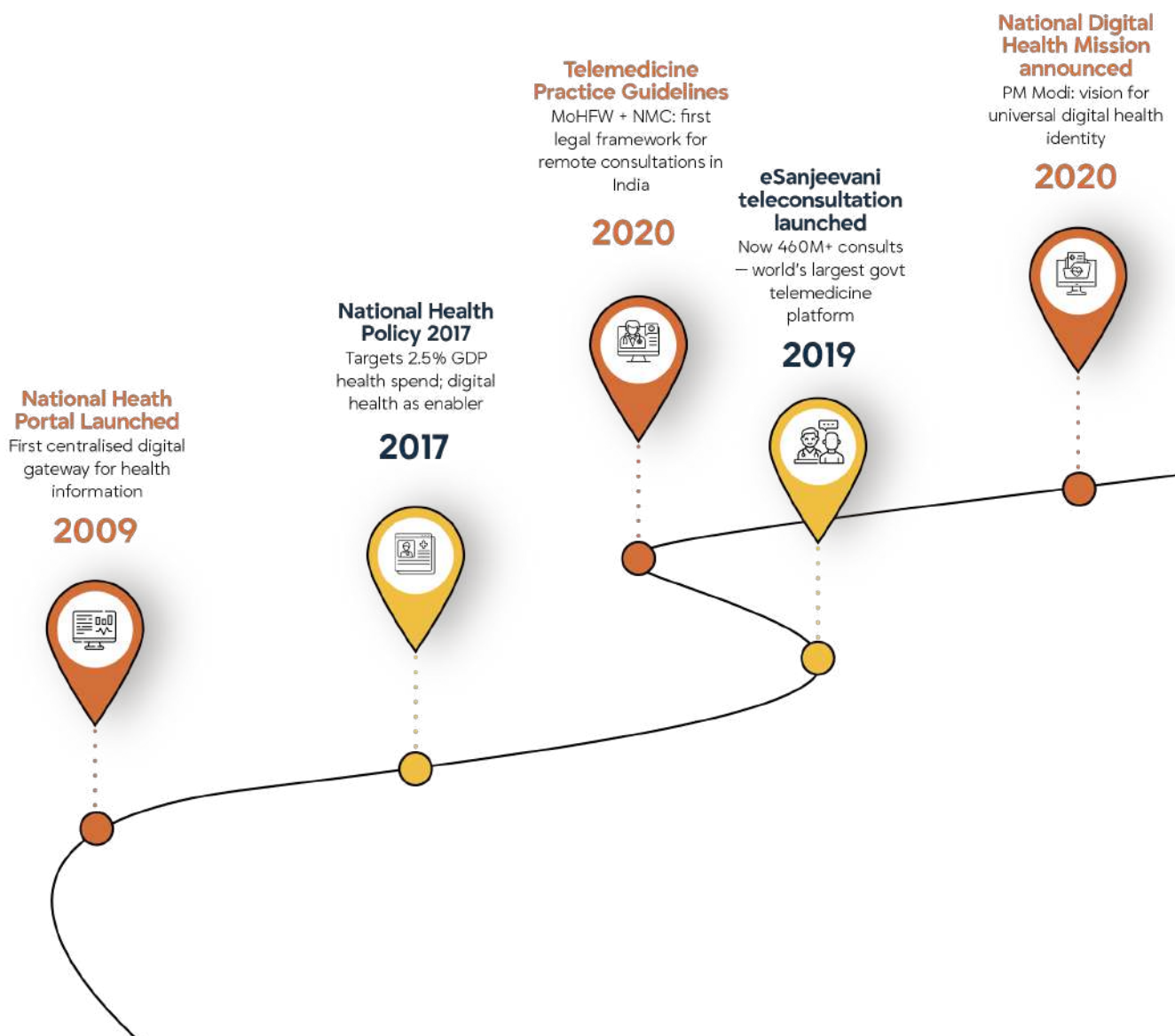
3.1 | Evolution from paper-based systems to digital health infrastructure:

