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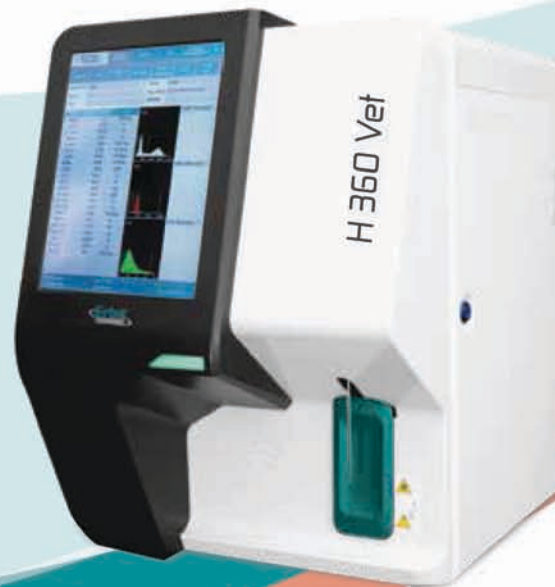


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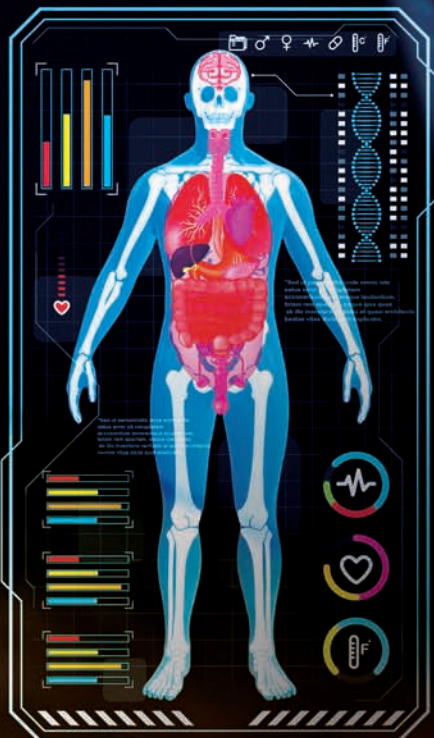
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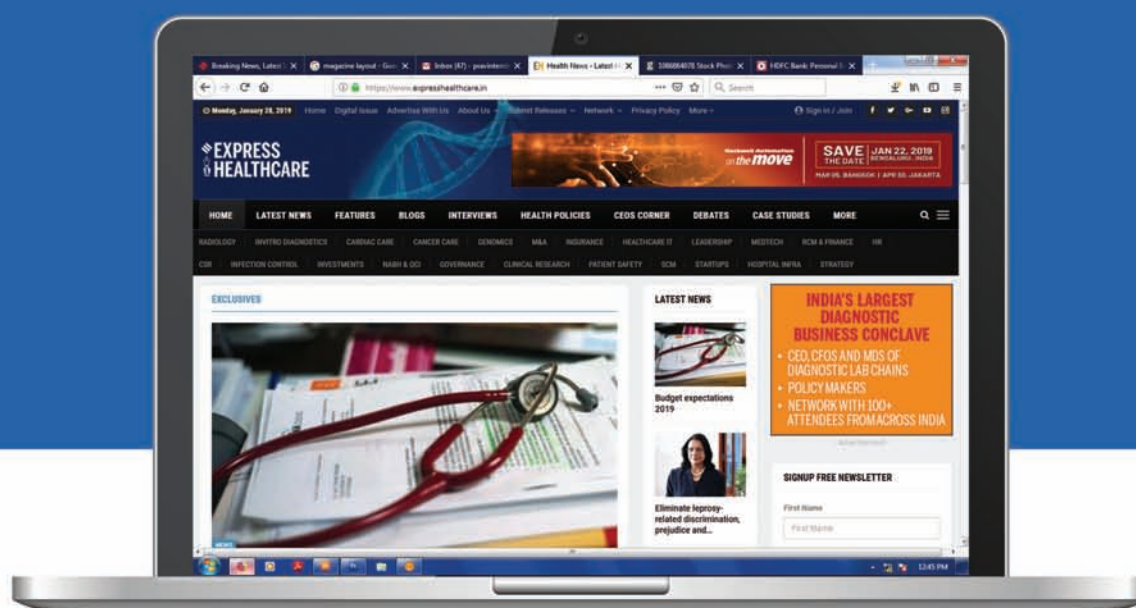
AI-ENABLED MEDTECH: THE NEXT LEAP

AI is taking medical devices beyond data capture, enabling them to interpret, predict and support clinical decisions. The shift could reshape how healthcare is delivered across India



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CONTENTS

COVER STORY



PUBLIC HEALTH

24 | IV-FCM: A NEW APPROACH TO MATERNAL ANAEMIA

MEDTECH

26 | WHAT YOUR SPEECH COULD REVEAL ABOUT YOUR BRAIN HEALTH

STRATEGY

28 | BEYOND TRADITIONAL SENIOR LIVING

FINANCE



P8: INTERVIEW
ALKA GOEL
FOUNDER,
ALKEMI GROWTH CAPITAL



P8: INTERVIEW
MANSI AGGARWAL
PARTNER,
ALKEMI GROWTH CAPITAL

EDUCATION



P12: INTERVIEW
DR PADMA VENKAT
DEAN, SCHOOL OF HEALTH
SCIENCES AND
TECHNOLOGY, UPES

LEADERSHIP



P14: INTERVIEW
DR UPASANA ARORA
MANAGING DIRECTOR,
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When regulations misfire

India's medical device makers continue to point out how amendments aimed to promote Ease of Doing Business actually end up doing just the opposite.

In a letter dated August 11, 11 national associations urged the government to reconsider the Draft Drugs, Medical Devices & Cosmetics Bill, 2026. The associations seek a standalone Medical Devices Act and a risk-based, engineering-focused regulatory framework, citing concerns around criminalisation of technical lapses, compliance burden, and the absence of an independent medical devices regulator. They also urged the MoH&FW to undertake a structured stakeholder consultation before finalising the Bill.

Against this backdrop, the amendments to the Medical Devices Rules 2017, announced on August 24, brought both relief and grief.

August 24's Gazette notification to the Medical Devices Rules, 2017 (G.S.R. 743(E) Amendment to Medical Device Rules, 2017) announced the inclusion of the European Union in the list of recognised stringent regulatory jurisdictions for waiver of clinical investigation requirements. Both Association of Indian Medical Device Industry (AiMeD) and Medical Technology Association of India (MTaI) have appreciated this move.

Another amendment has proved to be a double edged sword. On the positive side, manufacturers outsourcing product sterilisation to another facility holding a valid licence will no longer be required to obtain a separate loan licence for the outsourced sterilisation activity. This obviously reduces duplication, administrative burden, compliance costs and associated timelines, particularly for manufacturers that do not have in-house sterilisation facilities.

But it has been replaced with a mandate to mention sterilisation subcontractor details on every medical device package. Rajiv Nath, Forum Coordinator, Association of Indian Medical Device Industry (AiMeD) warns that this move, "instead of resolving industry concerns, has pushed manufacturers from the frying pan into the fire."

Pavan Choudary, Chairman, MTaI points out that removing separate licensing for outsourced sterilisation and setting uniform testing fees reflect a practical approach to reducing operational delays.

However, the MTaI statement cautions that the real impact of these changes will depend on how they are implemented on the ground. Clear guidelines are still needed on eligibility for EU-approved devices, the rationale behind specific fee structures, and the respective responsibilities of device makers and sterilisation units. Streamlining procedures must go hand in hand with strong quality checks and transparent, accountable post-market surveillance.

The AiMeD statement explains that the requirement for compulsory labelling of subcontractor details on each product is especially troubling for export shipments. It will reduce customer service flexibility, as manufacturers will be forced to wait for sterilisation by the subcontractor whose license number is printed on the packaging, rather than choosing the facility with the fastest turnaround time. Depending on cobalt strength and backlog, shipments could be delayed by 2-3 weeks, instead of being dispatched within a week.

MTaI recommends CDSCO consider a transition period, clarity on re-labelling versus batch-record disclosure, and alignment with global traceability norms, so that patient safety objectives are met without disrupting device availability or export competitiveness.

Nath's comments as part of the inauguration of the recent India Health event reflect the deep concerns of the domestic medtech sector. He touched on the need to position India as not just a



A recent amendment "instead of resolving industry concerns, has pushed manufacturers from the frying pan into the fire"

low-cost assembler but a genuine global hub for medical devices, moving from pseudo-manufacturing to true value-added manufacturing — where innovation, engineering, and quality define 'Made in India', not just mere repackaging, relabeling, or sterilisation.

But as he points out, genuine manufacturing means component transformation, assembly, and engineering innovation that creates measurable value addition.

Pseudo-manufacturing, where imports are lightly processed and passed off as "Made in India" need to be discouraged, and Nath recommended that minimum value-addition norms (e.g., 35-40 per cent) need to be in place to ensure credibility and prevent circumvention.

He also highlighted that competitiveness requires adherence to ISO, CE, and USFDA benchmarks and advocated that Indian medtech manufacturers must invest in quality systems, testing infrastructure, and certification to win global trust. He mentioned that the Indian Certification of Medical Devices (ICMED) Scheme was created to help build competencies and certify these to global ISO standards as the Bureau of Indian Standards (BIS) is not enough.

He once again made the case for a dedicated Medical Devices Act with proportionate, engineering-aligned regulation. He reasoned that India's pharma sector is already constrained by CDSCO's limited scientific review capacity. He also pointed out that while the government's Biopharma Shakti programme is creating a scientific review cadre for drugs, a parallel cadre for medical devices — with biomedical engineers, clinicians, and regulatory specialists — is essential to evaluate innovation credibly.

Nath also advocated for ease of doing business reforms, aimed at simplifying approvals, reducing inspector-raj style controls, and enabling faster market entry for safe devices. This will encourage startups, attract FDI, and align India with the International Medical Device Regulators Forum (IMDRF) and global best practices and make manufacturing more attractive than trading.

However what industry deems ease of doing business adjustments to the regulatory framework will need checks and balances. And that is the regulator's responsibility to citizens and patients.

In some cases, like the mandate to mention sterilisation subcontractor details on every medical device package, might add to the regulatory burden. But in the regulator's view, this is a way to ensure quality and patient safety, allowing improperly sterilised products to be traced back to the erring facility.

Nath poses critical questions that remain unanswered: Will overseas manufacturers and their subcontractors also be required to obtain Indian licenses and print details on packaging? Will there be a transition period for revising packaging inventory for both Indian and overseas manufacturers? These questions hint at the competitive business environment of India's medtech sector.

AiMeD advocates a balanced approach, "one that ensures patient safety without undermining competitiveness, exports, and the Make in India vision." MTaI's statement too echoes this sentiment, of working "alongside regulatory authorities to ensure these reforms build a balanced, credible system - one that advances healthcare growth, safeguards patient safety, and strengthens India's standing as a global medtech hub."

Balancing between these imperatives needs both sides - all sections of the medtech industry and government - to work towards a middle path.

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INTERVIEW

Alkemi's expansive bet on healthcare

Alka Goel, founder and **Mansi Aggarwal**, partner, Alkemi Growth Capital, set out to address the funding pain points facing early stage healthcare start ups. They are betting that the next wave of opportunity lies across preventive health, medical devices, and healthcare delivery. In a wide ranging conversation with **Viveka Roychowdhury**, they explain why domain expertise matters in early-stage healthcare investing, how they distinguish enduring trends from passing fads, and why creating new capacity is as important as consolidating existing assets. Edited excerpts

Can you give us a background about Alkemi Growth Capital and your work?

Alka Goel: Alkemi Growth Capital is a SEBI-registered Category II fund focused on health and wellness. We are a specialist fund because we believe that, particularly in health and life sciences, domain expertise is essential given the convergence of regulators, clinicians, physicians and patients.

Healthcare is more complicated and politically sensitive than many other sectors. We launched the fund in 2019 with the intention of being a catalyst for healthcare and wellness companies that have the potential to become leaders in their subsectors and change their trajectory.

Our view of healthcare is very broad: wellness, preventive health, devices, diagnostics, healthcare delivery, pharma, insurance and enabling industries. Most people typically view healthcare as hospitals, pharma companies and, sometimes, diagnostics. We take a much wider view.

At the same time, we have a fiduciary responsibility to our shareholders. The idea is to create substantial returns while doing good for society.

Since our launch in 2019, we have raised two funds with a total corpus of about Rs 1,000 crore. We have invested in about 23 companies, with another three in the pipeline. Across our portfolio, 75 per cent of companies have received follow-on



Alka Goel

investments, 90 per cent have seen material improvement in EBITDA margins since investment, and 25 per cent have expanded into international markets.

We are quite prolific at the early stage. Most funds are sector agnostic and may have one or two dedicated healthcare personnel, while we have five to six at any point in time. This gives us the capacity to develop deep relationships with operators and help our portfolio companies create value where needed.

What was the trigger for setting up Alkemi Growth

Capital? And explain the name. Is it taken from *The Alchemist*? Do you view your efforts as an attempt to turn ordinary things into gold?

Goel: When I was naming the company, we happened to be sitting in my apartment in New York, and *The Alchemist* was lying right there. I'm an avid reader, and I had invited some friends over to brainstorm a name.

The medicine, the transformation to gold, the magic, the idea that if you believe in something, the whole universe is with you — Alka, Mansi — it was all there. It felt as if that was the name we were meant to have. When you



Mansi Aggarwal

look back at the coincidences, you start feeling a sense of wonder.

And, first and foremost, the domain name was available, which itself is a big issue when naming a company.

But you asked how it came about. That's where Mansi comes in.

Mansi Aggarwal: I'm a doctor by training, and I started a medtech company soon after I graduated. Having studied at Stanford and then returned to India, I realised the stark differences after experiencing a different form of healthcare. Some countries do certain things better than India, while in some ways India does much

better than others.

When I returned, I realised that medical devices needed a lot of innovation. I personally experienced people not being able to get transferred between hospital beds. Sometimes a surgery was delayed by a day or two because there was no one to transfer a patient from one OT to another. And this was at AIIMS, the apex medical research hospital in the country. If the infrastructure was so poor there, I couldn't imagine what it was like elsewhere.

I also struggled to raise capital for a healthcare company that I believed had

significant potential. Comparable companies in the US would have been generating \$250-300 million in revenue. But because we were in India, there were fewer than 10-20 funds at that time. This was in 2009.

The lack of expertise and capital available to healthcare entrepreneurs led me to believe that domain expertise was needed. More capital had to go into healthcare, and that capital had to be domain expert because what we see can be very different from what a sector-agnostic fund sees.

We are not saying this with arrogance. But being close to operators and the healthcare ecosystem, you realise that the gaps are much wider than they appear.

Goel: I had spent about 17 years in New York, working in healthcare with McKinsey & Company and working with about 350 companies. When I studied the healthcare investment landscape, particularly life sciences and healthcare, there were focused funds for exactly this reason. How do you assess a cancer diagnostic? Everyone will say cancer diagnostics are needed, but whether it works and what the FDA bar will be are much harder questions.

There was clear evidence that domain-focused funds tended to do better because of their expertise, not necessarily at an individual fund level, but at the median and average level.

When Mansi and I joined hands, the pitch was simple: we know healthcare. Mansi had invented devices and started a company, while I had worked with 350 healthcare companies.

Of course, we had to start, make our own mistakes and deliver. Today, we are not just investing; we are also building the ecosystem. People don't appreciate how much work goes into not just finding companies to invest in, but actually helping build the ecosystem.

For example, we've partnered with government institutes to train entrepreneurs and doctors on

becoming entrepreneurs. It's not enough to innovate; you have to understand the commercial strategy.

We've invested in companies that most people would not touch. Whether they deliver remains to be seen, but investing in a diagnostic test requires much more conviction and courage because of the complexity of the science and the uncertainty involved.

That was the passion with which we started. Today, we've touched almost 3,000 companies.

As an early-stage funder, what's your exit plan and timeline?

Goel: When we underwrite a company, we estimate a five- to six-year holding period because it takes that long for companies to really blossom.

We come in when there is proof of concept in the core segment in which they participate. The expectation is that over five to six years, the company will blossom. That doesn't mean they don't raise capital from other investors in the interim. Many have raised substantial rounds after we came in.

The expectation in the immediate follow-on round is not an exit. It is really a five- to six-year horizon.

As healthcare moves from curative to preventive care, and India's demographics shift towards an ageing population, does there need to be a shift towards less visible but increasingly necessary parts of healthcare?

Goel: Healthcare is much wider. Diagnostics and hospitals are the visible parts of the value chain, and there has been a lot of late-stage capital flowing into them.

But even diagnostics is still largely unorganised. Only about 30 per cent is probably organised into national or heavily regional chains; the rest remains standalone labs. There is therefore enough runway for early-stage investors because the value proposition and tests offered by these labs can differ.

Similarly, big PE firms have

consolidated a large part of the corporate hospital sector. But there are still many standalone hospitals and a need for new capacity in tier-two and tier-three markets, asset-light models and single-specialty models. These can be incubated or started with smaller pools of capital than a large multispecialty hospital requires.

So two trends are happening in parallel: consolidation, which is being driven by PE, and new capacity and new models, which are being supported by investors like us.

Healthcare also extends well beyond hospitals, diagnostics and large pharma companies.

Ten years ago, preventive health was not a topic that came up much. Preventive health means taking proactive steps to manage your health before you become a patient. That trend has caught on globally, particularly post-COVID.

It is being driven by greater awareness, more options and young companies trying to make a difference. Wellness has many aspects. It could mean tracking your health through oximeters, glucose meters, wearables and preventive tests; better food and hygiene; skincare; or gyms. All of this contributes to preventive healthcare.

The segment is growing quickly, linked to increasing disposable incomes and awareness, changing food preferences and people's willingness to spend more on taking charge of their health. Lifespans are increasing, and people are living longer with NCDs. NCDs require lifestyle changes involving food, exercise, vitamins, supplements and nutraceuticals. It is a very large aspect of healthcare and an attractive area for investment.

How do you make your bets at a very early stage? What does your due diligence process look like?

