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I. BACKGROUND

The Confederation of Indian Industry (CII) recognizes the rapid health transitions that India is currently experiencing – India still needs to address the unfinished agenda of infectious diseases, nutritional deficiencies, unsafe pregnancies as well as the escalating epidemic of Non Communicable Diseases (NCDs). Today healthcare delivery in India is confronted by the triple challenges of Access, Affordability and Quality of Care. This composite threat to the nation’s health and development aspirations can be addressed by a concerted public health response that ensures efficient delivery of cost effective interventions towards 3 key areas of:

• Health Promotion
• Disease Prevention
• Availability, Access and Affordability of Diagnostic and therapeutic healthcare.

CII welcomes the Government’s goals as stated in the draft Health Policy 2015. We acknowledge the intention and vision to catalyse ‘the attainment of the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.’

Key features of the Policy

• The Draft policy is very comprehensive and duly acknowledges that health priorities are transitioning - maternal and child mortality, communicable diseases and non communicable diseases (NCDS) are gaining criticality. There remains high degree of health inequity with regard to access and affordability of healthcare services. Concerns of Quality of Care need to be addressed on priority, there needs to be better monitoring and integration of National Rural Health Mission (NRHM) and other disease control programmes to include a much wider range of healthcare services.

• This document emphasizes the definite existence of political will to ensure universal access to affordable healthcare services in an assured mode.

• It also recognizes that there has been an emergence of a robust healthcare industry over the years through Government support and provision of fiscal incentives.

• The “Key Policy Principles” as enumerated in the Draft are in the right direction. CII is happy that these principles have recognized the need for “inclusive partnerships”, especially that the “task of providing healthcare for all cannot be undertaken by the Government, acting alone. It will also require the widest level of partnerships with academic institutions, not-for-profit agencies, commercial private sector and the healthcare industry to achieve these goals.”

• The Draft Policy enumerates an 11 point “Policy Directions” focusing on a greater and evolved role of public health facets including ‘pre-paid’ health insurance for everyone, strengthening of primary care (preventive, curative) as the ‘cost effective
way’ of managing overall cost of care along with a renewed focus on expanding secondary care to the masses – taking it to the district level.

- CII has also been advocating for leveraging private sector resources to fill gaps in underutilized infrastructure and underserved areas. **CII welcomes the direction set in the Draft Policy for “Strategic sourcing” of primary, secondary, tertiary, non-clinical services from private players – on a need basis.** [Refer section 3.3.1.1 in the document].

- High emphasis on developing human resources (vis-à-vis infrastructure) – **leveraging ASHA workers** as frontline Health workers especially for preventive healthcare thus reducing the burden on secondary and tertiary care.

- **New methods of funding – pooling** of various social insurance schemes into a common scheme – **a suggestion that CII has been advocating for long.**

- Recognition of the need to bring an appropriate regulatory and governance framework.

- Strengthening supporting sectors like Medical Technologies, ICT for Health among others.

- Outlining the importance of Health research.
II. COMMENTS ON THE DRAFT POLICY

The Draft Health Policy is a comprehensive document of intent by the Government on the directions to be taken for ensuring quality healthcare to the masses. However, there are a few comments on the design, layout and contents - both in terms of emphasis and inclusion of critical areas in the document.

1. Document Design

1.1. Although there is a situational analysis from pages 4 to 13 (Section 2), a lot of the subsequent content also has significant references to the background and current status including a general explanation in a verbose narrative. Therefore the document is unable to offer a clear and succinct understanding and extraction of the future vision of health for India.

1.2. An alternative design maybe:

1.2.1. A longer preamble that addresses the Situational Analysis aspect. The Preamble needs to bring out more clearly that the Health Policy is the policy of Health India. In this policy there will be no divisions. The Policy may like to clearly articulate that the Government health services and the private hospital and corporate hospitals will work together and boundaries will be removed. Allopathic, Ayurvedic, Unani, Homeopathy, Siddha and Naturopathy together with Yoga and Meditation will all be a part of a new personalized integrated health policy. Similarly, there will be continuity between primary health centre, the community health sector and the tertiary health centre. Within the overall health policy will be components of pharmaceutical policy, Ayush policy and HIV policy. There cannot be separate policies for each of these.

