

ARTIFICIAL INTELLIGENCE IN MEDTECH SUMMIT 2026

SCALING AI IN MEDTECH & HEALTHCARE FOR ASIA PACIFIC

Summary Report | **NOV 2026**

ARTIFICIAL INTELLIGENCE

Knowledge partner: Access Partnership

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EXECUTIVE SUMMARY

The APACMed Artificial Intelligence (AI) in MedTech Summit 2026 brought together providers, industry and policy leaders to assess how AI is moving from pilots into routine healthcare delivery across Asia-Pacific. Across the sessions, speakers agreed that the central question is no longer whether AI can perform a task, but whether it changes clinical decisions, produces measurable value, and can be governed and adopted in practice.

Speakers stressed that clinical and financial value must be demonstrated rather than assumed. Clinical AI should be judged by documented changes in decisions at scale rather than by model sophistication, and population-level claims require population-level measurement. Financial cases require a pre-AI baseline, a full total cost of ownership and realistic utilisation assumptions, since projected returns can be highly sensitive to how much a tool is actually used.

Governance was framed as a requirement for system design rather than a policy document. Panellists noted that product-level regulatory approaches are increasingly shared across markets while AI-specific law continues to diverge, and in the European Union (EU), software is being treated as a liability-bearing product, including after deployment. Continuous validation, drift monitoring and change control were presented as necessary complements to one-time certification, and each use case should have a single accountable owner.

Adoption was described as a stakeholder problem as much as a technology problem. Private and public providers value AI for different reasons, revenue and cost control in one case and capacity and staff time in the other, and successful vendors engage clinicians and executives before procurement. Fear of job loss can undermine even a well-performing tool, and deployment timelines range from weeks for small clinics to more than a year for large organisations, largely because of internal approvals. Speakers cited data silos, privacy constraints and training data concentrated in a few markets as limits on scaling, while autonomous surgery was treated as an open ethical question rather than a near-term prospect.

Taken together, the summit points to three priorities for the region: evidence standards that match the claims being made, accountable governance built into operating models, and adoption designed around the workflows and incentives of the people who use the technology.

OPENING REMARKS

Speaker

Jonathan Primmer | Divisional Vice President, APAC, Abbott Vascular and APACMed Board Member

Overview

Jonathan framed AI in healthcare through three principles (digitise, democratise, decentralise) and three scales of impact (patient, health system, population), anchored on the premise that AI should inform clinical decisions rather than replace them.

Key Insights

- **The evidence bar for clinical AI is real trial outcomes, not technical sophistication.** Citing Oncotype DX and the TAILORx trial as an example, he argued that AI's value is proven when it changes a documented clinical decision at scale (e.g., approximately 70% of women able to safely skip chemotherapy), not by how advanced the underlying model is.
- **Singapore is building AI as national infrastructure, not isolated pilots.** Programs like Selena Plus (diabetic eye screening) and Healthier SG show AI embedded into system-wide capability, with a stated government goal of national imaging-AI capability by end of 2026 and AI-based risk screening from 2027.
- **AI's largest population-level value is reaching places with no specialists at all**. Citing World Health Organisation (WHO)'s 2024 tuberculosis estimates (a gap of roughly 2.4 million undiagnosed cases), he positioned AI-assisted screening as most valuable where it extends a clinical decision to populations that otherwise would not get one.
- **Oversight intensity should track system autonomy, not apply a single rule to all AI.** He proposed a spectrum from rule-based, explainable systems to adaptive, autonomous ones, arguing that governance (validation, monitoring, change control) should scale with where a system sits on that spectrum.
- **Three asks to industry.** Prove decision impact at the scale claimed (population claims need population-scale measurement); regulate by risk and intended use rather than uniformly; and make data interoperable across the patient-to-population chain.



FROM PILOTS TO P&L: BRIDGING THE AI VALUE GAP IN APAC MEDTECH

Speaker

Anastasia Miros | Partner, CFGI

Overview

Anastasia addressed how to build and defend the financial case for AI investment in MedTech operations, reframing the objective from cost-cutting to capacity creation, and walked through a methodology and worked example for quantifying return on investment (ROI).