Goel: As a company grows, there is much more comfort around the data. When

someone raises an angel or seed round, they are essentially taking a bet on the founder and the broad idea.

When we invest, we typically have two to three years of data, four years at most. A late-stage investor has much more verifiable data and a longer track record.

We are slightly different from seed investors because they typically have an idea and people. We have a little bit of both: some data showing the green shoots.

Think of it as a plant. Seed funding is literally the seed; you don't know whether it will sprout. When we come in, it is more like a sapling. It has sprouted, and the question is whether it can grow into a formidable tree that can withstand the vagaries of nature.

We look at the idea and the traction, but we are particularly looking for customer love. Whether B2B or B2C, do customers like the product? Are they willing to pay for it? Do they value it? Is it performing as claimed? We try to answer those questions by speaking directly to customers, vendors and the team. Our method is a mix of qualitative and quantitative analysis. As a company progresses through its lifecycle, the emphasis shifts towards quantitative data. We are somewhere in the middle.

Ultimately, it is a combination of factors: the founders, the team they are building, the price at which the company is available, the terms we get, and the belief or thesis we have about the company and the tailwinds we see.

Because we are in health and wellness, we believe we are somewhat more informed about what may happen three to five years down the line.

How do you distinguish a passing consumer fad from a long-term trend?

Goel: It starts with a founder identifying a customer insight and creating a product or service to help people maintain their health. It could begin with someone looking for more fiber, protein or

nutraceuticals.

Which nutraceutical it is — magnesium, plant-based products or something else — will keep changing. Companies have to continuously identify new needs and customer insights.

I don't think any company can say, "This is the product and I'm going to live and die by it for the next 10 or 20 years." Companies need incremental innovation. It could be packaging, pricing, marketing or new product innovation.

Many of our portfolio companies, across products and services, have new product development teams that continually discover what customers want. They need that capability because a company cannot sustain itself on a single product.

What opportunities and trends do you see that will remain investable for Alkemi?

Goel: Healthcare and wellness are fundamental needs and are growing at two to two-and-a-half times GDP. There are opportunities in every segment.

Take medical devices. As an industry, manufacturing and assembly were not well developed in India, and 80-85 per cent of medical devices were imported. That is changing. We are seeing companies develop organised and global ambitions in medical devices.

As India becomes more self-reliant, entrepreneurs are asking how they can create products here rather than import them. Can they meet the same quality and cost? Import substitution is feasible, as is innovation in medical devices.

Lenskart, for example, is ultimately a medical device company because prescription glasses are medical devices. It grew in what was a completely unorganised market, initially importing and later developing its own manufacturing and vertical integration.

We've also heard of the indigenously developed MRI machine and other Indian-made machines becoming exporters.

The same applies to biopharma manufacturing. A lot of capex and consumables for API and FDF manufacturing were imported. Indian entrepreneurs are increasingly excited about developing these capabilities here.

Healthcare delivery presents similar opportunities. Twenty years ago, Apollo Hospitals was the only publicly listed hospital. Today, there are many publicly listed single- and multispecialty hospitals. There is a need for more single-specialty facilities because different patients require different kinds of services.

We have invested in a mental rehabilitation company. The need always existed, but the sector was not organised. The company has 1,700 beds, making it one of the largest mental rehabilitation companies offering IPD services in the world.

People are becoming more open about mental health, including dementia, Alzheimer's, bipolar disorder and addictions. These are problems that need to be tackled.

We are also seeing insurance companies, corporate wellness companies and emergency medical services becoming more organised.

The opportunities are abundant. The question for us is whether these are the right founders to back, whether we are getting the right price,

whether the company can achieve good traction, and whether the rights and governance are appropriate. It is not just about the idea.

Are you looking to raise more funds?

Goel: Yes, we will be looking very soon, probably within another 12 months.

Any quantum you would like to indicate?

Goel: That is still being debated with the existing LPs. The strategy is likely to be very similar. We will speak to our existing LPs and understand the market. We will probably have a better view in six to nine months.

With a five- to six-year holding period, what kind of returns are you looking at?

Goel: It depends on the company. Some companies will do very well and deliver 10-12x. Some will not do as well. It is always a portfolio game.

Because it is equity and risk money, we are very wary of giving clear guidelines. The macroeconomic environment also plays an important role. You don't want to over-promise and under-deliver.

We track the companies closely. Many are at ₹600-700 crore in revenue today, so hopefully they will deliver very good outcomes. Some may not, and that's the nature of a portfolio.

A fund like ours invests in 18-20 companies in a fund. Some will not pan out because

there is risk attached to investing early. Some will over-deliver, while others will meet expectations. It is classic diversification.

Is there no planned focus on women's health?

Goel: Women's health is very important because women account for 50 per cent of the population. But we don't think about health and wellness specifically through that lens.

We've invested in PeeSafe, where 80 per cent of customers were women. But did we invest because it was a women's health company? No. We invested because there was a fundamental need.

So we don't have a deliberate focus on women's health. But some of our companies naturally focus on women's health because it has probably been a neglected sector. I would say every part of healthcare is neglected.

Healthcare needs a rehaul, frankly, and not just in India. Globally, people struggle with healthcare. We are both very passionate about healthcare, and I don't think there will ever be a gold standard in healthcare. You can always do better.

You have spoken about building capacity rather than simply consolidating existing assets. The recent parliamentary committee report has also raised concerns about private-equity consolidation and its impact on consumers.

Goel: Absolutely. Look at Cloudnine Hospitals, for instance. It didn't exist. It represents new capacity. Jagruti, another company we have invested in, has opened about seven or eight new medical rehabilitation centres with our money, adding almost 500 beds.

The same nuance applies to diagnostics. In 2015, there may have been around 1,000 diagnostic tests. For some tests, samples had to be sent outside the country. Today, there are more than 5,000 pathology tests.

Look at a company such as Redcliffe Labs. Fifty per cent of its labs are NABL certified, which ensures a level of quality.

So there is quality, capacity and the value proposition. We have also done consumer research around hospitals. People go to large hospitals, which have great facilities, but you can feel lost because the footfall is so high.

Not everyone needs to go to a large hospital for every ailment. Certain specialties, such as ophthalmology and urology, are increasingly moving out into more focused settings.

The catchment area is also important. You may travel miles for cancer care, but you probably won't do that for COPD or asthma, which occur frequently.

There are also less visible problems. Nurse attrition of 45-50 per cent is happening across hospitals. Nurses are

overloaded and mostly women, and they are not paid very well. Talent is one of the biggest issues for hospitals.

We are trying to address the staffing problem, which most people would not immediately associate with healthcare.

Take laundry. We've invested in a laundry company. What does laundry have to do with healthcare? An ICU bed generates five to six kilos of laundry every day. Laundry is an essential but non-core function.

Food is another example. Every patient needs a different kind of food. Hospitals are running larger restaurants than hotels. Food is an essential part of getting better. It is part of the treatment.

That is the point of our expansive view. Infection control, food, cleanliness and other essential functions all contribute to healthcare outcomes.

Even a company focused on cleaning hospitals can be part of healthcare because a regular domestic worker may not know hospital hygiene protocols. Laundry, cleaning and other functions are all part of the healthcare ecosystem.

For us, I think we have one of the most diverse healthcare portfolios out there. We want to make a change. We believe that if we change even a little bit, it can have compounding effects.

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INTERVIEW

The next healthcare workforce will need a new playbook

Healthcare is changing faster than the classrooms that prepare its workforce. AI is entering clinical decision-making, digital tools are moving care beyond hospitals, and prevention is becoming as important as treatment. Yet health sciences education is still shaped largely by traditional subjects, courses and silos. **Dr Padma Venkat**, Dean, School of Health Sciences and Technology, UPES, shares how health education needs to catch up, not just by adding new subjects, but by rethinking how students are prepared for the healthcare world they are about to enter, in an interview with **Lakshmipriya Nair**

Healthcare is becoming more interdisciplinary. Are our health education programmes keeping pace with this change? What are the biggest gaps you see in the way India currently prepares students for the healthcare needs of the future?

Healthcare is undergoing a tectonic shift, becoming deeply interdisciplinary. Today, some of the most innovative, technology-based healthcare solutions are actually emerging from professionals outside the traditional healthcare sector, such as engineers and software developers. Groundbreaking point-of-care technologies, digital wearables, diagnostics, physician support systems and remote monitoring services are transforming our entire system away from being strictly hospital and doctor centred to being personalised and preventive.

The conventional academic institutions in India are struggling to keep up with this rapid evolution. While many higher education institutions are striving to adapt their curricula to the health sector needs, their structures are not inherently nimble. They are bound by national regulations and time-consuming approval processes, meaning that by the time updates are approved and implemented, they are often too little and too late. This regulatory delay represents a critical bottleneck. A skillfully designed syllabus that parks a unit in every course for future topics may be a way to address the issue. Tutorials are another way to enhance student learning on current and future topics.



In this rapidly changing global landscape, our academic institutions must remain abreast of global scenarios, industrial needs, and successfully implement flexible yet robust curricula. We cannot teach what we do not know! Hence the faculty must quickly upskill themselves. The rise of advanced technology and Artificial Intelligence forces us to look inward and deeply introspect on the core strengths and foundational relevance of our educational systems in India.

From public health and nutrition to biotechnology and digital health, new career paths are emerging. How should institutions prepare students for this changing health sciences landscape?

The World Economic Forum's (WEF) Future of Jobs Report 2025 highlights that the global labour market is experiencing a massive structural churn with technology and healthcare emerging as two of the primary growth sectors leading up to 2030.

Predicting the exact nature of jobs even five years into the future is incredibly challenging because the health sector landscape is in a state of flux. However, we know that graduates from technology-oriented disciplines such as biotechnology, bioinformatics, biomedical engineering, and digital health will find themselves in high demand by industry and R&D. Beyond the permanent and vital need for doctors and nurses, there will be a parallel surge in demand

for allied health professionals, including experts in nutrition, dietetics, physiotherapy, and hospital-related technologies.

For students and parents worried about automation and the threat of artificial intelligence replacing human professionals, the outlook is actually highly reassuring. The WEF projects that between 2025 and 2030, tech-driven changes will create a net growth of 78 million jobs globally.

Within healthcare, AI is predicted to augment human capabilities rather than replace them. AI-augmented jobs will emerge across healthcare management, research, and teaching within both government and hospital systems. Our responsibility as educational institutions is to prepare students to work alongside these technologies, ensuring that AI-driven automation operates with competent and ethical human oversight and judgement, thereby enhancing health outcomes and administrative efficiency.

Do students today need to understand prevention, wellness and public health alongside clinical or technical skills? How can this be built into health education?

Absolutely! In an age dominated by constant digital distractions and sedentary habits, self-care, personal wellness, and public health awareness are more critical for our students than ever before. We must move beyond just domain specific and technical training; there is an absolute necessity to integrate wellness

and active lifestyle in student cycles. Opportunities to contribute to public health should be part of student experience. These may be as social internships, tutorials and projects.

While traditional sports and cultural activities remain highly valuable, we must proactively help students establish healthy routines that balance diet, regular physical exercise, and mental resilience. It is equally important to engage them in hands-on projects that focus on environmental sustainability, planetary health, and social responsibility. At the same time, we must help them build core human values like ethics, empathy, teamwork, and compassion, alongside the critical thinking skills and confidence they will need to excel in their future careers.

To achieve this in a practical and durable way, the University Wellness Program (UWP), a pedagogical innovation was pioneered. Rather than delivering lectures on wellness/sustainability, UWP provides an experiential, learning-by-doing platform where students undertake practical mini-projects focused on self-care, nutritional health, mental wellness, and campus sustainability. These projects are a part of the university's academic curriculum and evaluation systems, ensuring long-term durability. By designing and executing these projects, students build deep self-awareness, master essential soft skills like teamwork and communication, and develop the mental resilience needed to prevent burnout in high-stress

healthcare environments. Our graduates leave campus not only technically competent but also equipped to lead wellness initiatives in their future workplaces.

With healthcare increasingly bringing together technology, life sciences, nutrition and public health, what kind of interdisciplinary skills will be most valuable for the next generation of professionals? While specialised technical and analytical skills are of course essential, they are no longer sufficient on their own. The next generation of healthcare professionals must develop what I call the "Three Cs": critical thinking, communication, and a collaborative mindset. The future of healthcare does not exist in professional silos. E.g., a nutritionist, a software

engineer, and a public health specialist must be able to speak the same language to solve complex public health nutrition issues.

Technological literacy, AI and big data, and networks and cybersecurity as the fastest-growing skills demanded by employers worldwide. Therefore, the most valuable professionals will be those who can seamlessly blend these rapid technological advancements with deep human empathy and the ability to work in cross-functional teams.

There is growing interest in traditional knowledge systems such as Ayurveda alongside modern science. How should educational institutions approach this intersection while maintaining scientific rigour?

Indian Knowledge Systems,

or IKS, and Ayurveda are absolute academic and clinical treasure troves that have been largely ignored or unexplored by mainstream higher education institutions. Today, even though frameworks like the National Credit Framework prescribe credited courses on IKS, the subject is rarely integrated into the true psyche of the curriculum. Instead, it typically hangs on the periphery like a disparate appendage.

To bridge this gap, we firstly need genuine interest, expertise and academic innovation to build a transdisciplinary curriculum. There is a need to highlight the value of integrated modules. We must train health sciences students to apply clinical research, chemical profiling, and epidemiological studies to natural products and holistic

traditional practices.

Looking ahead, what are the emerging areas in health sciences that you believe students and educators should be paying greater attention to today?

The single most critical area of focus must be embedding relevant technology aspects into all health sciences programs, irrespective of the specific discipline. Whether a student is studying microbiology, public health, nutrition, nursing or clinical medicine, they must graduate with strong technological literacy.

We must pay attention to emerging domains like health informatics, bioinformatics, public health data analytics, and biotechnology. As highlighted by WEF, the balance between human

expertise and machine capabilities is shifting. Educators must design learning systems that teach students how to leverage AI tools, analyse complex data, and manage digital health platforms. The goal is to ensure that technology is never treated as a separate, isolated subject, but is instead woven directly into the clinical fabric of every single health program.

If you could change one thing about health sciences education in India to make graduates more future-ready, what would it be?

If I could change just one thing, it would be to make our health sciences education system more relevant to self, community, industrial and environmental needs.

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INTERVIEW

India's biggest strength is the quality of healthcare it delivers

Dr Upasana Arora, Managing Director, Yashoda Group of Hospitals in an interview with **Kalyani Sharma**, talks about the leadership challenges of scaling a hospital network and Yashoda's plans for sustainable expansion

Yashoda Group of Hospitals has expanded significantly over the years, with Yashoda Medicity being one of its biggest milestones. What have been the biggest leadership and operational challenges in scaling the organisation while ensuring quality of care remains consistent across facilities?

Our journey began in 1990 with Yashoda Super Speciality Hospitals, Kaushambi, Ghaziabad, which became a trusted healthcare institution across Delhi-NCR and was the first hospital in Ghaziabad, and among the earliest in Uttar Pradesh, to receive NABH accreditation. This early focus on quality and patient safety became an important foundation for the organisation as we expanded.

Subsequently, through our Medicentres in Karkardooma and Meerut, we expanded access to specialist care. We strengthened our clinical and referral network, while maintaining our founding culture of quality and focus on clinical leadership.

Yashoda Medicity represents the next phase of this journey. Designed as an integrated healthcare ecosystem through a "hospital within a hospital" model, it brings together 12+ Centres of Excellence and 65+ super-specialities, with dedicated clinical teams, infrastructure, and protocols. At this scale, our focus is on ensuring consistent quality across every centre and every shift through strong clinical governance, coordination between teams, adherence to



As healthcare becomes increasingly technology-enabled, our focus is on ensuring that technology strengthens clinical precision and efficiency while being effectively integrated into clinical practice

protocols, and responsiveness to patient feedback. NABH accreditation and alignment with JCI standards provide a structured framework to strengthen clinical governance and patient safety as we scale continuously.

For us, scaling has never been about expanding physical capacity alone. It has been about building the systems, people, and culture required to sustain the same standards of care as the organisation grows.

Yashoda Medicity has invested extensively in advanced clinical infrastructure and technology. What guided these investments?

Yashoda Medicity represents a long-term vision that began with a simple aspiration: to build a comprehensive healthcare institution with world-class services. Our objective is to make it a global healthcare brand, a landmark that patients across geographies associate with trust and outcomes.

Designed as an advanced tertiary and quaternary care centre, our investments in technology have been guided by the need to improve clinical precision and patient outcomes across specialties, including Oncology, Neurosciences, Cardiac Sciences, Robotic Surgery, Transplantation, and Critical Care. As disease patterns and the complexity of conditions evolve, our infrastructure must evolve with them.

We have invested over Rs 250 crore to build South

Asia's most advanced cancer care ecosystem, anchored by the Elekta Unity MR-Linac for real-time MRI-guided radiation, ETHOS with HyperSight and IDENTIFY for adaptive therapy, and EDGE with HyperArc and ExacTrac Dynamic for sub-millimetre targeting of complex tumours. Together, these technologies enable greater precision and more personalised treatment.

Our Robotics Department features the Da Vinci Xi Robotic Surgical System, Mako SmartRobotics, and the Medtronic O-arm with StealthStation Navigation, supported by integrated operating theatres and dedicated training infrastructure. We believe technology is only as good as the hands that use it. In collaboration with Intuitive, we launched India's largest robotic-assisted surgery training centre, enabling surgeons from India and overseas to train and refine their skills on these systems.

Our critical care infrastructure includes 252 modular ICU beds, with Dräger, making it among South Asia's largest modular ICU facilities. It is designed for patients requiring high-acuity monitoring following transplant surgery, complex oncology procedures, and neurological emergencies. Our Centre for Neurosciences and Bone Marrow Transplant programme, which treats both adult and paediatric patients, further strengthens this comprehensive care ecosystem.

While these are significant

investments, we evaluate them not only through financial metrics, but by their impact on clinical outcomes, treatment precision, length of stay, and ensuring patients receive the right care at the right time.

Many hospitals are expanding rapidly across India, but patients continue to raise concerns around affordability and transparency. In your view, what does a hospital need to do today to build and retain patient trust?