1.2.2 A distinct “Vision” section where Access to Healthcare for all may be the overriding Vision

1.2.3 A distinct section outlining the “policy” and ‘approach’

1.2.4. A distinct section on ‘implementation strategies, funding and governance especially focusing on :

- Physical reach/location – concentration in urban areas, large underserved areas in Tier II/Tier III cities and rural areas, last mile connect bottlenecks

- Enhancing availability/capacity of the system - infrastructure, Medical talent and human resources/ healthcare workers, doctors, specialists, diagnostic facilities and medicines.

- Quality/functionality of the healthcare system

- Health Financing and Affordability

- Governance and management of existing resources

1.3 In effect the document can be in 4 parts and the same essential components that have been used, may be used for connecting the key concepts.
2. Preventive /Promotive Health and Health Advocacy

2.1 Disease Surveillance and Screenings Programmes

The Policy may specifically articulate the intent for instituting disease surveillance and screening programs beyond HIV and TB to cover other communicable diseases such as hepatitis and NCDs like diabetes and cancers (cervix, oral, breast etc).

2.2 CII suggests the following inclusions maybe made concerning problems of growing risk burden for NCDs:

2.2.1 Expanding the involvement of Community based groups like PRIs (Panchayati Raj Institutions), NGOs, CBOs and Community forums like Ramayan Mandalis, Saas Bahu Sammelans to provide health education on prevention, screening and importantly Early Diagnosis.

2.2.2 Focused targeting of adolescents and other vulnerable groups and expanding health education to school curriculums

2.2.3 Opportunistic screenings to be integrated into existing disease control programmes and cross referrals from RNTCP and NPCB can help identify cases early.

2.3 Evidence based decisions to improve Public Health indices.

Though the policy states that the country is in line to achieve the MDG goals on infant and maternal mortality, India faces one of the highest burden of Infant Mortality (IMR) and Maternal Mortality Rates (MMR). In this context it will be important to generate the relevant data points on key causes of IMR and MMR, assess the unmet needs both from a technology and service delivery perspective and plan interventions accordingly. The policy may consider including the following:

2.3.1 Building capacity for management of key issues like sepsis (IMR), PPH and obstructed labour at various levels of healthcare.

2.3.2 Create a National Lab Strategic plan to augment the existing levels of infrastructure, quality assurance and skills set in laboratories.

2.3.3 Address diagnostic standards both in terms of technologies (including POC) and the types of tests that should be mandated in labs at various levels of healthcare

2.3.4 Establish CDC like structure to monitor epidemiology data, impact of access to medications on health indices.

2.3.5 Upgrade remits of ICMR to focus on development of longitudinal medical database.

2.4 Encouraging High Quality Diagnostics for Prevention

2.4.1 Given the increasing prevalence of and mortality from NCDs, the Policy needs to encourage efforts to prevent, diagnose, and treat NCDs efforts that, according
to the Draft National Health Policy, are still “nascent or initial.” Though the Draft National Health Policy proposes to support screening and prevention, it is essential to specifically mention in the Draft National Policy the need to institute infrastructure to support diagnosis and treatment through specific programs with target outcome timelines with respect to these efforts.

2.4.2 The Policy may look at development of institutional mechanisms e.g. a high powered Diagnostics Committee manned by senior officials from DBT, DST, CSIR, representatives from industry which can be tasked with leveraging media/govt IEC machinery to create public awareness about key healthcare issues and mobilize the population for disease screening / diagnosis and subsequent treatment.

2.4.3 The Draft may include a policy directive for developing standard treatment guidelines (STG) and for diagnostics for diagnosis and treatment of diseases.

2.4.4 Reaching the Workforce Population - The Policy may consider directives for instituting fiscal and other incentives for encouraging wide ranging workplace interventions in preventive and promotive health.

2.5 Urban Healthcare

2.5.1 The Policy may look at developing mechanisms for establishing a ‘Complimentary Research Network’ of private healthcare companies to focus on disease awareness of NCDs and Vaccine preventable diseases.

