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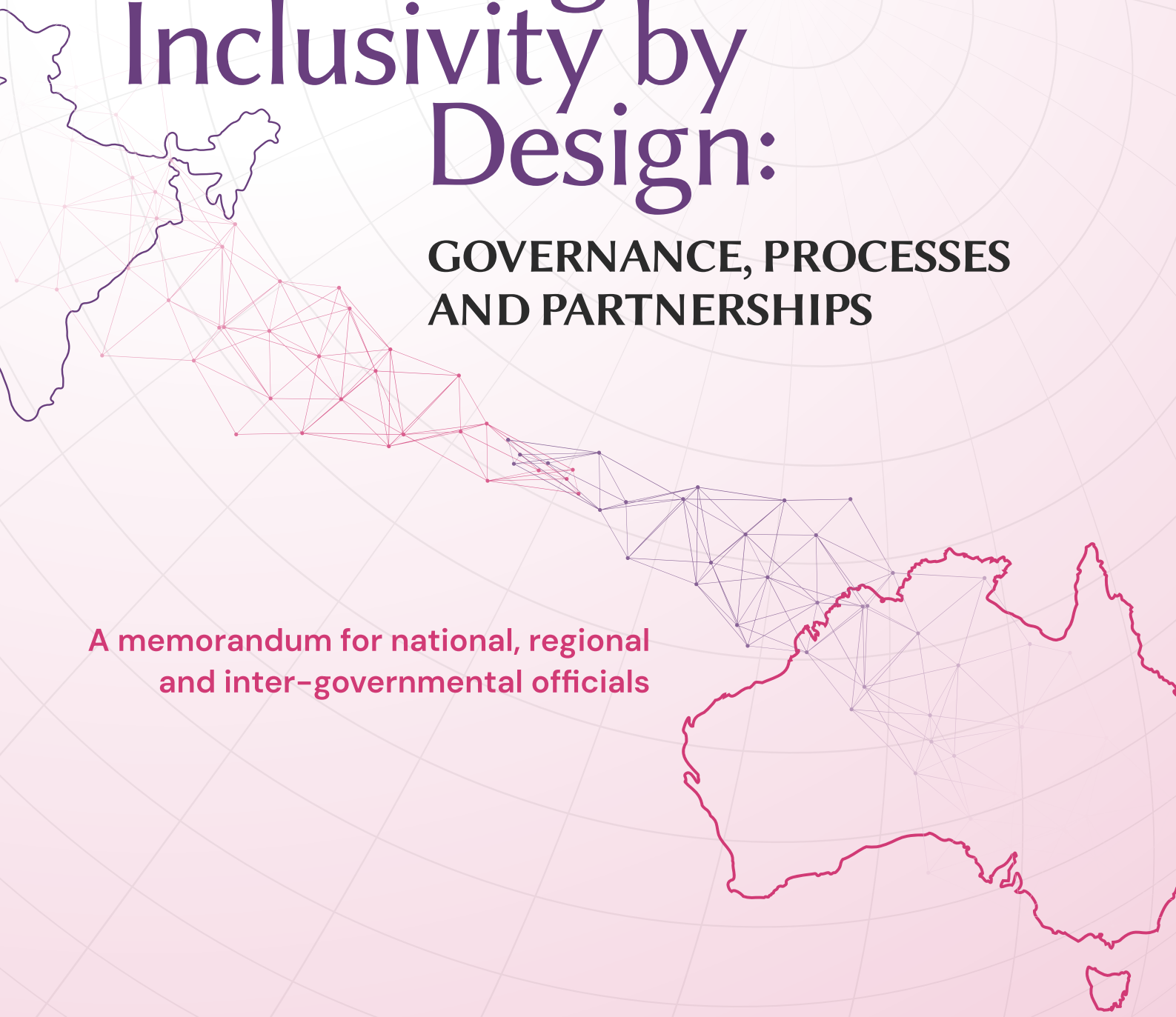
NALSAR HYDERABAD

Building Inclusivity by Design:

GOVERNANCE, PROCESSES AND PARTNERSHIPS



A memorandum for national, regional and inter-governmental officials

Grant deliverable for Project BUILD:
Building Inclusivity by Design in AI/ML Powered Healthtech
(Learnings Report Milestone 4) under the Australia India Cyber and Critical Technology Partnership

TABLE OF CONTENTS

TABLE OF CONTENTS

ABOUT PROJECT BUILD

ABOUT THE GRANT AND THE PROJECT

Project BUILD is a project funded under the Australia-India Cyber and Critical Technology Partnership (**AICCTP**), by the Australian Foreign Ministry. The AICCTP focuses on Australia-India collaborations on cyber and critical technology issues, and deepens institutional, research, business, and government linkages between the two countries.

Project BUILD is a one-of-a-kind bilateral exploratory study to provide policy and partnership recommendations to the Indian and Australian governments on enabling inclusive artificial intelligence (**AI**) in healthcare. At the time of applying for the grant, our preliminary research revealed that global policy documents largely set out principles for ensuring responsible AI (such as transparency, human-in-the-loop, safety, trustworthy) and a lack of policy playbooks to guide implementation of these principles, or indeed, on enabling inclusive AI in healthcare. The conversations and research around inclusive AI in healthcare were nascent and merited greater exploration, especially from an Australian and Indian perspective, given our diverse populations. Through the project activities, we looked to understand how individuals from academia, civil society, government, industry, and healthcare, are thinking about this policy gap, and whether they are actively using or creating ways to build inclusive approaches to AI in healthcare. We also sought to understand the barriers to healthcare access and provision faced by marginalised and vulnerable communities. And the role AI has played so far in mitigating or exacerbating these barriers, including for R&D.

MILESTONE 1	**Initial research and gathering of data points**
MILESTONE 2	**Constitution of an expert cohort:** We identified healthcare, technology, and inclusion experts in Australia (**Australian Experts**) and India (**Indian Experts**) for the Cohorts to travel and meet with. The Australian and Indian Experts comprised individuals from academia, industry, and government, to enable intra-sectoral and multi-disciplinary discussions
MILESTONE 3	**Exchange Tours to Australia and India:** We conducted two five-day Exchange Tours to Australia and India (**Exchange Tours**). The Indian Cohort travelled to Australia in October 2024, and the Australian Cohort travelled to India in February 2025. (b) We identified healthcare, technology, and inclusion experts in Australia (**Australian Experts**) and India (**Indian Experts**) for the Cohorts to travel and meet with.
MILESTONE 4	**A memorandum for national, regional and inter-governmental officials**
MILESTONE 5	**Co-Designing AI for Healthcare:** Toolkit for developers and deployers

ABOUT THE PROJECT PARTNERS

1. Ikigai Law is an award-winning public policy and law firm with a sharp focus on technology and innovation based out of India. The firm advises a wide range of stakeholders including the government, start-ups, industry associations, think tanks and multi-national companies. This project was executed by Ikigai Law. AI, data, cyber security, healthtech are some of its core areas of work. [1]

2. NALSAR University of Law (**NALSAR**) is one of India's premier universities of law. It provides comprehensive legal education, promote research, advance legal awareness in the community and assists in the rigorous analysis of contemporary issues. [2]

3. University of Melbourne, Centre for AI and Digital Ethics (**CAIDE**) brings a cross-disciplinary perspective to the ethical, regulatory and legal issues relating to Artificial Intelligence (AI) and digital technologies. CAIDE's research seeks to explore the impact, deployment and governance of AI. [3]

[1] We were the Ministry of Electronics and Information Technology's knowledge partner for India's G20 Presidency and supported the design and development of two deliverables for the Digital Economy Working Group. Our work included designing High Level Principles for a safe, secure, trusted and resilient digital economy and the Toolkit for Cyber Awareness and Cyber Education for Children and Youth ('G20 Toolkit'). We prepared these high-level principles by combining qualitative responses to a survey and desk research. | We also worked with NASSCOM and contributed to the Guidelines on GenAI. The first of its kind in India, these guidelines articulate principles for responsible development and deployment of AI, for researchers, developers and users. We researched the legal and ethical impact of AI and proposed socio-technical recommendations for different actors within the ecosystem. | We are partnering with the German development agency GIZ, Data Security Council of India (DSCI) and NASSCOM, to update a Handbook on Data Protection and Privacy for Developers of Artificial Intelligence in India. | We partnered with the British High Commission for a UK-India policy exchange on regulatory approaches to AI/ML enabled health-tech. We sought to find lessons for India from the UK's experiences in governing AI based healthcare products. Based on focused multistakeholder engagements, we prepared a report identifying partnership and advocacy initiatives for strengthening AI/ML related research, regulation, and adoption in India's healthcare ecosystem. We prepared two documents containing: (a) key learning for the Indian cohort based on the 5-day learning tour which included learnings from the UK ecosystem, Indian cohort's observations and key takeaways and; (b) Short Programme Evaluation Report that proposes policy recommendations based on our engagements with Indian and UK health tech experts on AI/ML enabled health tech. We are currently the implementing partners, working with the Ministry of Electronics and Information Technology (MeitY) and UNESCO to assess India's readiness for ethical and responsible AI adoption. Our team has been on the ground conducting stakeholder consultations nationwide, creating forums where government officials, academics, industry leaders, and civil society representatives can share their insights on strengthening India's AI ecosystem.