Healthcare is a service built on compassion, ethics, and clinical excellence. Over the last 35+ years, our focus has always been on building an organisation that can continue delivering quality care while remaining accessible and affordable. We have consistently worked to make even complex, high-end treatments accessible to patients across income groups, ensuring that cost is never the sole determinant of the care they receive.

Ethical practices are equally important, with clinical recommendations never being influenced by commercial considerations. Our doctors have no mandate or pressure to maximise surgeries; that has never been our approach. Ultimately, our focus remains on ensuring that the patient's journey is seamless and well-coordinated, from clinical decision-making to the care they receive throughout their treatment.

Could you highlight some of the infrastructure that distinguishes Yashoda Medicity?

Yashoda Medicity has been developed as an 8+ acre campus, with a capacity of 1,200 beds, 65+ super-specialties, and 12+ Centres of Excellence under one roof. The hospital has been built with large-scale critical care infrastructure, including 252 modular ICU beds, 22+ dedicated operating theatres, and multiple advanced endoscopy suites. It also houses comprehensive

transplant programmes covering liver, kidney, and bone marrow transplantation.

A distinguishing feature is our Advanced Emergency and Trauma Services, which are among the first in India to combine MRI, CT, and a dedicated Heart and Stroke Command within one continuum of care. This system is directly connected to CATH and DSA labs, allowing time-sensitive interventions to take place without patient transfers or procedural delays. The result is a faster, coordinated emergency response and improved patient outcomes in cardiac, stroke, and trauma cases, where every second counts.

In addition, the facility includes a rooftop helipad to support emergency patient transfers, and houses India's most comprehensive suite of medical technologies. Our objective throughout has been to build an integrated centre capable of delivering comprehensive tertiary and quaternary care across specialties, all within a single, connected campus.

Healthcare providers today are under pressure from rising costs, workforce shortages and increasing patient expectations. Which of these do you believe will have the greatest impact on hospital management over the next five years?

Human resources remain one of the most critical factors because healthcare brings together professionals across multiple departments, all working in tandem. Ultimately, patient care depends on the integrity and coordination of the people delivering it, supported by the right systems and technology. As healthcare becomes increasingly technology-enabled, our focus is on ensuring that technology strengthens clinical precision and efficiency while being effectively integrated into clinical practice.

Our priority is to retain

skilled professionals through an employee-friendly environment, continuous training, and professional development. At Yashoda Medicity, we focus on collaboration across clinical and non-clinical teams, creating a culture of belonging where employees feel valued and their perspectives are heard. We believe investing in people, technology, and systems together will be critical to meeting the evolving demands of healthcare.

India has emerged as a preferred destination for advanced medical care. What policy or ecosystem changes would further strengthen India's position in both domestic and international healthcare?

India's biggest strength is the quality of healthcare it delivers and its cost advantage. Patients from regions such as Africa, CIS countries, South Asia, and Europe choose India because they receive world-class treatment at significantly lower costs. At our hospitals, we are seeing strong patient inflow from South and Central Asia, including Uzbekistan, Kazakhstan, Kyrgyzstan, Tajikistan, Afghanistan, Bangladesh, Bhutan, Nepal, and Myanmar. We are also catering to a significant number of patients from African countries like Kenya, Nigeria, Sudan, and Gambia, as well as from the Middle East and West Asia. We have already signed almost 150+ MoUs and medical value travel (MVT) partnerships to support this inflow. With advanced infrastructure and cost advantage, we are contributing to India's role as a preferred destination for complex, high-end treatments.

MVT is also becoming more organised as the country builds a compelling MVT infrastructure, with advanced medical facilities, highly skilled healthcare professionals, and cost-effective treatments. Government initiatives

around integrated platforms, visa facilitation, and hospital coordination are further simplifying the treatment journey for international patients. Adding to this, as India moves towards the Viksit Bharat vision, strengthening healthcare access, digital infrastructure, and global healthcare partnerships will further support both domestic healthcare delivery and India's position as a global healthcare destination.

How are you preparing clinicians and healthcare professionals to effectively use these advanced technologies?

Preparing our healthcare professionals to work effectively with advanced technologies is an ongoing process. Technology can significantly strengthen clinical capabilities, but its impact depends on how effectively teams adapt to and use it. Our training therefore spans doctors, nursing, administration, and support teams, with programmes tailored to each function.

For doctors, this includes regular CMEs, academic sessions, hands-on workshops, and technology-specific training. Through our collaboration with Intuitive, surgeons from across the country and overseas undergo structured robotic surgery training at the Yashoda Institute of Robotic-Assisted Surgery Training Centre, India's largest robotic surgery training centre, with a dual-bay configuration for parallel and collaborative learning. Nursing training covers job training, infection control, NABH-aligned quality training, BLS and ALS certification, vaccination and cannulation workshops, and regular journal training. We have also participated in the Government of India's Mission NEEV programme, focused on early risk identification to reduce maternal deaths. Administrative teams, including IPD and OPD, are

trained in patient connect, quality care, and NABH guidelines. Across all these efforts, the focus remains on quality, patient safety, and ensuring every team member is equipped to deliver consistent care.

Could you share the Brand's long-term growth strategy, including plans for expanding the NCR network and other future expansion plans?

A significant part of our expansion will be driven through a brownfield-led approach, focused on acquiring and upgrading secondary care hospitals. This allows us to optimise capital deployment, accelerate time-to-market, and integrate these facilities into our clinical and operational framework with greater control.

Within NCR, we will also be coming up with a 150+ bedded hospital and will continue to strengthen our presence through lower capital intensity formats, including dialysis centres and cancer daycare units. These models enable access expansion and stronger referral networks without heavy capital deployment.

Geographically, our expansion is clearly defined across Delhi-NCR, including South and East Delhi, and focuses on Uttar Pradesh and the adjoining areas. Our upcoming 300+ bedded facility in Greater Noida is a key step in this direction, supported by a plan for a Biobank and Research Centre focused on rare diseases, genetics, and personalised therapies.

Medical value tourism definitely remains an important factor for us. With strong clinical capabilities and a clear cost advantage, we see steady growth in international patient inflow. Overall, we are focused on measuring expansion with strong regional depth and sustainable network growth.

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AI-ENABLED MEDTECH: THE NEXT LEAP

AI is taking medical devices beyond data capture, enabling them to interpret, predict and support clinical decisions. The shift could reshape how healthcare is delivered across India

By Kalyani Sharma

Where the adoption is real

India's MedTech sector is having its most consequential year yet on AI. A knowledge paper released by FICCI and Praxis Global Alliance at the 9th Edition of India Medical Device 2026 lays out the scale of what is at stake: a population crossing 1.47 billion, more than 230 million people expected to be aged 60 and above by 2036, and NCDs already accounting for over 65 per cent of deaths in the country.

Against this, India has just 9.6 physicians and 15.9 hospital beds per 10,000 people, both well below the global average. The gap between what the health system needs to deliver and what it currently can is precisely where the industry believes AI has the most to offer.

Dr Bipin Chevale, CEO, Gleneagles Hospital, Mumbai, points to the areas where adoption is already becoming visible. "The most meaningful AI adoption in Indian MedTech is currently visible in medical imaging, radiology, pathology, patient monitoring and cardiology, where AI is helping with faster interpretation, early detection and clinical decision support. AI-enabled ultrasound, ECG analysis and remote monitoring are also gaining traction. Surgical navigation and robotic technologies are emerging areas, particularly in larger hospitals."

That observation sets the tone for much of the conversation around AI in Indian MedTech: its strongest case may lie not in technological novelty, but in its ability to address persistent gaps in expertise and access.

Dr Sabine Kapasi, Global Health Strategist, Founder, ROPAN Healthcare, and UN advisor, sees the same pattern. "The strongest adoption is happening in areas where India faces a clear shortage of specialist expertise, particularly imaging, ECG interpretation, pathology, ultrasound guidance, patient monitoring and screening. The value of AI here is not about replacing doctors. It is about making specialist-level support available where a specialist may not be physically



The most meaningful AI adoption in Indian MedTech is currently visible in medical imaging, radiology, pathology, patient monitoring and cardiology

Dr Bipin Chevale

CEO,
Gleneagles Hospital,
Mumbai



The strongest adoption is happening in areas where India faces a clear shortage of specialist expertise

Dr Sabine Kapasi

Global Health Strategist,
Founder,
ROPAN Healthcare, and UN advisor



The barriers are largely operational, not algorithmic

Pavan Choudary

Chairman,
MtaI



Building clinical trust in AI-enabled medical technologies goes far beyond demonstrating accuracy or showcasing product features

Anuj Chahal

Founder and CEO,
Maverick Simulation Solutions

present, may be available only after a delay, or may already be handling too many cases. That ability to extend clinical expertise is where AI can make its most meaningful contribution to Indian healthcare."

Pavan Choudary, Chairman, MTaI, identifies diagnostic imaging as the clearest example. "Adoption is strongest where there's high diagnostic volume, specialist shortages and digitised clinical data - making diagnostic imaging (chest X-rays, CT, TB screening) the clearest use case. In practice, radiology includes chest X-ray and CT triage products. Cardiology includes AI-assisted ECG interpretation and remote cardiac diagnostics - an Indian hub-and-spoke ECG network reported -5-minute average diagnostic turnaround, showing how specialist-level support can extend to lower-resource settings. Ophthalmology and pathology/digital microscopy include retinal images and pathology slides that suit algorithmic analysis; AI is increasingly embedded in monitoring and clinical decision-support tools rather than sold as stand-alone products."

"For India, the most consequential applications aren't the most futuristic - they're the ones that screen large populations, prioritise abnormal cases, shorten reporting time and connect scarce specialist expertise to patients outside metro hospitals."

The emphasis on access also comes through in the experience of Anuj Chahal, Founder and CEO, Maverick Simulation Solutions. "The most meaningful AI adoption in India is occurring where the technology addresses a clearly defined clinical or operational problem, works with structured data, and delivers measurable improvements in speed, consistency, or access. Solutions that produce quantifiable gains such as faster turnaround times, more consistent interpretation, or expanded specialist reach."

"AI-enabled diagnostics remain the most promising area for scale, particularly in radiology, ophthalmology, pathology,

ECG interpretation, and point-of-care screening. Imaging is a natural starting point because digital scans can be analysed consistently; AI can support triage, flag urgent cases, assist reporting, and extend specialist expertise to hospitals that lack adequate access to radiologists or other specialists.”

For Vikas Sharma, COO, Cryoviva Life Sciences, the significance extends beyond individual devices. “AI is opening a new frontier for MedTech; however, the impact goes well beyond the application of AI-powered devices in hospitals. In diagnostic services, imaging, monitoring, and laboratory medicine, the technology could aid in translating the biological and clinical data into information that will enable better decision-making. The future for life sciences lies in linking those abilities to developments in precision medicine, regenerative medicine, and data-based patient management.”

The first question, therefore, is not where AI might eventually find a role, but where that role is already becoming visible in clinical practice. The pattern is clear: the applications gaining traction are those where AI can help extend scarce expertise without requiring the health system to wait for the specialist workforce to expand.

The device becomes a decision partner

If the first stage of AI adoption has been about helping devices interpret information, the next stage is about changing the role of the device itself. Medical devices are increasingly being designed to analyse data, identify patterns and support decisions rather than simply capture measurements.

Dr Sameer Vankar, Consultant Interventional Cardiologist, Medicovert Hospitals, Kharghar, Navi Mumbai, describes this shift from the perspective of day-to-day clinical use. “AI is helping medical devices become more intelligent and useful in day-to-day clinical practice. It can save valuable time during the diagnostic work-up by analysing large



The future of MedTech powered by AI would increasingly integrate diagnostics, continuous monitoring and predictive analysis of biological and patient level data

Vikas Sharma
COO,
Cryoviva Life Sciences



The next generation of AI-enabled medical devices should be accessible, affordable and easy to use

Dr Sameer Vankar
Consultant Interventional Cardiologist,
Medicovert Hospitals,
Kharghar, Navi Mumbai



The development of AI-powered technologies is gradually transitioning from standalone medical devices to platforms capable of processing multiple data types

Shrish Kumar
CIO,
Sri Balaji Action Medical Institute, Delhi

amounts of patient data and helping clinicians identify abnormalities more quickly. It can also support therapeutic decision-making by providing additional insights that help doctors choose and plan appropriate treatment. Another important benefit is remote monitoring, where AI-enabled devices can continuously track a patient's condition and alert the healthcare team to significant changes, allowing timely intervention even when the patient

is not physically in the hospital.”

The change is also reflected in device design itself. “As far as design is concerned, the development of AI-powered technologies is gradually transitioning from standalone medical devices to platforms capable of processing multiple data types,” says Shrish Kumar, CIO, Sri Balaji Action Medical Institute, Delhi.

Dr Ranjan Shetty, Medical Director & Lead Consultant -

Cardiologist, SPARSH Hospital, Infantry Road, Bangalore, takes the argument further into the hospital environment. “From the viewpoint of hospital technology, integration holds greater promise. The intelligent capabilities of these devices become more valuable when their insights can be integrated into electronic medical records, PACS systems, laboratories, and clinical work processes. Designing intelligent devices becomes a matter

of software, integration, and cybersecurity along with hardware capabilities.”

That integration is becoming important because a device increasingly sits within a wider information ecosystem. Its value is not determined only by what it can measure, but also by what happens to that information afterwards.

Ashishh Raichura, Founder & CEO, Scanbo Technologies, stresses: “Devices used to be measurement instruments. The clinician did the interpretation. That is no longer true for the modern generation of AI-enabled devices. The device now interprets alongside the clinician, and often flags what to do next.”

“This changes design in two ways. The device, the AI and the clinical record need to be built as one integrated system. Stitching AI on top of a legacy device after the fact does not work well; the signal quality, the workflow and the record all have to be designed together. The second change is that the device is no longer just an instrument. It is a decision partner.”

For Gaurav Goel, CEO and MD, Healthium Medtech, this evolution is already visible across different stages of care. “AI has the potential to transform Indian MedTech by helping clinicians interpret information faster, plan procedures more precisely, and monitor patients more effectively. Its applications are already extending across the continuum of care, from diagnosis and active interventions to post-surgical recovery. Image-based assessments are enabling more accurate tracking of wound healing, while computer-assisted technologies are enhancing pre-operative planning and intraoperative guidance across orthopaedics and arthroscopy. The integration of navigation technologies with intelligent algorithms is also supporting more data-driven planning and decision-making in robotic-assisted surgery.”

The direction of travel is therefore towards devices that are connected to the clinical context around them. But making a

device smarter does not automatically make it easier to adopt.

The barriers are operational, not algorithmic

The technology may work in a controlled setting, but health-care is an operational environment. Devices have to connect with existing systems, fit into established workflows and function within the constraints of hospitals and clinical teams.

That is why the obstacles to adoption increasingly sit outside the algorithm itself.

"The biggest barriers include limited clinical validation, interoperability issues, data privacy and cybersecurity concerns, along with the high cost of implementation. Hospitals also need trained staff, clear regulatory pathways and clinician confidence to integrate AI-enabled devices smoothly into everyday workflows," says Dr Chevale.

Dr Vankar sees another dimension to the problem: the gap between clinical and technical expertise. "One of the biggest barriers is the gap between the clinical need and the available technical expertise, as doctors understand the medical problem while technology teams understand the AI and device capabilities. Bringing both experts together on one platform is essential to develop solutions that are clinically relevant, practical and easy to integrate into existing workflows. Stronger collaboration between clinicians, MedTech experts, data scientists and hospitals can help bridge this gap and accelerate meaningful AI adoption."

The issue of workflow fit is equally important. "The most significant hurdles to routine adoption still include integration with existing systems, data quality, infrastructure preparation, cybersecurity, and physician acceptance. AI needs to make decision making easier; it does not need to add an additional interface or burden on anyone's shoulders. AI implementation will require process changes, user training, governance, and accountability," says Dr Shetty.

Chahal similarly sees data



AI needs to make decision making easier

Dr Ranjan Shetty

Medical Director & Lead Consultant - Cardiologist, SPARSH Hospital, Infantry Road, Bangalore



AI in MedTech is one of the most important levers India has to close the access gap

Ashish Raichura

Founder & CEO, Scanbo Technologies



With the right ecosystem in place, AI has the potential to help Indian MedTech improve access, affordability, and health-care capacity

Gaurav Goel

CEO and MD, Healthium Medtech

fragmentation and workflow integration as key barriers. "AI adoption in MedTech in India faces challenges that go beyond algorithms, with data fragmentation, validation gaps, workflow integration, skills shortages and economic uncertainty emerging as key barriers. Fragmented hospital systems and weak interoperability make it difficult to move AI from pilots to routine clinical use, while models developed elsewhere may not perform reliably

across India's diverse patient populations, clinical settings and devices. This makes broader local validation across different hospitals, regions and patient groups essential."

Choudary describes the barriers as largely operational rather than algorithmic. "The barriers are largely operational, not algorithmic. Interoperability means devices need to plug into HIS, EMR, PACS and lab systems, not add separate screens or manual data trans-

fer. ABDM's FHIR-based exchange is moving India in this direction, but hospital digitisation remains uneven. Workflow and human factors mean that even accurate algorithms fail if they add alert fatigue or extra steps - AI needs to fit the clinician's workflow, not the reverse. Trust and accountability require clinicians to have clarity on an algorithm's intent and limits."

"The right model for most higher-risk uses is human-in-

the-loop decision support with clear override - echoed in Indian cardiology literature on local validation, calibrated alerts and bias surveillance. Economics also matters: hospitals weigh integration costs, licences, IT infrastructure, training and maintenance, not just purchase price - adoption stays pilot-stage without demonstrated ROI. Data governance is equally important: privacy, consent and cybersecurity are patient-safety issues, not just IT issues; ICMR's ethical guidelines address this across the AI lifecycle."

An AI capability has little value if accessing it makes the clinician's job harder. The next challenge, therefore, is not simply proving that the technology works, but demonstrating that it works in the environments where it is expected to operate.

