ICRIER

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

ICRIER PROSUS
CENTRE FOR INTERNET AND DIGITAL ECONOMY

Australian Government
Department of Foreign Affairs and Trade

# Outcome Document

# Workshop on Transformation of Health Systems Through Digital Public Infrastructure


**Author**

**Shailly Gupta**
**Mehak Aggarwal**


2026

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## Acknowledgements

Our sincere gratitude goes to colleagues and external experts for insightful comments and discussions that enriched the workshop. We would like to thank Payal Malik (Lead, IPCIDE and Digital Economy, Startups and Innovation vertical, ICRIER) for designing and chairing the workshop. We would also like to thank Maria Khan (Consultant, ICRIER) and Bhargavee Das (Research Associate, ICRIER) for organising the workshop. In addition, we would like to thank Shailly Gupta (Fellow, ICRIER) and Mehak Aggarwal (Research Assistant, ICRIER) for the preparation and finalisation of this outcome document. We would also like to acknowledge Neha Arora, Raj Kumar Shahi and Rajesh Chaudhary for logistics organisation. Rajesh Chaudhary designed the outcome document.

We would like to acknowledge ICRIER Prosus Centre for Internet and Digital Economy (IPCIDE) and the University of Queensland (UQ), Australia. This workshop was convened as part of an Australia-India Cyber and Critical Technology Partnership (AICCTP) project titled, "A Paradigmatic Shift in Public Service Delivery: Inclusive, Efficient and Secure DPI", funded by the Department of Foreign Affairs and Trade (DFAT), Australia.

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**Disclaimer:** This is a best-faith effort to summarise the learnings from the workshop held. They, in no manner, represent the views of ICRIER.

# Outcome Document
# Workshop on Transformation of Health Systems through Digital Public Infrastructure

## 1. The Context

Digital Public Infrastructure for Health (DPI-H) is a novel and evolving paradigm for the digital transformation of health systems. It refers to a country's digital health infrastructure- a set of reusable digital building blocks, including health IDs, shared trusted health registries and open health networks, that enable the creation of inclusive, scaled and user-driven applications in a health system.

The DPI-H approach is gaining traction across countries such as India, Brazil and Kenya, primarily to substitute traditionally siloed and fragmented digital health solutions with integrated and interoperable systems.

As of 7th January, 2026, 846.4 million health IDs (ABHA) have been created in India, 0.7 million health professionals registered on the Health Professional Registry (HPR) and 0.4 million health facilities have been onboarded on the Health Facility Registry (HFR)." In terms of usage of ABDM, 815 million health records have been linked to ABHA, 178 million scan and share tokens have been issued and 0.2 million facilities are using ABDM enabled software.

## 2. The Workshop – An Overview

ICRIER, in partnership with the University of Queensland (UQ), Australia, and the ICRIER Centre for Internet and Digital Economy (IPCIDE) hosted a hybrid workshop, "Transformation of Health Systems through Digital Public Infrastructure" on 09 January 2026 in New Delhi. 42 experts representing government, the private sector, international organisations and civil society gathered to engage in a full-day dialogue (*please see Annexure 2*). The case in focus was the Ayushman Bharat Digital Mission (ABDM) to gain deeper insights into the functioning of this flagship DPI-health initiative of India. This workshop has been convened by ICRIER in partnership with the University of Queensland (UQ) as part of an Australia-India Cyber and Critical Technology Partnership (AICCTP) project titled, "A Paradigmatic Shift in Public Service Delivery: Inclusive, Efficient and Secure DPI", funded by the Department of Foreign Affairs and Trade (DFAT), Australia. The workshop was designed and chaired by Ms. Payal Malik, Lead, IPCIDE and Digital Economy, Startups and Innovation vertical at ICRIER.

The importance of this workshop cannot be overstated. The workshop, had two sessions focusing on, "Strengthening Technical Foundations for Inclusive and Efficient DPI-Health", and a "Discussion on Governance, Public-Private Partnership and Security in DPI-Health".

The first session of the workshop identified technical design principles that can guide countries in implementing DPI-H systems that are both technically robust and socially inclusive. Participants spoke on milestones and challenges in promoting interoperability in digital health through ABDM, efficiency gains and technical barriers from the provider perspective, ensuring inclusion by design and shared learnings from international experiences of building interoperable digital health systems.

Participants in the second session engaged in dialogue on the levers of ABDM impact through a decentralised governance model, levers of regulatory interventions in ABDM diffusion, market participation and public-private partnership in scaling ABDM and data governance and cybersecurity for privacy preserving and secure DPI-H. Some questions posed to the Participants covered ways in which ABDM has been streamlining the patient journey and improving operational efficiencies through workflow transformations among healthcare providers and other ecosystem stakeholders.