2.5.2 A separate cadre maybe engaged for screening of NCDs in urban areas – Municipal Corporations in states function as a separate system. The policy may look to include the need for collaborating with urban local bodies to synergize health interventions implemented by NCPCDS, Ministry of Health and Family Welfare and Urban Development. [Enclosed is the National Whitepaper developed by CII on the actionable recommendations to further strengthen the care and management of Diabetes as well as other NCDs – Annexure IV]

2.6 Introduce Country-wide Cancer Registry

According to government figures, India registers approximately 2.8 million cancer cases every year. The number of deaths per year is 500,000. However, the real cancer burden and mortality rate in India is unknown. In order to properly assess and address the growing incidence of cancer, a country-wide Cancer Registry needs to be implemented.

2.7 Establishing National Radiotherapy Centres

The Policy may specifically include an intention to institute a country-wide initiative for the development of Radiotherapy services. Direct Government intervention to establish National Radiotherapy Centers would dramatically increase access to care for millions of Indian cancer patients who cannot afford treatment in the private sector. The Policy may consider directives for engaging with the Private Sector to develop public-private partnerships for enabling such expansion.
3. Organization of Public Healthcare Delivery through Strategic Partnerships

3.1 The intention articulated in the draft Policy for significantly enhancing the capacity of the public healthcare delivery systems through 11 focus areas is very welcome. However, it may be emphasised that build up of such a system, in terms of infrastructure, human resources, diagnostic facilities et cetera will naturally have a long gestation lag.

3.2 World over no Government has been able to provide 100% healthcare delivery totally through government financing and public delivery systems and through its own resources, including in a country like USA which spends 17% of its budget on public health and healthcare delivery.

3.3 The draft Policy may like to emphasize the pressing need for a “multidimensional” approach to provide healthcare delivery to 1.2 billion people with varied disease patterns and medical needs. The basic issue in India’s health system is that although the network of delivery settings is in its place, it is working in isolation, leading to increased medical costs and an imbalance in the patient inflow catered to by these healthcare facilities. Availability of skilled medical, nursing, paramedical and allied workforce is another roadblock which is adding to the challenges of a broken healthcare delivery chain in India. There is a need to streamline the value chain of the delivery system in order to provide a comprehensive delivery and here we would like to make some proposals:

3.3.1 There is enormous potential for significantly enhancing the capacity of the healthcare delivery system by leveraging the human resources, capacity and care protocols available with the private sector health system which, the policy has acknowledged, has developed significantly over the years. Such partnerships can take various forms:

3.3.1.1 While Primary Care is best delivered by the Government, given its vast network at the grassroots level, these can however be strengthened and made more efficient through private sector support of telemedicine and teleradiology in a “hub and spoke” model.

3.3.1.2 On Secondary and Tertiary care the Policy has acknowledged that there is a need for a significantly expanded and de-centralised healthcare delivery. While the Government can build up its own capacity, it will be challenged by the availability of Doctors, Specialists, Nurses and Paramedics etc. On the other hand, the healthcare industry – both public and private have over, the last 20 years, the significant capacity and experience. While government hospitals remain overcrowded and short of specialists, the private sector has some excess capacity within itself which can be leveraged to bring the shortfall is provided predetermined, realistic, cost plus based models can be developed in consultation. The private sector has created over 70% of the new beds in the last decade, and have delivered almost 70% of the health services in India and can complement the Healthcare delivery efforts of the public system. CII believes that a pooling of “expertise” “technology”, “clinical” and “administrative protocols” can make a very large number of additional
beds functional and many new jobs. This can also help in percolating down the benefits of the country’s progress in bringing the latest procedures and technology to its citizens to the smaller cities and rural India which have not happened so far.

3.3.1.3 There is an urgent need to augment the supply of doctors, specialists, nurses and paramedical, especially in there too and the cities smaller and rural areas. The country at present has an average of only one medical college for 1438.4 lakh population with a skewed distribution of medical colleges across states. The government’s intention to build 15 more AIIMS in addition to the current number of 6 will take time before the benefits percolate down to the ground level. The private sector can help in better utilization of the existing workforce in the following manner:

- Upgrading the quality of the medical colleges by leveraging the high-end service expertise of the private sector.