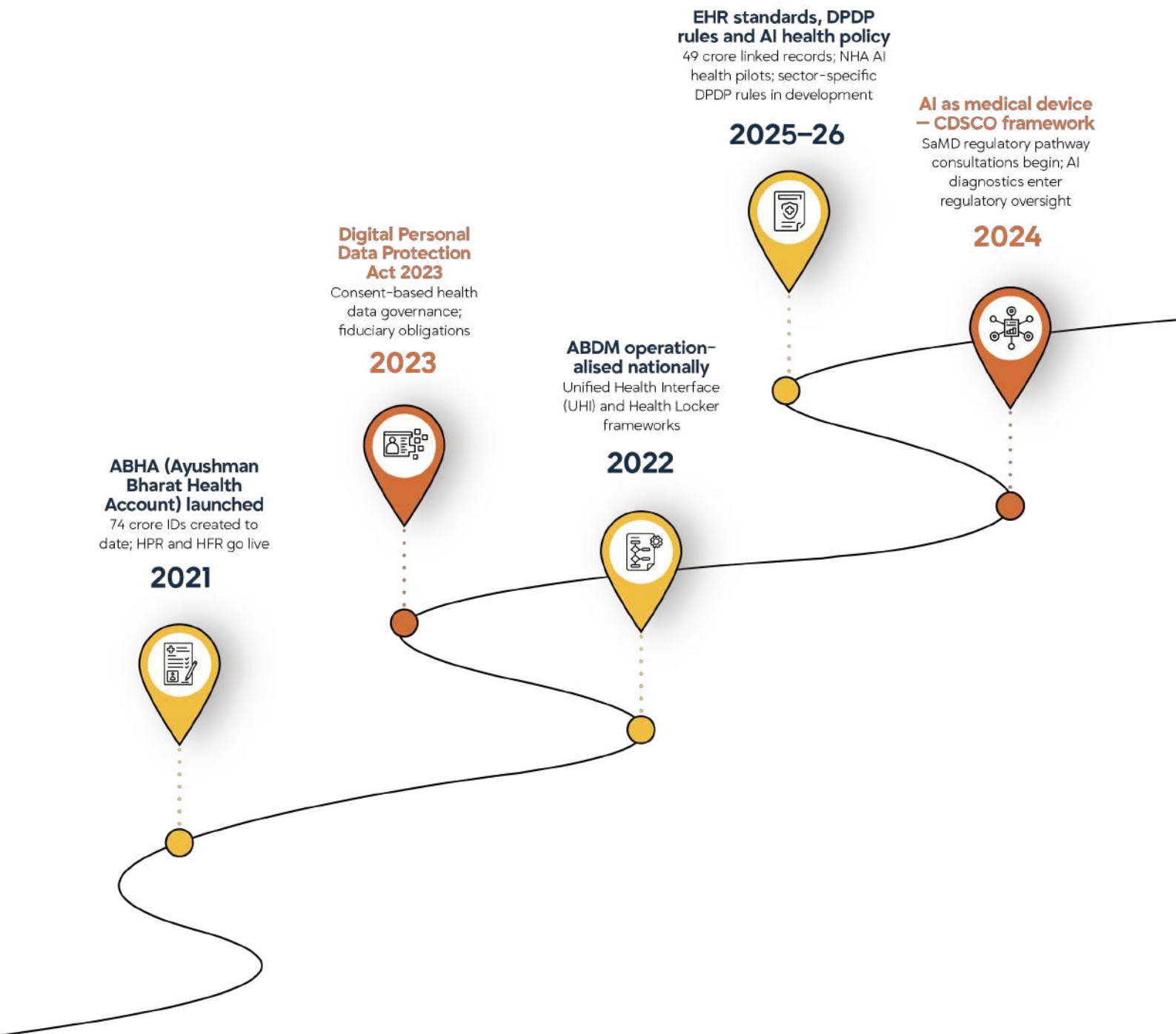
One of the most consequential shifts in India's digital health journey is the move away from paper-based records toward electronic health records (EHRs) and digital clinical workflows. For decades, the absence of longitudinal patient records meant that care was episodic and disconnected; a patient visiting a new facility would arrive without a history, forcing clinicians to start from scratch. Digital health records, linked through Ayushman Bharat Health Account (ABHA) and accessible with patient consent, are beginning to change this, enabling continuity of care across providers and geographies. Beyond patient records, the digitization of disease registries, immunization data, and vital statistics is improving the quality and timeliness of public health information available to planners and policymakers.



India's Digital Health Journey

From paper registers to national digital infrastructure



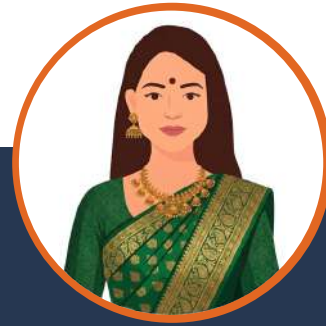


3.2

ABDM and the Architecture of a Connected Health Ecosystem

The COVID-19 pandemic accelerated this shift dramatically, demonstrating both the fragility of analog systems under pressure and the potential of digital tools to sustain continuity of care. Initiatives such as CoWIN, eSanjeevani, and the rapid scale-up of telemedicine showed that India's population was ready to engage with digital health platforms when they were made accessible and relevant. The imperative now is to build on this momentum with a durable, interoperable infrastructure that serves every segment of the population.