[2] NALSAR has worked on "Access to Justice for Marginalised Communities", with the United Nations Development Program and the Government of India. NALSAR has the Centre for Disability Studies examining the rights of persons with disabilities.

[3] CAIDE focuses on issues of fairness, accountability and transparency in AI and to guide the development and appropriate policy settings for effective use across society.

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We acknowledge the First Nation peoples of Australia and acknowledge their continuing connection to land, waters and community. We pay our respects to the people, the cultures and the Elders past and present. We honour their enduring connection to land, waters, and culture, and express our gratitude for their custodianship, wisdom, and continuing role in guiding us toward a more inclusive and respectful future.

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Project BUILD has greatly benefited from the active engagement of its Indian and Australian Cohorts, comprising experts from healthcare, technology, academia, policy, and civil society. Their participation in learning exchanges, discussions, and policy dialogues has been invaluable in shaping the projects outcomes. We acknowledge their contributions in fostering cross-border collaboration and enriching the discourse on AI inclusivity in healthcare.

1. AUSTRALIAN COHORT MEMBERS:

- Dan Stinton, CEO, Healthengine
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1. Speakers in Australia

- Dr. Simon Coghlan, Senior Lecturer in Digital Ethics Computing and Information Systems, University of Melbourne
- Prof. Piers Gooding, Associate Professor, La Trobe Law School
- Prof. Jeannie Paterson, Professor of Consumer Protection and Technology Law, Director of the Centre for AI and Digital Ethics
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2. Speakers in India

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EXECUTIVE SUMMARY

This memorandum, titled Building Inclusivity by Design: Governance, processes and partnerships, is a grant deliverable for Project BUILD (BUilding IncLusivity by Design in AI/ML Powered Healthtech) under the Australia India Cyber and Critical Technology Partnership (**AICCTP**). To accomplish its goals, Project BUILD partners conducted extensive desk research and facilitated conversations between experts from healthcare, inclusion, and technology in the two countries through two Exchange Tours, This report builds on the learnings from these tours to provide a background on the AI in healthcare sector in Australia and India and produce actionable recommendations.

Report Structure and Overview

The report is divided into several sections:

1. Introduction: Captures the potential role of AI in healthcare and stresses why ensuring inclusive AI is crucial for the safe, ethical, and equitable deployment of AI in the sector.

2. Overview of Australian and Indian healthcare, inclusion, and technology landscapes: This section unpacks several aspects, including healthcare infrastructure and funding, the potential of AI to enhance access, enablers of scaling AI, community engagement, and the research and innovation ecosystem in both countries. This section serves as a background to digest and understand the rest of the report.

3. Key learnings from the Australian and India Exchange Tours: Key takeaways from the tours demonstrated a willingness to ensure inclusion among stakeholders but highlighted the urgent need for defining inclusive AI in healthcare. Other findings emphasized adopting a systematic approach to inclusive AI through co-design, incorporating qualitative research techniques, sandboxes, and simulation research and training, and ensuring mechanisms for assessing and building consumer trust and clarifying governance mechanisms on inclusive AI. Stakeholders also stressed the need for multi-stakeholder collaboration between academia, civil society, government, and industry.

4. Conclusion: The report concludes by outlining next steps cantered on defining inclusive AI in healthcare. This definition should then be used as a framework to build AI tools that are fit for purpose and to evaluate their inclusiveness. The report argues that leveraging this definition could spark collaborations, help cement standard understandings of inclusive AI throughout the AI lifecycle and encourage the government to craft policies that such notions. Enabling inclusive AI is a shared responsibility between developers and deployers, overseen and encouraged by the government.

INTRODUCTION

In this section we capture the role AI can play in expanding access to affordable healthcare, the global AI policymaking conversation, and our motivations for undertaking a bilateral project to explore policy and partnership ideas for enabling inclusive AI.

1. AI and healthcare:

The market for AI in healthcare has grown rapidly. Estimates suggest that the global market for AI in healthcare is expected to reach USD 491 billion by 2032.[4] In this report, we refer to the use of artificial intelligence and related technologies that are being used in healthcare settings and are helping augment or automate tasks typically taken by medical professionals include research and service delivery.[5] Some common use cases include AI used for: (a) diagnostics and imaging: (b) medical scribes; (c) remote monitoring and telehealth; and (d) administration of clinical establishments.[6] At the same time, the benefits are not spread evenly due to a variety of structural factors. AI solutions may struggle to reflect the realities and needs of diverse or underserved and marginalized communities, whether due to geography, language, disability, race, culture, or socioeconomic status – further exacerbating existing health inequities.[7]

2. Why study "inclusive AI in healthcare"?

The global call to action on inclusive AI has intensified in recent years. The statement signed at the Paris AI Action Summit in February 2025, highlighted the need for an inclusive approach to AI, to ensure that AI is human-centric, ethical, safe, secure and trustworthy.[8] The concept of "inclusive AI" calls attention to barriers, such as disability, race, gender, socioeconomic status, geographic location, or cultural context, that can limit a person's ability to fully benefit from health innovations. With AI systems, there is a risk of replicating existing inequities in society,[9] including inherently skewed power structures, which should be an additional consideration in building inclusive AI in healthcare. Although AI applications hold the promise of efficiency and accuracy, historical biases in datasets, uneven digital infrastructure, and accessibility hurdles may inadvertently exclude vulnerable and underserved groups.[10] Human rights instruments including the Universal Declaration of Human Rights[11] and the International Covenant on Economic, Social and Cultural Rights[12] both enshrine the right to health.

[4] World Economic Forum, AI Transformation of Industries: The Future of AI-Enabled Health: Leading the Way, (January 2025)
[5] Centre for Internet and Society, AI for Healthcare: Understanding Data Supply Chain and Auditability in India, (November 2024)
[6] World Economic Forum, AI Transformation of Industries: The Future of AI-Enabled Health: Leading the Way, (January 2025)
[7] British Medical Association, Principles for Artificial Intelligence (AI) and its application in healthcare
[8] AI Action Summit, Paris, Statement on Inclusive and Sustainable Artificial Intelligence for People and the Planet, 10-11 February 2025
[9] Zajko, M. (2022). Artificial intelligence, algorithms, and social inequality: Sociological contributions to contemporary debates. Sociology Compass, 16(3), e12962.
[10] World Economic Forum, Bias in AI is a real problem. Here's what we should do about it, (September 2018)
[11] Office of the United Nations High Commissioner for Human Rights and World Health Organisation, Right to Health, Factsheet No. 31.
[12] International Covenant on Economic, Social and Cultural Rights, (December 1966)

THE AUSTRALIAN AND INDIAN HEALTHCARE, INCLUSION, AND TECHNOLOGY LANDSCAPES

1. Background

This chapter provides an overview of the Australian and Indian healthcare, inclusion, and technology landscapes. It has been compiled through a mixture of secondary research and insights from the Exchange Tours.

2. Unpacking Australia and India's healthcare and technology landscapes

The subsequent section unpacks the healthcare and technology landscapes in India and Australia, acting as background information for readers of the report. Aspects of the landscape we cover include (a) Healthcare infrastructure and funding; (b) AI's potential to enhance access to healthcare; (c) Enablers of scaling AI in healthcare; (d) Co-design and community engagement; (e) Measuring and standardising inclusivity; (f) Government funding and involvement in AI in healthcare; and (g) Research and innovation ecosystem.

a. Healthcare infrastructure and funding:

Australia operates a well-funded dual public-private system with AUD 33.91 billion[13] allocated to public hospitals in 2025-26 (12% increase), a total health expenditure of AUD 252.5 billion (10% of GDP), and 45% of citizens holding private health insurance.[14] The system benefits from universal Medicare coverage, modern infrastructure, and AUD 951.2 million invested in digital health over four years.[15]

India manages healthcare for 1.4 billion people with a spending of 3.8% of GDP in financial year 2024.[16] India faces severe infrastructure shortages with only 1.4 hospital beds per 1,000 population versus WHO's recommended 3.5.[17] The country has the world's largest private healthcare system[18], with one 2019 estimate stating that out-of-pocket payments constitute 47.1% of total health expenditure.[19]

b. AI's potential to enhance access to healthcare:

Australia has a population of about 26 million and a vast landmass with a concentrated urban population[20], with a minority of people residing in distant rural regions. In some parts, Australians must travel 800 km merely to access secondary healthcare.[21] Indigenous communities and remote populations have historically been underrepresented in healthcare datasets, leading to potential biases in AI-driven diagnostics and treatment recommendations.[22] Additionally, Australia is also a multicultural society which includes different immigrant communities, as well as an aging