- Work with the Nurses Council in aligning nursing qualifications with the medical specialty to support and help strengthen their career trajectory.

- Create training and accreditation opportunities for the 3 lakh strong group of medical practitioners for the Healthcare Sector Skills Council (HSSC).

- Similarly, the Healthcare Sector Skills Council can enhance the training and skill development models for ASHA workers. Private hospital providers which are members of the HSSC can partner in developing evidence-based practical modules for ASHA workers.

- Integrate and mainstreaming AYUSH Doctores practitioners in the Medical workforce. [The draft policy may refer to Section 4.2 of this document]

A presentation made to the Hon, Prime Minister and Hon. Health Minister on these aspects is enclosed as Annexure I.

3.3.2 CII is happy to see the reflection of this addition in the draft Healthcare policy in terms of the stated intention of quitting delivery gaps through “strategic purchasing”. However, the contours of this policy direction are not very clear and a special section may be introduced in the Policy for specifying it in very clear terms.

3.3.3 Similarly, the policy should have a strong emphasis on the approach to an role of PPPs in healthcare delivery and a detailed section articulating the government stand on this may be included in the document. The draft Policy may consider the creation of a central Nodal Agency for PPPs for facilitating and dissolving issues arising out of the PPPs and developing robust and standardised PPP models which have not yet developed in the country. Such an agency also can look at creation of pilot sites where government and private providers actively collaborate to develop frameworks of quality assurance, payments and reasonable profitability.

3.3.3.1 There are conflicting positions on the role of the private sector in Healthcare delivery in India e.g. on the one hand the Policy acknowledges the emergence of a robust healthcare sector and envisages the private sector within it to be
possible delivery partners. However in several sections especially reference 4.3.11 is not very complementary about the private sector although this sector takes care of 70% of the healthcare necessities of the country.

3.3.3.2 CII has been advocating for the Government to take a decisive approach for more of a “payer” rather than a “provider” role through an enhanced role of Health Insurance (CII’s detailed recommendation enclosed as Annexure II). CII is happy to see the acceptance of this suggestion in the envisaged reorientation of the role of Public Hospitals (Section 4.3)

4. Human Resource - Leveraging available resources

4.1 The Total number of allopathic doctors and nurses in the country lags the WHO benchmark of 2.5 doctors per 1000 population, at 2.2 per 1,000 people. In addition to the shortage of medical human resource, the problem of underutilization also exists.

4.2 Since it is clear that the healthcare deliverables within NHAM cannot be achieved with the existing human resource challenges (eg doctors unwilling to visit remote or not so remote rural areas), CII is happy that the Health Policy has taken it’s suggestion made earlier for utilizing and integrating the existing workforce to address shortfalls especially by creating new cadres of B.Sc in Public Health, Nurse Practitioners, developing ASHA workers as frontline Health workers and mainstreaming AYUSH Doctors etc.

4.3 The focus on upscaling Nurses into Nurse practitioners and ASHA workers are very much in the right direction. The Policy must articulate the approaches for implementing this aspect.

4.3.1 In this connection the creation of State and All India cadres of Public Health specialists may also be included in the policy.

4.3.2 The Policy should clearly articulate that legal and academic frameworks will be established so that above categories are empowered to carry out their functions up to a certain level of autonomy, especially in relation to prescription of Drugs.

4.3.3 The Healthcare Sector Skills Council (HSSC) is piloted by CII, NSDC and leading Healthcare Services Providers and plays a critical role in developing skilled human resources in healthcare which maybe given due credence in the Policy. The policy may reconsider the creation of an independent board for allied health and use HSSC suitably. [Enclosed is Annexure III for detailed reference]

4.4 Postgraduate Medical Education - The Health Policy of the country should state clearly that it is not necessary, nor feasible to continue to have two types of postgraduate degrees in the country – MD from the University and DNB from the National Board.
4.4.1 The Policy may like to consider boosting fellowships and exit exams like MRCD and FRCS which certify and recognize work done in a specific field.