The Ayushman Bharat Digital Mission (ABDM) is the cornerstone of India's digital health strategy, providing the foundational architecture for a unified, interoperable health ecosystem. It has registered more than 88 crore accounts and has linked more than 98 crore health records. At its core, ABDM enables every citizen to have an Ayushman Bharat Health Account (ABHA), a unique health identifier that links medical records, prescriptions, diagnostic reports, and insurance information across providers. The Healthcare Professionals Registry (HPR) and Health Facility Registry (HFR) are two more digital tools for improving trust and enabling better care coordination. By ensuring a federated architecture and application programming interfaces (APIs), ABDM allows private-sector innovators to build on the public digital health infrastructure, fostering a competitive ecosystem of health applications. This federated, consent-based architecture balances the need for data integration with individual privacy rights, positioning India as a global model for population-scale digital health governance.



Meet Sunita, A 42-year-old Teacher From Jaipur Managing Type 2 Diabetes. Every Time She Visited A New Clinic, She Carried A Worn Folder Of Paper Prescriptions And Lab Reports — Half Of Them Misplaced, None Of Them Complete. Today, Her Abha Id Tells The Whole Story. Her Endocrinologist In Jaipur, The General Physician She Saw During A Work Trip To Pune, And Her Pharmacist Back Home All Access The Same Verified Record — With Her Consent, In Seconds. Her Insurer Processes Her Annual Check-up Claim Without A Single Physical Document. Sunita Doesn't Think About Interoperability. She Just Knows Her Doctors Finally Understand Her Full History.

3.3

Expanding Access Through Digital Channels: Telemedicine and Remote Care

Telemedicine has emerged as one of the most impactful applications of digital health in India, dramatically expanding the geographic reach of specialist care. The eSanjeevani platform, launched by the Ministry of Health and Family Welfare, has served 46,99,36,308 patients to date, having onboarded more than 2 lakh service providers, connecting patients in remote and underserved areas with doctors they would otherwise never be able to access.

The Telemedicine Practice Guidelines of 2020 provided the regulatory framework that legitimized and accelerated this shift, enabling registered medical practitioners to consult, diagnose, and prescribe digitally for the first time. For patients managing chronic conditions, digital channels have reduced the need for repeated in-person visits, lowering both the financial and logistical cost of staying in care. As connectivity improves and digital literacy grows, telemedicine has the potential to fundamentally rebalance the relationship between geography and access to quality healthcare in India.

Uttar Pradesh offers a telling example of what thoughtful HMIS implementation can achieve. Recognising that the national platform was not meeting the decision-making needs of district administrators, the state built its own data system — the UP-HMIS — to capture indicators critical to local health planning. The result was a more responsive, actionable information infrastructure in one of India's most health-burdened states.

3.4

Data as a Public Good: Health Data in Planning, Policy, and Accountability

The digitization of health services is generating an unprecedented volume of structured health data ranging from clinical records and claims to disease surveillance reports and community health worker interactions.

When aggregated, anonymized, and made accessible for analysis, this data becomes a powerful public good, enabling evidence-based planning, responsive policymaking, and greater accountability across the health system.

As evidenced by the examples above, realising this potential requires robust data governance frameworks that protect individual privacy, ensure equitable access to insights, and build public trust in the systems that collect and use health information.

India's 'Health Sentinel' platform, developed by Wadhwani AI and deployed at the National Centre for Disease Control, illustrates the potential of AI-powered surveillance. Since its rollout in 2022, the tool has issued over 5,000 real-time outbreak alerts, replacing laborious manual screening of news and reports with automated detection — reducing analyst workload by as much as 98% while keeping epidemiologists in the loop to verify signals before they reach officials.



04

**How AI is
Transforming the
Healthcare Ecosystem**

4.1 | Infrastructure

AI is redefining how health facilities are planned, managed, and maintained. By analysing patient flow, bed occupancy, and staffing patterns, AI tools are helping hospitals optimise operations and allocate resources more efficiently – reducing bottlenecks and enabling more responsive scheduling.

In overstretched public health systems, where the margin between functional and overwhelmed is narrow, even incremental gains in operational efficiency can have significant impact on patient outcomes.

Predictive maintenance systems are reducing equipment downtime by flagging potential failures before they occur – particularly consequential in rural and district-level facilities, where a malfunctioning diagnostic machine may mean patients travelling significant distances to access basic tests.

AI-driven supply chain management is improving the availability of drugs and medical devices by anticipating demand, reducing wastage, and flagging procurement gaps before they become shortages.

At the district and state level, demand forecasting tools are enabling health administrators to plan service delivery more responsively, particularly during disease outbreaks or seasonal surges. Together, these applications are making the health system more resilient and cost-effective across the full spectrum of India's health infrastructure.





4.2 | Service Delivery & diagnosis

AI is increasingly embedded in the clinical encounter, augmenting the capacity of both specialists and frontline workers to deliver accurate, timely care. Indian startups are leading this shift;

Qure.ai uses deep learning to detect conditions such as tuberculosis, heart failure, and stroke from radiological images, while Niramai has developed a radiation-free, touchless device for the early detection of breast cancer. In ophthalmology, companies like Artelus and Remidio are enabling remote eye screening coupled with telemedicine, bringing tertiary-level care to underserved populations .