Key Insights

- **The right question is "more with the same," not "same with less".** She argued that framing AI investment around headcount reduction is the wrong starting point; the stronger business case comes from using AI to expand capacity, output, or service quality with existing teams.
- **Financial value concentrates in five decision points.** Pricing, order conversion, production cost, service-resolution speed, and stock-loss reduction were each illustrated with a named-company example (including Aldi and Klarna), showing impact on profit, cash, or capacity rather than headcount alone.
- **No credible business case exists without a pre-AI baseline.** She stressed that financial impact cannot be quantified without a comparator, in the same way a clinical trial requires a control group. Many organisations attempt to prove AI value without ever having captured one.
- **True AI cost is total cost of ownership, not token cost.** Beyond build and inference cost, she highlighted ongoing human-in-the-loop maintenance, governance and monitoring (including cybersecurity), and an exit or retirement plan as frequently overlooked cost components.
- **ROI is highly sensitive to utilisation, not just unit economics.** In a hypothetical worked example, a utilisation rate of about 60% produced positive payback by year three, while utilisation below roughly 40% made the same model value-negative, illustrating how adoption behaviour can outweigh the underlying cost-benefit analysis.

POLICY, GOVERNANCE & MARKET READINESS: ENABLING AI-ENABLED MEDTECH ACROSS APAC

Speaker & Moderator



Lucas Nicolet-Serra | Partner, K&L Gates
Sutowo Wong | Managing Director, AI x Data, Temus
Carl Shiu | Director, Regional Marketing and Scientific Affairs, Asia Pacific, Sysmex

Moderator:
Megan Lim | Associate Director, Access Partnership

Overview

This panel covered how AI/MedTech regulation is evolving across Singapore, the wider Asia Pacific region, and the EU, and what this means for governance design and liability exposure for companies deploying AI-enabled healthcare products.

Key Insights

- **Regulation is converging on products, diverging on AI-specific law.** Panellists noted that Singapore's guidelines and device-approval base are increasingly used as a regional reference point, with reliance-style recognition easing approval elsewhere. Divergence is sharper at the level of dedicated AI legislation, where the EU AI Act, Korea's AI framework, and Thailand's still-forming approach are each taking different shape.
- **Software is becoming a liability-bearing "product," not just hardware.** Panellists noted that the revised EU Product Liability Directive (Directive (EU) 2024/2853), which member states must transpose by 9 December 2026, extends product-liability rules to software, including AI systems that continue to evolve after deployment. This could extend liability exposure beyond a single release and affects questions of data retention and of which party bears risk when a system is modified after deployment.
- **Governance only works if it is built into the system, not just written down.** Panellists converged on embedding governance into technical architecture, such as agent access controls, retry limits, and observability, rather than relying on policy documents that staff may not read or follow. Ongoing drift monitoring was flagged as especially important for Retrieval-Augmented Generation (RAG)-based systems.
- **Every AI use case needs a single, named, accountable owner.** Shared or diffuse ownership across business units was identified as a recurring governance failure mode. Panellists argued that a central register of use cases, each with one accountable owner, is necessary even where AI implementation spans multiple functions.
- **Deployment, not regulatory approval, is where most health-tech pilots fail.** Companies that only deliver the product (without Electronic Medical Record (EMR) integration, a clear RACI structure (i.e., Responsible, Accountable, Consulted, Informed), monitoring, and clinician training) struggle to translate regulatory clearance into adopted workflows. The advice was to "sell the department," not just the device.
- **AI business cases routinely understate their true cost.** Verification and quality assurance of AI outputs is frequently left out of cost models, understating the human effort required and inflating the apparent return once implementation is underway.