Building the evidence, earning the trust

Clinical trust has become one of the central questions around AI-enabled MedTech. Accuracy on a dataset is only one part of the equation. Hospitals and clinicians need evidence that a technology performs reliably across different populations and real-world settings.

"The major issue lies in gaining trust of the insights generated by AI. There should be adequate evidence for safety, efficacy, and reproducibility of the insight across different patient populations. As far as emerging technology is concerned, there must be evidence even after the regulatory approval of the device," says Sharma.

Dr Kapasi believes that the evidence needs to be generated closer to the environments in which the technology will ultimately be used. "Clinical trust will be built through evidence generated in Indian healthcare settings, not through accuracy numbers alone from overseas studies. AI-enabled devices need to be evaluated across medical colleges, district hospitals, private hospital networks and resource-constrained settings because the conditions in which these technologies operate can be very different."

"The evidence also needs to answer a more useful question than whether the algorithm is accurate. Does it help doctors diagnose faster? Does it reduce missed cases? Does it improve referrals? Does it reduce complications? Most importantly, does it change clinical decisions in a way that improves patient outcomes? Those are the measures that will determine whether AI moves from an impressive demonstration to a trusted clinical tool."

Chahal argues that building trust requires evidence throughout the technology lifecycle. "Building clinical trust in AI-enabled medical technologies goes far beyond demonstrating accuracy or showcasing product features. True trust is earned through transparent validation, clinically relevant evidence and continuous monitoring in real-world settings. This means defining the intended purpose clearly, testing across diverse patient populations and clinical environments, and moving beyond retrospective datasets to prospective evaluations, workflow integration and health-economic assessments. In India, shared testing and benchmarking infrastructure, supported by initiatives like the IndiaAI Mission, can help address data representativeness, bias, cybersecurity and interoperability. Ultimately, clinician involvement across the AI lifecycle from product conception to deployment is indispensable to ensure these technologies address real clinical needs, produce actionable outputs and fit seamlessly into healthcare workflows."

That need for real-world validation is also reflected in how devices are developed and tested. "AI is fundamentally transforming medical devices by evolving them from static, fixed-function products into dynamic, adaptive, and connected systems driven by software. Today, a medical device is no longer just hardware; it integrates sensors, algorithms, clinical data, and feedback mechanisms to deliver smarter, more responsive care," says Chahal.

For Dr Shetty, validation must ultimately translate into measurable clinical outcomes. "Physician trust has to come through proper validation and evidence of effectiveness, especially for varied Indian patients. The evaluation process will have to measure important outcomes such as diagnostic accuracy, patient safety, efficiency, and early intervention."

The bar is therefore moving from technical performance to demonstrable clinical impact. For MedTech companies, that means evidence cannot be treated as something added after product development. It increasingly has to influence how the technology is designed, validated and introduced into care.

Regulation is moving, reimbursement has some catching up to do

Evidence may establish whether a technology is clinically useful, but regulation determines the pathway through which that technology can enter the healthcare system. At the same time, procurement and reimbursement determine whether it can move beyond isolated deployments.

The regulatory environment is evolving, but the industry is still navigating how AI-enabled products should be assessed, purchased and paid for.

"India's regulatory and procurement frameworks are evolving, but they still need clearer, AI-specific pathways for validation, approval, accountability and post-market monitoring. Reimbursement is also an important gap, as healthcare systems need clearer models to recognise and pay for AI-enabled technologies based on demonstrated clinical value," says Dr Chevale.

Choudary points to several recent developments in regulation, while noting that reimbursement remains less mature. "Regulation: the most concrete recent development. CDSCO has formalised diagnostic AI software as requiring a formal medical-device licence, closing a long-standing gap."

"CDSCO's Draft Guidance on Medical Device Software

(October 2025) separates Software in a Medical Device (SiMD) from Software as a Medical Device (SaMD), with a four-tier risk classification (Class A-D). Class A/B is licensed by state authorities; Class C/D - including AI cancer-detection tools - falls under CDSCO's Central Licensing Authority. An Algorithm Change Protocol (ACP) allows iterative AI/ML updates without constant re-licensing, addressing the "adaptive AI" regulatory gap. Final guidance was released 21 July 2026 - a live regulatory shift worth flagging, not settled history."

"Reimbursement: less mature. Programmes like AB PM-JAY reimburse via treatment packages rather than paying separately for AI/software - the 2026 guidelines continue this package-based approach. There's room to move toward evidence-based recognition of AI that demonstrably improves outcomes or cost of care.

Procurement: beginning to respond - tenders have appeared for AI-ready portable digital X-ray systems compatible with AI chest-X-ray interpretation. Next, specifications should evaluate evidence quality, interoperability, cybersecurity and lifecycle support, not just price or an "AI" label."

The reimbursement question is also closely linked to the way healthcare institutions assess value. "India also needs regulatory frameworks that will take into consideration the evolving nature of AI while at the same time ensuring patient safety. The procurement and reimbursement systems must move towards an outcome- and value-based approach rather than focusing only on the cost of a device," says Kumar.

Raichura sees reimbursement as the larger unresolved issue. "Regulation is catching up faster than reimbursement.

CDSCO has evolved meaningfully, and India's Medical Device Rules give a working framework. AI-specific regulatory guidance is still developing, but that is true globally. Reimbursement is the bigger lag. Most Indian health insurance and payment models were built

for procedures and consultations, not for continuous AI-enabled care between visits or for the kind of point-of-care intelligence that can prevent a hospital admission. Until payment models evolve, adoption of AI-enabled MedTech in India will be concentrated in segments that can absorb the cost without insurance support: government programmes, corporate hospitals, and out-of-pocket premium care."

For Dr Vankar, the pace of evolution remains an important concern. "India's regulatory, reimbursement and procurement frameworks are evolving, but the pace remains slower compared with Western countries, particularly as AI-enabled MedTech is developing rapidly. There is a need for clearer pathways around AI validation, clinical evidence, regulatory approval, reimbursement and procurement, so that useful technologies can move from innovation to routine clinical practice more efficiently. A more responsive framework, developed in consultation with clinicians, MedTech companies and regulators, can help India adopt AI-enabled technologies faster while maintaining patient safety and clinical standards."

The issue is therefore no longer simply whether India has a regulatory framework. It is whether regulation, payment and procurement can evolve at a pace that allows clinically useful technologies to move from pilots into routine care.

The road to the patient who needs it most

The next phase of AI-enabled MedTech is likely to be defined less by standalone intelligent devices and more by connected systems that bring together diagnostics, monitoring, patient history and clinical intelligence.

For Sharma, that could fundamentally alter the way healthcare is delivered. "The future of MedTech powered by AI would increasingly integrate diagnostics, continuous monitoring and predictive analysis of biological and patient level data. Such approaches would help detect diseases early and

implement personalized care for the same.

For India, the potential is even greater since the healthcare system creates large amounts of heterogeneous clinical data. With responsible management and translation of such data into intelligence, AI can facilitate the transition of the health care delivery system to become predictive, preventive and personalised. The focus should not be on innovation for innovation's sake, but on delivering measurable clinical benefit and extending quality health care to all."

Dr Kapasi sees the opportunity in distributing clinical intelligence beyond major centres. "The next generation of devices will be more connected, predictive and embedded into clinical workflows. Instead of looking at one data point in isolation, devices will increasingly bring together imaging, vital signs, biomarkers, patient history and risk models to help clinicians identify problems earlier and make decisions with more context.

For India, the bigger opportunity is distributed clinical intelligence. A primary health centre or district hospital may not have immediate access to every specialist, but it can have technology that helps a general physician identify a high-risk patient, interpret a diagnostic signal or decide when a referral is necessary. That could change healthcare delivery at scale by extending specialist support beyond major cities and tertiary hospitals, rather than waiting for specialist availability to expand at the same pace as demand."

Choudary outlines a future in which AI-enabled devices increasingly move into primary and rural care.

"What's coming: Point-of-care diagnostics include handheld ultrasound with automated interpretation, smartphone retinal cameras for diabetic screening, AI-guided ECG patches, cartridge-based molecular tests. These bring specialist-level assessment to primary and rural care. Continuous monitoring wearables and bedside sensors track vitals, glucose, and

arrhythmias in real time, catching deterioration before it becomes an emergency. Ambient AI in clinics (mic/camera-based) auto-documents visits, cutting clinician paperwork. Imaging and pathology automation AI acts as a "first reader" for X-rays (TB, pneumonia), CT, mammography, and pathology slides, clearing normal cases and flagging suspicious ones. Closed-loop and assistive systems include automated insulin delivery, AI-guided surgical tools, decision support built into the device itself."

"What this means for India: it closes the specialist gap. Radiologists and pathologists are scarce and city-concentrated. AI lets a nurse at a rural PHC do screening that would otherwise need a referral. It enables screening at scale. TB, diabetic retinopathy, cervical/oral cancer, and cardiovascular risk are massive burdens here; cheap AI tools make mass screening programs viable. India already runs some for TB chest X-rays and retinopathy. It also plays to India's frugal-engineering strength. Devices built for patchy power, low bandwidth,

and offline inference suit the market better than hospital-grade Western equipment. Finally, it plugs into digital health infrastructure. With Ayushman Bharat Digital Mission and health IDs, device outputs could feed into longitudinal records enabling real follow-up and referral tracking instead of one-off tests."

The same shift is visible in the expectations around affordability and usability. Dr Sameer Vankar says, "The next generation of AI-enabled medical devices should be accessible, affordable and easy to use, so that they can be adopted across different levels of healthcare, not just advanced centres. Their outputs should be clinically meaningful and easy for clinicians to interpret, supporting doctors rather than replacing their judgement. They should also help both patients and doctors with follow-up, remote monitoring and long-term disease management, making care more continuous and proactive."

Dr Shetty also sees connected and predictive systems as a route to extending specialist expertise. "Next generation

devices will be more connected, predictive and contextual, with the ability to pick up early warning signs and facilitate intervention when required. For India, the potential benefits would be to extend specialist expertise to remote areas."

For Chahal, this evolution is ultimately about integration rather than intelligence alone. "The real shift for the MedTech industry is therefore from innovation-first to evidence-and-integration. The winners will not simply be those building smarter devices, but those that can demonstrate clinical value, integrate into real hospital workflows and augment clinicians rather than replace them."

Goel similarly argues that the opportunity lies in moving beyond isolated applications. "Having said that, the larger opportunity lies in scaling these applications from individual use cases to broader clinical adoption. This will depend on generating robust evidence of clinical value across diverse patient populations and real-world care settings. With the right ecosystem in place, AI has the potential to help Indian

MedTech improve access, affordability, and healthcare capacity, while also driving innovations that can be applied across other resource-constrained healthcare markets."

And for Raichura, the ultimate measure of this transition remains the patient. "The next generation will do more, not less. Devices will interpret, predict and increasingly take on defined parts of the clinical workflow directly where evidence supports it. For India, this could be significant. A community health worker equipped with the right diagnostic technology and clinical intelligence can do work that once required a specialist, a lab and weeks of waiting. She does it in minutes, for a patient she knows by name.

The important design question, in my view, is not human or machine. It is whether the patient at the centre of that care retains agency, understanding and control over what happens to them and to their health data. Get that right, and AI in MedTech is one of the most important levers India has to close the access gap."

Ultimately, the success of AI-enabled MedTech will be measured not by the number of devices deployed, but by whether those devices help close some of the access gaps that make specialist care difficult to reach in the first place. The technology is becoming more capable. The more difficult task is making that capability clinically useful, economically viable, trusted by healthcare professionals and accessible beyond the country's most advanced hospitals. That is ultimately the test for the next phase of AI-enabled MedTech: whether greater intelligence in the device translates into better, more accessible and more accountable care for the patient.

Way forward

The next leap will be about making AI-enabled devices not just smarter, but more useful, trusted and accessible. For India, that could mean taking specialist-level clinical intelligence closer to the patient.

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Chhattisgarh's efforts in ending Lymphatic Filariasis in the state

Dr Jitendra Kumar, State Program Officer, National Vector Borne Disease Control Programme (NVBDCP) and **Dr Chinmaya Das**, State Consultant, NVBDCP, discuss the state's approach, progress and the priorities that will shape its efforts towards the 2027 elimination target

Lymphatic filariasis does not arrive with urgency. It builds slowly, often unnoticed, and by the time it becomes visible, the damage is difficult to reverse. For many families, it becomes a long-term burden that affects mobility, work, and dignity.

Commonly known as elephantiasis, lymphatic filariasis is a parasitic disease caused by microscopic worms transmitted through mosquito bites. Once inside the body, these worms damage the lymphatic system, and over time, this causes severe swelling of the limbs, genitals, and breasts. People with advanced symptoms often cannot walk, work, and care for their families with their full strength. The condition is not fatal, but the suffering it causes – physical, social, and economic, is profound and lifelong.

India continues to carry one of the world's highest burdens of lymphatic filariasis, with millions still living in at-risk areas despite decades of progress. As India works towards eliminating the disease by 2027, Chhattisgarh has emerged as an important part of the national effort, with 18 endemic districts conducting a mass drug administration campaign in 2026.

The national approach has shifted accordingly. What was once a steady programme is now being run in mission mode. Mass Drug Administration (MDA) continues to be the core strategy, with preventive medicines given to entire at-risk populations. In states like Chhattisgarh, these campaigns are now conducted once a year on 10th February, with greater emphasis on ensuring in-front consumption.

The focus today is not only



Dr Jitendra Kumar



Dr Chinmaya Das

The focus today is not only on making treatment available, but also on strengthening awareness, improving participation, and ensuring that every household understands the importance of preventive care to help interrupt transmission

on making treatment available, but also on strengthening awareness, improving participation, and ensuring that every household understands the importance of preventive care to help interrupt transmission.

On the ground, the February 2026 MDA round reflects the scale of this effort. Across 18 districts, the programme was implemented through 65 blocks, with all block-level officers trained to support delivery. More than 2,200 Ayushman Arogya Mandirs reported conducting activities, with around 90 per cent actively engaged in mobilisation efforts.

For many households, the face of the programme is not a hospital or government official

but the local Mitani explaining the disease and the benefits of preventive chemotherapy. During the February 2026 MDA round, over 28,000 Mitanis participated, and close to 10,000 had been trained specifically to address refusal, while almost all were trained to ensure improved uptake of the drugs. Nearly 5,000 planning meetings were held with frontline workers, along with thousands of local influencer interactions. These efforts are helping strengthen trust and participation, especially in areas where awareness and uptake have traditionally been lower.

While there has been encouraging progress, continued efforts remain important to en-

sure wider and more consistent coverage across all communities. Awareness of the disease has increased, but there is still an opportunity to deepen understanding around prevention and the importance of taking medication regularly.

The programme is being implemented through coordinated efforts. The government leads the initiative, with technical support from the World Health Organisation. It is also supported through GSK Cares, a CSR programme by GSK in partnership with PCI, which focuses on strengthening awareness and last-mile delivery in communities.

At the same time, the impact of the disease goes beyond transmission. Conditions such

as lymphedema and hydrocele continue to affect many people, highlighting the need for both prevention and care.

The 2027 elimination target is ambitious, but it has also accelerated collaboration, community mobilisation, and focused public health action across endemic regions. Sustained efforts, consistent execution, and continued community trust will remain central to achieving this goal.

For Chhattisgarh, this is a critical phase. The state now plays a key role in the larger national effort. What happens here will shape the outcome of the broader mission.

Public health programmes often succeed at the last mile when communities are reached effectively and consistently. India's elimination target can move closer to reality if microplans continue to improve, demand generation efforts are strengthened, and families remain engaged in preventive action before the disease returns.

That is where the focus now remains.

INTERVIEW

IV-FCM: A new approach to maternal anaemia

As Uttar Pradesh scales up intravenous ferric carboxymaltose (IV-FCM) for eligible pregnant women, **Dr Priti Kumar**, FOGSI Vice President (North Zone) and President, Lucknow Obstetrics and Gynaecology Society (LOGS) discusses its role in maternal anaemia care, the importance of timely diagnosis, and lessons for wider adoption across India in an exclusive interview with **Swati Rana**

Uttar Pradesh has scaled up IV Ferric Carboxymaltose (IV-FCM) for pregnant women with moderate-to-severe iron-deficiency anaemia. What prompted this shift, and how significant is it for maternal healthcare in India?

When haemoglobin levels among pregnant women fall below 11 g/dL, it is defined as anaemia. The severity is determined based on haemoglobin levels and classified as: mild (10.0–10.9 g/dL), moderate (7.0–9.9 g/dL), and severe (<7.0 g/dL).

The shift reflects the need for a more targeted approach to managing iron-deficiency anaemia in pregnancy. Oral iron remains the first-line treatment for most pregnant women, but there are women with moderate or severe anaemia who do not tolerate oral iron, do not respond adequately to it, have difficulty maintaining adherence, or present later in pregnancy when there is less time to correct anaemia.

India has been battling maternal anaemia for decades despite multiple interventions. Where do you see IV-FCM fitting within the broader Anaemia Mukh Bharat strategy?

IV-FCM should be viewed as one part of a broader, case-based approach to anaemia control. The revised strategy places greater emphasis on identifying anaemia and its severity, understanding the underlying cause, providing the appropriate treatment, counselling, and ensuring follow-up and tracking. This reflects the recently released Anaemia Mukh Bharat



Abhiyaan Operational Guidelines (29 June 2026), which expand the earlier 6x6x6 framework into a 7x7x7 structure and move service delivery from a "Test, Treat, Talk" (T3) approach to "Test, Treat, Talk, Track" (T4).

Within this framework, IV-FCM has a defined role for women with iron-deficiency anaemia who meet the criteria for intravenous iron. It complements rather than replaces oral iron, while the wider anaemia programme also needs to address nutritional and non-nutritional causes of anaemia.

How important is timely screening and diagnosis in ensuring the success of IV-FCM therapy, and what can be done to improve early detection of iron-deficiency anaemia during pregnancy? Screening is the starting point for appropriate treatment. Routine haemoglobin testing during antenatal care helps

identify anaemia and determine its severity, while clinical evaluation and, where indicated, investigations such as serum ferritin help establish whether iron deficiency is the underlying cause.