[13] Government of Australia, Hon Mark Butler MP, Government building Australia's future with more money for public hospital reform (6 February 2025)
[14] Duckett S. Commentary: The Consequences of Private Involvement in Healthcare - The Australian Experience. Healthc Policy. 2020 May;15(4):21-25. doi: 10.12927/hcpol.2020.26228. PMID: 32538345; PMCID: PMC7294448.
[15] Krahe MA, Larkins SL, Adams N. Digital health implementation in Australia: A scientometric review of the research. Digit Health. 2024 Nov 13;10:20552076241297729. doi: 10.1177/20552076241297729. PMID: 39539722; PMCID: PMC11558741.
[16] 3.8% of GDP includes capital expenditure for infrastructure and healthcare insurance schemes. See, Government of India, Economic Survey of India 2024-2025
[17] EH News Bureau, Health infrastructure is one of the primary challenges in India's healthcare sector, 30 November 2023
[18] Sengupta A, Nundy S. The private health sector in India. BMJ. 2005 Nov 19;331(7526):1157-8. doi: 10.1136/bmj.331.7526.1157. PMID: 16293815; PMCID: PMC1285083.
[19] Kamath S, Maliyekkal J, Elstin Anbu Raj S, Varshini RJ, Brand H, Sirur A, Singh V, Prabhu V, Sumit K, Kamath R. Understanding out-of-pocket expenditure in India: a systematic review. Front Public Health. 2025 Jun 9;13:1594542. doi: 10.3389/fpubh.2025.1594542. PMID: 40552236; PMCID: PMC12183295.
[20] Australian Government, Centre for Population, Australia's Population
[21] Day 1 Session 2 discussion in Melbourne, Annexure I: Summary of Discussions from Australia Exchange Tour, Supplementary Materials. Also see: Legislative Council's Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, (May 2022)
[22] Day 4 Session 2, Australia Discussion with Emily Bogue, Annexure I: Summary of Discussions from Australia Exchange Tour, Supplementary Materials. Also see: Tamika Worrel, The Conversation, AI affects everyone – including Indigenous people. It's time we have a say in how it's built, (October 2024)

population who need digital health services. Indigenous communities in Australia have significantly worse health outcomes.

India's immense population[25] is spread over large cities and thousands of villages. This necessitates a heterogeneous approach. Healthcare access in India is highly uneven – urban centres boast advanced hospitals while many rural areas struggle with basic services.[26] Large segments of the population are marginalised by factors such as poverty, caste, gender, language, and geography.[27] Improper AI implementation runs the risk of widening existing care gaps. Inclusivity in India thus demands designing AI that functions offline or with low connectivity, accommodates linguistic diversity, socio-economic conditions and considers cultural sensitivities.[28] This raises the stakes for getting inclusivity right.

c. Enablers of scaling AI in healthcare:

Australia's healthcare infrastructure is advanced, but the country's vast geography means accessibility is uneven. In urban areas, hospitals are highly digitized – most have EHR systems, and there is integration with the national My Health Record (**MyHR**) system (an online summary health record for each citizen), but citizens have an opt out mechanism in place.[29] Recognizing the importance of data interoperability—the ability of fragmented health data systems to share data in a seamless manner regardless of any restraints—Australia released a National Healthcare Interoperability Plan 2023–2028 to ensure systems can share data seamlessly.[30] Access to secondary and tertiary healthcare can be challenging for patients. Telehealth is increasingly used in Australia, with some Aboriginal clinics employing AI screening tools that allow specialists to remotely review patient results without requiring travel.[31] Satellite clinics equipped with AI-enabled diagnostic devices (like a handheld ultrasound with AI guidance for remote nurses) are being piloted to reduce the need for patients to travel.

India's vast network of primary health centres (**PHCs**) and growing number of health & wellness centres (targeted to be 150,000 centres offering teleconsultation and basic diagnostics) provide physical infrastructure for rural healthcare. The government has also laid groundwork for digital health infrastructure through the Ayushman Bharat Digital Mission (**ABDM**),[32] which is creating unique health IDs and EHRs nationwide. This digital backbone can support AI applications. IIT Kanpur and the NHA are in the process of deploying tools under the ABDM which will allow providers to validate their healthcare applications and improve access to healthcare data.[33]

d. Community engagement:

Inclusive AI in healthcare requires more than just top-heavy decision making; it benefits greatly from engagement with end-users, community engagement, and participation of civil society and a variety of other stakeholders.

[23] Australian Human Rights Commission, Cultural and Racial Diversity, (2024)
[24] Australian Institute of Health and Wellness, Health and Wellbeing of First Nations People, (July 2024)
[25] See here for more.
[26] Ghia C, Rambhad G. Implementation of equity and access in Indian healthcare: current scenario and way forward. J Mark Access Health Policy. 2023 Mar 26;11(1):2194507. doi: 10.1080/20016689.2023.2194507. PMID: 36998432; PMCID: PMC10044314.
[27] Kumar D. Inequality Among Marginalized Sections in India: An Analysis. Int J Contemp Res Multidiscip. 2025;4(3):243-248.
[28] Day 5 Session 2, Discussion in NASSCOM Session, Annexure II: Summary of Discussions from India Exchange Tour, Supplementary Materials
[29] The Guardian, Melissa Davey, My Health Record: after 12 years and more than $2bn, hardly anyone is using digital service, (June 2022)
[30] Australian Digital Health Agency, Connecting Australian Healthcare NATIONAL HEALTHCARE INTEROPERABILITY PLAN 2023-2028
[31] Department of Health and Aged Care, Senate Select Committee on Adopting Artificial Intelligence (AI): Submission from the Department of Health and Aged Care, (May 2024)
[32] ABDM marks 3 years
[33] National Health Authority and IIT Kanpur sign MoU for development of digital public goods for AI in Healthcare, (September 2024)

In **India**, the most successful initiatives actively involve the "last mile" stakeholders (patients, community workers) in development and deployment. NGOs and community health workers (**ASHAs**) often act as the bridge between cutting-edge technologies and the local population.[34] For example, EnAble India has pioneered methods to help develop AI-powered solutions for people with disabilities. Similarly, Google's eye-screening AI was developed in partnership with clinicians from Aravind Eye Hospital,[35] and AIIMS is collaborating with primary care providers to investigate breast cancer risk factors.[36]

In **Australia**, there is a more formalized focus on community engagement. It is evident in the healthcare system's approach to Indigenous health, where indigenous communities are now often involved as liaisons or co-researchers to guide culturally appropriate healthcare.[37] Consumer advocacy organizations in Australia (such as the Health Care Consumers' Association) are frequently consulted by government bodies – the AAAiH consortium includes consumer representatives alongside clinicians, technologists, and policymakers in shaping the national AI health roadmap.[38] For example: DoHAC has the Health Peak and Advisory Bodies Program which specifically builds capacity in peak organizations to seek their contributions in key health priorities, and ensure that views of stakeholders are expressed in health policy decisions.[39] This multi-stakeholder ethos helps surface the concerns of marginalized groups early in the design process.

e. Measuring and standardising inclusivity:

Both India and Australia lack universal standards to measure inclusivity. In Australia, some clinical standards and procurement processes assess AI tools' community impacts, and efforts are underway to include inclusivity metrics in digital health strategy evaluations.[40] One tangible framework is the National Digital Health Strategy itself, which includes goals like improving access for Aboriginal and Torres Strait Islander peoples, people in rural areas, and older Australians.[41]

India does not have a uniform system to assess inclusivity in AI healthcare. Instead, proxies and emerging practices are used, focusing mainly on coverage and impact—such as tracking how many rural or low-income individuals access AI-based health services to help reduce inequalities.[42]

f. Government funding and involvement in AI in healthcare:

The **Australian government** invests considerably in healthtech through various channels. One major avenue is the Medical Research Future Fund (**MRFF**) – a AUD 20 billion sovereign fund that finances medical innovation.[43] Australian state governments also invest in healthtech and even facilitate AI procurement by funding pilot concepts and creating framework agreements, which allow for adoption. Victoria, New South Wales, and Queensland allocate funds for digital health innovation through startup grants, hospital trials, and innovation hubs. Additionally, Australia also is keen on government-industry collaboration. An example of government-industry collaboration is the Digital Health Cooperative Research Centre (**DHCRC**) – AUD 200+ million government-industry-university venture driving digital health innovation, supported by 61 participants, ranging from the Department of Health and Aged Care, annalise.ai, and Monash University.[44]