AiSteth, developed by Bengaluru-based Ai Health Highway India, converts heart and lung sounds into visual waveforms transmitted via Bluetooth to a mobile app, allowing primary care providers in rural areas to conduct cardiac and respiratory assessments that can be remotely interpreted by cardiologists, a critical innovation given India's shortfall of just 4,000 cardiologists for a population of over a billion .

AI-assisted diagnostics across radiology, pathology, and ophthalmology enable faster and more accurate readings, particularly in settings with limited specialist availability. Personalized treatment pathways, especially for non-communicable diseases, are allowing care to be tailored to individual risk profiles and clinical histories.

4.3

HR, Manpower & Training

One of AI's most significant contributions in the Indian context is its ability to extend the reach of an overstretched health workforce. **ASHABot, developed by Khushi Baby in partnership with Microsoft Research India, is a WhatsApp-based AI chatbot that empowers ASHA workers, the backbone of rural healthcare, by providing multilingual, evidence-based answers to clinical queries via voice notes, drawing from India's public health manuals and UNICEF guidelines .** Khushi Baby's broader Community Health Integrated Platform has been used by 75,000 community health workers to reach 48 million people, supported by Ministry of Health funding, and randomised controlled trials showed a 12% improvement in complete infant immunisation as a result of the digital intervention . Simulation-based training platforms and AI tutors are making high-quality medical education more accessible, allowing learners in tier-2 and tier-3 cities to develop skills previously available only in major teaching hospitals. Workforce planning tools are helping governments map the distribution of health personnel and design targeted interventions to address critical shortages.

4.4

Integrating the Pharmaceutical and Supply Chain Ecosystem

AI and digital platforms are bringing much-needed transparency and efficiency to India's pharmaceutical supply chain. Digital tracking systems are enabling real-time visibility across the procurement, storage, and distribution of medicines, reducing leakages and stockouts at public health facilities. Procurement inefficiencies — long a source of waste and inequity in the public health system — are being addressed through data-driven demand planning and vendor management tools.

The growth of e-pharmacies and digital prescription platforms is improving access to medication, particularly for patients in remote areas who previously faced significant barriers to obtaining prescribed drugs. These platforms are also reducing the circulation of spurious and substandard medicines by creating auditable, end-to-end digital records. The result is a supply chain that is more accountable, more responsive, and better aligned with patient needs.



4.5

Transforming Health Financing and Insurance

Digital infrastructure is fundamentally changing how healthcare is financed and how insurance operates in India. AI-powered claims processing is reducing turnaround times, enabling cashless hospitalisation at scale, and flagging fraudulent claims with far greater accuracy than manual review.

The National Health Claims Exchange (NHCX), developed under the Ayushman Bharat Digital Mission by the National Health Authority in consultation with IRDAI, aims to create a unified portal connecting hospitals nationwide with nearly 50 insurance providers, standardising and simplifying the exchange of health claims data, documents, and images to make processing more transparent and efficient.

The integration of insurance data with individual health records via ABHA IDs is enabling more accurate risk profiling, fairer premium pricing, and better continuity of care across episodes. For beneficiaries, particularly those from lower-income households covered under PMJAY, these improvements translate into a more reliable and less burdensome experience of accessing insured care.

4.6

Catalysing Research and Innovation

India's scale is one of its greatest assets in the development of AI for health. NITI Aayog, in collaboration with the Department of Biotechnology, is building a comprehensive database of cancer-related pathology and radiology images covering over 20,000 patient profiles, with a focus on cancers most prevalent in India; data that will be exposed to AI technologies to build locally relevant solutions.

The availability of anonymised, population-scale health data spanning diverse geographies, disease burdens, and demographic profiles is enabling clinical research, epidemiological studies, and the development of AI models that reflect the realities of the Indian population. Academic-industry partnerships enabled by this digital health data infrastructure are accelerating innovation in drug discovery and diagnostics. As regulatory frameworks around health data mature, India is well-placed to become a global hub for health AI research and innovation.





05

**Case Studies /
Pilots**

The journey of digitization and integration of AI in Indian healthcare is a lesson of constant innovation, large-scale implementation of solutions, and bridging the gap between pilots and what it actually does when released into the complexity of a real health system. The case studies cited below are some such examples portraying the scale of AI solutions and how these are transforming healthcare service delivery across the length and breadth of the healthcare ecosystem of our country thus reaching the last mile.



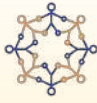
Google's Diabetic Retinopathy Screening

A deep learning model trained on over 128,000 retinal images was shown, in a landmark 2016 study in JAMA, to detect referable diabetic retinopathy with a sensitivity of 90.3% and a specificity of 98.1% which matches or exceeds the performance of board-certified ophthalmologists. In the Indian validation cohort, conducted in partnership with Aravind Eye Care System and Sankara Nethralaya, the model performed comparably. The program was subsequently piloted in primary health centres and vision centres in Tamil Nadu and Telangana. The model's output flags high-risk cases for referral to an ophthalmologist, extending screening opportunity to rural areas with limited access to ophthalmologists.