The effectiveness of ABDM's technical architecture in supporting the inclusion of rural, remote, and marginalized populations by design, the lessons from state implementation and

microsite projects, the integration journey of health-tech providers and the pathways to leverage ABDM building blocks for innovation were also discussed.

Finally, there was an open discussion on the potential for ABDM as a replicable DPI model for the Global South, and the contextual adaptations necessary for the same.

The ICRIER Prosus Centre for Internet and Digital Economy (IPCIDE), set up jointly in 2022 by the Indian Council for Research on International Economic Relations (ICRIER), one of India's premier economic think tanks, and Prosus Services B.V., the largest consumer Internet company in Europe, provides policy evidence to inform India's digital transformation.

## 3. The Workshop – Special Addresses

Giving his welcome address at the workshop, **Dr. Shekhar Aiyar, Director & CE, ICRIER**, said, "India is a pioneer in the DPI field. Examining the micro- and macro-economic impact of DPI across a range of uses should keep economists busy for a long time to come. Applying DPI to critical governance programs promises broader socio-economic progress and inclusion not just in India, but also in the rest of the Indo-Pacific. With this event, we hope to not only strengthen the DPI framework and its application to select use cases, but also facilitate its adoption more widely, both in India and other countries."

**Dr. Ram Sewak Sharma, Distinguished Visiting Professor at IIT Kanpur and Former CEO of the National Health Authority**, attended the workshop as a keynote speaker and presented the key Architecture Principles of India's DPI. He said, "We must consider the scale of adoption given the high diversity in India. Interoperability is key for transparency".

**Professor Clair Sullivan, Director, Queensland Digital Health Centre, The University of Queensland, Australia**, also presented her keynote address. She said, "Technology alone cannot improve digital health. There is a Quintuple aim of healthcare. Building trust is key."

A Special Address was given by **Mr. Vikram Pagaria, Director, IT (ABDM & AB PM-JAY), State Coordination (ABDM), ABDM Adoption (Private) & IEC-ABDM, National Health Authority**. He said, "ABDM promotes interoperability. There is now a focus on achieving adoption and awareness of ADBM – these are the challenges faced currently. Frictions in the healthcare system need to be solved. Stakeholders want immediate results – the value proposition of ABDM needs to be clear."

**Mr. Satyanarayana Jeedigunta, Chief Advisor at C4IR India, Distinguished Fellow and Chairperson, DPI Academy at Artha Global and Former Secretary, Department of Electronics & IT, Government of India**, gave his keynote address. He said, "We are thinking of moving from an outputs-focused approach to health outcomes-focused approach. Health is a multidimensional issue. Digital health is not necessarily about digital but it is about health.

We must look at four dimensions – people, process, technology and business model. Build capacity and awareness."

**Mr. Vinayak Godse, CEO, Data Security Council of India** was also a keynote speaker at the workshop. He shared that, "India is a great market for B2C innovation."

University of Queensland (UQ), Australia is one of the leading universities globally, as a pioneer for its impact-focused research.

## 4. The Inaugural Session

**Dr. Shekhar Aiyar, Director and Chief Executive** at the Indian Council for Research on International Economic Relations (ICRIER) opened the workshop discussing the Ayushman Bharat Digital Mission (ABDM) at the microeconomic and macroeconomic levels. Dr. Aiyar noted that micro-innovations would eventually manifest at the macro level. He laid emphasis on the assessment of inclusion and taking stock of DPI pioneers in the Indo-Pacific region and beyond.

**Dr. Ram Sewak Sharma, Former CEO, NHA**, in his keynote reflected on the 4-year journey of ABDM. Digital Public Infrastructure is defined as the technology building blocks with open standards and enabling rules to drive innovation at scale. The technology must be open, transparent, and interoperable. DPI design must take account of India's diversity and ensure inclusion at scale for India's 1.4 billion people. He highlighted the India Stack foundations: Aadhaar (2009), e-KYC (2012), e-Sign (2015), DigiLocker (2016), UPI/Bhim (2016), and BBPS. Its 3 layers include market, governance, and tech standards. The DPI approach increases innovation and competition, enhances openness and sovereignty, and reduces cost of entry into the system, as against an all-government or all-private approach.

The architectural principles of India's DPI include data minimisation, privacy by design, inclusion, ecosystem not being a monolith, and innovation at population scale. A success case is CoWIN which was cited as a scalable, universal platform developed in weeks, managing 1.3 Bn+ vaccinations in thousands of locations when mobility was an issue. The core building blocks of ABDM include the ABHA number, Healthcare Professionals Registry, Health Facility Registry, and Drug Registry. There is an underlying vision to create a National Digital Health Ecosystem. The guiding principles are Federated Data Architecture, Single Source of Truth, Wellness and Citizen-Centric, Voluntary Participation, Privacy and Security by Design. Technology in the health space improves access and affordability. India's Approach to DPI is to treat it as a public good, enabling free markets, and a level playing field in comparison to "private highways".

