Field Notes

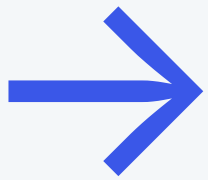
India Health Exhibition 2026

THE SETTING

I spent 3 days at India Health Exhibition 2026.

Notes from the floor, the talks, and the panels — on AI, hospitals, and where both are headed.

Here's what stood out.



First, credit where it's due: IHE's process was genuinely smooth.

Shuttle service from the metro straight to the hall.

Online registration meant walking in on a phone QR scan — no queue, no time lost.

Small thing, but it's the kind of operational detail that's easy to get wrong at scale.

The IHE team didn't.

Who was there

The floor was mostly medical device and med-tech vendors — but the energy was somewhere else.

A handful of AI firms were present, working with a fraction of the booth space of the large device companies.

That space didn't match the interest they were pulling in.

AI pull didn't fade

Conventional wisdom says the last day of an expo is a ghost town.

Day 3 didn't play along.

The AI startup stalls kept drawing crowds right through the final day — no drop-off against the pattern everyone expects by day three.

Even hardware is pitching AI

Talk to a medical device company today, and AI comes up within minutes.

Even firms selling hardware are building AI into their pitch — improving diagnostic precision is the use case that came up again and again.

What AI is actually for

Two lines from the talks that I keep coming back to:

- "Tech alone cannot transform: care needs to be delivered at the right time in the right manner."
- "AI is an enabler like other technologies, but patient outcomes, patient safety, patient access, and patient experience remain the pillars that AI must strengthen."

The second one is the test I'd apply to any AI pitch: which of those four pillars does it actually move?