Niramai - Detecting Breast Cancer Without a Radiologist

Niramai Health Analytix, a Bengaluru-based startup, is addressing the problem of breast cancer screening from a different direction. Conventional mammography requires expensive equipment and a radiologist to read the images. Niramai's Thermalix platform uses thermal imaging using a chest-mounted camera that captures heat patterns in breast tissue combined with AI analysis to flag abnormalities consistent with malignancy. The system is designed for primary care settings and is portable, non-invasive, radiation-free, and can be operated by a trained health worker without any radiological expertise. Niramai has been deployed in over 900 locations across India, including government hospitals, primary health centers, and corporate health camps. It has partnered with state NHM programs in Karnataka and Maharashtra and with organizations including HelpAge India for community-level screening drives.



Wadhvani AI

Wadhvani AI Tuberculosis Detection and the Sputum Smear Problem

India carries 28% of the world's TB burden (Global TB Report 2024). Conventional sputum smear microscopy, which is the primary diagnostic tool in most district-level settings, is highly operator-dependent, and the shortage of trained laboratory technicians means that slides are often read inaccurately, delaying treatment. Wadhvani AI developed a system that digitizes sputum smear microscope images and applies AI analysis to detect TB bacilli. This reduces dependence on technicians' skills and enhances reporting speed. In validation studies conducted in Mumbai and Gujarat in partnership with NTEP, the system demonstrated sensitivity of 88% and specificity of 87% was in tandem with those of trained staff. Moreover, when the tool was introduced into busy district laboratory settings, it reduced average result turnaround time from 48 hours to under 4 hours.

Across these and other AI tools, several patterns repeat with enough consistency to constitute genuine lessons.

First, the algorithm is rarely the point of failure. What falters at times is the milieu and support infrastructure like lack of internet connectivity, training on using the tools, procurement bottlenecks etc.

Second, co-design with the end user makes a material difference. Pilots in which health workers were involved in shaping the tool's interface and workflow showed higher adoption than those in which a finished product was handed down.

Third, a pilot that works in one district does not automatically work in the next. Language, infrastructure, local disease burden, community trust, and institutional capacity all vary enough that each new geography is, in some meaningful sense, a new pilot.

Finally, the referral gap is structural. AI tools that improve diagnosis without simultaneously strengthening the next step in the care pathway is just a part of the whole process.

Hence, as Dr. Soumya Swaminathan, former Chief Scientist of the WHO, has observed: "The bottleneck in global health has never been the technology. It has always been the system in which the technology has to function."

This observation captures, more precisely than any performance metric, what India's AI health pilots have collectively demonstrated.



06

India's attempt to integrate AI into the health system has resonance in other countries as well. Several other countries are also on the pathway to revamping health care through digitization and the optimal use of AI, some with sufficient resources and structured regulatory environments, others with more constrained infrastructure. Each effort portrays something that India can learn and adopt in accordance to its demographic needs.



6.1

The United Kingdom : Regulation First, Then Scale

The UK's NHS AI Lab , launched in 2019, represents perhaps the most deliberately structured approach to AI adoption in public healthcare anywhere in the world. Its founding principle was that AI in healthcare must earn the right to be deployed at scale, and that earning that right requires a clear regulatory pathway, independent validation, and post-deployment surveillance.

The Lab's most visible output is the AI and Digital Regulations Service, which provides guidance on evaluating AI tools before procurement, covering clinical evidence standards, cybersecurity, data governance, and algorithmic bias assessment.

The Lung Cancer AI Program, rolled out across 11 NHS trusts, demonstrated that AI-assisted CT scan analysis reduced the time to lung cancer diagnosis by an average of 52 days compared to standard radiologist workflow providing a direct impact on stage at diagnosis and survival outcomes.

What India can take from the UK model is not the funding scale but the regulatory architecture: a pre-procurement evaluation framework, a post-market surveillance requirement, and an independent funding stream for validation that is separate from commercial deployment. Regulatory clarity in advance of deployment is the UK's most transferable lesson, and it is precisely what India currently lacks for AI-enabled medical devices.