**Professor Clair Sullivan, Professor, University of Queensland and Director, Queensland Digital Health Centre**, Australia defined DPI in her keynote address as shared, reusable digital building blocks for the public good, enabling public and private innovation. She highlighted the quintuple aim of improving clinical outcomes, equity, patient experience, provider wellbeing, and lowering costs. There are three horizons to look out for - (1) Digital foundations (e.g., QLD ieMR – electronic medical records); (2) Data & Analytics transforming patient care; and (3) New models of care. She further warned that projects can fail despite being legal and ethical if they lack the "social licence". This means that a dynamic, informed public approval is key for DPI in the health sector. She also argued that inclusion must be intentional, specifically within data analytics and digital workflows. The key takeaway is that "Trust enables care".

## 5. Session 1: Technical Foundations for Inclusive & Efficient DPI-Health

This session was moderated by Mr Sundeep Agarwal, Senior Vice President of Regulatory & Quality, Remidio Innovative Solutions Pvt Ltd, and Ms. Bhargavee Das, Research Associate, ICRIER.

**Mr. Vikram Pagaria, Director, IT (ABDM & AB PM-JAY), State Coordination (ABDM), ABDM Adoption (Private) & IEC-ABDM, National Health Authority** laid out the operational philosophy underlying ABDM. He characterised the implementation of ABDM as a, "marathon, not a T20 match." He stated the NHA ethos being open to suggestions and opinions. ABDM promotes interoperability through three gateways - Health Information, Health Interface (healthcare services) and claims processing.

With respect to data governance, he clarified that the government does not store patient data; it provides the Health Infrastructure Exchange (Gateway) and Consent Manager for viewing and sharing. Users have granular control and can select exactly which records to share. Some challenges faced include,

- Adoption as a major hurdle given that the healthcare system is not fully digitised (lacking the requisite hardware, constraints on capacity). Focus is now on adoption, capacity building, partnerships with academic institutions, and public-private partnerships (PPPs);
- Stakeholders want immediate benefit, question how its advantageous for them (this is a friction point stemming from voluntariness);
- Awareness of ABDM is lacking;
- Stakeholders have privacy concerns despite no central repository and there being individual lockers with patient records.

There is an issue of power asymmetry such that doctors and hospitals currently hold the highest power in the healthcare system, and thus they must recognise the benefits of interoperability for all.

Nevertheless, there are some financial and non-financial incentives. Financial implications from usual delays in patient discharge can be avoided by making claim adjudication smoother, clinical decision support systems, a reduction in physician burnout through AI-voice-to-text in patient consultations and digital prescriptions.

**Dr. Prem Kumar, President, Surgical Society of Bangalore** provided technical and clinical insights through sharing a tertiary care perspective. He highlighted that clinical efficiency through improved data quality, data portability, reduced waiting times and smoother referrals can be achieved. This is especially relevant for cases where missing records become a risk, particularly lower and lower-middle income group patients, amnesia/dementia patients. When patients are unaware of prior investigations necessitating re-initiation of investigations, digital records can help reduce these redundancies.

Some general challenges include the infrastructure gaps (lack of laptops in Tier 2/3 cities), interoperability challenges, the "digital divide" (inconsistent connectivity), plural systems of medicine that need semantic clarity and the "click tax" - workflow mismatch and cognitive load. Another major issue is to do with consent, trust and liability – doctors require granular details of patients' medical history, and voluntariness of disclosure with regards to medical history poses a challenge for clinicians, who require complete medical history for diagnosis and determining best treatment course.

Some recommendations suggested included embedding ABDM into routine clinical workflows, linking ABDM to real clinical incentives, building high-impact clinician use-cases (like geriatric patients who take regular drugs and never discontinue), and holding dedicated sessions on ABDM by medical societies such as IMA.

**Dr. Pankaj Gupta, Director, Libra Social Research Foundation and Member of WHO-ITU** shared insights on strategic adoption and execution of ABDM. He noted that while India has succeeded in policy and architecture, the challenge remains in the execution and adoption of ABDM. He proposed a "Showcase Model" wherein there is a focus of resources on "mature states" (South and West) to create high-volume success stories rather than spreading resources thin in "aspirational" states. He identified financial drivers as essential, specifically linking ABDM with DPDP compliance and the National Health Claims Exchange (NHCx) for insurance. He further suggested using Artificial Intelligence (AI) as the individual interface to solve "Click Fatigue" and the data entry burden; specifically advocating for Generative and Ambient AI for clinicians. Dr. Gupta warned that the current "alphabet soup of regulation" and conflicting mandates stifle innovation.