This is particularly important because not every case of anaemia should be treated with intravenous iron. Women who do not respond adequately to iron therapy or who may have another underlying condition require further evaluation so that treatment can be directed towards the actual cause.

What criteria are being used to identify pregnant women eligible for IV-FCM, and at what stage of pregnancy is the treatment most effective?

IV-FCM is not intended for every woman with anaemia; it is reserved for selected women with iron-deficiency anaemia. The national guidelines

identify specific clinical situations, including pregnant women between 13 and 34 weeks with severe anaemia, as well as women with moderate anaemia after the first trimester when oral iron is not tolerated, adherence is poor, or haemoglobin has not improved adequately after oral therapy.

The underlying cause of anaemia also needs to be established before intravenous iron is given. Haemoglobin assessment and, where indicated, serum ferritin testing can help establish iron deficiency, while other causes of anaemia should be excluded.

Before administering IV FCM, it is important to assess for and rule out contraindications, including evidence of iron overload (serum ferritin >150 µg/L), known hypersensitivity to iron preparations or the excipients of iron sucrose or FCM, anaemia not caused by iron deficiency, liver disorders such as jaundice or cirrhosis, renal failure, acute cardiac failure, and known thalassemia, sickle cell disease, or hemolytic anaemia.

How does IV-FCM compare with conventional oral iron therapy in terms of efficacy, speed of recovery, patient compliance, and maternal outcomes?

The two approaches have different roles. Oral iron is effective, widely available and remains appropriate for the majority of pregnant women. IV-FCM is particularly useful when oral iron is not tolerated, adherence is poor, the response is inadequate, or rapid correction is required.

The key advantage of FCM is the speed with which iron

can be replenished through a single infusion, compared with a daily oral regimen over several weeks. It can therefore achieve a faster rise in haemoglobin levels and replenish iron stores more effectively in women who require intravenous iron treatment. The established benefit is the faster correction of maternal anaemia, while research continues to strengthen our understanding of its impact across broader maternal and neonatal outcomes.

One of the key advantages highlighted is single-dose administration. How does this improve adherence and reduce treatment gaps, particularly in resource-constrained settings?

The single-dose approach reduces the burden of a treatment regimen that otherwise requires daily oral iron over several weeks. Gastrointestinal side effects and the practical difficulty of maintaining daily treatment can contribute to poor adherence and treatment gaps.

With FCM, a large dose can be administered in a single sitting, allowing iron stores to be replenished more rapidly without depending on continued daily dosing. This can be particularly useful when there is limited time before delivery and timely correction of anaemia is important.

Dose in pregnancy: IV-FCM is given as an infusion of up to 1000 mg in one sitting (mixed in 100 mL of normal saline over about 15 minutes) and should not be administered more than once a week. If

more iron is required, additional doses may be given after 7 or 14 days. A woman should not receive more than 1500 mg of IV-FCM during one pregnancy.

What early observations or outcomes have emerged from the rollout in Uttar Pradesh?

The rollout in Uttar Pradesh marks an important shift towards a more case-based approach to managing maternal anaemia within the public health system. The significance of IV-FCM is not simply the addition of another iron formulation, but the ability to offer a clinically appropriate option for women who need more timely correction of iron-deficiency anaemia.

As the rollout progresses, its integration into routine

anaemia care can help strengthen a more responsive approach to women who do not benefit adequately from conventional oral iron therapy.

What logistical, infrastructure, or training challenges need to be addressed for wider adoption of IV-FCM across public health facilities?

The most important consideration is that IV-FCM is administered within a setting that can ensure appropriate patient selection, safe infusion and monitoring. Facilities need to be equipped to recognise and manage rare serious hypersensitivity reactions, and patients should be observed following administration.

The national operational guidelines provide a framework for patient

selection, contraindications, safe administration, monitoring and adverse-event reporting. Following these protocols consistently, along with ensuring that healthcare teams are familiar with the administration and monitoring requirements, is central to safe delivery at scale.

From a policy perspective, how can other states consider adopting a similar approach? What lessons from Uttar Pradesh's implementation could guide national scale-up?

The key lesson is that IV-FCM works best when integrated into an organised anaemia-management pathway rather than treated as a standalone intervention. This means identifying the women who are most likely to benefit, assessing iron deficiency

where indicated, following safe administration protocols, and maintaining monitoring and follow-up.

A phased and systematic approach can help integrate the treatment into existing public health services while maintaining the clinical safeguards needed for appropriate use. The emphasis should be on delivering the right intervention to the right patient at the right time.

What additional measures—beyond iron supplementation—are needed to sustainably reduce the burden of maternal anaemia and improve pregnancy outcomes in India?

Anaemia is multifactorial, and iron deficiency is only one of its causes. Sustainable reduction therefore requires attention to

nutritional deficiencies, infections, chronic inflammatory conditions, haemoglobinopathies, dietary diversity, sanitation and other social and environmental factors.

Alongside appropriate treatment, the broader approach should include counselling on treatment adherence and healthy diets, promotion of locally available iron-rich foods, deworming, improved water, sanitation and hygiene practices, and management of infections and other non-nutritional causes. Follow-up and evaluation of non-responders are equally important so that underlying causes are identified and managed appropriately.

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INTERVIEW

What your speech could reveal about your brain health

A simple conversation could hold clues to early cognitive decline. Researchers at the University of Sheffield are exploring this through CognoSpeak, an AI-powered tool that analyses speech and language to assess cognitive health. It could help identify patients who need further investigation before they reach specialist services.

That could address some of the biggest challenges in neurological care i.e. long waiting times, stretched specialist capacity and limited access to assessment. The approach is also being explored in conditions such as stroke and Motor Neuron Disease.

But the bigger question is whether AI can become a trusted part of clinical care. That means proving its accuracy across diverse populations, meeting regulatory requirements and showing clear value for patients and health systems.

Professor Heidi Christensen, Professor of Spoken Language Technology, and **Dr Madhu Pahar**, Research Fellow, School of Computer Science, University of Sheffield, discuss what CognoSpeak could mean for the future of neurological assessment, in an exclusive interaction with **Lakshmipriya Nair**

What's the core problem in neurological care that CognoSpeak is trying to solve?

Christensen: The core problem is the long wait time and resource intensity involved in assessing cognitive decline. Traditional clinical pathways rely on specialist memory clinics, paper-based assessments, and costly neuroimaging, creating large backlogs as populations age. CognoSpeak addresses this by providing an easy-to-use, fast, non-invasive digital biomarker tool using artificial intelligence to analyse speech patterns and language use. The tool will help triage patients with memory problems to detect people at risk of mild cognitive impairment (MCI) and early-stage dementia, reduce unnecessary specialist referrals and speed up diagnosis for those who genuinely need intervention.

Pahar: CognoSpeak is an innovative online tool which uses a virtual agent to ask 14 different memory-probing, clinically effective questions on both mobile and web platforms^[1]. Multimodal data such as audio and video are recorded and analysed by AI



Professor Heidi Christensen

to identify signs of cognitive decline such as mild cognitive impairment (MCI) or dementia^[2].

Your early results show 87 per cent accuracy and over 90 per cent sensitivity. What does that mean for clinicians and health systems trying to manage growing caseloads?

Christensen: High sensitivity (over 90 per cent) means that the tool can effectively identify

almost every patient with early signs of cognitive changes. This should drastically reduce false negatives, meaning it should catch nearly everyone showing real signs of memory or thinking changes.

For busy clinics struggling with long waiting lists, its overall 87 per cent accuracy makes it a reliable triaging tool for patients entering their waiting lists. People at low risk



Dr Madhu Pahar

can be reassured quickly by their local family doctor without needing long, stressful hospital visits for them and their families, while those at higher risk can be fast-tracked to specialists for immediate testing and early treatment.

How do you see this fitting into existing care pathways, is it a screening tool, a triage tool, or something that

changes the whole model of assessment?

Christensen: CognoSpeak is a triage and decision-support tool in primary and secondary care for those patients who are concerned about their memory.

Pahar: However, it's important to note that it won't be replacing clinicians; instead, it will improve the referral process by providing an assessment using speech

biomarkers before a patient is seen in the memory clinic.

How do you plan to scale this research to enable real-world deployment? Are you working with the NHS, industry partners or looking at commercialisation?

Pahar: Yes, we are currently collecting data from several primary and secondary NHS clinics along with various memory clinics across the UK to ensure CognoSpeak is trained using representative data in terms of gender, age, dialect and language background.

Christensen: We are currently working with the University of Sheffield's outstanding commercialisation team and exploring investment, licensing and spinout opportunities.

What made you extend the technology to other conditions? Is it possible to widen its potential across other conditions?

The University of Sheffield-based CognoSpeak project involves neurologists and computer scientists. The initial focus was on dementia assessment, but in recent years we have established systems focusing on Motor Neuron Disease (Amyotrophic lateral sclerosis) as well as Stroke survivors - both conditions mean patients are at increased risk of cognitive impairment.

What are the main barriers, be it regulatory, financial or trust-related to getting AI tools like this adopted at scale?

Christensen: There are significant barriers involved with taking a tool like CognoSpeak, where we have demonstrated excellent results on real-world data, and putting this in the hands of NHS practitioners.

A main hurdle is around the regulatory approvals needed. Because this is classified as Software as a Medical Device, we have to meet - understandably - high standards for regulators governing the UK market, and



Fig: Distribution of the multilingual English community centres across the UK, and the local community research champions who assisted in data collection [3, 4]

High sensitivity (over 90 per cent) means that the tool can effectively identify almost every patient with early signs of cognitive changes. This should drastically reduce false negatives, meaning it should catch nearly everyone showing real signs of memory or thinking changes

internationally when we expand into other markets.

We are also working with health economists to better understand the overall costs and other benefits to patients, the NHS and society as a whole.

Finally, we must ensure that all users (patients, care-partners and clinicians) trust the tool and find it meaningful to use. Otherwise, it won't achieve the intended benefits, such as improved accuracy and assessment time.

Pahar: To gain trust from users and healthcare workers, we need to make sure that this AI technology isn't just seen as a 'black box' where you feed in speech and a likelihood score is displayed without any interpretation. The underlying question "why" needs to be answered. Currently, CognoSpeak provides acoustic and linguistic cues as a personalised assessment tool; however, we are always investigating additional ways

to identify signs of cognitive decline so that the results are clear, interpretable, and clinically meaningful.

Where's the biggest opportunity for this technology to expand access, particularly in areas with limited specialist services?

Christensen: Throughout the project, there has been a deliberate focus on improving access for underserved communities, be it in rural areas or for UK ethnic minority communities where we know there are language and cultural barriers we need to better understand and address.

Pahar: One specific aspect of CognoSpeak has been to focus on the ethnic minority groups where multilingualism (English is spoken as an additional language) is common, and dementia prevalence is projected to increase most rapidly among these communities. Local

research champions worked hard to recruit multilingual English-speaking participants; however, due to limited basic English proficiency among cognitively impaired multilinguals, our data remained biased towards healthy multilinguals. This presents a perfect opportunity for CognoSpeak to expand its focus to identifying cognitive decline among multilingual English speakers in the UK.

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Christensen: The CognoSpeak project is co-lead by Prof Heidi Christensen (Computer Science) and Dr Daniel Blackburn (Neurology) with contributions from a growing number of researchers and fellow academics from a wide variety of disciplines.

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INTERVIEW

Beyond traditional senior living

As India's ageing population grows and expectations around later-life care evolve, senior living is increasingly being viewed as more than a real estate offering. The Shrem Group and Emoha partnership has led to the launch of Shremoha, a senior living platform that seeks to combine hospitality, community living and geriatric care within a single model.

Nitan Chhatwal, Founder, Chairman and MD, Shrem Infrastructure and Co-founder, Shremoha and **Saumyajit Roy**, Co-founder and CEO, Emoha Elder Care and Co-founder, Shremoha discuss the gaps in India's senior living ecosystem, the role of integrated care, and why they believe purpose-driven ageing will shape the next phase of eldercare in the country, in an exclusive interview with **Kalyani Sharma**

What gap in India's senior living and eldercare space led to the creation of Shremoha, and what are you hoping to do differently with this model?

Nitan Chhatwal: The idea came from thinking about what a senior living home should really offer. There is eldercare available through organisations such as Emoha and Age Care Labs, and there is expertise in hospitality and real estate. But we felt there was no single model that brings all of these elements together from how a senior living community is built and what facilities it should have, to how it is operated and how care is provided.

That is why we came together to create Shremoha. We want to bring these different capabilities together and create a senior living model that takes care of the entire experience.

Is the plan to eventually take Shremoha to cities across India?

Chhatwal: I hope so. That is certainly the ambition. But we want to start slowly. We are trying to do something different, so we don't want to rush the process. We want to establish the model first and then take it forward.

Our first two projects are in Delhi NCR and Pune, and we are keen to expand from there.



Nitan Chhatwal

Shremoha brings independent living, hospitality and geriatric care together. How will this work as residents' care needs change over time?

Chhatwal: When you think about people in their 80s and 90s, their care needs become much more prominent. But we are also looking at the younger elder in India—the

people in their 50s and 60s who are looking forward to having a great life for the next 30 or 40 years.

These are people who have achieved something in life and now want to upgrade their lives. They want to live in curated spaces and communities with like-minded people, do things that are meaningful and relevant,



Saumyajit Roy

and at the same time have the reassurance that geriatric care is available when they need it.

If I am 60 and my wife is 55, for example, we may want to live independently today, but we also want to know that whatever happens to either of us over the next 30 years, the community is designed to provide the

highest level of care whenever required.

Whether there is a gradual or sudden change in health, that care should already be available. Bringing that level of care together with hospitality is what makes the model different. Otherwise, we have seen real estate-led senior living examples by the dozens in India.

How do you see senior living developing in India over the next five to ten years, and what role do you see Shremoha playing?

Chhatwal: We need to be among those who seed this category. That's the hope. But let's start slow and build it properly.

What do you think older adults in India are looking for today that traditional senior living options may not offer?

Saumyajit Roy: People are living longer and they don't necessarily want to simply retire. They want to continue doing things. Once you become an empty nester, you also start looking for space and a different way of living.

The idea is to shift gears and create the work-life balance that you may not have been able to create when you were working hard. You want to create that in the later years of your life.

For us, the twin goals are not just depth of care—geriatric care, assessments, a blueprint of care and coordination but also engagement and activities, so that people remain relevant and busy.

Today, some senior living players may not have the depth of care management that a geriatric care company like Emoha naturally brings to its members. When that depth of geriatric care is blended into a senior living community, with proper

Care is often thought of purely from a physical or healthcare perspective. But care does not mean only healthcare. You need social, occupational, emotional and physical care

assessments, regular check-ups and the ability to address chronic conditions and other interventions, the difference becomes much more significant.

If you move from a conventional residential project into a senior living project where engagement or care is inadequate, the shift may not be very significant. But when the best of hospitality and geriatric care come together, it changes the experience completely. And it is measurable—you can actually measure what improvements have happened in an elder's life.

What does care mean in the Shremoha model beyond healthcare?

Roy: Care is often thought of purely from a physical or healthcare perspective. But care does not mean only healthcare. You need social, occupational, emotional and physical care.

All of this needs to be stitched into the day-to-day rhythm of the Shremoha community. From what you do when you wake up in the morning, to what you eat for breakfast and the activities

you participate in throughout the day, all of these things contribute to making you feel more fulfilled. They can improve your sleep and other health parameters as well.

It is about creating the whole environment. You have to think about everything from facilities inside the room and within the community to the ability to access small doctor appointments and other services. Every small piece of information and data can contribute to understanding the resident better and ensuring that the right support is provided.

Infrastructure is also critical. If you don't have the infrastructure, you cannot provide the level of care you want to provide. For example, if you need to put an ICU bed into a room, the room has to be designed for that possibility.

At the same time, people should not feel that they are moving into a place because they are old or dependent. You don't have to wait until retirement to live there. You should be able to enjoy the environment and feel that this is your home. You should

not feel that you cannot do certain things because of your age. The key idea we constantly talk about is ageing magnificently, living magnificently.

What does "living magnificently" mean in practical terms for a resident?

Roy: It means being able to pursue your aspirations at every age. Your aspiration could be to work as a consultant, pick up a new hobby, learn painting or sculpture. In a normal setting, you may have the thought, but that thought does not always become reality.

At Shremoha, there is an active director who thinks about these things and understands what residents may want to do. In hospitality, particularly resorts, there is somebody constantly thinking about events and experiences. We want the same approach within the Shremoha community.

Recently, one of our elders, who is 83, came to Emoha. I asked her, "What are three things you would want to do this year?" She

said, "I want to fly a kite. I have never done kite flying. I want to go on a train ride to Kerala with 20 friends. And I want to be in a fashion show."

I told her that all three would be done. One of our team members has now been given the responsibility of making these happen over the next four to five months.

If this ecosystem wasn't there, these things could remain dreams. There is a life without purpose, and without purpose, there is no life.

At every age, purpose matters. You also need exposure to new experiences. When a young child goes to school, they don't know whether they are good at chemistry or drama. They experience different things and discover what interests them.

Similarly, Shremoha's activity calendar will expose residents to new people, experiences, food, nutrition, health talks and other activities. It can make you think, "I didn't know this. This is interesting. Let me try it."

And you are trying it with a community that is also motivating you to participate. That changes the experience. In a regular apartment, it is difficult to curate all of this within your own home. At Shremoha, the idea is to have all of this available within the community.

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Hospitals don't have a revenue problem. They have an execution problem

Dr Akash Rajpal, healthcare transformation leader and former COO, Jaslok Hospital and Masina Hospital, explains why execution and not tariffs, bed additions or fresh capital will define India's next generation of successful hospitals

India's healthcare industry has attracted unprecedented capital in recent years through IPOs, mergers & acquisitions, private equity and strategic investments. Investors are backing hospitals not merely because they own valuable assets, but because they believe superior execution can unlock disproportionate value through sharper operations, higher utilisation, clinical distinction and economies of scale.

Capital is merely the entry ticket. The next decade will not belong to whoever builds the most hospitals — it will belong to whoever executes with the greatest discipline.

Indian healthcare is entering an execution era.