[34] Day 4 Session 2, Enable India Session in Bengaluru, Annexure II: Summary of Discussions from India Exchange Tour, Supplementary Materials
[35] Rajroshan Sawhney, How AI is making eyesight-saving care more accessible in resource-constrained settings, (October 2024)
[36] The Indian Express, Ankita Upadhyay, AIIMS devises new breast cancer detection tool: How AI and ASHA workers work together to map risk factors, help in early diagnosis, (December 2024).
[37] CSIRO, Digital Health Design, (July 2021)
[38] Australian Alliance for Artificial Intelligence in Healthcare, AI Alliance Leadership
[39] Australian Government, Department of Health and Aged Care, Health Peak and Advisory Bodies Program, (updated July 2025)
[40] Luckraj Discussion on Clinical Decision Tool and connected publication, Annexure II: Summary of Discussions from India Exchange Tour, Supplementary Materials
[41] National Digital Health Strategy
[42] Day 1 Session 3, CoE Discussion in New Delhi, Annexure II: Summary of Discussions from India Exchange Tour, Supplementary Materials
[43] Australian Government, Department of Health and Aged Care, Medical Research Future Fund
[44] Digital Health Cooperative Research Centre, About and Participants

The **Indian government** has increased funding for health technology, especially AI, as part of the IndiaAI Mission.[45] AI Centres of Excellence (**CoEs**),[46] including one for healthcare that received about INR330 crore (USD 40 million),[47] are being established to connect government agencies, research institutions, and startups. These centres aim to accelerate R&D in areas like cancer diagnostics and public health analytics, focusing on inclusion and commercial scalability. States such as Tamil Nadu[48] and Kerala[49] also support healthtech projects, with Kerala launching an AI-powered eye disease screening initiative.[50] While these efforts boost innovation and ecosystem growth, challenges remain—particularly bureaucratic hurdles and ensuring sustainability and inclusivity after initial funding.[51]

g. Research and innovation ecosystem:

Australia's AI healthcare ecosystem relies on partnerships between universities, public health institutions, and government agencies. National bodies like CSIRO and the NHMRC consistently fund AI research, emphasising safety, effectiveness, and equity.[52] The University of Melbourne's Digital Health Validitron SimLab provides simulated clinical environments to test digital health tools, addressing usability issues before hospital implementation. While not directly related to patient access, this approach improves accessibility by ensuring AI tools are user-friendly and widely adopted.

India's AI healthcare sector is rapidly evolving, addressing issues of scale, cost, and diversity. Leading institutions like AIIMS, IISc, IITs, and IIITs drive research, with IISc building a multi-speciality hospital to boost innovation.[53] ARTPARK[54] at IISc collaborates with government on data-driven public health projects, while the IndiaAI Mission's CoE in healthcare connects academia and industry for practical AI solutions. The Medical Cobotics Centre at IIIT Delhi supports translational research combining robotics and AI for healthcare and offers simulation-based training for clinicians nationwide.[55]

[45] IndiaAI Mission
[46] Centre sets up centres of excellence for health, agriculture and sustainable cities.
[47] Centre sets up centres of excellence for health, agriculture and sustainable cities.
[48] Tamil Nadu to set up AI labs to support startups and academics, (November 2024)
[49] Kerala launches AI powered chronic eye disease screening, (February 2025)
[50] Kerala launches AI powered chronic eye disease screening, (February 2025)
[51] Day 5 Session 1, Bengaluru Session with Arvind and Uma Nambiar, Annexure II: Summary of Discussions from India Exchange Tour, Supplementary Materials
[52] See CSIRO, Future of Health and CSIRO, CSIRO report highlights 'extraordinary era' of AI in healthcare, (March 2024)
[53] IISc to build 800 bed hospital
[54] ARTPARK
[55] Indraprastha Institute of Information Technology, New Delhi, Medical Cobotics Centre

KEY LEARNINGS FROM THE AUSTRALIA AND INDIA EXCHANGE TOURS

1. Background

This chapter captures our learnings from the meetings held during the Exchange Tours, that are key to arriving at actionable insights for devising domestic policy and crafting international partnerships for inclusive AI in healthcare. Co-design with end consumers emerged as a key takeaway. Cohorts' Members discussed at length how co-design can be implemented through the lifecycle of AI systems. Other takeaways included the need to define inclusive AI in healthcare, use of qualitative methods, sandboxes and simulation research to develop and deploy inclusive AI in healthcare and building trust among consumers.

2. Key learnings

a. Demonstrable willingness to ensure inclusion:

Discussions during both Exchange Tours revealed relevant stakeholders' commitment to ensuring that AI used for healthcare does impede access to or provision of healthcare. Inclusion should not be an afterthought emerging because of an unintended consequence, but a key consideration through the AI lifecycle. In Australia, there is an emphasis on localising AI products used in healthcare, to cater to specific Australian diseases, healthcare priorities (e.g., aged care) and challenges (e.g., cultural, geographic, and linguistic barriers to accessing healthcare). Some of the examples that show this emphasis is the "CVD risk calculator" launched by the Heart Foundation,[56] the health equity research supported at the University of Melbourne's Validitron SimLab,[57] and Healthdirect's clinical decision support system and symptom checker.[58]

In India, AI innovations are created to tackle an existing socio-economic challenge. Incorporating feedback or inputs from intended users could be vital to the workflow. Wysa's mental health chatbot, and the AI retinal scan readers created by Forus Health and Medevplus were examples of AI being calibrated to ensure inclusion. For instance, the retinal scan reading tools needed to work across age groups (e.g., droopy eyelids of elderly people or smaller eyes of infants) and disease states (e.g., cataract or colour blindness).

Inclusion relies on consumers viewing AI as usable, safe, and trustworthy, especially among those hesitant to seek help. Designing inclusive healthcare AI requires considering psychological safety, emotional risk, and cultural diversity in expressing distress. Involving people with lived experience, peer supporters, community counsellors, and caregivers directly shapes how inclusive these AI tools become.

5C Network's approach to inclusive AI in healthcare[59]

The company's approach centres on connecting five key stakeholders - patient, physician, diagnostician, hospital, and AI, which ensures that solutions are co-created with input from all these groups, including underrepresented and rural communities.

- **Stakeholder engagement:** 5C Network actively involves healthcare professionals, patients, and community representatives in the design and validation of its AI tools. This participatory

[56]Nelson MR, Banks E, Brown A, Chow CK, Peiris DP, Stocks NP, Davies Ao R, Raffoul N, Kalman L, Bradburn E, Jennings G. 2023 Australian guideline for assessing and managing cardiovascular disease risk. Med J Aust. 2024 May 20;220(9):482 -490. doi: 10.5694/mja2.52280. Epub 2024 Apr 16. PMID: 38623719.

[57]Read more about the Validitron SimLab at the University of Melbourne here.

[58]Read more about Healthdirect's clinical decision support system and symptom checker here.

[59]5C Networks' Kalyan Sivasailam was an Indian Cohort Member who travelled to Australia as part of Project BUILD's Exchange Tour to Australia. 5C Network is an Indian healthtech company that uses AI and a network of radiologists to provide fast, accurate, and accessible radiology interpretation for X-rays, CTs, and MRIs, connecting hospitals to expert analysis via cloud-based platforms, aiming to solve radiologist shortages and improve diagnostic quality with technology like its AI-powered "Bionic Suite".

approach ensures that the needs of diverse users—such as rural populations, non-English speakers, and those with limited access to specialists—are considered from the outset. The company partners with organizations like NVIDIA and Microsoft to tailor AI solutions for India's linguistic and cultural diversity, making its platform accessible to a broader user base. By conducting pilot deployments and clinical validation studies in varied settings (including rural and underserved areas), 5C ensures that its AI tools are not only technically robust but also contextually relevant and equitable.[60]

- **Inclusive product features:** The 5C Network's AI platform, including its Bionic Suite, is designed to support anomaly detection, triage management, and quality control in radiology. These tools are built to assist radiologists rather than replace them, enhancing diagnostic accuracy and efficiency while maintaining human oversight. The platform's architecture integrates multimodal AI systems that combine imaging data with clinical context, ensuring comprehensive and personalized care. This approach helps bridge the gap in radiology expertise, particularly in regions with limited access to specialists.[61]

- **Accessibility and scalability:** 5C Network's commitment to inclusivity extends to making its AI solutions accessible and affordable. The company offers its platform as a per-inference service, allowing hospitals to pay based on scan modality and urgency. This model is scalable and capital-efficient, enabling even small and rural hospitals to benefit from advanced radiology services without the need for on-site experts. By deploying AI at zero cost across its client base, 5C has accelerated COVID screening and management, supporting healthcare providers in accelerating diagnosis and treatment.[62]

- **Continuous improvement and feedback loops:** 5C Network maintains a feedback loop with users and stakeholders, continuously refining its AI tools based on real-world experiences and input. This iterative process ensures that the platform remains responsive to the evolving needs of diverse populations and addresses emerging challenges in healthcare delivery.[63]

b. Stakeholders underscored the need for a definition of inclusive AI in healthcare:

As AI becomes part of healthcare delivery, defining and measuring "inclusivity" is crucial to track progress and hold systems accountable. Both India and Australia are grappling with how to operationalize the concept of inclusivity in AI healthcare. Cohorts members and speakers in both countries acknowledged that enabling inclusive AI in healthcare is not uniformly a consideration across the industry, and that there were challenges in enabling inclusion. For instance, how much inclusion is enough? Is inclusive AI in healthcare intended to mean including the entire population? Can AI tools be evaluated for inclusivity and if so, how? Inclusion and equity are multifaceted issues, impacted by many factors such as the usability of the user interface, the way the AI tool is implemented, and hardware integrations. Similarly, any exclusionary practices or choices made during the design of the AI tool also impact how inclusive the AI is. "Inclusion" therefore, must be pegged to known barriers and known reasons for discrimination or exclusion in the real world. Any definition should draw on international human rights instruments, such as the Universal Declaration of Human Rights[64] or the International Covenant on Economic, Social, and Cultural Rights.[65]

[60]NASSCOM Centre of Excellence IoT and AI, 5C Network: A Digital Diagnostics platform using AI to empower India's radiology ecosystem and support India in fighting Covid-19!. See also: YourStory, 5C Network: Redefining Radiology with AI for Bharat and Beyond, (July 2025)

[61]5C Network, Research. See also, 5C Network, Bionic Suite.