**Mr. Vikas Kharbanda, Partner, Healthcare & Life Sciences Practice, Arthur D. Little, Dubai** spoke on economic complexity. He argued that healthcare is a tripartite system involving payers, providers, and patients. He noted that the interaction between payers and providers is currently a "zero-sum game" with no incentive for negotiation; therefore, digital adoption needs to be mandated, especially in the public sector.

**Dr. Kavitha Palaniappan, Assistant Professor, Centre of Regulatory Excellence, Duke-NUS Medical School, Medical School,** presented a comparative global analysis. She compared ABDM to the UK's NHS Spine, Australia's MHR, and Singapore's NEHR. She identified ABDM's scalability challenges including digital literacy, connectivity, and data fragmentation.

She noted that NEHR has fragmented provider markets while the NHS Spine has a complex centralised design. She concluded that long-term sustainability for ABDM requires sustained governance discipline and outcomes linked strictly to incentives. She finally advocated for privacy-preserving national analytics workflows, prioritising usability and workflow integration, sustained and continuous investment, strengthening ecosystem governance, and capability building.

**Dr. Surajit Nundy, Founder, Raxa Health,** provided insights on the importance of being critical of fake data. He highlighted that the economic case for digitization has not been figured out yet, there does not seem to be a great economic argument for ABDM. There has not been receipt of any interoperable record across the network yet. There is no incentive to share data amongst healthcare providers and patients alike, the government needs to work on encouraging people to share their data. The real challenge is how to get a full medical record. There is a question on whether to get the full picture of a patient's medical history or not. Limited data is worse than having no data. The government needs to get the systems, patients, payers and providers to digitize and share data. He cited Obamacare that drove digitization in the United States to share an example of the government providing economic incentives in the health sector.

**Dr. Neelesh Kapoor, Chair, Public Health, Diabetes India** shared his views on clinical delivery and operational efficiency. He stated that western solutions will not work if they increase clerical workload. Doctors want queues in hospitals. There is a perception that problems have changed. Now there are teams of doctors in metros. “Scan and share” is working well but it will not work everywhere. Due to digital availability, there is too much work. Doctors want peace of mind. There is a lot of expectation from patients. Further, developers must understand the perceived vs. real issues on the ground. He observed an "all or none" phenomenon regarding adoption; doctors should not be burdened by systems that are difficult for them or their staff to use. He laid out technical barriers, specifically that legacy Health Information Systems (HIS) are unable to communicate with ABDM APIs and noted the complexity of FHIR (Fast Healthcare Interoperability Resources) implementation. He further raised the issue on the trust deficit among patients and workforce constraints where small providers lack the basic "digi-stack" or training. Some proposals for Scale included making ABHA mandatory where money flows, investing in capacity building, involving clinicians at all levels of dialogue, focusing on 3-4 high impact cases, and providing "plug and play" ABDM connectors. Further, people do not want to share their OTP when visiting hospitals. There is a trust deficit in the government. What is the cost of interoperability?.

## 6. Session 2: Discussion on Governance, Public-Private Partnership and Security in DPI-Health

This session was moderated by Mr Sundeep Agarwal, Senior Vice President of Regulatory & Quality, Remidio Innovative Solutions Pvt Ltd, and Ms. Bhargavee Das, Research Associate, ICRIER.

**Mr. J. Satyanarayana, Distinguished Fellow and Chairperson, DPI Academy at Artha Global and Chief Advisor, C4IR India, World Economic Forum** gave the keynote address. He stated that ABDM is at a crossroads; ABDM 2.0 is now a leading initiative for the NHA, realignment to health for all and patient experience with strategic initiatives looking at health as a complex multidimensional initiative. He questioned the right metrics to measure success, defining digital health as "not so much about digital, but about health".

Thereafter, he outlined four dimensions for achieving success as follows,

(1) People (capacity building, both internal and external – create demand side awareness);

(2) Process (technology has been created but hospitals are old and reforms are tedious with long procedures);

(3) Technology (tactical interoperability, human interoperability, security, and privacy to be reviewed with UNDP Universal DPI Safeguards and need to align with DPDP rules); and

(4) Business Model (moving away from a single monolithic DPI, HR for health).

He further advocated for a State-led, Federated Architecture with core hubs distributed across states. In addition, he explained how sustainability requires rigorous streams of revenue and economic incentives so that the value becomes vital and "nobody can stop it thereafter". “Trust and Thrust” are critical to take it forward – trust of all ecosystem players and thrust by state and central governments.

**Mr. Vinayak Godse, CEO, Data Security Council of India** discussed quantum technology adoption and maintaining security in the health sector. He argued that security and privacy must be treated as a public good. With respect to data protection, most DPIs are "data-blind", but is there a way to make data exchange possible? The goal is to optimise investment so every player derives benefit. It is important to figure out how people in the ecosystem earn enough money to invest in privacy and security.