PROVIDER PERSPECTIVE: WHAT HOSPITALS NEED TO TRUST & ADOPT AI-ENABLED MEDTECH

Speaker & Moderator

Dorothea Koh | Co-Founder & CEO, Bot MD
Dr Lohendran Baskaran | Senior Consultant Cardiologist and Director, CVS.AI Research Lab, National Heart Centre Singapore

Moderator:
Juan Gomez | Regional ICT Director, APAC, Terumo

Overview

This panel explored how AI-enabled medtech moves from idea to implementation in provider settings. Panellists drew on experience with private and public providers, clinics and a cardiology research lab, and focused on how value is defined for different buyers, what builds clinician trust, and why adoption depends on people as much as on the technology.

Key Insights

- **Value depends on who the buyer is: private providers prioritise revenue and cost control, while public providers prioritise freeing capacity and staff time.** Private-sector leaders ask how a product can make money without increasing costs, whereas public hospitals are more focused on clearing backlogs and relieving staff pressure. Technology providers need to tailor their value proposition to each audience.

- **Engage clinical and executive stakeholders before procurement, which is the purchasing channel rather than the starting point.** Successful vendors begin with doctors, the CEO, Chief Marketing Officer (CMO) and Chief Information Officer (CIO), and aim to understand what each wants to buy and why. A first meeting with procurement usually signals that the decision has already been shaped, and an internal champion helps carry the product through.

- **Trust is built on predictability and reliability, and must be designed into the product.** Clinicians are demanding users who will judge a tool within minutes. Panellists argued that AI should produce consistent, explainable behaviour and show clear value within the clinical workflow early, so that clinicians return to it.

- **Adoption depends on every stakeholder's incentives, and fear of job loss can undermine even a well-performing AI.** One vendor reported that its AI handled 90 to 95% of inbound queries, yet staff kept intervening because they feared losing their jobs, and the vendor had to remove human reply access. AI worked best in small, stretched teams and high-volume clinics with no spare capacity, so each user group's Key Performance Indicators (KPIs) and barriers must be understood.

- **Deployment timelines range from weeks for small clinics to a year or more for large organisations, mainly because of internal approvals.** Motivated small teams can go live in a week or two, while pharma, medtech and large provider projects can take far longer, largely because of approvals and coordination.

- **AI is expected to become commoditised, and organisations that do not keep pace risk a slow competitive decline.** Panellists likened AI's trajectory to earlier technology shifts and noted that markets with less legacy infrastructure can move from no AI to widespread adoption quickly. An open question from the floor was how organisations can align staff incentives with AI adoption as the technology becomes widely available.



TRUST & SAFETY: BUILDING CONFIDENCE IN AI-ENABLED MEDTECH

Speaker & Moderator

A/Prof Adam Chee | Director, AI Development Office, Singapore General Hospital
Mia Hoffmann | AI Quality Architect, Resaro
Phil Dang | Senior Director, Product Security, Information Security & Risk Management, Johnson & Johnson MedTech
Kathy Tan | Director, Regional Privacy Officer, APAC, Olympus

Moderator:
Alex Toh | Partner, Rajah & Tann

Overview

This panel examined how AI-enabled medtech can earn trust across three connected areas: AI assurance and validation, cybersecurity, and data governance. Perspectives came from a public hospital AI development office, an independent AI assurance provider, a medtech product security lead and a regional privacy officer. The consistent message was that trust rests on evidence and transparency maintained across the product lifecycle, not on a one-time certification.

Key Insights

- **Hospitals assess AI devices on intended use, regulation, clinical fit, cost and vendor support.** Software deployments also need clear ownership of hardware, updates and IT operations, and vendors should disclose their limitations openly.
- **AI systems need continuous validation because models drift and performance varies across populations and devices.** Validation should match the clinical use case, and a system weaker on one manufacturer's devices may still suit a hospital that uses only another's.
- **Independent assurance helps AI move beyond pilots, because regulated buyers trust evidence that is not self-certified.** Independent testing covers reliability under expected variation and, for language and agentic models, resistance to adversarial prompts.
- **Cybersecurity is designed in from the outset and verified through penetration testing.** Regulation, infrastructure risk, privacy and buyer trust all drive the requirement, and vulnerability counts have roughly doubled in three years. AI is expected to accelerate both research and attacks.
- **Security is an ongoing posture across the full AI lifecycle, not a one-time event.** Protection covers data inputs, secure training and runtime updates, and post-deployment monitoring, with layered defenses because breaches are a matter of when, not if. Resilience as AI accelerates attacks remains an open question.
- **Trust depends on data quality, provenance and transparency, plus change management that keeps clinicians able to use updated systems.** Governance is most credible when framed around people and openly acknowledging that no system is perfect. Making validation findings actionable without overloading clinicians remains an open question.