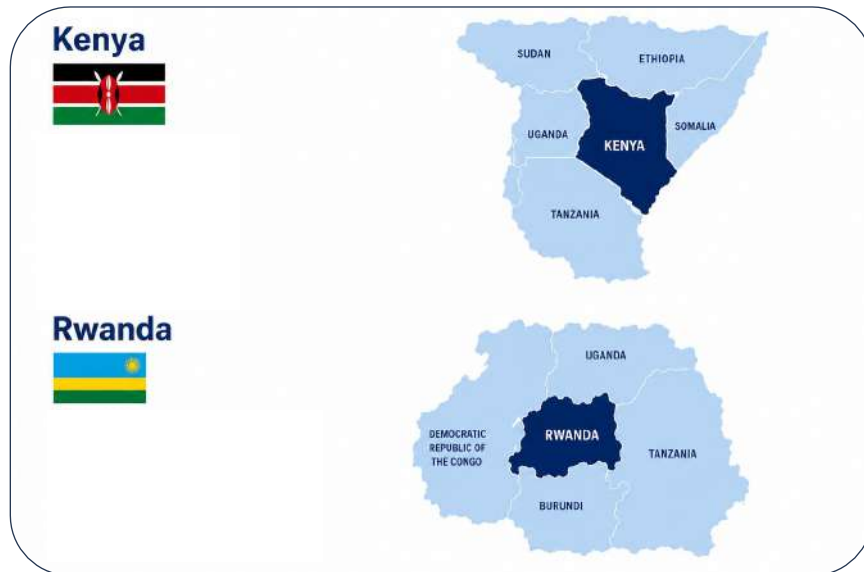


6.2 | Estonia : Interoperability as the Cornerstone

Estonia's achievement is about the federated architecture. Since 2008, Estonia has operated a national electronic health record system in which every citizen has a unique digital identity linked to their health records, every healthcare provider is required to contribute to and draw from the shared system, and every citizen has the right to view, control, and audit access to their own data. It is a federated architecture where records sit at the source (hospital, laboratory) and are made accessible through standardized exchange protocols. The distinction matters because it means the system is not a single point of failure, and individual providers retain ownership of their data while enabling national-level aggregation. This is the same federated architecture that is the backbone of ABDM.

A physician seeing a patient for the first time has immediate access to their full medication history, previous diagnoses, laboratory results, and imaging reports. Emergency care becomes faster because health care providers can access a patient's critical information in the field.

India's ABDM is, in its underlying architecture, closer to the Estonian model. ABHA is a pointer system, not a centralized record, and the UHI is a federated exchange protocol. The gap is in the mandate and adoption discipline. In Estonia, provider participation is mandatory. In India, it remains largely voluntary, and the gap between the number of ABHAs created and the number of health records actually linked reflects this.



6.3 Kenya and Rwanda –Reformation through limited resources

The most directly transferable international lessons for India may come from Kenya and Rwanda, two nations that have achieved remarkable digital health outcomes with budgets far more constrained than India's.

Rwanda's health system is built around a community health worker backbone of over 45,000 CHWs, each equipped with a smartphone and a suite of digital tools for maternal health tracking, immunization reporting, and disease surveillance. The system is integrated with the national electronic medical record and has contributed to maternal mortality falling by more than 75% between 2000 and 2020. The fulcrum of change here is making the frontline worker the centre of the digital system rather than an afterthought.

Kenya's mHealth ecosystem demonstrates how mobile-first design enables reach in low-connectivity environments. The M-Tiba health wallet allows users to save and spend money specifically on healthcare, integrated with a network of clinics and pharmacies, a form of health financing innovation that has enrolled over 3 million users. Kenya's use of AI for predictive disease surveillance, developed with support from the Africa CDC and Masimo, has been specifically designed for low-bandwidth operation, unlike many Indian pilots that assume reliable connectivity.

For India, these are the most directly relevant benchmarks: systems designed around constraint rather than despite it, built mobile-first, and centered on the community health worker as the primary interface.



07

**Patient, Community &
Societal Perspectives**

The impact of digitization and AI in healthcare depends on how effectively they are used by healthcare providers, community health workers, and patients. Technology that is not used does not improve health. In India, adopting AI is not only a technical and policy challenge but also a social one. Understanding why people adopt or resist digital health tools is as important as understanding how the tools work.

7.1

Digital Literacy – The Access Gap Beneath the Adoption Gap



India had over 820 million internet users by 2024, making it the second-largest online population in the world. But internet access and digital health literacy are not the same thing. A person who uses WhatsApp does not necessarily know how to create an ABHA, navigate a teleconsultation, or interpret a digital health report.

A 2023 survey by the Internet and Mobile Association of India found that while smartphone penetration has expanded rapidly in rural areas, the ability to perform

health-related digital tasks like booking an appointment online, accessing a lab report, and operating a teleconsultation app remains substantially lower among rural populations, women, older adults, and those with lower levels of formal education.

The digital health divide is not primarily a device problem. It is a literacy problem that intersects with the same social fault lines that determine access to health services more broadly.



7.2

Trust – The Invisible Infrastructure



Effective health systems run on trust. Patients share sensitive information with doctors because they trust that it will be used for their benefit and kept confidential. The introduction of AI and digital systems into this framework raises trust issues about whether the data and information will remain confidential.

In a 2022 qualitative study conducted by the Public Health Foundation of India across urban and rural sites in four states, the most commonly expressed patient concerns about digital health tools were not about technology per se. They were about who has access to their health data, whether an employer or insurer could use a digital diagnosis against them, and whether a machine making a recommendation about their health was trustworthy without a doctor they knew and respected behind it.