He also explained the issue of liability by highlighting that accountability and liability currently lie with the end-user (patient), which is a major issue that must be addressed. He also noted that privacy technologies "won't come for free" and require investment from both government and private sectors.

**Panel Interventions & Implementation Insights**

**Ms. Pallavi Gupta, Senior Director – Policy Advocacy, Intelehealth** noted that despite the eSanjeevani and ABHA linkage, many people are unaware that their ABHA IDs have been created. There is a lack of interoperability on the ground in government portals, hampering public sector ABDM integration.

**Dr. Harsh Shah, Assistant Professor, Indian Institute of Public Health,** stated that ABDM will direct workflows but we need to build better applications. He distinguished between user needs: clinicians need descriptive apps, while policymakers require prescriptive analytics. More innovation needs to go into the application part of it.

**Ms. Padmani Vishwanath, WHO,** defined 3 principles for inclusion - (1) Allow facilities to retain control over their data; (2) a "Firelight Strategy" – design for the weakest link first; and (3) Modernise existing systems instead of replacing them.

**Mr. Himanshu Burad, Officer on Special Duty (OSD) to Mission Director, ABDM,** noted that like UPI and Aadhaar, health DPI has a long gestation period. Success depends on how intuitive the apps are rather than just the infrastructure. ABDM ensures a minimum level of security and makes patients owners of their health data, and ensures accountability through audits. He highlighted that with Gen Z and Gen Alpha being digital-first generations, the digitisation in healthcare is inevitable.

**Mr. Akshat Mandloi, Nodal Officer, Madhya Pradesh** focused on efforts at 6 urban microsites - urban areas/areas with higher number of private clinics & hospitals. He shared how there was collaboration with private players to push HMIS and ABDM components. As a result, they were the first ones to complete the microsites in the country. Challenges observed include infrastructure/connectivity gaps and low provider/beneficiary adoption, HR and capacity constraints, system integration and interoperability challenges, ABHA creation and data

quality issues. He reiterated that health is a state subject and hence we need different approaches to implement ABHA across states. KPIs recorded and sites should be evaluated on this basis. There is a goal to convert microsites into Digital Health Districts.

**Ms. Apoorva Gupta, Project Lead (Digital Health), International Innovation Corps, University of Chicago Trust, India** observed that Project Management Units (PMUs) were absent in the initial few years, though they were meant to be started in the first year. Users do not know what ABHA is and how to use it, while providers have become "closed-door" due to privacy concerns. Change management is the key horizon. Roles and responsibilities to be clearly detailed, and the framework must be designed to take care of compliance standards to ensure trust.

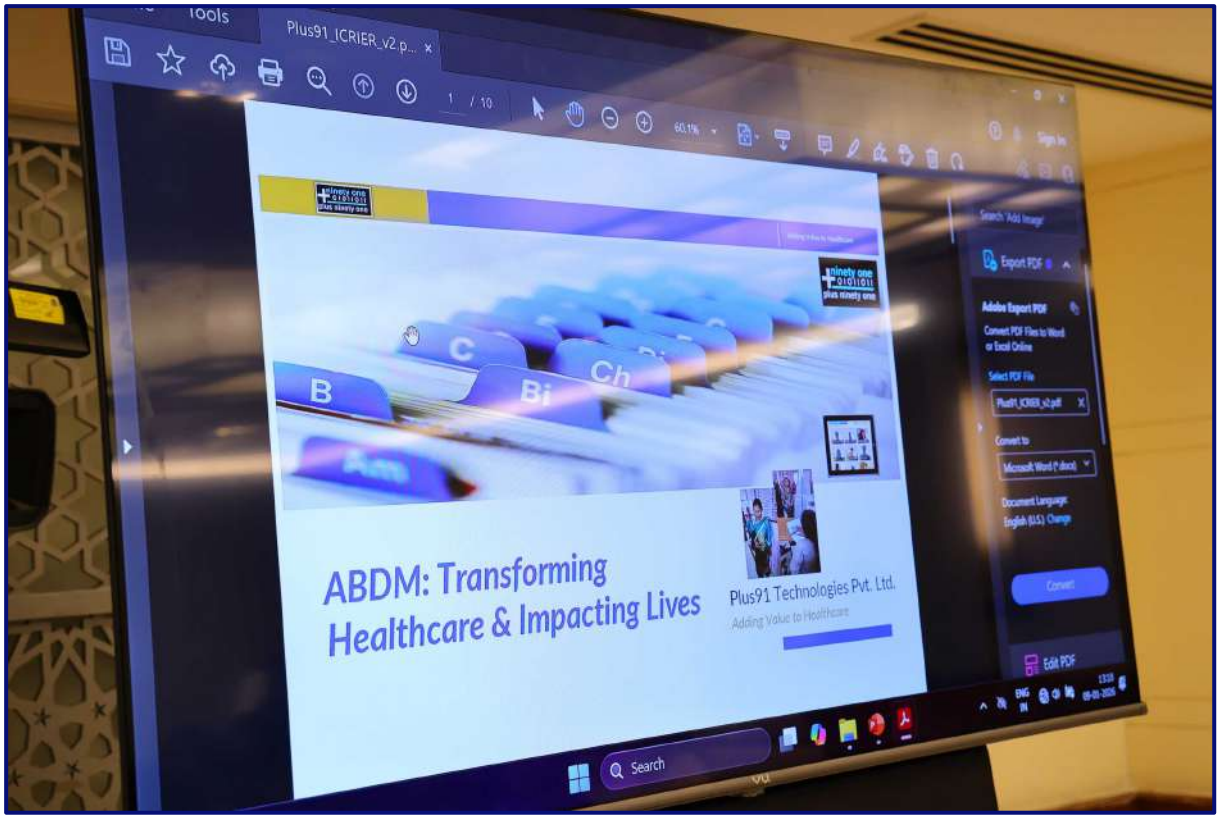
**Ms. Shiffali Singla, Senior Digital Health Analyst, ACCESS Health International** reported findings on ABDM microsite implementation, noting that IEC material is very sparse and facility adoption is hard to sustain.