Boards and investors gravitate toward occupancy, EBITDA, ARPOB, ROCE and capacity additions. These metrics matter, but they are lagging indicators. They merely reveal the cumulative outcome of thousands of granular decisions made every single day across the hospital floor.

Hospital performance can be envisioned as a pyramid, built layer upon layer. Infrastructure: beds, equipment, capital expenditure confers the right to operate.

Clinical excellence, reflected in patient safety, evidence-based care, accreditation and outcomes, is what earns trust. Operational excellence — the calibre of patient flow, OT and OPD scheduling, workforce planning, revenue cycle management and supply chain — is what converts that trust into productivity. Enterprise value, the EBITDA, ROCE, ARPOB and reputation that boards ultimately chase, is simply the by-product of getting the first



three layers right.

None of this is accidental. It is engineered through discipline.

From an operational lens, the more incisive question is not why EBITDA is depressed, but what is driving it.

Is OT utilisation falling short of potential?

Are first cases commencing on schedule?

Are cancellations eroding throughput?

Is OPD-to-IPD conversion underwhelming?

Are discharge delays holding beds hostage?

Are claims being rejected over documentation lapses?

Is expensive equipment lying idle?

Are referrals leaking out through weak doctor engagement?

Address these leading indicators, and the financial metrics tend to follow.

Operational excellence begins well before a patient ever reaches the OT. It begins with the very first impression: valet parking, registration queues, elevator waits, poorly sequenced diagnostics, a chaotic discharge. Every point of fric-

tion erodes both the patient experience and the hospital's throughput.

Every hospital harbours hidden capacity. The question is whether leadership has the discernment to locate it.

At many hospitals, protracted OPD waits quietly erode clinic productivity and OPD-to-IPD conversion. Deceptively simple interventions help: digital queue management, health-awareness programmes, dedicated play areas for children, cafés, and bedside or online billing. These are modest changes, but they often lift the waiting experience and patient satisfaction more decisively than any capital-intensive investment could.

Delayed discharges constrict bed capacity, congest the ER and stall new admissions. Planning discharges a day in advance, automating discharge summaries, and orchestrating early coordination between clinicians, nursing, pharmacy, billing and insurers alongside streamlined cashless authorisation can meaningfully compress discharge turnaround and liberate beds.

Idle OTs, underutilised

equipment, fractured workflows and billing leakages quietly erode margins. Sharper OT scheduling and punctual first cases address the clinical dimension, while RFID asset tracking, utilisation analytics and preventive maintenance address the equipment dimension. On the revenue side, efficient claims processing, daily billing reconciliations and vigilant tracking of referral leakage collectively lift productivity without deploying additional capital.

Each intervention appears modest in isolation. Together, they render the hospital faster, safer and more efficient, while freeing clinicians and nurses to devote more time to patients precisely where they create the most value.

Execution, ultimately, is a function of people and culture.

Hospitals with engaged doctors, empowered nurses and motivated staff consistently outperform those that lean on infrastructure alone. Sound nurse-to-bed ratios, continuous training, transparent performance management, leadership development and clearly defined career paths improve retention and productivity, while ESOPs help anchor leadership continuity. Constructive engagement with employees and representative bodies fosters trust, minimises disruption and strengthens organisational stability.

Culture is not a soft consideration. It is a strategic asset.

Operational excellence cannot stop at the hospital's walls, either. Many hospitals deliver exceptional clinical care yet articulate it poorly, and people frequently mistake "I haven't heard of them" for "they're not good." Sharing clinical outcomes, quality in-

dicators, patient-safety initiatives, research, accreditation and patient testimonials builds confidence among patients, payers and referring doctors alike.

Genuine engagement with GPs, family physicians, corporate clients, insurers and local communities strengthens referrals and deepens trust. Effective marketing is not about visibility for its own sake — it is about communicating authentic value and helping people appreciate the calibre of care on offer.

Sometimes weak referrals have little to do with weak performance. They are, more often, simply a case of good work going unnoticed.

The finest hospitals balance clinical outcomes, patient experience, operational efficiency and financial sustainability in equal measure. Strong governance is what binds these together into a single operating model, where every department pulls toward a common goal instead of operating in silos.

Consider two hospitals with an identical Rs 1,000 crore investment. One operates at 82 per cent occupancy and 24 per cent EBITDA. The other languishes at 61 per cent occupancy and 13 per cent EBITDA.

Identical capital. Divergent operating systems.

As capital grows increasingly abundant, execution will emerge as the true competitive differentiator. Hospitals that consistently elevate clinical quality, patient experience, productivity and trust will generate disproportionate value for patients, employees, investors and society alike.

Capital may build hospitals. Execution builds enduring institutions.

How healthcare facilities should prepare for the DPDP Act

Sunder Rajan Radhakrishnan, Advocate, Bombay High Court and Partner, SR Law Associates, discusses the implications of the Digital Personal Data Protection Act, 2023 for healthcare providers, and outlines the key steps facilities should take to prepare for its implementation

The Digital Personal Data Protection Act, 2023, with penalties upto Rs 250 crore, will come into effect in seven to eight months, yet awareness levels in the healthcare sector are poor. R. Sunder Rajan, Advocate, Bombay High Court, SR Law Associates and Hon. Addl. Director, Institute of Medicine & Law explains the nuances and suggests a few steps for healthcare facilities to comply with the Act by May 13, 2027.

In about seven to eight months, a privacy law with the highest penalty will roll out in India. The Digital Personal Data Protection Act, 2023 *aka* DPDP Act, and its rules will come into full force on May 13, 2027. Its impact on the healthcare sector is expected to be significant with never before seen penalties. This is not merely a compliance item, but a sea change in the way of functioning for all healthcare providers.

Patient data is now treated like a property and its storage and use by healthcare providers will need express permission from the patient.

A handwritten document (say a prescription) is not digital data, however, if you photograph it with your mobile phone, it becomes digital data. Any data in digital format that is identifiable to an individual is "Personal Data".

Who are covered?

Patient is called the "Data Principal". Anyone who collects data from the patient is a "Data Fiduciary". Clinics, nursing homes, hospitals, pathological laboratories, imaging labs, blood banks, clinical trial organisations, phar-



macies and even insurance companies are classified as a Data Fiduciary. Anyone contracted or outsourced for the purpose of processing this data is a "Data Processor". This includes SaaS/IT vendors, data entry operators, third party file storage vendors, cloud storage companies etc.

A child or a vulnerable person who cannot represent herself will be represented by a parent or legal guardian. In such a case, both the parent/guardian and the minor/vulnerable patient will both be Data Owners.

Data Protection Board

"The Data Protection Board of India" (Sec 18 of the Act) will have the power to entertain and decide complaints, and impose a penalty on the party that is in contravention to the Act. In other words, this Board will have quasi-judicial powers.

This Board will be a completely digital office. It means that anyone from any part of India can file an online complaint against a hospital, clinic, pharmacy or pathology laboratory, and they can also file the reply online. The detailed procedure will be an-

nounced later.

The Board will have powers to issue summons for ensuring the participation of the accused party. They will also have powers to direct any Central or State Government officer for assistance, including the Police. This gives broad powers to the Board.

At the time of writing this article, the selection process for the members of this Board is in progress.

Significant Data Fiduciary

Some organisations may collect, store and process large amounts of healthcare data. Based on certain criteria such as 1. Large amount of personal data, 2. High transaction volume 3. Sensitive data (like health or financial).

Such SDFs will have a higher level of scrutiny and checks conducted on them. They will also have to comply with additional statutory requirements, such as:

1. Every SDF will have to appoint a Data Protection Officer (DPO). This DPO will be the nodal officer for the organisation and will be the point of contact for the Data Protection Board

2. SDF should conduct a Data Protection Impact Assessment (DPIA) and conduct an Audit in its organisation to ascertain the risk associated with the current process and data flow. The Board will notify dates and the category of Data Fiduciaries.

3. This impact assessment and audit should be carried out every year and its report with observations has to be submitted to the Board

4. In cases where Artificial Intelligence (AI) software is

used, the SDF must ensure that there is absolutely no risk to the rights of the Data Principals (more in the 'Rights of Data Principals' section below)

5. SDF's must ensure that the Data storage, processing and the flow of traffic is NOT transferred out of India. There is a possibility that the government will bring out further notifications on the topic. However, it is safe to restrict the transfer of data outside India.

Consent management

This is the most significant portion of this Act. It is in fact the SOUL of this piece of Law. To explain it in simple words, in order to collect, use, store, process and even to communicate with the Data Principal, the Data Fiduciary will have to obtain the 'Consent' of the Data Principal.

After November 2026, the Data Protection board is supposed to announce a list of approved Consent Managers. All Data Principals, will communicate their consent through these Consent Managers to the Data Fiduciary.

The reason for this is to:

- A. Have an electronic trail that can be used as evidence under the new BSA, 2023 (*Bhartiya Sakshya Adhiniyam*) in the court of law
- B. The Data Principal will deal with only the Consent Managers for providing their consent. This will act as a gateway for a multitude of Data Fiduciaries
- C. It will be simpler for the Data Principal to view and manage the list of Consent given at a single place

Rights of the Data Principal

I. Consent has to be free, unconditional and clear. If a Data Fiduciary makes an offer (say a discount) and if consent is given, then such consent is illegal and relevant penalties of the Act will apply on the healthcare provider

II. Every data type taken must contain, the purpose for which the data is being taken, what is the intended use of such data, till when will be the data stored in the healthcare provider's system. A piece of advice: Do not collect data, which is of no use to you. This may cause additional liability

III. Data Principal has the 'Right to Delete'. This means that the Data Principal can withdraw the consent anytime, for any reason and the Healthcare provider has to not only delete the data from all

his systems, but also provide a communication back within 72 hours (or as per policy, but 72 hours is recommended) certifying that all data has been deleted. This is a legal document and may be produced as evidence.

IV. Data Principal can raise a request to the Data Fiduciary about the status of their consent and what personal data is available. Data Fiduciary has to accept such requests through the website or app or both.

V. Data Fiduciary and Consent Manager have to publish a grievance mechanism on

The Data Protection Board of India (Sec 18 of the Act) will have the power to entertain and decide complaints, and impose a penalty on the party that is in contravention to the Act. In other words, this Board will have quasi-judicial powers

their website, clearly listing the rights of the Data Principal, the name and contact of the responsible officer with an escalation matrix, including the process of raising a complaint to the Board. Acknowledgement of any grievance raised or request raised has to be immediate. Any unresolved grievance has to be clearly listed and made ready to be provided to the Board when requested or as per notification schedule.

VI. All Notices of erasure, receipt of data, breach of data either accidentally or through deliberate means has to be reported to the Data Protection Board and to each affected Data Principal immediately. There should be a notice within a short time as notified. A detailed report within 72 hours to be published as to what actions were taken to stop such leak, mitigate the situation and steps to prevent further leak has to be communicated to the Data Protection Board.

Here is what healthcare providers should know/do:

1. The DPDP Act, 2023 and its Rules will come into full force from May 13th, 2027. Form an internal steering committee to overlook all the aspects of becoming compliant. These changes are going to take time. Begin early and give at least six months for these changes.

2. To collect, store, use and erase a healthcare provider must seek Consent. This consent is a legal document and will be used as evidence in the court of law.

3. All data has to be stored in an encrypted form, with access control. Till further notification, store all data only within India. Such data has to be stored in an immutable database. This means that such a database has to be a "Write Once Only" database.

4. Your website needs to change. Include the policy statement, privacy statement, terms and conditions for data use, consent management related information, withdrawal of consent section, erasure of data section, escalation ladder with clear contact information.

5. Children and vulnerable

persons data is given special protection under this act. Do not use patient data for any other purpose than what it was consented for.

6. Data Fiduciary will be solely liable for any violation by Data Processors. Ensure robust processes in place while transferring data to and from laboratories or pharmacies, and with consent.

7. Training and Internal Policy creation are as important as the IT side of the process. This is an often neglected area. Train everyone, beginning from the security personnel to CEOs. Inculcate this in the new hire on-boarding programme. Run a re-certification or a refresher programme every quarter.

8. Do not keep medical records at the nurse station. It is easy for anyone to access it with a camera, leading to data leakage.

9. Appoint a qualified Data Protection Officer (DPO). This is mandatory for SDF's. However, it is recommended to identify a qualified individual to drive this as a function irrespective of the healthcare facility's size.

10. Hospitals, clinics, nursing homes, pathology laboratories, imaging centres, pharmacies, hospital software providers, cloud storage providers, vendors, clinical trial organisations and even blood banks are covered. Anyone collecting patient data for providing healthcare services or working for someone who does or for any other purposes are covered under this Act.

11. Hire a privacy lawyer, to relook at all your contracts such that they are in line with the DPDP Act.

Should we take this seriously?

This is a question that gets asked often. Is this Law really as strict as it sounds? Rs 250 crores is not a small amount, no other law has this penalty. Is such a law even possible to be implemented in India?

Similar questions were raised when GDPR (General Data Protection rights) was implemented in Europe. The recent court cases show us that not only they are serious about it but the penalties levied are already at the levels of millions of euros.

The Government has provided a time of 18 months from the date of publishing of the rules in November, 2025. This elapses on May 13, 2027. However, awareness levels about this law is very low among healthcare providers.

This is now the law. Follow it. Earnestly. Get compliant.



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TRANSFORMING HEALTHCARE

Data, AI, and the New Care Model

Express Healthcare and **Express Computer**, in collaboration with SAP, brought together healthcare leaders in Mumbai on August 19, 2026, for a high-level industry forum examining how data, AI and digital technologies are reshaping healthcare delivery and organisational decision-making

As healthcare organisations across India accelerate their digital journeys, the discussion is increasingly moving beyond technology adoption to questions of data quality, interoperability, standardisation, clinician acceptance and organisational readiness. These themes came through strongly at the **Express Healthcare-SAP forum**, where healthcare leaders from hospitals, diagnostics, specialty care and the wider healthcare ecosystem shared experiences of building digital foundations while preparing for greater use of AI.

The forum, themed 'Transforming Healthcare: Data, AI, and the New Care

Model', brought together CXOs and digital leaders to examine how technology can support three interconnected priorities: improving patient experience, strengthening clinical outcomes and driving operational efficiency.

A recurring message through the discussions was that AI cannot be viewed in isolation. Organisations first need reliable, structured and accessible data, supported by standardised processes and systems that clinicians and other frontline teams can actually use.

What follows are selected insights and perspectives shared by the distinguished speakers:



- Digital health infrastructure has moved from pilot to national backbone. The Ayushman Bharat Digital Mission is no longer just a government IT initiative. It now functions as India's core interoperability layer, linking patient identity, health records, and facility registries into a single connected system that hospitals can build on.
- Telemedicine and AI diagnostics are already delivering measurable clinical impact, not just promise. Platforms like e-Sanjeevani have shown that AI-assisted care and remote consultations can operate at national scale, while AI tools embedded in disease programmes are showing real gains in early detection and outbreak surveillance.

JOY CHAKRABORTY
Deputy CEO, P. D. Hinduja National Hospital and Medical Research Centre, Mumbai and President, Association of Healthcare Providers of India (AHPI - Maharashtra & Goa)



I do not clearly differentiate between the cultural mindset and the digital mindset. When we talk about digital transformation, the human being is very much in the picture. When driving the digital journey, it cannot be limited to a series of sessions. We need to build digital literacy and give clinicians hands-on exposure to AI and other digital tools.

DR SHILPA TATAKE
CEO,
Jupiter Hospital,
Thane



When you look at consolidation across different geographies, the mindset and cultural differences can be significant. As organisations expand across locations, aligning these differences becomes an important part of ensuring consistency.

DR GIRISH GAUR
COO,
Rivaara Labs

POST EVENT



Digitisation and AI can help us build predictive models. When you have a predictive model, you can work beforehand to avoid emergencies and complications. Hospitalisation goes down and the cost of delivery goes down. Predictive models are going to be very, very key.

INDRANIL ROY CHOUDHURY
Director & CEO,
Apex Kidney Care



The immediate priority should not simply be to introduce AI, but to build a robust digital infrastructure and create high-quality, integrated data repositories. Only then can automation and AI deliver their full potential and create sustainable improvements in healthcare delivery.

RUPESH CHOUBEY
Vice President-Regional COO,
Maharashtra and MP,
HCG



Among other healthcare solutions, we also help hospitals, diagnostic chains, and medical practitioners unify their procurement data into a reliable data source and standardise their processes, enabling AI and emerging technologies to deliver predictive outcomes. With the right data foundation, AI can improve forecasting, optimise inventory levels, and enhance cash-flow management.

PRATEEK SISODIA
Assistant Vice President-Finance,
MedikaBazaar



Digitisation and AI can help us build predictive models. In many chronic patients, predictive models can help identify risks early, allowing us to act before emergencies and complications occur. This can bring down hospitalisation, save precious lives and the cost of care. However, the current challenge is to get the corrected data to build responsive AI models.

SAURABH GUPTA
Regional Director, KIMS Hospitals



We have scaled to more than 200 locations, and the only reason we have been able to scale is because of standardisation of processes. For 25 years, we have collected and maintained digital medical records, and in today's AI world, that medical record is essentially gold for us.

AARAS VASA
ED and Group CFO,
Dr Batra's Positive Health Clinic

POST EVENT



Clinical outcomes are both a healthcare imperative and an economic driver. Better outcomes create trust, and trust attracts patients, clinicians and talent—giving healthcare entrepreneurs the foundation to build and scale great institutions. The role of capital is not simply to fund that growth, but to bring the capabilities and partnerships that help amplify it.

ARUN SADHANANDHAM
Managing Director,
Private Equity, OrbiMed Asia



We are moving from a paper-based model to digitisation, but EMR penetration is still not very high in India. Clinician adoption is one of the most important challenges we face. A lot of data is available, but getting actionable intelligence from that data is the next challenge.

DR SAMEER KULKARNI
CEO,
Dr L H Hiranandani Hospital



I believe that as we move towards AI 2.0 and 3.0, not only the AI roadmap but also the institutional hierarchies will take the center-stage. While AI agents, bots, services, sensors become an essential part of every team and will increasingly support decision-making, the ultimate accountability must continue to rest with the CXO. Ultimately, AI can process data faster and provide valuable insights, but human judgement and responsibility remain critical. The real opportunity is to make AI a trusted co-pilot, while building the right level of AI literacy among healthcare professionals and leaders.