7.3

Gender Dimensions – Women at the Intersection of technology and access to health care



Marginalized communities in India face compounded barriers to accessing digital health. Across dimensions of gender, caste, income, geography, and age, large segments of the population are less likely to own a smartphone, have independent internet access, or possess the digital literacy needed to navigate health platforms effectively. Health-related decision-making, particularly in rural and low-income households, is often not individual — it is mediated by family structures, community norms, and social hierarchies that shape who can seek care, when, and through what means.

Beyond access, there are dimensions of comfort, trust, and safety. An individual seeking reproductive health advice, mental health support, or information about domestic violence or substance use through a digital platform is not only seeking health information — they are also navigating questions of privacy, stigma, and personal safety that are specific to their situation and social context. Digital health tools designed without attention to these dimensions — without ensuring, for instance, that a user's sensitive health data is not accessible to others sharing a device or a household — may inadvertently create new vulnerabilities for the very populations they aim to serve.



08

Way Forward :

How can digitization of health systems & AI be optimally integrated

India's AI health opportunity is real. The challenge, and the reason this report has been necessary, is that the gap between what is possible and what is consistently delivered remains wide. Closing that gap is not just a technical problem. Several cross-cutting themes emerge clearly from the preceding chapters.

AI tools work where the surrounding system is ready to support them. Diagnostic AI without a referral pathway, or teleconsultation without digital literacy, delivers partial benefit at best. The tool is necessary but not sufficient.

The gaps that AI can most immediately help to close are the gaps created by the unequal geographic distribution of specialists like radiologists, cardiologists, ophthalmologists, mental health professionals, and the absence of continuity in health records. These are large, important, and addressable.

8.1 Policy Recommendations



with dedicated funding, a cross-ministry governance structure, and a five-year roadmap. This mission should coordinate AI deployment across public health programs, set procurement standards, fund independent validation of AI tools, and report publicly on outcomes. Without a dedicated institutional home, AI health policy will continue to develop in silos across MoHFW, MeitY, CDSCO, NHA, and IRDAI without strategic coherence.

The framework should classify AI tools by clinical risk, require pre-market validation using Indian population data for high-risk applications, mandate post-market surveillance, and establish an adverse-event reporting mechanism specific to AI failures. This framework should be operational within 12 months.

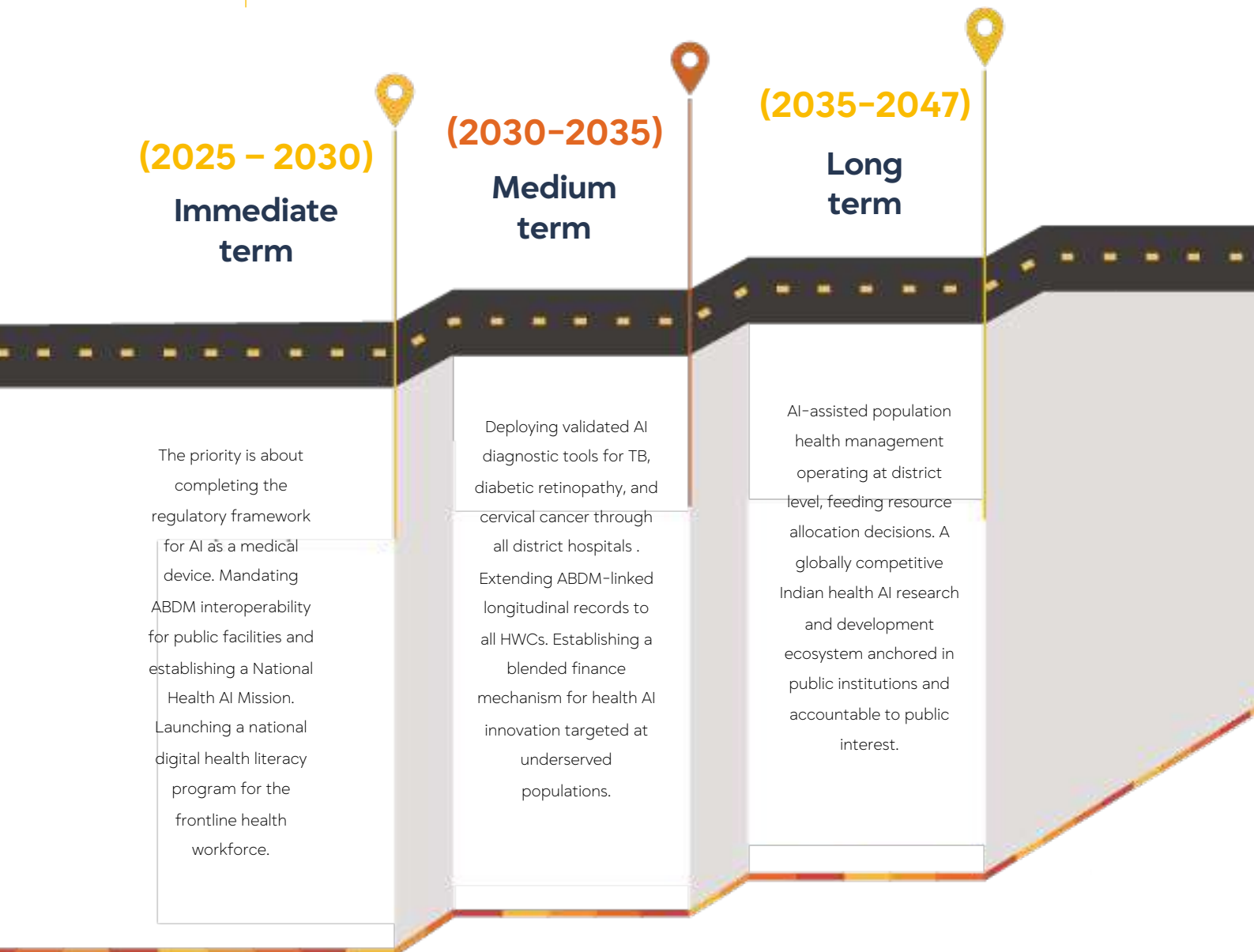
for all facilities receiving public funding, with a graded implementation timeline and financial incentives for private sector adoption. The current voluntary framework has produced 74 crore ABHA IDs and 49 crore linked records, but the disproportion between IDs created and records linked reveals the adoption gap that only mandates and incentives can close.