**Dr. Harsh Parikh, Founder and Director, DRiefcase Health-Tech Private Limited,** argued for making digital tools a part of medical college courses to ensure new doctors are "digital first". Patient-first approach needs to be adopted and government must come in here to ensure this happens. He stated that "rocking the boat" must come from the top; healthcare has not gone digital because it has not been a priority. With respect to economic incentives, he shared that there is no incentive in the private sector - the government must migrate all claims to an electronic platform to force adoption. He further noted that "Scan and Share" is like "DigiYatra for hospitals," reducing entry time by 4–5 hours and lowering operating costs.

**Mr. Siddhartha Bhattacharya, Secretary General, NATHEALTH,** shared that the big drivers of lack of adoption (demand side and value side) are lack of private sector regulation and many cumbersome compliances. He identified measures for creating demand - (1) Creating Digital Governance (Trust) and (2) Real applications, such as digitising registries for organ donation traceable via ABHA IDs.

**Ms. Vidya Bhavani, Founder, Destratum Solutions Private Limited,** shared that in Tamil Nadu, doctors remain reluctant to adopt digital solutions even when use cases are found.

**Mr. Aditya Patkar, Co-Founder, Plus91,** observed that his largest rollout was in Ghana rather than India, and within 2-3 years of rollout, claims were settled faster and 600-700 facilities were integrated. In India, standardised encouraged him to invest and he undertook a major government project in Bihar. Challenges faced therein included quick changes in vendors for NHA, lack of awareness faced by both patient and provider. He found that the major point of emphasis for adoption is diagnostics, especially cause the field is digitised already, clinicians (non-emergency) who often rely on diagnostics. A focus area for integration is pharmacies on-boarded (Bihar), with 70-80% OPD integration. He recommended targeting lack of awareness, lack of usage of records to save time/money, and tiered incentives to address these barriers.




Finally, **Mr. Abhishek Gautam, Founder, Ambula, Odisha** reported that patients are unwilling to pay for longitudinal records and doctors fear redundancy and job cuts, especially at small scales.

## 7. Key Takeaways – A Summary by Mr. Sundeep Agarwal, Senior Vice President of Regulatory and Quality, Remidio

- Privacy by Design;
- Sandbox Integration - policymakers and people on the ground have different perspectives;
- API integration;
- Encryption and decode – system has to be user friendly;
- Cannot be generalised – different experiences from 100 microsites. Cannot replicate the West;
- Cybersecurity – need to clearly define who is responsible in case of leaks.

Consensus was that while India has established a world-class technical architecture (India Stack), the focus must now shift from building "blocks" to ensuring strategic adoption, clinical usability, and sustainable governance.

The Indian approach to DPI is rooted in federated architecture principles, ensuring data remains decentralised while allowing for seamless exchange via the Unified Health Interface (UHI). Key principles include "Privacy by Design" and "Data Minimisation". Participants argued for an inclusion-first approach, designing for the "weakest link" (the least digitally literate) and

modernising existing systems rather than wholesale replacement. The CoWIN platform was praised for its ability to handle 1.3 billion people, proving that scale and inclusion can coexist.

Nevertheless, barriers to adoption exist,

- Clinical Burnout - Clinicians expressed concern over "click tax" – the increased cognitive and clerical load of digital entry.
- Infrastructure Gaps - Tier 2 and 3 cities face significant shortages in basic hardware (laptops) and consistent connectivity.
- Trust Deficit - There remains a lack of awareness among patients regarding ABHA IDs and a mistrust of data privacy among providers.