[62]NASSCOM Centre of Excellence IoT and AI, 5C Network: A Digital Diagnostics platform using AI to empower India's radiology ecosystem and support India in fighting Covid-19!. See also: YourStory, 5C Network: Redefining Radiology with AI for Bharat and Beyond, (July 2025)

[63]YourStory, 5C Network: Redefining Radiology with AI for Bharat and Beyond, (July 2025)

[64]Universal Declaration of Human Rights

[65]International Covenant on Economic, Social, and Cultural Rights

c. Stakeholders stressed the need to incorporate qualitative research techniques, sandboxes, and simulation research and training:

Assessing inclusiveness of AI in healthcare cannot be purely based on the false positive or false negative rates, or an assessment of how well the tool performs in comparison to a human clinician. Cohorts members and speakers discussed the use of qualitative research methods and simulation research to facilitate such assessments. Cohorts' members and speakers also discussed the value of qualitative research methods in understanding, capturing, and meaningfully leveraging the lived experiences of the end consumer, which can then be used for designing and deploying inclusive AI in healthcare. And for making policies for supporting the oversight and governance of inclusive AI in healthcare.

Simulation research – The Digital Health Validitron[66]

- **Overview:** The Validitron is based at the University of Melbourne, operating state-of-the-art simulation-based research facilities within the Melbourne Connect innovation precinct. It comprises a multi-disciplinary team of clinicians and research experts in digital health implementation, UX/human factors validation, and evaluation. The Validitron works with healthcare partners, start-ups and larger enterprises, government, researchers, and clinician innovators both within and beyond Australia.

- **Approach:** Their multi-disciplinary approach includes the use of simulation to overcome access and feasibility challenges experienced when trying to perform digital health research, development, and testing activities in the real world.

- **Example of simulation research:** The Validitron supported the evaluation of "Brain Tumours Online", with co-design methods and its simulation facility.[67] The team noted that patients with brain tumours often face complex symptomatology and have varying needs. Additionally, patients can drop off from participating because of poor prognoses or rapid changes in their illness. Patients also have varying physical and cognitive abilities, typically experiencing fatigue and cognitive dysfunction as well. Engaging with such patients meaningfully, with their respective needs in mind, requires a flexible co-design approach. The team opted for different avenues to get inputs from these patients and carers. These avenues included clinician-researcher-led semi-structured interviews, online workshops, consumer-initiated needs-based working group, and usability testing workshops. Bereaved carers were able to provide inputs on end-of-life information or interventions. During the semi-structured interviews, end-users provided inputs on their experiences of diagnosis and treatment, current unmet needs, current use of digital health technologies, and any other use cases for digital health for their care. This led to the building of "Brain Tumours Online" which has a three-pronged approach to support unmet needs of brain tumour patients: (a) The tool has a curated database of resources on topics including symptom management, emotional, financial, transport and accommodation needs, and existing and new treatments and research; (b) It has an online platform where users can connect and share their stories through discussion forums and online webinars; and (c) Finally, the tool provides a directory of validated digital symptom self-management interventions for patients and carers.

[66]Professor Mahima Kalla was an Australian Cohort Member who travelled to India as part of Project BUILD's Exchange Tour to India.

[67]Kalla M, Huckvale K, Bradford A, Schadewaldt V, C E Bray S, Borda A, Burns K, McAlpine H, Thomas J, Capurro D, Abreu Lourenco R, Cain S, Chapman W, R Whittle J, J Drummond K, Krishnasamy M. To framework, or not to framework? Reflections from co-design of a digital supportive care platform for patients with brain tumours and their carers. Digit Health. 2025 May 11;11:20552076251339302. doi: 10.1177/20552076251339302. PMID: 40357426; PMCID: PMC12066856.

d. Stakeholders emphasised the benefits of adopting a co-design approach to inclusive AI in healthcare:

A systematic approach is needed for inclusive AI in healthcare that adequately addresses cultural differences. Co-design is a collaborative process where designers and non-designers jointly create solutions.[68] Designers facilitate the process, drawing on participants' insights—especially end-users—to drive innovation and effective problem-solving.[69] Co-designing should be dynamic, responsive and agile, adapting to local contexts. Co-design itself is often not linear or systematic,[70] and is supposed to be organic, dynamic and adaptive so that it can respond to local contexts. That said, the appropriate deployment of co-design principles requires systematic thinking.

For instance, in mental healthcare, stakeholders from India and Australia noted that mental health AI must account for cultural differences in distress, support-seeking, language, literacy, and stigma. Both groups stressed the importance of psychological safety, trauma-informed communication, and awareness of emotional tone to ensure equitable access and trust in mental health AI tools.

Some of the recommendations discussed algorithmic audits, by third parties which help assess AI systems for bias and performance across different demographic subsets.[71] Other suggestions include the use of diverse evaluation datasets, detailed stakeholder consultations throughout the lifecycle of the AI development, conducting field trials in varied settings (not just labs), and including inclusivity as a key outcome measure in pilot studies (not just clinical efficacy but also reach and equity outcomes). Stakeholders also noted that better-quality datasets are key to enabling inclusive AI in healthcare.

How Wysa implements co-design[72]

Wysa is an evidence-based digital mental health intervention built on a hybrid AI and human-in-the-loop model. This model helps ensures governance, clinical safeguards, and psychological safety in mental health, and places it on a stronger footing in the digital mental healthcare space. Wysa, integrates co-design with end users, through multiple, structured participatory processes. The team establishes specialist co-design groups, actively seeking diverse input from specific user communities such as students, caregivers, under-represented groups, people with disabilities, and those with chronic conditions. Feedback is collected in-app, through app store reviews, and targeted research projects, and this input directly informs iterative improvements in the app's features and usability.[73]

Key elements of user co-design:

- Specialist co-design groups are formed for ongoing user input, especially for research-driven development.
- Remote usability testing involves users carrying out defined tasks with designs or prototypes, while the design team observes behaviour and collects feedback. This feedback is analysed to derive actionable insights.

[68]Interactive Design Foundation, Co-Design
[69]Interactive Design Foundation, Co-Design
[70]To framework, or not to framework? Reflections from co-design of a digital supportive care platform for patients with brain tumours and their carers, Mahima Kalla, Kit Huckvale, Ashleigh Bradford, Verena Schadewaldt, Sarah C. E. Bray, Ann Borda, Kara Burns, Heidi McAlpine, Joseph Thomas, Daniel Capurro, Richard De Abreu Lourenco, Sarah Cain, Wendy Chapman, James R. Whittle, Katharine J. Drummond, Meinir Krishnasamy
[71]Centre for Internet and Society in BLR. See also: Centre for Internet and Society, AI for Healthcare: Understanding Data Supply Chain and Auditability in India, (November 2024)
[72]Wysa's Chief Psychologist, Smriti Joshi was an Indian Cohort Member who travelled to Australia as part of Project BUILD's Exchange Tour to Australia.
[73]Wysa's Accessibility Statement

- Iterative design cycles incorporate user recommendations: the product evolves through repeated testing and refinements based on real user experiences and pain-points.[74]
- Broad user feedback channels, such as app reviews and surveys, also signal areas for improvement or new feature development.[75]

Co-design in clinical research and participatory design:

- Clinical and product research at Wysa is "strongly guided by the voice of the user through co-design and qualitative methodologies." User insights influence both the direction and the evaluation metrics of Wysa's mental health interventions.[76]
- Wysa's co-design process aligns with participatory design best practices,[77] including collaborative ideation, iterative user feedback, and co-creation sessions. This fosters a sense of agency and ensures the solution is tailored for real-world, diverse user needs[78]

Impact on accessibility and inclusivity:

Wysa's design process prioritizes accessibility by aligning with WCAG guidelines on clarity, navigation, and visual contrast, incorporating user feedback regarding inclusivity from various communities. This user-centric approach makes the app more responsive to the needs of historically excluded populations.[79]