CASE STUDY: AI WORLD MODELS IN SURGERY: PAVING THE WAY FROM TRAINING TO AUTONOMY

Speaker

Dr Miles Upton | Regional General Manager, APAC, Cambridge Consultants, part of Capgemini

Overview

Dr Miles Upton presented a collaboration between Cambridge Consultants, CMR Surgical and NVIDIA that uses AI world models to create a physically realistic simulation of a surgical procedure. The aim is to democratise access to robotic surgery training, which he described as an elite tool used by a minority of surgeons. He closed by asking whether such systems should progress towards semi-autonomous and autonomous surgery, and under what ethical and safety conditions.

Key Insights

- **Traditional training methods each trade off realism, repeatability and access.** Synthetic tissue is accessible and repeatable but does not look realistic, cadavers feel realistic but are neither repeatable nor adaptable, and simulators are repeatable but lack a realistic feel.
- **World models learn real physical behaviour rather than relying on scripted scenarios.** Trained on surgical procedures, the model represents how tools interact with tissue, becomes more accurate with more data, and can capture more physical parameters than traditional simulation.
- **A pilot generated a fully simulated robotic procedure using 600 hours of CMR Surgical training data.** Cambridge Consultants worked as system iteration partner with CMR and NVIDIA's physical AI model, and the output included needle passing on a CMR console.
- **Data access, ownership and privacy are the main barriers to scaling.** Each organisation holds its own data silo, and the presenter questioned whether it is realistic to escape those silos between platforms. Sharing data across geographic and regulatory boundaries adds further complexity.
- **Training data bias is a concern because most surgical robotics procedures take place in the US.** Models trained on a narrow patient population may not generalise, so the question is how to make training data more representative.
- **Progressing from training to autonomy raises unresolved ethical and safety questions.** Autonomous driving is ahead in governance, and the presenter asked whether autonomous surgery should be pursued and whether it could prove safer than human surgery. Ethics was presented as the final, still-open challenge.

OPERATIONALISATION: AI READINESS, ADOPTION AND COMPETITIVE RELEVANCE WITHIN MEDTECH COMPANIES

Speaker & Moderator



Varun Maheshwari | Director, Compliance Program, Medtronic
Santosh Nair | Head of Data & AI Portfolio, Siemens Healthineers
Shweta Bhardwaj | Director, Global R&D and Digital Policy, Johnson & Johnson MedTech
Dr Miles Upton | Regional General Manager, APAC, Cambridge Consultants, part of Capgemini

Moderator:
Dr Gayathri Haridas | Associate Director, Access Partnership

Overview

The panel examined what AI adoption means for medtech firms, with a focus on identifying value, preparing the workforce, establishing governance, and scaling successful pilots into production. The central message was clear: organisations should prioritise the clinical and business value of AI, strengthen data governance, build role-specific capabilities, and keep human accountability at the center of every decision.