Healthcare was described as a tripartite system involving payers, providers, and patients. Experts suggested that for private sector adoption, there must be a financial driver, such as migrating all insurance claims to an electronic platform to create a mandate for digitisation.

## 8. Conclusion and Critical Recommendations

The workshop concluded that DPI is not merely a digital project but a fundamental health system transformation. Success depends on moving beyond technical outputs to meaningful health outcomes, supported by a state-led, federated model that balances innovation with rigorous data protection. The following steps were suggested in the workshop to achieve the above.

- **Mandatory Integration -** Link ABHA usage to financial flows (reimbursements/insurance) to incentivise adoption.
- **Microsite Strategy -** Use the microsites model to create high-volume success stories in strategic areas before a national rollout.
- **Capacity Building -** Integrate digital health tools into medical college curricula so that the next generation of doctors is "digital-first".
- **Security as a Public Good -** Ensure the government invests in cybersecurity frameworks that are "user-friendly" and transparent regarding liability in case of data leaks.
- **Longitudinal Records -** Focus on the value proposition of longitudinal health records, particularly for geriatric or chronic care patients who move across state lines.

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## Appendices

**Appendix 1 – Agenda**

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### Workshop on

### Transformation of Health Systems through Digital Public Infrastructure

**Date:** Friday, 9 January 2026, **Time:** 10:00 AM to 16:30 PM (IST),
**Venue:** Marigold, India Habitat Centre, New Delhi

**10:00 – 10:30 AM : Registration and Refreshments**

***Inaugural Session***

**10:30 – 10:35 AM : Welcome Address** by **Dr. Shekhar Aiyar,** *Director & Chief Executive, ICRIER*

**10:35 – 10:50 AM : Keynote Address** by **Dr. Ram Sewak Sharma,** *Former CEO, National Health Authority*

**10:50 – 11:00 AM : Keynote Address** by **Professor Clair Sullivan**, *Director Queensland Digital Health Centre, The University of Queensland, Australia*

**11:00 – 13:00 PM : *Session 1: Discussion on Strengthening Technical Foundations for Inclusive and Efficient DPI-Health***

The technical foundations of Digital Public Infrastructure (DPI) in healthcare represent a critical determinant of whether digital health systems can achieve the dual objectives of inclusion and efficiency at population scale. The discussion aims to identify technical design principles that can guide countries in implementing DPI-Health systems that are both technically robust and socially inclusive. The key focus areas of the session are as follows:-

- Understanding milestones and challenges in promoting interoperability in digital health through ABDM
- Efficiency gains and technical barriers from the provider perspective
- Ensuring inclusion by design
- Learnings from international experiences of building interoperable digital health systems

Moderated by **Mr. Sundeep Agarwal**, *Senior Vice President of Regulatory & Quality, Remidio; and* **Ms. Bhargavee Das**, *Research Associate, ICRIER*

**Opening Remarks** by **Ms. Payal Malik**, *Professor, ICRIER*

**Special Address** by **Mr. Vikram Pagaria**, *Director, National Health Authority*

**Interventions by Panelists**

**13:00 – 14:00 PM : Lunch Break**

**14:00 – 14:05 PM : Opening Remarks** by **Ms. Payal Malik**, *Professor, ICRIER*

**14:05 – 14:15 PM : Keynote Address** by **Mr. Satyanarayana Jeedigunta,** *Chief Advisor, C4IR India; Distinguished Fellow and Chairperson, DPI Academy, Artha Global*

**14:15 - 14:25 PM : Keynote Address** by **Mr. Vinayak Godse,** *CEO, Data Security Council of India*

**14:25 – 16:00 PM : *Session 2: Discussion on Governance, Public-Private Partnership and Security in DPI-Health***

Beyond technical aspects, the outcomes of DPI-H also hinge on aligning governance approaches, models of private sector engagement and security principles to mission objectives. The session aims to distil governance principles and security frameworks that can guide countries in establishing trustworthy, accountable, and secure DPI-Health systems while fostering sustainable public-private collaborations. The key focus areas of the session are as follows:-

- Levers of ABDM impact through decentralised governance model
- Levers of regulatory interventions in ABDM diffusion
- Market participation and public-private partnership in scaling ABDM
- Data governance and cybersecurity for privacy preserving and secure DPI-H

Moderated by **Dr. Priyanka Singh**, *Lecturer, The University of Queensland;* **Mr. Sundeep Agarwal**, *Senior Vice President of Regulatory & Quality, Remidio; and* **Ms. Bhargavee Das**, *Research Associate, ICRIER*