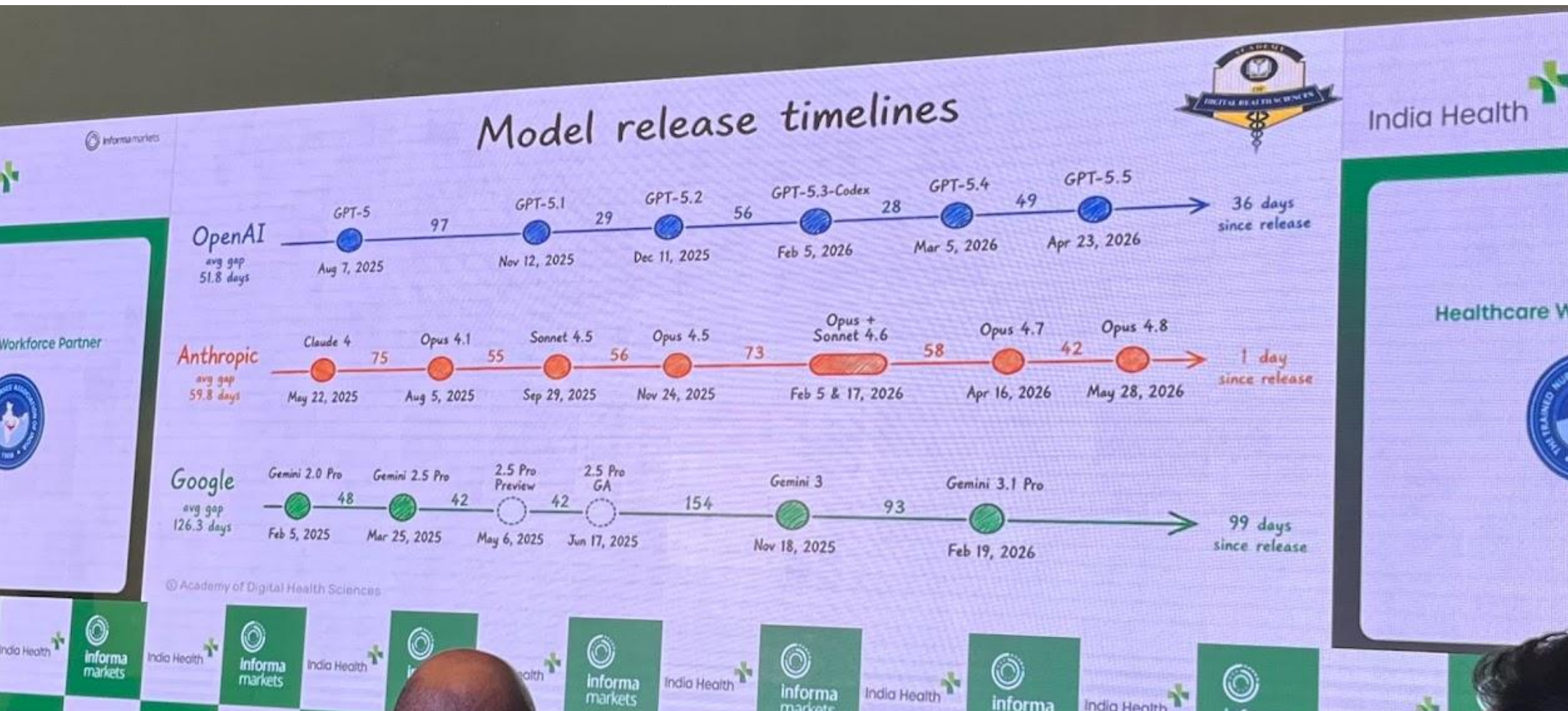
AI needs scaffolding, not hype

AI is becoming the heart of healthcare with new models releasing faster than ever — but it doesn't work standalone.

The framing from one talk: speed is the name of the game, we need to be thinking in months, not years.

But AI needs scaffolding — robust, high-fidelity data feeds — to be useful. Adopting it just because of the hype is a recipe for disaster.

Dr. Rajendra Pratap Gupta had his own framework for thinking about where AI actually is in that maturity curve.

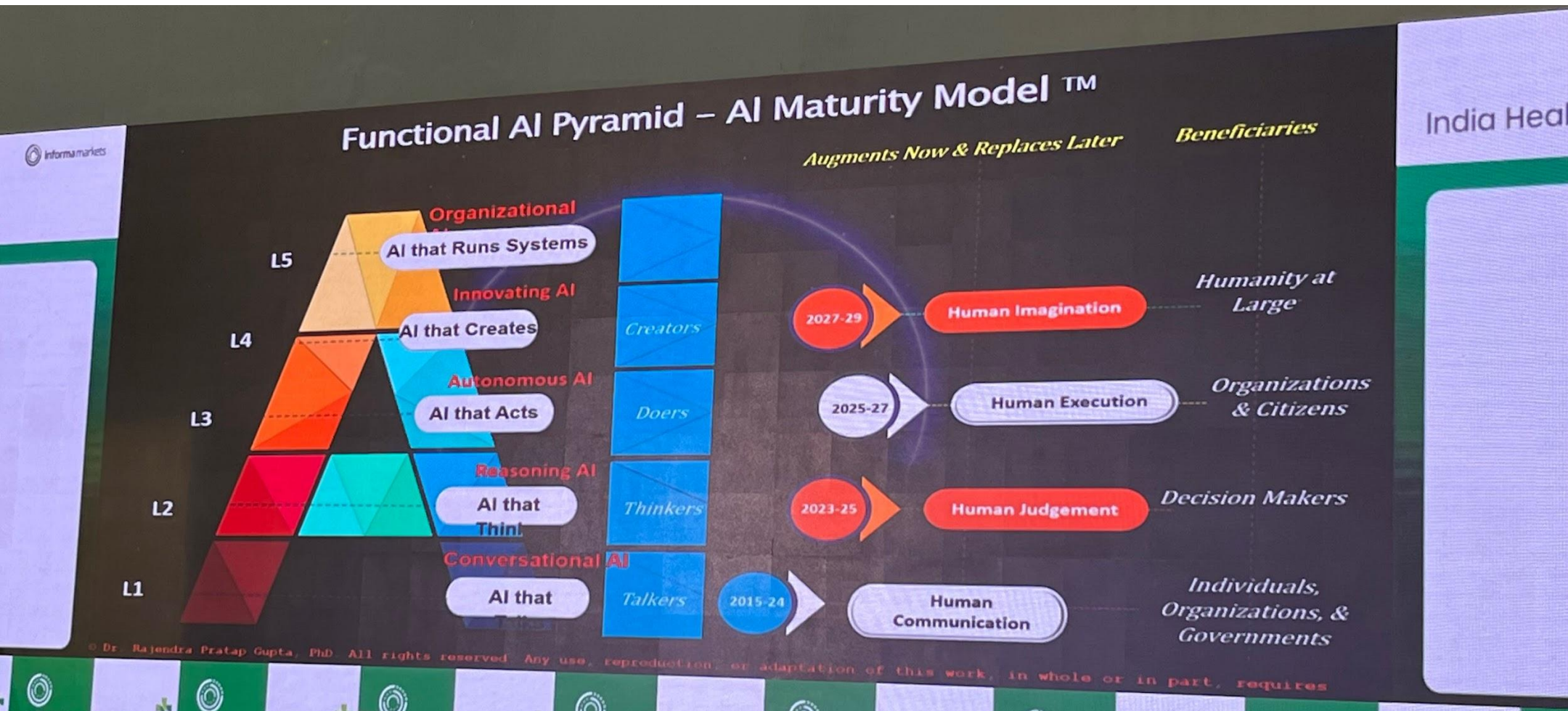


Dr. Gupta's Functional AI Pyramid

Dr. Rajendra Pratap Gupta laid out a 5-layer maturity model for where AI is headed, each layer mapped to a rough time frame:

- **L1 — Conversational AI, "AI that talks"** (2015–24) — augments human communication. Beneficiaries: individuals, organizations, governments.
- **L2 — Reasoning AI, "AI that thinks"** (2023–25) — augments human judgement. Beneficiaries: decision makers.
- **L3 — Autonomous AI, "AI that acts"** (2025–27) — augments human execution. Beneficiaries: organizations & citizens.
- **L4 — Innovating AI, "AI that creates"** (2027–29) — augments human imagination. Beneficiaries: humanity at large.
- **L5 — Organizational AI, "AI that runs systems"** (2030 onwards) — AI operating at the level of the organization itself.

Framework: Dr. Rajendra Pratap Gupta, PhD.



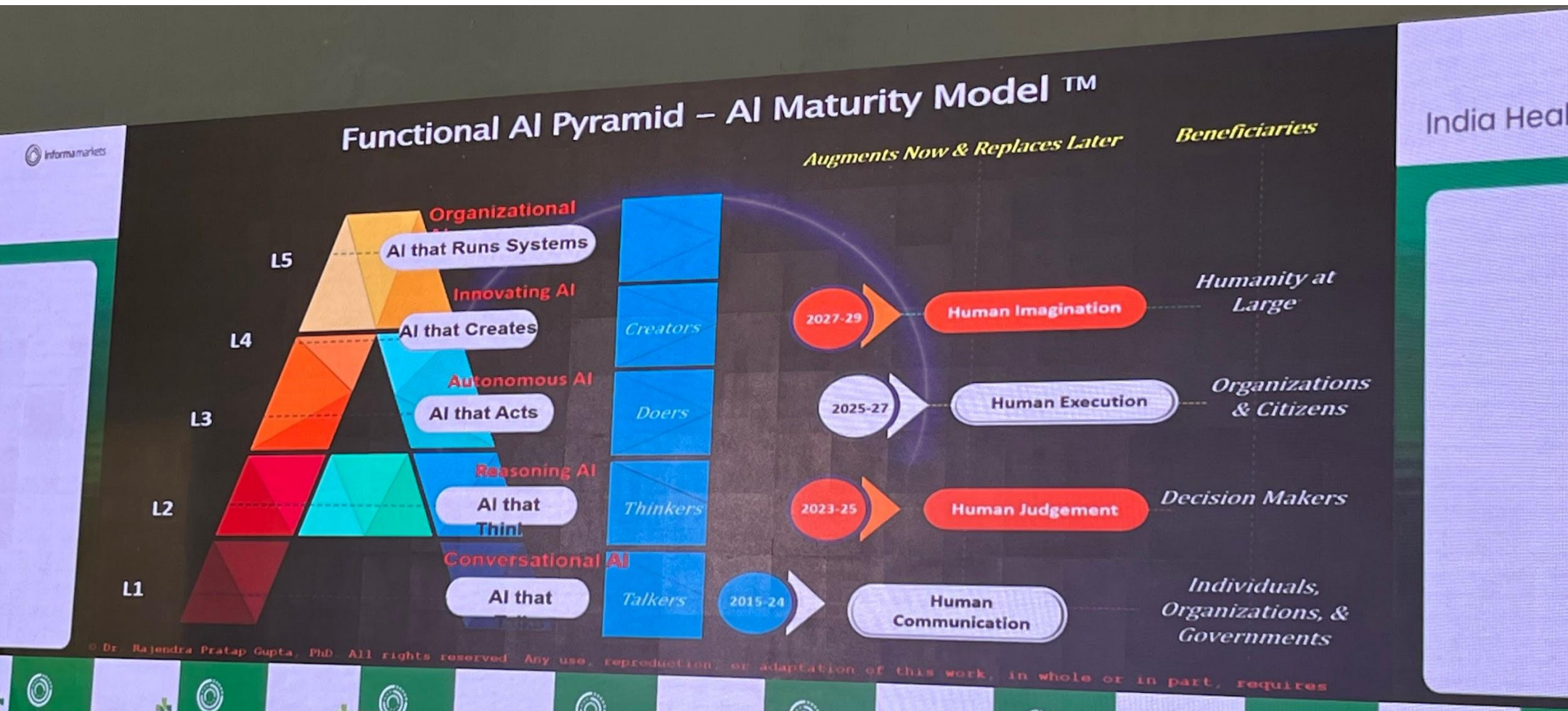
The bold claim inside the model

Every layer of that pyramid carries the same label running alongside it: "Augments Now & Replaces Later."