5. Healthcare Infrastructure

5.1 Draft Health Policy acknowledges that we should have at least 1000 beds per million population (1 per 1000) and they should be distributed such that within what is known as the golden hour - a secondary care facility can be accessed. This will require a huge infrastructure build. Despite adding 2 million new beds, India would still fall short by another million beds to meet the need. Health Policy should provide mechanisms to access capital required for Healthcare infrastructure growth and address the issue of low Return on Capital Employed (RoCE) for hospitals in India. Despite Healthcare being accorded infrastructure status, the benefits of this are yet to accrue to the Healthcare provider.

6. Health Financing/Affordability

6.1 National Health Assurance Mission (NHAM)

The draft Policy should clearly articulate the contours of the National Health Assurance Mission whereby all persons below the poverty line will receive a quantum of healthcare, 50 essential drugs of good quality free, 30 diagnostic tests free, 30 Ayurvedic drugs free at the primary healthcare level. At the secondary and tertiary level, Health Assurance will be enabled through Health Insurance. Those below the Poverty Line will continue to receive free services at the Secondary level and at the Tertiary level. While all these are mentioned in different sections of the Policy, this aspect should have a dedicated section. The draft policy should also include the institution of a National Health Assurance Agency. This agency can also develop deeper institutional capacity and understanding of health financing options within the government so models & mechanisms most compatible with other policy directions can be evolved.

6.2 Financing of Health Systems

6.2.1 The policy states healthcare for all on the basis of a tax-based financing mechanism. Instead of levying additional cess on income tax to finance universal healthcare, perhaps the Government should explore mechanisms of leveraging other parts of it’s existing taxation pool and expanding the ambit of its tax coverage as currently a mere 2.89% of the population is filing income tax returns.

6.2.2 The Policy may aim at expanding and institutionalizing the ambit of social health insurance to ensure that the population accessing public healthcare facilities is able to avail services free of cost beyond those being provided by the national health programs associated with communicable diseases. These programs after all address less than 6% of morbidities and 25% of communicable disease burden in India.

6.2.3 The CII Sub-Committee on “Accessibility; Health Insurance” has prepared a White Paper on “Moving Towards Universal Health Coverage in India”. This is a multi-stakeholder effort. This paper is a culmination of efforts of the past two years and it consisting of a roadmap for the Government to provide Healthcare for all its citizens. The proposal comprises of following key highlights:
6.2.3.1 The unique hybrid model proposes to strengthen primary healthcare and other determinants of health like safe drinking water, sanitation, nutrition etc. by making it the core focus of the Government and public health system. Access to curative care, both secondary and tertiary, would be through the Insurance mechanism, using empanelled public and private healthcare providers. The Policy may suggest facilitating pilot projects which integrate preventive health check ups in RSBY as well as other social schemes.

6.2.3.2 To lead the whole process, it is proposed to set up a National Health Assurance Agency, to coordinate with all the relevant Ministries, departments, States, Medical Associations, Health and Insurance Regulators.

6.2.3.3 The paper proposes to use “insurance” and “risk pooling” as the mechanism for delivering the secondary and tertiary care. The use of insurance has been proven to provide faster scalability, better control and efficient operations and this mechanism has evolved over the past decade as the best way to drive accessibility and affordability of healthcare.

6.2.3.4 CII’s suggests leveraging Health Insurance as an effective tool for enabling health coverage for all and CII recommends that the contours of suggestions are suitably incorporated in the policy. (A Presentation and Executive Summary on Hybrid Model is enclosed as an Annexure II).

6.4 To ‘strategise prevention’ as a mechanism for achieving better healthcare results, Health Insurance may be leveraged for encouraging and the following policies may be considered for inclusion in the draft health Policy:

- More pilot projects to design mechanisms for covering out-patient services within RSBY and other social schemes should be facilitated.
- RSBY is currently focused on funding the treatment of complications. It should also be linked to prevention of diseases e.g. preventive health checkups and explore enhancing the limit coverage.

6.5 The NHP document only refers to health insurance from the social scheme perspective and ignores the role of employer sponsored health insurance (group cover) and retail insurance (individual & family coverage). It provides no vision of how the government would utilize traditional levers such as tax incentives to expand both categories. In addition, Government, regulator & industry role in developing health insurance awareness through structured initiatives is critical to market expansion but it finds no expression in the document.