**Opening Remarks** by **Dr. Priyanka Singh**, *Lecturer, The University of Queensland*

**Interventions by Panelists**

**16:00 – 16:05 PM : Vote of Thanks** by **Ms. Shiva Kanwar,** *Fellow, ICRIER*

## Appendix 2 – Participants List

| S.No. | Name | Designation | Mode |
|---|---|---|---|
| 1 | Neelesh Kapoor | Chair Public Health, Diabetes India | In Person |
| 2 | G Veerapandian | State Mission Director, AP | Virtual |
| 3 | Oshia Garg | Research Associate, ACCESS Health International | In Person |
| 4 | Siddhartha Bhattacharya | Secretary General, NATHEALTH | In Person |
| 5 | Aditya Patkar | Co-founder, Plus91 | In Person |
| 6 | Sri Vidhya Bhavani Munuswamy | Co-founder, Destratum Solutions Pvt Ltd | Virtual |
| 7 | Harsh Parikh | Founder and Director, DRiefcase Health-Tech Private Limited | In Person |
| 8 | Abhishek Gautam | Founder, Ambula | In Person |
| 9 | Pallavi Gupta | Senior Director – Policy Advocacy, Intelehealth | In Person |
| 10 | Surajit Nundy | Founder, Raxa Health | In Person |
| 11 | Vikram Pagaria | Director, IT (ABDM & AB PM-JAY), State Coordination (ABDM), ABDM Adoption (Private) & IEC-ABDM, National Health Authority | In Person |
| 12 | Harsh Shah | Assistant Professor, Indian Institute of Public Health | In Person |
| 13 | Vikas Kharbanda | Partner, Healthcare & Life Sciences Practice, Arthur D. Little, Dubai | In Person |
| 14 | Sundeep Agarwal | Senior Vice President of Regulatory & Quality, Remidio Innovative Solutions Pvt Ltd | In Person |
| 15 | Akshat Mandloi | Nodal Officer, MP ABDM | In Person |
| 16 | RS Sharma | Former CEO, NHA | Virtual |
| 17 | Prem Kumar | President, Surgical Society of Bangalore | In Person |
| 18 | Kavitha Palaniappan | Assistant Professor, Centre of Regulatory Excellence, Duke-NUS Medical School | Virtual |
| 19 | Vinayak Godse | CEO, Data Security Council of India | In Person |
| 20 | J. Satyanarayana | Distinguished Fellow and Chairperson, DPI Academy at Artha Global and Chief Advisor, C4IR India, World Economic Forum | Virtual |
| 21 | Clair Sullivan | Professor, University of Queensland | Recorded |
| 22 | Padmini Vishwanath | Senior Research Specialist, WHO | In Person |
| 24 | Sunita Nadhamuni | Board and Strategy, Medtronics Labs | Virtual |
| 25 | Pankaj Gupta | Director, Libra Social Research Foundation, and Member of WHO-ITU | In Person |
| 26 | Himanshu Burad | Officer on Special Duty (OSD) to Mission Director, ABDM | In Person |
| 27 | Apoorva Gupta | Project Lead (Digital Health), International Innovation Corps, University of Chicago Trust, India | In Person |
| 28 | Virtual Program Monitoring Unit | Office of State Mission Director, AP | Virtual |
| 29 | Daniel Buckley | First Secretary (Cyber and Critical Technology), Australian High Commission | In Person |
| 30 | Bodhish Thomas | Head, Pupilfirst | Virtual |
| 31 | Priyanka Singh | Lecturer, Queensland University | In Person |
| 32 | Luhut Sinambela | Queensland University | Virtual |
| 33 | Susmita Dexeena AP ABDM | Office of State Mission Director, AP | Virtual |
| 34 | Hasini | Office of State Mission Director, AP | Virtual |
| 35 | PO | Office of State Mission Director, AP | Virtual |
| 36 | S Sreedhar VPMU | Office of State Mission Director, AP | Virtual |
| 37 | CHFW - AP | Office of State Mission Director, AP | Virtual |
| 38 | Srikanth VPMU | Office of State Mission Director, AP | Virtual |
| 39 | Yuvarajan Subramaniam | Office of State Mission Director, AP | Virtual |
| 40 | Charan Tej | Office of State Mission Director, AP | Virtual |
| 41 | Mallikarjuna | Office of State Mission Director, AP | Virtual |
| 42 | Shiffali Singla | Senior Digital Health Analyst, ACCESS Health International | In Person |

**Our Offices:**
4th Floor, Core 6A, India Habitat Centre, Lodhi Road, New Delhi-110003

The Isher Building, Plot No. 16-17, Pushp Vihar, Institutional Area, Sector 6, New Delhi-110017

**O**: +91 11 43112400 / 24645218 | **W:** https://icrier.org/ipcide/
**Email:** ipcide@icrier.res.in