Not assists. Replaces. That's the edge behind another line of his from the same event: "Nothing that you do right now you will be doing in 2030."

By his own timeline, we're already past the augmentation phase for communication and inside the one for judgement — execution and imagination are next in line, before 2030 arrives.

Whether AI actually reaches that far on schedule is the real debate. But as a way to place a given AI tool on the maturity curve — talks, thinks, acts, creates, runs — it's a genuinely useful lens.



“Nothing that you do right now you will be doing in 2030.”

– Dr. Rajendra Gupta, PhD

The data question will become heavier in the AI age

Data portability is hard.

Ownership, processing rights, and retention are three different things — and companies are wary of what ABDM and DPDP require of them.

Also worth separating: generic AI tools are not the same category as specialised ones, and shouldn't be evaluated the same way – especially when it comes to the data policies that apply to them.

What AI can't do

Tech can widen health access. It cannot deliver compassion. That was the clear line from the panel: AI aids, it doesn't replace human touch.

Anjan Bose (NatHealth) framed why ethics matters more in healthcare than almost anywhere else — it's the one sector where the end of the value chain is a human being in pain, surrounded by anxious family.

Tech is a double-edged sword here: right hands, real good; wrong hands, the opposite.

What AI can't do

Builders and providers are two sides of the same coin in carrying that responsibility.

Tech without intelligent, experienced interpretation is dangerous — and AI models differ in their interpretations, same as doctors do.

That's not a reason to avoid AI. It's a reason to be careful with it.

“Either we live with AI or we live alone.”

Rajiv Kovil
(Zandra Health)

How hospitals should compete now

Hospitals have moved through three eras of differentiation.

Era 1: who has the best infrastructure.

Era 2: who can handle the most volume.

Now: who delivers the best patient experience.

AI has a real role to play in that third era — which is a big part of why interest in it is booming, from both providers adopting it and builders creating it.

"You don't have to train people to take care of their family. That is the mindset we need to inculcate at our hospitals."

Dr. Sheenu Jhawar
(Apex Hospitals)

What hospitals need by 2030

Competing in 2030 will take a startup mentality — paired with compassionate care.

That combination came up repeatedly on the panels: agility on one side, the human core of the business on the other. Neither alone is enough.

Also, a hospital's ability to attract and keep good people runs through its systems, not just its intent.

"Everyone wants to join a good system. Create good systems, protocols and SOPs at your hospital."

– Cdr. Navneet Bali
(Clearmedi Hospitals)

Where the need actually is

Tier 2 and 3 cities have a more acute healthcare need than metros and tier 1 — and capital is starting to follow.

PE entities are reaching tier 2/3 through patient capital: unlike debt, where EMIs start almost immediately, PE gives a 10+ year horizon.

That matters in a sector where most hospitals take 4-5 years to break even.

OOPE is declining; AB is picking up

Out-of-pocket expenses are declining — decisively, though gradually — in several tier 2/3 markets.

In some cities, PM-JAY / Ayushman Bharat is now the majority revenue source.

Gwalior: one hospital draws 90% of IP revenue through AB.

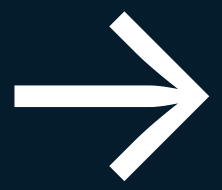
Nanded: one hospital is at 100% IP revenue through AB.

That's a structural shift in how these markets fund care.

WHAT THIS MEANS

Three days, three clear signals:

1. AI momentum in Indian healthcare is real — but the winners will be the ones who treat it as scaffolding for outcomes (most immediate use case: patient experience), not a marketing feature.
2. Tier-2/3 cities can unlock growth but need incredible operational discipline to maintain margins while delivering quality care.
3. Well known sources of revenue are changing and new ones are emerging – AB, GIS. Which in turn is changing how hospitals operate and manage revenue cycles.



Aviral Prakash