6.6 There is no mention about creating an environment of innovation in health insurance so that more products that meet consumer needs emerge. Although an independent regulator (IRDA) governs the sector, a policy direction towards innovation and market expansion has to be encouraged and supported by various government organs.

7. Medical Research

7.1 This section is very weak and does not read well. The health policy document, must mention nanotechnology and stem cell research /innovations as these would be the next big thing in the area of Medical R&D.
7.1.1 **Industry – Academic Research** - There is a need to create public platforms to promote better linkages between industry and academia and R&D labs by encouraging **Centres of Excellence (CoE)** for research and education through private sector participation.

7.1.2 Steering Committees that bring together relevant agencies with the Health Ministry should be contemplated.

7.1.3 A common Sector Innovation Council for the Health Ministry should be strengthened and made functional.

7.2 **New Drug Discovery Research** - There can be a separate emphasis in the Policy on new Drug Discovery research – both from Allopathy and traditional medicines systems. The Vision and Policy for catalyzing such research need to be clearly articulated in a distinct manner.

8. **Quality/functionality of the healthcare system**

8.1 While the Policy in the paras on Situational Analysis points out current Quality/functionality of the Healthcare system as a key area of concern, the Document, however, does not have any specific section dealing with it other than a cursory mention in Section 4.3.3.3.

8.2 **Community Monitoring of Government programmes** - The policy of the country is to encourage more Community Monitoring of government programmes. This must be strongly articulated within the document. In this context it may want to address the pressing need to **drive frugal innovations in processes and service models**, in the lines of creating ‘micro clinics’ designed for rural areas which are **integrated with community groups** and possible linkages to educational courses like B.Sc in Community Health which could help set up a **whole entrepreneurial generation** that enables access.

9. **Medical Technology**

CII Medical Technology Division (MTD) has been proactively working on the key issues with the Government, involving all the stakeholders of the, Medical Electronics, Devices, Equipments and Technology Industry. The division has been a nodal point of reference, providing a forum for dialogue between the Government and companies from the medical technology sector. CII MTD has very active participation of domestic and global medical technology manufacturers with true representation of big companies and SME’s who are dedicated to the advancement of medical technology, improvement in patient care and driving high quality cost effective health care technologies for India. **CII MTD represents 75% of total value in India Medical Device Industry and this composition should be kept in mind, while drafting any policy framework for medical devices in the country.** The submissions are restricted to chapter 8 of Draft National Health Policy 2015, exclusively written for medical technologies.

9.1 **Manufacturing**: To support “Make in India” initiative of Honorable PM, we need to build & strengthen the manufacturing infrastructure as follows:

9.1.1 Streamline the process of setting up manufacturing facilities in India by designating medical technology hubs with the right infrastructure in place to support complex medical technology manufacturing.
9.1.2 Create training hubs around these manufacturing hubs to ensure a ready supply of trained talent to support these hubs. Industry to assure recruitment from these hubs.

9.1.3 Provide manufacturing incentives for example, tax support, low cost funding to spur investments and to make the business case attractive.

9.2 **R&D and Innovation:** While we are known as Pharmacy of the World, we also know that we have missed the bus for innovation in pharma. However, we could develop India as a R&D and innovation hub for medical technologies by rewarding local and market appropriate innovation as follows:

9.2.1 A National Innovation Policy linked to our disease profile is required and should be organized in a way that we reward results in innovation which are locally relevant in India.

9.2.2 Expand initiatives like BIRAC to medical technology; these initiatives should be broadened to cover more research and support more local innovation. These schemes should provide seed capital, viability gap funding, co-fund start-up projects and support the commercialization of innovations.

9.2.3 Government should create strong incentives for commercialization of ideas by creating access to reimbursement in the government funded schemes using a value based approach.

9.2.4 Provide a longer term view (10 yrs window) for 200% weighted tax deduction on approved expenditure on R&D activities as the gestation period is high in this industry.