Example of Wysa's co-design process:

- **The language challenge:** Wysa encountered significant challenges when expanding into non-English-speaking populations. When Wysa was first introduced in India, a direct translation of its English-language AI model into Hindi proved ineffective.
- **Co-design:** To address this issue, Wysa's development team co-designed the chatbot's Hindi-language responses by collaborating with community representatives and psychologists. Instead of relying solely on automated translation, the team worked with rural women in Rajasthan, adolescent girls in tribal communities, and paramilitary personnel to understand the specific mental health vocabulary and expressions used by different demographics.[80]
- **Feedback loop:** Wysa's experience demonstrated that co-designing AI responses with affected communities is essential for ensuring inclusivity in mental health AI tools. Crucially, Wysa's approach to inclusivity was iterative in nature. They kept incorporating feedback, working together with communities on the ground and targeting the relevant users to ensure that the AI-tool can be improved.

e. Stakeholders underscored the need for assessing and building trust among consumers:

Cohorts' members and speakers discussed the relevance of assessing consumer trust, consumer access, and consumer concerns, before deploying AI in healthcare or diving into policymaking. This assessment helps craft policy that meet consumer needs more effectively. It also helps policymakers, industry, and civil society decide how to raise awareness including calling out any risks or conditions of use. One such example was a "citizen jury study" in Australia, as described in the box in this point.

[74]Wysa's Accessibility Statement
[75]Wysa's FAQ page
[76]Wysa, Clinical Evidence
[77]Interaction Design Foundation, Participatory Design
[78]Wysa's Accessibility Statement, and
[79]Wysa's FAQ page and Wysa's Accessibility Statement
[80]Wysa, Impact

Australian citizen jury study to understand citizen sentiments on use of AI in healthcare and to enable citizen's policy recommendations[81]

1. **Rationale of the study:** The rationale was to directly support a diverse sample of Australians in making informed recommendations about using AI technology in health care, ensuring policy reflects public perspectives on benefits, risks, trust, and fairness.

2. **Partners of the study:** University of Wollongong (Australian Centre for Health Engagement, Evidence and Values), Macquarie University, University of Queensland, Sortition Foundation (for recruitment), and observers from various organisations with a professional interest in AI and consumer engagement

3. **Methodology of the study:** The study used a deliberative democracy approach by convening a citizens' jury, recruited through the independent Sortition Foundation. Thirty residents were randomly selected to represent Australian diversity, and they participated in a structured deliberation process to develop consensus recommendations.

4. **Steps in the study:**

- Juror recruitment via mail invitations distributed proportionally across states and territories
- Pre-jury educational materials and expert presentations delivered to participants
- A three-day, in-person deliberation involving discussions, breakout groups, drafting, and revising recommendations
- Observers from professional organisations attended but could not influence deliberations
- Final recommendations were written, discussed, revised, and voted upon by jurors.

5. **Discussion themes:** The citizens' jury identified 13 theme clusters for discussion relating to artificial intelligence in health care. These clusters represented the main concerns and perspectives raised by the jurors during their deliberations:

- Streamlined workflows, better clinician time management, increased testing access.
- Efficiency and system improvements of health system performance and outcomes.
- New knowledge generation, support for evidence-based practice.
- Risks to human care, clinician well-being.
- Potential sources and consequences of bias.
- Direct risks to patients.
- Need for oversight and accountability.
- Complexity and challenges in recognising and mitigating bias.
- Equity concerns with data, training sets, and outcomes.
- Shared sources of bias among developers and algorithms.
- Importance of ongoing testing, validation, and use of local data.
- Need for diverse training data, equity in access and outcomes.
- Making data shortcomings and AI limits clear to clinicians and the public.

These clusters formed the basis for the jury's recommendations and shaped the policy proposals for responsible AI adoption in Australian health care.

6. **Key findings:**

- Strong support for an independently governed national charter on AI in healthcare
- Jurors saw potential for AI to improve efficiency, outcomes, and trust, but emphasized risks such as bias, errors, dehumanisation, and impact on clinicians
- Concerns included algorithmic and automation bias, transparency, real-world evidence, and the need for equitable access and ongoing evaluation. All recommendations achieved strong support, focusing on governance, fairness, accountability, clinical effectiveness, and data representativeness.

[81]Carter SM, Aquino YSJ, Carolan L, Frost E, Degeling C, Rogers WA, Scott IA, Bell KJ, Fabrianesi B, Magrabi F. How should artificial intelligence be used in Australian health care? Recommendations from a citizens' jury. Med J Aust. 2024 May 6;220(8):409-416. doi: 10.5694/mja2.52283. Epub 2024 Apr 17. PMID: 38629188.

7. Specific policy recommendations made by the Study: The recommendations reflect a desire for robust governance, continual oversight, and meaningful community participation to ensure safe, fair, and effective use of AI in Australian health care. The study called for:

- An overarching, independently governed charter and regulatory framework for AI in health care.
- AI governance to maintain balance between benefits/harms and fairness, and bias and include clinical and technical standards and open-source software use.
- Mandate processes for ongoing evaluation, impact reporting, and transparency.
- Promote health equity and fair inclusion of diverse populations, with representative training data.
- Support community involvement and information, clinician training, conflict of interest management, and protection of patient choice.

f. Reporting mechanisms for understanding AI's working and building trust:

Cohorts' members and speakers discussed the value of implementing reporting mechanisms for AI to enable a better understanding of questions including: (i) how the AI works; (ii) the kinds of issues that cropped up during the deployment of the AI; (iii) how the issues were managed when they occurred; and (iv) future strategies or product modifications to prevent or identify these issues in advance of them happening. In the Australian Exchange Tour, the cohorts' members and speakers discussed how open-ended or prescriptive reporting mechanisms should be. The consensus was to avoid forms or overly specific questions and to opt for broad questions that give companies the freedom to report in their own words, thereby preventing reporting from becoming a tick-box exercise.[82] Cohorts' members and speakers also agreed on the need for different reporting and impact assessments for different AI tools used, based on the context of their use (e.g., level of involvement of a clinician) and level of risk to human life (e.g., a diagnostic tool versus an AI powered robot for surgery).

g. Clarifying governance considerations:

Cohort members highlighted the significance of risk stratifying AI applications when developing governance and oversight policies for inclusive AI in healthcare. They also emphasized the need for policy approaches that effectively balance inclusion and privacy, which can sometimes be at odds. In addition, the group proposed establishing expert-in-the-loop models to evaluate risks related to inclusion as opposed to the personalization of decision-making.

Australia's response to increased use of medical scribes

Doctors in Australia are increasingly using AI during patient consultations, with about 15 AI scribe companies emerging recently. The Royal Australian College of General Practitioners (**RACGP**) is reviewing how to safely integrate these tools. Clinicians are concerned about data storage, access, and security of AI-generated notes, as well as potential errors in documentation. In response, the Australian Health Practitioner Regulation Agency (**AHPRA**) has released guidelines for responsible AI use in clinical settings.[83]

[82] Day 5 Session 1, Session with Farah Magrabi and Didar Zowghi. Annexure I: Summary of Discussions from Australia Exchange Tour, Supplementary Materials. Professor Farah Magrabi was an Australian Cohort Member who travelled to India as part of Project BUILD's Exchange Tour to India.

[83] AHPRA, Artificial Intelligence

h. Push for multi-stakeholder collaboration between academia, civil society, government, and industry is needed:

Cohort members and speakers in both countries acknowledged that multi-disciplinary and organisational partnerships are useful for driving inclusive AI in healthcare. These partnerships could be for evaluating AI used in healthcare, supporting simulation research before AI solutions are deployed, or incubating digital health or medical device companies working towards making sure their healthcare AI solutions are built to be inclusive, and deployed inclusively.

Multi-Stakeholder Cooperation at the Medical Cobotics Centre and Indraprastha Institute of Information Technology, Delhi[84]

i. **About the centre**: The Medical Cobotics Centre (**MCC**) is a joint initiative established by iHub Anubhuti (**TIH-IIIT-Delhi**) and IHFC (**TIH-IIT Delhi**) aimed at bridging the gap between medical and engineering fields through a collaborative platform focusing on training, research, new product development, and commercialization. Research and projects supported by MCC include AI, medtech, and simulation-based training for healthcare providers, incubation of medical and healthcare startups, and commercialization of research to address healthcare challenges.

ii. **USP of the Centre:**

- **Simulation research and training:** MCC supports simulation research by integrating AI in healthcare training and providing a platform to develop simulation-based healthcare training tools. This bridges the gap between healthcare providers and technology developers, allowing practical development and testing environments.
- **Collaboration potential:** The MCC acts as a vehicle for collaboration by bringing together academia, civil society, government, and industry stakeholders who typically work in silos. By creating an ecosystem that encourages interaction and partnership, MCC drives inclusive innovation in AI and healthcare technologies.
- **Cross disciplinary collaboration:** The MCC has a cross-disciplinary collaboration platform, incubation facilities, and a focus on presenting sustainable, indigenized medical technologies. Organizations partnering with MCC gain access to cutting-edge research, product development support, and a collaborative network to scale inclusive AI solutions in healthcare effectively.