Key Insights

- **Value and ownership come before scale.** Successful AI adoption starts with identifying both commercial and clinical value. Many organisations can run low-cost pilots, but the real challenge is being rigorous about where that value actually exists. Scaling means moving beyond experimentation toward measurable outcomes, and it depends on a strong data foundation and high data quality. Challenges with customer 360-degree view tools show how quickly weak data undermines a project. Business ownership is also a mandatory requirement: no AI solution should scale until a business owner is accountable for it.
- **Build compliance in from the start.** Compliance should be designed in from ideation, not bolted on at launch. Early privacy engagement helps avoid severe losses, such as regulators ordering a company to delete an entire model because its data was procured unlawfully. Compliance teams add real value by recommending techniques such as de-identification or anonymisation, which keep projects within regulatory limits.
- **Talent with both domain and digital fluency ("bilingual") talent drives a future-ready workforce.** Bilingual talent combines domain expertise with digital and AI capabilities, and it is foundational to a future-ready workforce. In healthcare, critical thinking and human judgment are essential to ensure AI outputs never compromise patient safety. Core skills should include basic AI literacy and cybersecurity, so that employees strengthen the organisation's defences rather than becoming a source of risk.
- **Governance must work across global markets.** Governance has to address data provenance, including the ability to fulfill patient data deletion requests. Organisations should be transparent about when users are interacting with AI chatbots or automated systems. Operating in multiple markets means navigating varied rules, such as disclosure requirements in Australia or cross-border transfer rules in Japan.
- **Competitive advantage comes from combining expertise with AI.** The most critical factor for competitiveness is pairing deep domain knowledge with AI capabilities. Rather than simply hiring AI agents, companies should focus on how AI can augment existing specialised expertise.



WHAT NEEDS TO HAPPEN NEXT: PRIORITIES FOR RESPONSIBLE AI ADOPTION IN MEDTECH ACROSS APAC

Speaker & Moderator

Kimberly Zhang | Head Healthcare Redesign, Alexandra Hospital
Leon Jackson | Global Head of Digital Transformation, Roche Information Solutions

Moderator:
Cheng Wei Swee | Director, Access Partnership

Overview

The panel discussed the strategic implementation of AI in healthcare, focusing on moving from pilot projects to sustainable transformation through agile partnerships, funding models and workforce redesign.

Key Insights

- **Technology should enable care, not replace human touch.** Digital tools are most valuable when they strengthen patient care rather than take its place. A key priority is job redesign: using technology to automate administrative work so clinicians can practice at the top of their license. This requires moving from solving isolated technical requests to managing entire value streams across different job groups.
- **Innovation management is shifting from projects to products.** Organisations are moving away from long requirement phases and toward iterative deployment cycles. In parallel, decision-making in public healthcare is becoming more centralised, which helps reduce fragmentation and improve system-wide benefits.
- **Fragmented systems and funding challenges slow the scaling of innovation.** Scaling healthcare innovation is harder than in life sciences because global healthcare systems are so varied. Organisations such as APACMed can help companies move beyond pilots toward commercially sustainable models by mapping regulatory hurdles and advocating for clearer categories of AI applications and use cases. Funding presents a related challenge. Life science startups often need five to ten years of runway before reaching the market, yet long-term funding for them remains scarce. Current funding models, including contract research organisations (CROs) and private equity, may not fully meet the specific needs of this industry.
- **Agile partnerships work better than over-engineered procurement.** Stakeholders should replace rigid procurement with an agile, partner-based approach. Digital transformation succeeds when operational problems are solved through iterative collaboration, not simply by deploying technology. Communication between providers and medtech companies should remain open to help bridge the gap between clinical and industry expertise.

CLOSING REMARKS

Speaker

Su Fen Ong | Lead, Health Data & AI, APACMed

Overview

Su Fen closed the event by reflecting on the day's breadth. Over the course of the programme, speakers and moderators covered AI value and the path from pilots to P&L, policy and governance across APAC, hospital trust and adoption, AI in surgery, operational readiness within MedTech companies, and priorities for responsible AI adoption. APACMed will continue to work with partners and stakeholders to collectively shape a trusted, secure and innovation-led future that delivers real impact for patients and health systems across APAC.

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About APACMed

The Asia Pacific Medical Technology Association (APACMed) represents manufacturers and suppliers of medical equipment, devices and in vitro diagnostics, industry associations, and other key stakeholders associated with the medical technology industry in the Asia Pacific region. APACMed's mission is to improve the standards of care for patients through innovative collaborations among stakeholders to jointly shape the future of healthcare in Asia-Pacific. For more information, visit **www.apacmed.org**