9.3 **Appropriate Regulations:** In order to promote and grow an industry sector, it is of utmost importance to have an appropriate regulatory framework, which will support the sustainable growth of the industry and for that it is required to have:

9.3.1 We must have regulations that are dedicated, predictable, transparent, globally harmonized and appropriate for medical devices. It could preferably be based on a separate medical device regulatory act and governed by an independent regulatory body with specialized regulators.

9.3.2 Create a “one–window” institution to ease the regulatory burden for the industry and reduce the bureaucracy associated with approval for development, technology transfer and manufacturing.

9.3.3 The government has to promote transparent and evidence based pricing and reimbursement policies. It needs to develop a dynamic procurement mechanism for assessing the clinical outcomes and cost effectiveness of a medical technology to determine its merit for inclusion in public insurance schemes.

9.3.4 Government should table discussions on a PPP framework for operationalization of partnerships as well as discussions around training and accreditation, particularly when it comes to healthcare workers.

9.4 **Clinical Investigation:** requirements should recognize and accommodate the inherent differences between medical devices and drugs. These differences should be considered in regulation(s) pertaining to clinical investigations on human subjects.
in order to find balance between improving public health with new, innovative technologies and safeguarding (individual) human life as follows:

9.4.1 Not all medical devices require de novo clinical investigations before being placed on the market or made available for use. In many cases, adequate evidence of safety and performance may be obtained by non-clinical evaluation and reference to clinical evidence from similar devices already established in clinical practice.

9.4.2 In general, the clinical safety and performance of medical devices are not significantly affected by ethnic differences between populations. Therefore, presuming its conformity with ethical requirements, evidence from clinical investigations in other jurisdictions should generally be accepted as the basis for marketing authorization in India.

9.4.3 The diverse range of medical devices and their intended uses means that some are inherently associated with lower risks and some with inherently higher risks (e.g., a tongue depressor or simple wound dressing is generally considered to be of lower inherent risk than an implantable heart valve). Medical device classification systems reflect these differences, as should requirements for clinical evidence.

9.4.4 For the majority of medical devices, it may be reasonable to supplement pre-market clinical evidence with clinical experience and systematic post-marketing surveillance data, rather than requiring a new pre-marketing clinical investigation.

9.4.5 It is also to be considered that using of pre-existing clinical data from clinical experience (published studies in scientific articles, post-market data etc.) can have significant benefits when compared with clinical investigation data.

9.4.6 We propose to consider limiting the clinical investigations only to medical devices or functionalities thereof where there is not sufficient pre-clinical or clinical data available to demonstrate safety and/or performance. Thus it might be indicated to disapprove any proposed clinical investigations solely for regulatory purposes.

9.5 Price Regulations & Reimbursement: The price control format for drugs and medical equipment needs to be evaluated after due consideration. While controlling prices of medical devices may seem a convenient option but may cause more chaos while achieving little. Unlike drugs, medical devices and equipment delivery system is complex. More than patients, healthcare providers decide what their objectives are and how they are going to deliver them. The industry has very little to determine prices.

9.5.1 In terms of purchasing services from private sector through CGHS and ECHS like mechanisms, the govt should relook at the pricing and the rates at which these services are being currently procured as the current pricing could cause over prescription of diagnostics / drugs and at the same time not ensure adequate quality.

9.5.2 The government needs to promote transparent and evidence based pricing and reimbursement policies. It needs to develop a dynamic procurement mechanism for assessing the clinical outcomes and cost effectiveness of a medical technology to determine its merit for inclusion in public insurance
schemes. Therefore, HTA (Health Technology Assessment) and DRG’s (Diagnosis Related Groups) should be adopted to standardize the pricing and reimbursement processes across all government schemes/systems. Procurement through government channels shouldn’t be exclusively basis the lowest bid and parameters like quality, company track record etc. should be taken into account.

9.6 **Human Resources:** This is one of the most important pillar to support the growth of medical technology sector in the country. India has been the leader in engineering and IT education and skills and fortunately these two disciplines are also the basis of medical technologies. Therefore, we need to device a mechanism to take advantage on our strengths as follows:

9.6.1 Government, Industry and Academia should jointly define the expectations from new graduates. Based on these requirements, the academia must put together a curriculum designed at developing the desired skill sets.