[84] IIIT-D's Professor Tavpritesh Sethi was an Indian Cohort Member who travelled to Australia as part of Project BUILD's Exchange Tour to Australia.

PARTNERSHIPS BETWEEN AUSTRALIA AND INDIA

Australia and India have the potential to jointly implement inclusive AI in healthcare. This section proposes specific partnership models that can be implemented by stakeholders cross the ecosystem – to augment the bilateral relationship between the two countries and also enable the ecosystems to engage, partner with and mutually benefit through the adoption of AI in healthcare. The recommendations were drawn from gaps identified in the exchange tours and conversations between the cohorts.

These partnership suggestions cut across four themes: (a) Institutions; (b) Training and upskilling; (c) Building of repositories and information sharing; and (d) Testing and evaluations.

1. Institutions

a. An inter-ministerial committee or agency to advise on the creation of a policy to implement inclusive AI in healthcare:

- Why: There is a need for a multi-disciplinary co-design of policies for enabling inclusive AI in healthcare. And for evaluation of AI products to assess their inclusivity. The assessments will provide inputs for incrementally improving the AI. It will also help build public trust in AI.
- Who and How: In both Australia and India, a non-profit council should be formed with Project BUILD's Australian and Indian cohort members as the council members to advise on: (i) Creating a policy to implement inclusive AI in healthcare in India (i.e., practical steps based on the tenants). In India for instance, the ICMR would be best placed to co-design and drive policies for inclusive AI in healthcare; and (ii) using the policy to assess the inclusiveness of AI products seeking or legally requiring such an assessment. In India for instance, the MedTech Mitra initiative would be best suited to facilitate such co-design of AI products or policies.[85] The council can be housed under a government department or agency's supervision.

b. Setting up an academia-government-industry partnership to evaluate inclusive AI when AI is used for public health:

- Why: There is a need to assess inclusive AI in healthcare when AI is used in the context of public health, to ensure the AI is inclusive for broader participation that will in turn help shape inclusive AI.
- Who and How: Partnership between Centre of Excellence at the All India Institute of Medical Sciences (**AIIMS**) New Delhi[86], the National Health Authority (**NHA**),[87] the Healthdirect[88] and the Validitron SimLab[89] to –
  - Harness the power of simulations and sandboxes for testing AI used in public healthcare for its inclusivity. For example, Healthdirect and NHA could consider partnering to create the APIs and contours to demonstrate successful completion of any milestones regarding AI in healthcare.
  - Conduct joint research on best practices and challenges on implementing AI in healthcare. AIIMS, NHA, Healthdirect, and Validitron SimLab could partner for this research and knowledge sharing.

[85] MedTech Mitra is a strategic initiative to hand hold medtech innovators as the navigate research and regulatory approvals and processes. It is a joint initiative of NITI Aayog, ICMR, and the CDSCO (India's medical device regulator).
[86] Read here for more on the Centre of Excellence (CoE) for AI in healthcare led by the All India Institute of Medical Sciences (AIIMS). See also the Learnings and Follow-up Report section that covers conversations with the key leaders from the AIIMS CoE.
[87] The National Health Authority runs India's Ayushman Bharat Digital Health Mission (ABDM) and the ABDM Sandbox.
[88] Read more about Healthdirect's clinical decision support system and symptom checker here.
[89] Read more about the Validitron SimLab at the University of Melbourne here.

2. Training and upskilling

a. Training and upskilling of Inclusive Design Thinking in AI:

- Why: There is a need for trainings and knowledge sharing sessions on what is inclusive AI in healthcare. The trainings and knowledge sharing sessions could go beyond healthcare and be customised for other sectors as well, to ensure optimum use of resources.
- Who and How: This may be done through a curated curriculum and assessment plan which can explore inclusive design through the lifecycle of AI used in healthcare. The curriculum could then be imparted through government bodies set up for upskilling (e.g., Skill India Digital Hub[90] MOOC courses which offer self-paced virtual learning across disciplines including AI development) or by industry bodies (e.g., TechCouncil Australia, NASSCOM, NatHealth, Confederation of Indian Industry etc). The course curriculum could cover inclusive design thinking where the tenants of inclusive AI are taught and discussed through a case study approach. This can get developers to explore problems and solutions for issues such as: (i) sourcing representative datasets; (ii) working in multidisciplinary teams to get the best quality and most relevant AI solutions; (iii) understanding how to implement co-design through the lifecycle of AI.

3. Repositories

a. Building repositories for knowledge sharing on AI in healthcare, between Australia and India: [91]

- Why: Knowledge and practical experience on inclusive AI in healthcare must be shared cohesively. Australia and India are diverse countries, with multiple marginalised and vulnerable communities and their access to healthcare needs to be enhanced. Additionally, both countries are exploring ways to regulate AI to make it safe to use in healthcare. These repositories could help in the policymaking process by providing a one-stop portal for actors in both countries seeking information on best practices regarding AI in healthcare.
- Who and How: Australian and Indian government departments for healthcare should collaborate for knowledge creation and sharing on AI in healthcare as it is an evolving landscape. They should build online repositories to capture learnings from the development, deployment, and regulation of AI in healthcare. Repositories can be use-case specific. Some use-cases to consider:
  - Building a repository to study and learn from the use of medical scribes - India's National Medical Commission can partner with Australian Health Practitioner Regulation Agency (**AHPRA**), to study the use of medical scribes in India and Australia, to create a case study repository. The repository can build on AHPRA's existing database of case studies[92] with the help of questionnaire with open ended questions, for doctors to report incidents on exclusions by AI.
  - Building a repository of incident reporting and suggesting methods for incident reporting for AI medical devices – The medical device regulators of Australia and India could collaborate to create this repository. CSIRO's Data61 team on AI Diversity and Inclusion have developed a methodology to assess reported AI incidents for violation of inclusive practices and have compiled a repository of such incidents. This methodology could be tailored for AI in healthcare[93] and to create a public repository of such incidents reported and the actions taken to address these problems.

[90] The hub is operated by the National Skill Development Corporation, under the Ministry of Skill Development and Entrepreneurship, and is "specially designed and developed to skill, reskill and upskill Indian individuals through an online training platform, API-based trusted skill credentials, payment and discovery layers for jobs and entrepreneurial opportunities."

[91] The specific mechanisms of coordination between the departments and agencies discussed in these partnership ideas have intentionally been left to the discretion of the departments and agencies themselves. This is to ensure that changes in departmental funding, organisation, goals, and immediate requirements are accounted for appropriately, while devising their collaboration strategies.

[92] Australian Health Practitioner Regulation Agency's "Examples of newer generative AI tools used in healthcare"

[93] Rifat Ara Shams, Didar Zowghi, Muneera Bano, AI for All: Identifying AI incidents Related to Diversity and Inclusion, Journal of AI Research, Journal for Artificial Intelligence Research, Volume 83, (27 June 2025)

4. Testing and evaluation

a. Forming a partnership to evaluate the inclusivity of selected AI healthcare tools:

- Why: There is a need to evaluate how inclusive AI in healthcare impacts human rights beyond just the exclusion of diverse populations.
- Who and How: Australian Human Rights Commissioner (**AHRC**), Australian Genomics, National Human Rights Commission India (**NHRC**), and the Office of the Chief Commissioner for Persons with Disabilities in India would be best placed to commission a joint study to test the working definition and tenets of "Inclusive AI in Healthcare" proposed in this project. The working definition and tenets will be tested on existing AI used in healthcare and will result in that captures how inclusively the AI was developed and deployed digital. The study can map the level of inclusivity of 3 AI products used for healthcare and 3 AI medical devices in Australia and India.

b. Developing and testing scoring or evaluation strategies to assess inclusiveness:

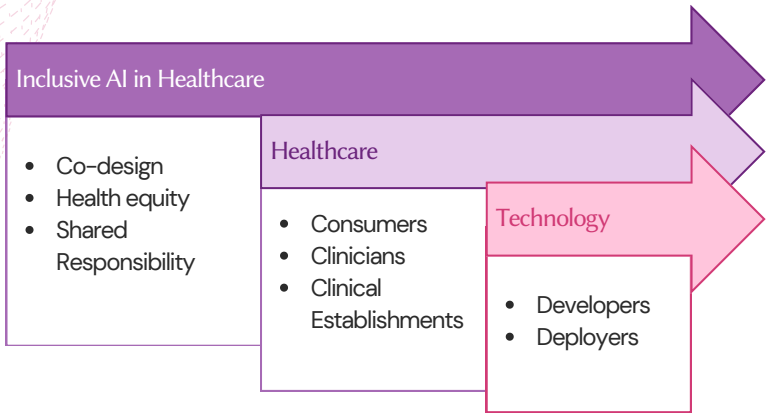
- Why: There is a need for evaluating and measuring inclusivity of AI used in healthcare to ensure health equity and safety of AI tools used in healthcare. Creating these evaluation methods and measurement metrics will support assessments on how inclusive AI algorithms are. The assessments will also provide inputs for incrementally improving the AI. It will also go a long way to building public trust in AI used in healthcare.
- Who and How: The Data61 team at Commonwealth Scientific and Industrial Research Organisation (**CSIRO**)[94] has done extensive research on inclusive AI, including proposing a definition of inclusive AI, guidelines for diversity and inclusion in AI, a comprehensive question bank to assess organisational readiness and maturity for inclusive AI. They have explored ways to embed and evaluate inclusivity in AI. Their research outputs such as the "Inclusive AI Toolkit" can be explored and utilised with support from the Indian Council of Medical Research (**ICMR**)[95], with the aim of developing and testing methods to assess the inclusiveness of AI in healthcare. ICMR is best placed to support CSIRO on the toolkit because – (a) it has diverse data sets on cancer, covid and other diseases,[96] a national network of research facilities which can be leveraged for conducting tests and validating the evaluation methods; and it sets India's policies on biomedical and health research, providing guidance on tackling issues such ethical considerations arising from AI in healthcare.[97]

[94] CSIRO or the Commonwealth Scientific and Industrial Research Organisation, is Australia's national science agency and innovation catalyst, which works towards solving the greatest challenges through innovative science and technology.
[95] Indian Council of Medical Research (ICMR), which sits under the Ministry of Health and Family Welfare in India, is the apex body in India for the formulation, coordination and promotion of biomedical research.
[96] See the National Cancer Registry Programme run by the ICMR's National Centre for Disease Informatics and Research.
[97] ICMR, Ethical Guidelines for Application of Artificial Intelligence in Biomedical and Health Research, 2023

CONCLUSION

This report attempts to capture the keys factors impacting inclusive AI in healthcare. Through direct engagements between Indian and Australian delegations, the report unpacks Indian and Australian landscapes capturing their respective diversities in healthcare services, inclusion, and technology. These are intended to inform actionable policy recommendations, partnership ideas, and an implementation roadmap, to enable inclusive AI in healthcare, across both the countries.

In this concluding section, we illuminate how to enable inclusive AI in healthcare, starting with defining the concept, moving to crafting tenets to implement the concept, and then leveraging policy enablers to incentivise the adoption of the concept in Australia and India.



What: To enable inclusive AI in healthcare, we need to first define it. The definition should unpack the elements of inclusivity, AI, and healthcare, and clarify how these elements interact with each other. Elements include health equity, human behaviour (such as help-seeking behaviours, consumers' use of digital tools), or geographics, cultural, and language related factors, medical knowledge, patient care realities (such as power dynamics in the clinician-consumer interaction, context where AI tool is used)

Why: A definition creates and governs the space for creative problem solving, so that the AI tools are fit for the purpose they are designed for. The definition can affirm that inclusive AI in healthcare does not mean creating services and products that cater to every user's specific requirement, but that it is an iterative process, with scope for incremental improvements.

How: This definition can help developers, deployers, and government to together with the intended users and beneficiaries of the AI tool, to design, evaluate, govern, and oversee the tool being developed or deployed. The design, evaluation, governance, and oversight of AI in healthcare to ensure inclusivity may need to be done by relying on qualitative metrics and research studies. These studies may be in addition to the clinical or other safety studies needed to meet regulatory requirements.

Who: The government must oversee and encourage inclusive AI in healthcare, and enabling it is a shared responsibility between developers and deployers. The governments of Australia and India should consider various policy measures and partnership ideas, nationally and bilaterally, to enable, govern, and incentivise inclusive AI in healthcare.

Next Steps: To enable inclusive AI in healthcare, there are considerations and steps to be considered and implemented through the lifecycle of the AI tool. This may involve referring to the definition of inclusive AI in healthcare, and taking steps to ensure the definition is being met. For instance, to ensure that the AI is appropriately characterising the colloquial phrases used by consumers to describe their ailments, qualitative research may be needed. The deployer can employ techniques such as observation of clinician-consumer sessions, and analysis of user feedback.

Our next report as a part of this project is a proposed toolkit for co-designing inclusive AI. It defines inclusive AI in healthcare and identifies legal and policy enablers that are critical to creative a conducive landscape for allowing co-design. The report subsequently identifies eight tenets that help identify barriers to inclusion and also applies them to four hand-picked real-life case studies to map out their practical impact.

TENETS OF INCLUSIVE AI IN HEALTHCARE

PROJECT OUTPUTS

Project BUILD produced the several outputs which may be found in the Supplementary Materials document. The outputs are briefly summarised here. All outputs can be found at our website.

1. Concept note:

The concept note surveys existing policy discourse on inclusive AI in healthcare to arrive at research questions and a scope for Project BUILD. We corroborated our preliminary assessment that there was a need for setting out an approach or framework for actors in the AI and healthcare ecosystems to ensure that marginalised and vulnerable communities are included in AI used in healthcare. To stress test and refine the concept note, we conducted a focus group discussion with Indian technology, inclusion, and healthcare experts, to gather their inputs on inclusive AI in healthcare. This concept note is part of Milestone 1 of our Grant Deliverables.

2. Briefing Paper On Australia's Legal And Policy Landscape For AI, Inclusion, and Health-Technology:

This paper captures the landscape of the relevant healthcare, inclusion, and technology laws, policies, and regulators in Australia, based on the research questions in the concept note. The landscape paper was shared with Cohort Members from Australia and India, to create the collective understanding of the policy and legal landscape for the Exchange Tours. The paper also provides a list of questions for the Cohort Members to explore with experts during the Exchange Tours. The paper is a part of Milestone 2 of our Grant Deliverables.

3. Briefing Paper On India's Legal And Policy Landscape For AI, Inclusion, and Health-Technology:

This paper captures the landscape of the relevant healthcare, inclusion, and technology laws, policies, and regulators in India, based on the research questions in the concept note. The paper was shared with Cohort Members from Australia and India, to create the collective understanding of the policy and legal landscape for the Exchange Tours. The paper also provides a list of questions for the Cohort Members to explore with experts during the Exchange Tours. The paper is a part of Milestone 2 of our Grant Deliverables.

4. Background Brief for Government:

This report summarises the key learnings from the Exchange Tours to Australia and India, including the concept, value, and implementation of co-design principles. The learnings captured were based on the conversations among Cohort Members (e.g., at the cohort brainstorming sessions we had during the tours) and the insights shared by the speakers who met with the Cohort Members in both countries. The report also provided partnership ideas for Australian and Indian academia, civil society, government, and industry to consider bilaterally, to drive inclusive AI in healthcare. The report fulfils Milestone 4 of our Grant Deliverables.

5. Co-Designing AI for Healthcare: Toolkit for Developers and Deployers:

This Report offers a definition for "inclusive AI in healthcare", tenets for implementing inclusive AI in healthcare through the lifecycle of AI, four use cases to demonstrate implementation, and policy enablers for driving inclusive AI in healthcare. The report is intended for developers and deployers and holds persuasive value for procurers as well. The report fulfils Milestone 5 of our Grant Deliverables.

GLOSSARY

ABDM	Ayushman Bharat Digital Mission
AI	Artificial Intelligence
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADHA	Australian Digital Health Agency
AHPRA	Australian Health Practitioner Regulation Agency
AHRC	Australian Human Rights Commissioner
AIAs	Algorithmic Impact Assessments
AIIMS	All India Institute of Medical Sciences
ASHAs	Accredited Social Health Activists
BIS	Bureau of Indian Standards
CAIDE	Centre for AI and Digital Ethics
CDSCO	Central Drugs Standard Control Organisation
CDSS	Clinical Decision Support System
Co-design	A participatory approach where stakeholders, including end-users, collaborate in the design and development of AI systems, ensuring inclusivity
CoEs	Centres of Excellence
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DoHAC	Department of Health and Aged Care

DPI	Digital Public Infrastructure
DPDPA	Digital Personal Data Protection Act 2023
DST	Department of Science and Technology
EHR	Electronic Health Records
eSanjeevani	National Telemedicine Service of India
GDPR	General Data Protection Regulation
ICMR	Indian Council of Medical Research
IECs	Institutional Ethics Committees
IMDRF	International Medical Device Regulators Forum
MeitY	Ministry of Electronics and Information Technology
MoHFW	Ministry of Health and Family Welfare
NHA	National Health Authority
NHRC	National Human Rights Commission India
PWD	Persons with Disabilities
PMJAY	Pradhan Mantri Jan Arogya Yojana
SaMD	Software as a Medical Device
Tele MANAS	National Tele Mental Health Programme
TGA	Therapeutic Goods Administration