ANSHUMAN WAHAL
Solution Advisor, SAP



When you talk about scale, change management is the biggest and single most important factor. Technology intervention, digitisation and AI can deliver outcomes, but even the best implementation or solution can fail if adoption or acceptability among people within the organisation is a challenge.

ANUKUL GHUWALEWALA
Executive Director,
PwC India



Eventually, AI is going to enable, help, aid or provide a co-pilot scenario to help us make better decisions. But the decision still needs to be human."

DR SURESH NADAR
Group CIO,
Dr Batra's Positive Health Clinic

POST EVENT



Along with the data, I feel the process also needs to be standardised. If an organisation has multiple hospitals or branches, the same processes and definitions need to be followed across them. Otherwise, you will not be able to derive the impact at an enterprise level."

ANAGHA WALANJU
CIO,
K J Somaiya Hospital and Research Centre



"If you connect the data into one single consolidated platform, a lot of value can be created, both for the patient experience and for organisational decision-making."

NITIN DHINGRA
Group CTO (EVP),
Indira IVF



Core → Data → Intelligence
AI is only as intelligent as the data it trusts and the core it stands on.

SANTOSH MEHER
HOD-IT, KIMS Hospitals

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India's immunology revolution: How CLIA and FIA are reshaping the diagnostics market

Ajinkya Upasani, Product Manager-CLIA & FIA, Transasia Bio-Medicals Ltd, discusses the market trends, technology shifts and growth opportunities shaping India's evolving immunodiagnosics landscape

India's immunodiagnosics landscape is undergoing a significant transformation. For decades, laboratories relied on conventional technologies such as ELISA and manual immunoassays for testing infections, hormones, autoimmune disorders and tumour markers. Today, however, rising test volumes, growing clinical expectations and the expansion of diagnostics beyond metropolitan centres are accelerating the shift towards automated, high-performance immunoassay technologies.

At the forefront of this transformation are Chemiluminescence Immunoassay (CLIA) and Fluorescence Immunoassay (FIA). Their growing adoption is not simply a technology upgrade. It reflects a broader market shift towards diagnostics that are faster, more scalable, reliable and accessible.

For India's diagnostic industry, this evolution represents both a technological transition and a substantial growth opportunity.

A market moving towards Automation

The growing burden of chronic diseases, cancer, endocrine disorders and infectious diseases is increasing the demand for laboratory testing. At the same time, clinicians and patients increasingly expect faster turnaround times and dependable results.

This is changing what laboratories look for in an immunology platform. Automation, analytical performance, test-menu breadth and workflow efficiency are becoming increasingly important, particularly as laboratories expand their testing capabilities and handle higher volumes. The expansion of diagnostic services



into Tier-2 and Tier-3 cities is further strengthening this demand.

The result is a market increasingly moving away from labour-intensive processes towards technology platforms that can deliver greater productivity without compromising quality.

CLIA: Powering high-volume Immunology

For medium- and high-volume laboratories, CLIA has emerged as a key technology platform. Its combination of sensitivity, specificity, reproducibility and automation makes it suited to a wide range of immunology applications, from thyroid and reproductive health to infectious diseases,

oncology, cardiac markers, vitamin assays, autoimmune disorders and therapeutic drug monitoring.

The scale of the opportunity is significant.

CLIA currently accounts for nearly 80 per cent of India's immunodiagnostic market, with the Indian CLIA market estimated at approximately Rs 4,345 crore. Reagents represent the majority of revenues, underlining the recurring nature of immunology testing and the importance of a strong, sustainable reagent ecosystem. The CLIA analyser market is also projected to grow at approximately 8 per cent CAGR through 2033.

For diagnostic businesses, this makes CLIA more than an

analyser investment. It is a platform for expanding test menus, increasing laboratory throughput and building recurring testing revenues.

FIA: Taking Immunology beyond the central laboratory

While CLIA is strengthening its position in high-volume laboratories, FIA is opening another important growth avenue: decentralised and routine immunology testing.

Compact design, affordability, ease of operation and rapid turnaround make FIA particularly relevant to smaller laboratories, nursing homes and regional hospitals. Its applications span thyroid, diabetes, cardiac, inflammatory, infectious disease, vitamin and renal-function testing.

The market momentum is particularly noteworthy. India's FIA market is estimated at approximately Rs 1,184 crore in FY 2025-26 and is projected to grow at 12-15 per cent annually, positioning it among the fastest-growing segments within immunodiagnosics.

This growth also mirrors a larger transformation in healthcare delivery: bringing advanced diagnostics closer to the patient.

The decentralisation opportunity

India's diagnostics market is no longer defined solely by large laboratories in major cities. As healthcare infrastructure expands into smaller cities and towns, there is growing demand for technologies that can deliver reliable results without the infrastructure or complexity traditionally associated with large central laboratories.

This is where FIA and other decentralised immunology

platforms can play a strategic role.

The increasing demand for Point-of-Care Testing across hospitals, clinics and decentralised healthcare settings is creating a market for platforms that combine laboratory-quality performance with speed and operational simplicity.

For diagnostic providers, the opportunity is therefore twofold: scale testing at the top end through automation while extending access at the point of care and in underserved markets.

From better technology to better laboratory economics

The value proposition of CLIA and FIA extends beyond analytical performance.

Automated immunology platforms can help laboratories manage higher testing volumes, accelerate reporting, improve quality control and reduce manual intervention. They can also enable laboratories to bring a wider range of tests in-house, reducing dependence on external reference laboratories.

This has direct implications for laboratory efficiency and patient experience.

For laboratories, the ability to consolidate more testing under one technology platform can translate into improved workflow utilisation and greater operational control. For clinicians and patients, it can mean faster access to clinically relevant results.

In an increasingly competitive diagnostics market, technology is therefore becoming an important enabler of both clinical value and business growth.

The next growth frontier:

Beyond the metros

India's next phase of diagnostic growth will depend heavily on how effectively advanced technologies move beyond major metropolitan centres.

Laboratories in emerging markets require solutions that balance performance with affordability, automation with simplicity, and advanced capabilities with ease of adoption. The need is particularly strong as specialised testing expands across Tier-2 and Tier-3 cities.

This creates a significant opportunity for diagnostic technology companies to develop platforms specifically suited to India's diverse laboratory landscape.

The winning solutions are likely to be those that can deliver global-quality performance while addressing local operating realities.

Make in India: From import dependence to innovation

Another important dimension of India's immunology opportunity is the emergence of indigenous diagnostic technologies.

Historically, the CLIA and FIA ecosystem has depended significantly on imported instruments and reagents. Growing domestic manufacturing capabilities, however, are creating the possibility of a more self-reliant immunodiagnostics ecosystem.

Locally developed platforms can potentially reduce import dependence, strengthen supply-chain resilience and improve affordability. More importantly, domestic innovation can enable manufacturers to design solutions around the specific requirements of Indian laboratories and healthcare providers.

This is where Make in India moves beyond manufacturing. It becomes an opportunity to build intellectual property, develop indigenous technology and create globally competitive diagnostic platforms.

Building an Indian immunodiagnostics ecosystem

The growth of CLIA and FIA is creating opportunities across the wider diagnostics value chain—from analysers and reagents to automation, service, distribution and decentralised testing.

As immunology testing volumes rise, the recurring nature of reagent consumption makes the strength and reliability of the reagent ecosystem increasingly important. At the same time, expanding test menus and automation will create demand for platforms that can grow

alongside laboratories.

For manufacturers, this represents an opportunity to move from selling individual instruments to building long-term diagnostic ecosystems around laboratories and healthcare providers.

The road ahead

India's immunology market is entering a phase where technology, accessibility and economics are converging.

CLIA is establishing itself as the preferred platform for high-volume, high-sensitivity immunology testing, while FIA is creating new possibilities for routine and decentralised testing. The next stage of growth will be determined not simply by how advanced these technologies are, but by how effectively they can be deployed across India's diverse health-

care landscape.

For diagnostic companies, the opportunity is clear: develop solutions that combine performance, automation, affordability, accessibility and dependable supply.

For laboratories, the transition offers an opportunity to improve productivity, expand testing capabilities and strengthen their competitive position.

And for India, the larger opportunity is to build an immunodiagnostics ecosystem that not only meets domestic demand but also establishes the country as a centre for diagnostic innovation. The immunology revolution is therefore not merely about replacing one testing technology with another. It is about redefining how diagnostics are delivered: faster, smarter, more accessible and increasingly made in India.



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Halcyon: Advancing radiation therapy with precision and efficiency

Malti Sachdev, SVP & Head Varian India, Siemens Healthineers, discusses how advancements such as the Halcyon radiotherapy platform are helping bring together imaging, positioning, motion management and workflow capabilities to support more streamlined and precise cancer treatment

When we talk about cancer care, prevention and early detection often dominate the discussion. Yet an equally important story unfolds after diagnosis, when patients and care teams turn their attention to treatment. In that moment, precision, efficiency, and patient care come into focus. Cancer treatment typically involves a combination of surgery, chemotherapy, immunotherapy, and radiation therapy. Among these treatment modalities, radiotherapy remains one of the key components of cancer management, with nearly 50 per cent of patients requiring it at some point during their care.

Growing patient volumes and increasing treatment complexity require radiotherapy teams to balance precision with efficiency. Technology plays a key role not only in delivering radiation but also in supporting a smooth, consistent, and patient-centered treatment experience.

At Siemens Healthineers, we are focused on advancing cancer care across every stage of the patient journey. By enhancing the patient's experience, enabling more personalised care, streamlining clinical workflows and making innovation more accessible, we help care teams improve outcomes and move closer to creating a world without fear of cancer.

Halcyon radiotherapy platform from Siemens Healthineers, brings together advanced imaging, patient positioning, motion management and workflow capabilities in a compact, highly integrated system. For centers facing growing patient volumes, this combination of speed, standardization and workflow simplicity can be particularly valuable.

Halcyon platform is designed around a simple objective:

helping care teams deliver high-quality treatments efficiently, while making the treatment experience comfortable for patients.

Precision starts with confidence in positioning

Accurate patient positioning is fundamental to radiotherapy. Halcyon introduces the PerfectKinetic Dynamic Couch, providing six degrees of freedom for patient positioning and correction. Its multidimensional movement is designed to help clinicians make precise adjustments while simplifying the positioning process.

The platform can also integrate IDENTIFY surface-guided motion management, enabling clinicians to monitor patient positioning and motion during treatment. Together, these technologies can support greater confidence in patient setup and treatment delivery.

This focus on positioning is complemented by Halcyon's



integrated image-guided radiotherapy capabilities, helping clinicians verify patient anatomy and position as part of the treatment workflow.

Imaging that supports informed treatment delivery

High-quality imaging plays an important role in image-guided radiotherapy. Halcyon incorporates HyperSight, an advanced

cone-beam CT imaging technology designed to provide fast image acquisition and high image quality.

By bringing advanced imaging directly into the treatment platform, Halcyon can help clinicians obtain the information they need within a streamlined workflow. This is particularly relevant as radiotherapy continues to move toward more personalized approaches that depend on understanding changes in patient anatomy.

Putting the patient experience at the center

Radiotherapy can be an unfamiliar and stressful experience for patients. Every part of the treatment journey from entering the treatment room to positioning and imaging can influence how comfortable and confident a patient feels.

Halcyon incorporates a 100 cm wide bore, a quiet system design and smooth movement to provide a patient-friendly treat-

ment environment. The integration of advanced positioning and motion-management technologies can further support a treatment experience designed around patient comfort.

With IDENTIFY, the platform can also support surface-guided workflows that may reduce reliance on traditional positioning methods such as tattoos, depending on the clinical workflow and configuration.

The focus is therefore not only on what happens during radiation delivery, but on how technology interacts with the patient throughout the treatment process.

Advancing sustainable radiotherapy

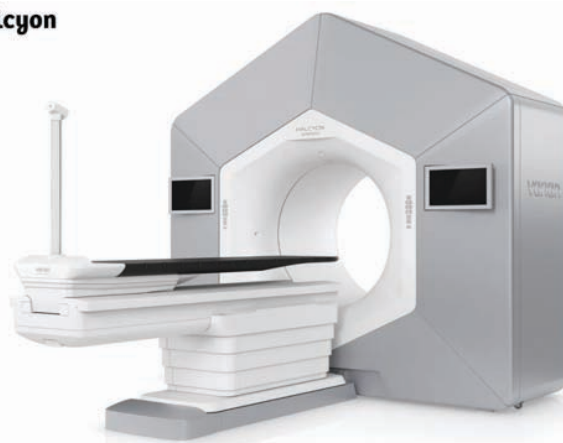
Our mission is to expand patient impact by improving access to care, limiting our environmental footprint, and engaging our diverse teams worldwide to drive lasting change.

Halcyon reflects this vision by combining clinical excellence with responsible design. It consumes up to 70 per cent less power¹ than a C-arm linac and requires roughly 65 per cent less concrete² for bunker construction, reducing both costs and CO₂ emissions. With a 24 per cent reduction in weight,³ Halcyon has a lighter freight burden which leads to less energy consumed in transport.

References:

1. Based on Hull University Teaching Hospitals experience compared to Clinac-iX. Your results may vary. Hull University Teaching Hospitals was not paid for this data.
2. Compared to a C-arm linac and based on EMEA internal data. 460m³ for C-arm bunker v. 160m³ for Halcyon.
3. Based on internal data compared to C-arm linac. Data available on request.

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Truevis Technologies: Strengthening India's advanced imaging and cancer care ecosystem

Truevis is expanding its presence across India, with a particular focus on Tier-II and Tier-III cities. Having completed its initial installations, the company is targeting 100+ installations during the current year, reflecting its ambition to contribute to the expansion of advanced diagnostic and cancer-care infrastructure

India's healthcare landscape is undergoing a rapid transformation, driven by growing demand for advanced diagnostics, increasing cancer-care requirements and the need to expand quality healthcare beyond major metropolitan centres. At the same time, India is placing greater emphasis on developing domestic capabilities in medical technology and reducing dependence on imports.

Truevis Technologies Pvt. Ltd. is emerging as an integrated medical technology company focused on this opportunity, with a portfolio spanning CT, MRI, PET-CT, Digital Subtraction Angiography (DSA) and Linear Accelerators (LINACs). Its approach goes beyond equipment supply, combining technology partnerships, system integration, installation, clinical applications, engineering and lifecycle service support.

Growing opportunity for PET-CT and advanced imaging

PET-CT is becoming increasingly important in modern oncology, supporting disease detection, staging, treatment planning and monitoring. India has witnessed substantial growth in PET-CT infrastructure, with the number of scanners increasing significantly over the past decade. Yet access remains concentrated in larger cities, creating considerable potential for expansion into emerging healthcare markets.

Truevis is addressing this opportunity by expanding its presence across India, with a particular focus on Tier-II and Tier-III cities. Having completed its initial installations, the company is targeting 100+ installations during the current year, reflecting its ambition to contribute to the ex-



Domestic manufacturing and localisation form an important part of Truevis's long-term strategy. Through its operations at the Andhra Pradesh MedTech Zone (AMTZ), Visakhapatnam, the company is strengthening its capabilities in local assembly and system integration

pansion of advanced diagnostic and cancer-care infrastructure.

Taking Make in India forward

Domestic manufacturing and localisation form an important part of Truevis's long-term strategy. Through its operations at the Andhra Pradesh MedTech Zone (AMTZ), Visakhapatnam, the company is strengthening its capabilities in local assembly and system integration.

India's medical-device sector is also showing strong momentum. Medical-device exports increased from approximately US\$2.5 billion in FY2021 to US\$4.1 billion in FY2025, highlighting the country's growing

capability in sophisticated medical technology.

For Truevis, localisation represents more than manufacturing. It also means developing domestic engineering, technical support, service and supply-chain capabilities that can improve equipment availability and long-term sustainability for Indian healthcare providers.

Connecting with the nuclear medicine community

Truevis's participation in the 30th Annual Conference of the Society of Nuclear Medicine India (SNMI) Southern Chapter, held at Novotel Goa Dona Sylvia in August 2026, provided an im-

portant platform to engage directly with the clinical community.

The conference attracted 300+ participants, including nuclear medicine specialists, hospital representatives and industry professionals. With PET-CT as a key focus, Truevis held detailed discussions around the evolving requirements of nuclear medicine infrastructure in India.

Discussions also explored the feasibility of local manufacturing of PET-CT and LINAC systems, technology collaboration, component localisation, technical support and future opportunities in the Indian market. These interactions provided valuable

insights into customer expectations and the challenges associated with deploying advanced imaging and radiotherapy technologies.

The conference also generated several potential business leads and opportunities for strategic partnerships, while strengthening Truevis's engagement with leading nuclear medicine professionals and healthcare decision-makers.

Building the ecosystem around the technology

As advanced medical equipment becomes more sophisticated, successful healthcare delivery increasingly depends on what surrounds the equipment installation, applications, uptime, engineering support, training and lifecycle service.

Truevis is therefore building multidisciplinary capabilities to support healthcare providers across the equipment lifecycle. Its objective is to help hospitals maximise technology utilisation, improve operational reliability and deliver advanced diagnostic and cancer-care services more effectively.

With its focus on advanced imaging, radiation oncology, domestic localisation, clinical engagement and expansion into emerging healthcare markets, Truevis Technologies is positioning itself as more than an equipment provider. The company is seeking to become a long-term technology and infrastructure partner in India's evolving healthcare ecosystem.

As demand for PET-CT, advanced imaging and precision cancer care continues to grow, Truevis's integrated approach could play an important role in making these technologies more accessible, locally supported and sustainable across India.



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ImaCath™ WOUND DRAIN CATHETER

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Designed for critical drainage applications, ImaCath™ is a silicone wound drain catheter developed for closed-suction and negative-pressure drainage near surgical incisions.

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- Silicone wound drain catheter
- Closed-suction / negative-pressure drainage
- Flexible silicone construction
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- Sterilizable by Gamma, ETO & Steam Autoclaving
- Designed for precision medical applications

APPLICATION

Post-Surgical Wound Drainage
ImaCath™ is designed for placement near surgical incisions to facilitate controlled removal of wound fluids through a closed-suction, negative-pressure drainage system.