clarifying consent requirements for health data, obligations of health data fiduciaries, and the conditions under which de-identified health data may be used for AI training and research. Until these rules exist, every health AI developer is navigating an ambiguous legal environment, and every patient is without the specific protections they are entitled to.

through curriculum reform in medical and nursing education, structured upskilling programs for the existing workforce, and a dedicated skilling program for ASHAs and community health officers covering digital tool use, basic data literacy, and AI-assisted decision support.

8.2

A Phased Roadmap



The very fabric of India's health system is shaped by the scale of need, the pace of demographic change, and the rising burden of non-communicable disease, creating an urgency and need for immediate response. AI is a tool , one that works well when the surrounding system is designed to support it, when the data it learns from reflects the people it is meant to serve, and when the humans in the ecosystem- the ASHA, the CHW, the doctor all understand its limitations as well as its capabilities. The goal of AI in Indian healthcare is not to reduce the health system to an algorithm. It is to extend the reach of human care with the careful attention of a skilled clinician, the trusted relationship of a community health worker, the institutional knowledge of a well-run health program to every person in India who needs it. That goal is worth the considerable effort this report has tried to map.



Annexure

Annexure 1: List of Abbreviations

ABHA	Ayushman Bharat Health Account
ABDM	Ayushman Bharat Digital Mission
AI	Artificial Intelligence
API	Application Programming Interface
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy
CBT	Cognitive Behavioural Therapy
CDSCO	Central Drugs Standard Control Organisation
CHO	Community Health Officer
CHW	Community Health Worker
CoWIN	COVID Vaccine Intelligence Network
CT	Computed Tomography
CVD	Cardiovascular Disease
DBT	Department of Biotechnology
DPDPA	Digital Personal Data Protection Act
DR	Diabetic Retinopathy
ECG	Electrocardiogram
EHR	Electronic Health Record
GDP	Gross Domestic Product
GOI	Government of India
GSMA	Global System for Mobile Communications Association
HFR	Health Facility Registry
HPR	Healthcare Professionals Registry
HWC	Health and Wellness Centre
ICMR	Indian Council of Medical Research
INC	Indian Nursing Council
IRDAI	Insurance Regulatory and Development Authority of India

JAMA	Journal of the American Medical Association
ML	Machine Learning
MoHFW	Ministry of Health and Family Welfare
NABARD	National Bank for Agriculture and Rural Development
NCD	Non-Communicable Disease
NHA	National Health Authority
NHM	National Health Mission
NHCX	National Health Claims Exchange
NHP	National Health Policy
NLP	Natural Language Processing
NMC	National Medical Commission
NITI Aayog	National Institution for Transforming India
NPNCN	National Programme for Non-Communicable Diseases
NTEP	National Tuberculosis Elimination Programme
OOP	Out-of-Pocket (health expenditure)
PHC	Primary Health Centre
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPRA	Proportion of Population Reporting Ailments
PRO	Producer Responsibility Organisation
RCT	Randomised Controlled Trial
SaMD	Software as a Medical Device
SIDBI	Small Industries Development Bank of India
TB	Tuberculosis
TISS	Tata Institute of Social Sciences
UHI	Unified Health Interface
UPI	Unified Payments Interface
WHO	World Health Organisation

Annexure 2

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