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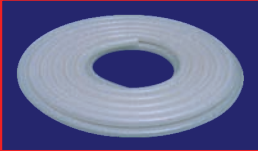
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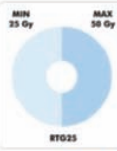
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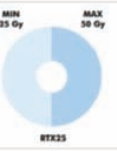


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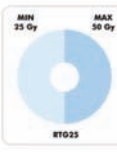
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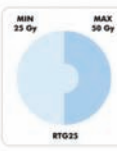
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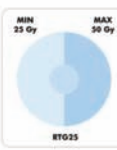


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Minimum



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Wound Drain Catheter Tubing (ImaCath™)

A Silicone Drainage Solution Engineered for Post-Surgical Wound Management By Ami Polymer Pvt. Ltd. (APPL) — Specialists in Medical Tubing & Implants

Introduction

Post-surgical wound management is one of the most critical determinants of a patient's recovery outcome. Accumulation of blood, fluid, or exudate at a surgical site can lead to swelling, infection, delayed healing, and prolonged hospital stays. To address this challenge, surgical teams rely on closed-suction wound drainage systems — and at the heart of these systems lies a component engineered for precision, biocompatibility, and reliability: the Wound Drain Catheter Tubing.

Ami Polymer Pvt. Ltd. (APPL), a globally recognized manufacturer of advanced polymer-based medical solutions since 1998, has developed the Wound Drain Catheter Tubing under its proprietary brand ImaCath™. Built on the company's platinum-cured silicone tubing platform, ImaCath™ is specifically engineered for efficient post-operative fluid removal, helping reduce complications and support faster, safer healing.

This article presents a detailed overview of the ImaCath™ Wound Drain Catheter Tubing — its design, working mechanism, features, clinical applications, technical specifications, and the manufacturing excellence and regulatory credentials that stand behind it.

Product Overview: What Is ImaCath™?

ImaCath™ Wound Drain Catheter Tubing is a specialized silicone drainage tube designed for efficient post-operative fluid removal through closed-suction drainage systems. It belongs to APPL's wider family of Platinum-Cured Silicone Tubing solutions — a category of high-purity, biocompatible tubing engineered for sterile fluid and gas transfer in direct patient-contact applications.

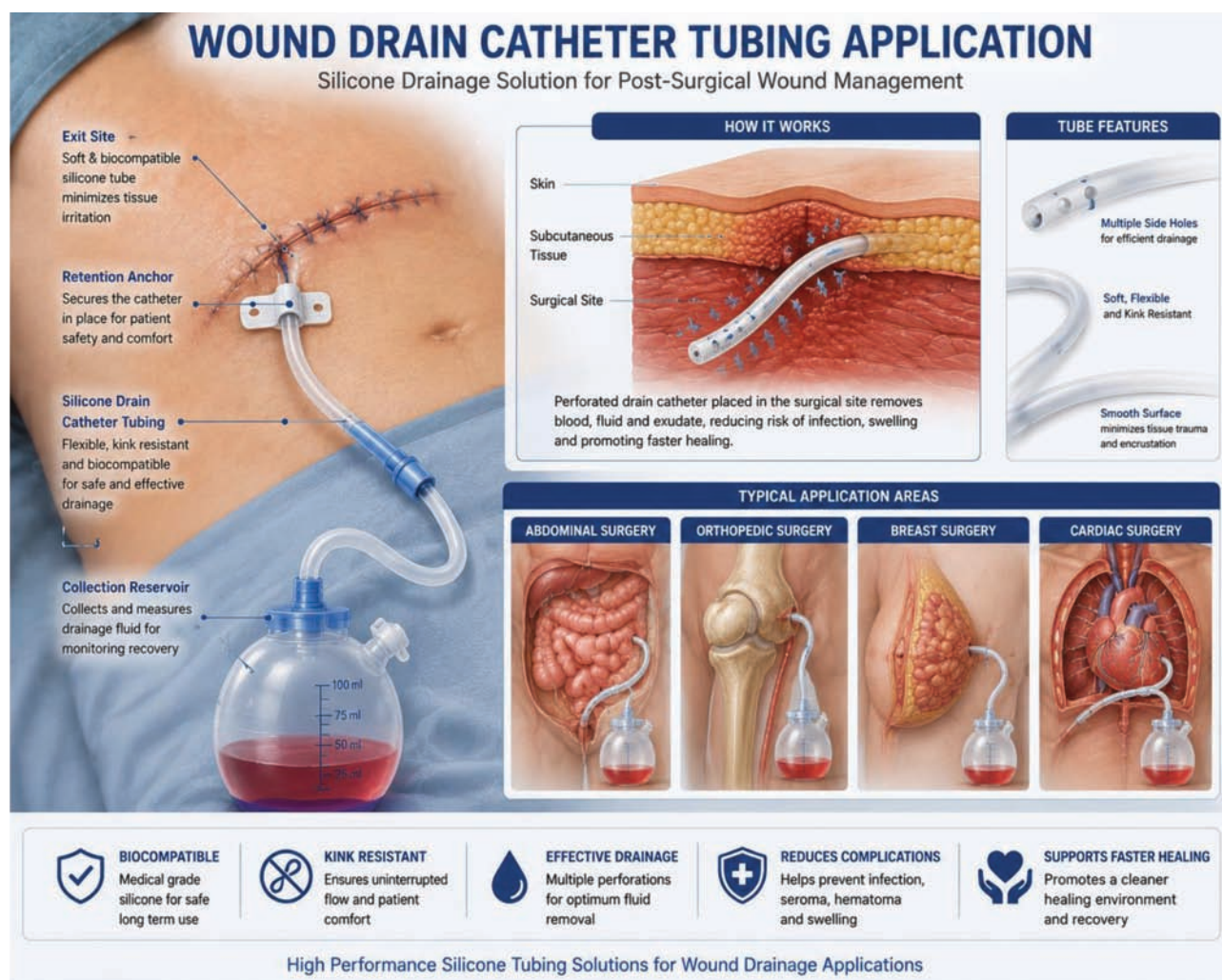


Figure 1: Application overview of the ImaCath™ Wound Drain Catheter — cross-section, tube features, closed-suction collection, and typical surgical applications.

The core purpose of ImaCath™ is simple but vital: after surgery, it is placed at or near the surgical site to continuously remove blood, fluid, and exudate that would otherwise accumulate beneath the skin. By keeping the surgical site clear of built-up fluid, the tubing helps to reduce the risk of infection and swelling while promoting faster healing — directly supporting better clinical outcomes and patient comfort during recovery.

Anatomy of the Drainage System

The effectiveness of a wound

drain catheter depends on the coordinated design of several components working together as a single closed system. ImaCath. is built around four key elements:

● **Exit Site.** The point where the catheter tubing exits the patient's skin. It is constructed from soft, biocompatible silicone that minimizes tissue irritation at the point of contact, an important factor given that this site remains in place for the duration of the drainage period.

● **Retention Anchor.** A securing element that holds the catheter firmly in position at

the exit site, preventing accidental dislodgement while maintaining patient safety and comfort throughout the recovery period.

● **Silicone Drain Catheter Tubing.** The core drainage conduit itself. flexible, kink-resistant, and biocompatible, engineered for safe and effective fluid transport from the surgical site to the external collection point.

● **Collection Reservoir.** The external container connected to the tubing that collects and measures the drainage fluid, allowing clinicians to monitor the volume and character of output

as an indicator of the patient's recovery progress.

How It Works

ImaCath™ operates on the principle of closed-suction drainage. A perforated section of the catheter is placed directly within the surgical site, positioned beneath the subcutaneous tissue and skin layers. The perforations — multiple side holes along this segment — allow blood, fluid, and exudate to enter the tubing from the surrounding tissue.

Gentle negative pressure, generated at the collection reservoir, draws this fluid

steadily away from the surgical bed, through the tubing, and out through the exit site into the reservoir, where it is collected and measured. This continuous, controlled removal of fluid reduces the buildup of pressure and moisture at the wound site — two key contributors to swelling, infection risk, and delayed healing — thereby supporting a faster and safer post-operative recovery.

Design & Engineering Features

Tube Features

- **Multiple Side Holes.** Enables efficient, distributed fluid uptake along the length of the catheter placed at the surgical site.
- **Soft, Flexible and Kink-Resistant.** Adapts easily to the contours of the surgical site without collapsing or restricting flow.
- **Smooth Surface.** Minimizes tissue trauma and reduces the likelihood of encrustation or blockage over the drainage period.

Material & Performance Characteristics

As a member of APPL's Platinum-Cured Silicone Tubing range, ImaCath inherits a set of high-purity material properties that make it suitable for direct, prolonged patient contact:

- **Biocompatibility and Chemical Inertness.** Silicone tubing that is inert to tissues and cells, reducing the risk of adverse biological reactions during use.
- **Superior Flexibility with Kink Resistance.** Manufactured with excellent flex crack resistance, allowing the tubing to withstand repeated movement and positioning without failure.
- **High Transparency and Smooth Flow.** The tubing exhibits excellent transparency with no odor or taste, which enhances shelf life and allows clinicians to visually monitor fluid flow.
- **Compatible with Major Sterilization Methods.** The tubing is compatible with EO Gas, Gamma, and Autoclave sterilization methods (material-dependent), supporting standard hospital sterilization workflows.
- **Manufactured in Certified**

Cleanroom Environments. Produced using PLC (Programmable Logic Controller)-controlled extrusion technology within certified cleanroom environments, inspected by laser online inspection devices for critical dimensional consistency.

Technical Specifications

The following specifications apply to APPL's Platinum-Cured Medical Grade Silicone Tubing platform, the base technology underlying the ImaCath™ Wound Drain Catheter Tubing:

Tube Construction	Transparent or translucent silicone tubing, with the option of an integrated radiopaque line or compound
Flexibility	High flexibility with excellent kink resistance
Chemical Resistance	Resistant to commonly used medical fluids
Shore Hardness	Available in soft to medium grades
Sterilization Compatibility	EO Gas, Gamma, and Autoclave (material-dependent)
Shelf Life	5 years from date of manufacture
Storage Condition	Store at 15–30°C, in a clean, dry environment away from direct sunlight

Clinical Applications

ImaCath is designed to support post-operative recovery across a broad range of surgical disciplines. Its flexible, kink-resistant, closed-suction design makes it suitable for placement at diverse anatomical sites, wherever controlled removal of post-surgical fluid is required.

Abdominal Surgery

Following abdominal procedures, fluid and blood can accumulate within the surgical cavity. ImaCath, placed at the surgical bed, provides continuous closed-suction drainage, helping to reduce the risk of intra-abdominal fluid collection, swelling, and associated infection while supporting recovery of the surgical site.

Orthopedic Surgery

In orthopedic procedures, such as joint replacements or major bone and soft-tissue surgeries, post-operative bleeding and fluid buildup around the surgical site can impede healing and increase infection risk. ImaCath's soft, kink-resistant tubing accommodates the mechanical demands of these sites while maintaining reliable

drainage flow.

Breast Surgery

After breast surgery, including reconstructive or oncological procedures, seroma (fluid) formation is a common concern. ImaCath provides gentle, continuous suction drainage that helps minimize fluid buildup beneath the skin, supporting smoother healing and reducing the likelihood of complications requiring further intervention.

Cardiac Surgery

Cardiac and thoracic surgical

procedures often require careful post-operative monitoring of fluid and blood output from the chest cavity. ImaCath's biocompatible, closed-suction system enables clinicians to both remove accumulated fluid and monitor drainage volume via the collection reservoir, an important indicator during post-cardiac-surgery recovery.

Manufacturing Excellence & Regulatory Compliance

ImaCath is manufactured within APPL's advanced production ecosystem, which integrates laser-controlled extrusion systems, automated hose production lines, fully automatic microwave continuous curing systems, and in-house tooling and mold manufacturing, all operating within an ISO Class 10000 certified cleanroom manufacturing environment.

The company's regulatory and quality credentials that underpin its silicone tubing portfolio, including ImaCath, include:

- **Certifications.** TUV Nord-certified Integrated Management System (IMS) covering ISO 9001:2015, ISO 14001:2015, ISO 45001:2018, ISO 27001:2022, and ISO

13485:2016.

- **Regulatory Registration.** The company is CDSCO certified and US FDA Registered (Registration No. 3023054050).

- **Drug Master Files.** APPL holds Drug Master Files (DMF #26201, 32560, 32558, 32556, 32559, 32561 and 32549) accredited by US FDA for its tubing and hose manufacturing.

- **NSF-51 Certification.** The company's Platinum Cured Silicone Resin, along with its Imapure and Imaprene tubing lines, hold NSF-51 certification.

- **BPOG Extractables Test-**

in international markets.

- **Global Presence.** With sales presence in 50+ countries and over 3,000 satisfied global customers, APPL combines global reach with dedicated, responsive service.

Conclusion

The ImaCath™ Wound Drain Catheter Tubing exemplifies Ami Polymer's core mission of enabling healthcare through precision-engineered polymer solutions. By combining a thoughtfully designed drainage system — exit site, retention

anchor, silicone tubing, and collection reservoir — with the material advantages of platinum-cured medical-grade silicone, ImaCath™ delivers a reliable closed-suction drainage solution across abdominal, orthopedic, breast, and cardiac surgical applications.

Backed by a globally certified manufacturing ecosystem, extensive regulatory documentation, and independent safety validation, ImaCath™ stands as a trusted choice for surgical teams and OEM partners seeking a dependable, biocompatible wound drainage tubing solution for post-surgical patient care.

APPL follows BPOG standardized extractables testing protocols for its single-use products and tubing systems.

- **Independent Validation.** Product safety is independently validated through TOXIKON (USA) Extractables & Leachables studies, USP Class VI testing, and ISO 10993 biocompatibility evaluations.

Why Choose Ami Polymer for Wound Drain Catheter Tubing?

- **Advanced Extrusion Technology.** Manufacturing relies on PLC-controlled extrusion technology to ensure consistent tube dimensions and quality at scale.

- **Rigorous Quality Systems.** Strict adherence to ISO 13485 quality systems governs every stage of design, development, and production.

- **OEM Customization.** APPL offers full customization for OEM requirements, drawing on a track record of 5,000+ customized product solutions developed for global partners.
- **Complete Validation & Regulatory Support.** Products are backed by complete validation and regulatory support, including biocompatibility and extractables/leachables testing, to ease regulatory acceptance



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Polymed introduces HAEM-O-TAP, AV Fistula Cannula: The future of flow

For patients dependent on haemodialysis, vascular access is vital for long-term care. Haem-O-Tap supports long-term AVF patency through appropriate clinical practice and access-care protocols

For patients undergoing haemodialysis, vascular access is far more than a clinical necessity—it's the life-line to dialysis. An arteriovenous fistula (AVF) provides access to the bloodstream for subsequent dialysis treatments, making its preservation essential for long-term dialysis care.

Throughout a patient's dialysis journey repeated needle punctures place, ongoing mechanical stress on the AV fistula making cannulation technique, site selection, device design and access-care preservation important considerations for healthcare professionals.

With finite cannulation sites, careful access management and appropriate cannulation practices are essential to support long-term vascular access care.

Elevating safety and care with Polymed

Dedicated to advancing vascular access care in dialysis patient along with safety. Polymed introduces Haem-O-Tap—an advanced AV Fistula Cannula engineered around its three-core design principle

Flow • Flexibility

• Mobility Advanced cannulation technology

Post cannulation there can be mechanical stress on vessel. Haem-O-Tap features Soft and Flexible PP Cannula designed to minimise Fistula trauma during dialysis.

The flexible, needle-free design offers a gentler touch on the fistula, reducing fistula injury risk unlike traditional metal needles thereby making cannulation safer and more comfortable.



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Furthermore, the integrated Automatic Anti-Reflux Valve actively minimises possible blood backflow, reducing exposure & contamination risk. This feature protects both the patient and the healthcare professional, making cannulation cleaner, safer, and more secure.

Confidence through quick vessel confirmation

During cannulation, timely confirmation of vessel entry and a successful fistula puncture is essential for reducing the need of multiple unwanted

needle pricks and a successful fistula puncture. Haem-O-Tap features Flashback Mechanism that provides quick visual confirmation of fistula entry, helping healthcare professionals proceed with greater confidence and precision while minimising potential fistula trauma & damage.

Flexibility that supports mobility

Dialysis patients spend a significant amount of time undergoing prolonged treatment sessions, making smooth flow,

flexibility, and mobility essential to their overall experience. Haem-O-Tap features a Flexible Cannula Design to support better patient mobility during dialysis. The PP grade plastic cannula minimises infiltration into the fistula wall providing greater patient mobility and reducing the risk of fistula damage from hand movement.

Improving mobility around the access site helps minimise discomfort and restriction, allowing patients to feel more at ease throughout & post their dialysis session and also re-

duces probability of fistula damage due to unintentional hand movement.

Flow engineered

Consistent blood flow is fundamental to effective haemodialysis. Haem-O-Tap features Uniform Pore Distribution designed to support smooth, uninterrupted high-flow dialysis while helping minimise vascular stress.

Haem-o-tap with engineered cannula design intended to deliver reliable performance while supporting the delicate nature of vascular access, helping maintain a balance between quality dialysis and need to sustain fistula integrity for longer period of time.

Thinking beyond a single dialysis session:

For patients dependent on haemodialysis, vascular access is vital for long-term care. Haem-O-Tap supports long-term AVF patency through appropriate clinical practice and access-care protocols.

This long-term perspective reflects a broader philosophy that: patient safety is not only limited to the cannulation procedure; but also extends to protecting the vascular access that patients rely on for continued dialysis.

Safety with a sustainable perspective

From rigid fistula puncture to flexible indwelling design. Haem-O-Tap brings multiple considerations together in one AV Fistula Cannula.

Haem-O-Tap is designed to improve patient convenience supporting flow, flexibility and mobility, while putting patient safety at the heart of every cannulation.



Alphenix Core+

**Floor-mounted multi-access
single-plane system**



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