9.6.2 Academia with support from government should cultivate a culture of collaboration on campus by providing the necessary platforms for interaction with industry. Universities must facilitate interaction between the students of medical technology and business management to ensure cross-pollination of knowledge.

9.6.3 Healthcare Sector Skill Council should take as a priority the development of the medical technology skillset. This should form part of their mandate and drive the right talent development initiatives. Allocate funds to set up Centers of Excellence for medical technology training.

10. **Pharmaceutical Sector**

10.1 **Drug Regulatory Process and Clinical Trials**

After the Dr. Ranjit Roy Chaudhury Expert Committee Report, which was accepted by the Government within three weeks 22 of its 25 recommendations have been implemented or are being implemented. The Accreditation Process for Centres where clinical trials are to be carried out, the Ethics Committees and the Chief Investigators are to be accredited. Already around 800 members of the Institute Ethics Committees have been trained. Three organizations will be doing the Training Committees. All the Standard Operating Procedures have been completed and the Quality Council of India is going to carry out the Accreditation Process. Based on all these and many other activities the Health Policy should state that a model, transparent and ethics based drug regulatory system is being set up in place and already the number of clinical trials being approved are increasing. The optimism as a result of a lot of hard work by many is well founded.

11. **Regulatory Framework**

11.1 The draft policy addresses key concerns of enforcing quality, professional ethics and good practice in the area of Regulatory framework for Professional Education of the 4 professional councils of medical, dental, nursing and pharmacy. Towards this, CII submits the need to introduce policy and regulatory reforms in medical education including relaxation in minimum requirements for infrastructure etc for facilitating setting up of Private Sector Medical Colleges. [The draft Policy may refer to Sec 4.3.2 in this document].
III. CONCLUSION

CII recognizes and appreciates the Draft National Health Policy 2015 as a powerful document of intent which encapsulates the Health vision towards the attainment of the highest possible levels of good health and well-being of the population.

The draft policy should include a strong emphasis on governance, develop a single overarching central body that provides a suitable interface between public and private stakeholders, and articulate a clear implementation roadmap to different aspirations in the policy, especially with respect to the public system would be highly desirable.

The draft should also define a vision towards developing a strong regulatory framework around the above formulas.

While the document covers care delivery and basic prevention but fails to discuss the role of social messaging and enhance citizen awareness as a road towards improved health. Being a long-term vision. It should also focus on education and social behaviour modification as parties to improved health.

Last, but not the least, and very importantly, this policy document must reflect and have a special emphasis on possible mechanisms of connecting the dots in Indian Healthcare. A critical shortcoming of the Indian Healthcare system is although the network of delivery settings is in place, each of them is working in isolation leading to an increased medical cost burden and an imbalance in patient inflow catered by these healthcare facilities. There is a pressing need for a multi-dimensional approach to provide delivery to 1.2 billion people with varied disease patterns and medical needs. The draft Policy should specially articulate the directions and mechanisms for streamlining the value chain of the delivery system in order to provide a comprehensive delivery system.

We also humbly submit that the final Policy may document the intensive consultative processes with various stakeholders as well as any tools that may have been designed to specifically assess the strengths and weaknesses of a national health strategy.
BUILDING A HEALTHIER INDIA
THE PRIVATE HEALTH SECTOR COMMITMENT

Presentation to
Hon’ble Prime Minister of India

January 2015

Dr Naresh Trehan,
Chairman
CII National Committee on Healthcare

© Confederation of Indian Industry
Contents

1. INTRODUCTION

2. JOINING THE DOTS FOR DELIVERING HEALTHCARE TO INDIA

3. WE CAN START WORKING TOGETHER

4. LOOKING TO THE LEADERSHIP
Draft Health Policy 2015 acknowledges:

- Changing priorities in Health – Maternal and child mortality, Non communicable diseases.
- High degree of inequity in outcomes and access.
- Need for significantly expanded and decentralized healthcare delivery.
- Quality of care.
- Incidence of catastrophic out of pocket expenditures.
“Private sector feeling strongly committed to join hands”
### 2000-2015 - Emergence of a robust Healthcare Industry

**Total Beds**

<table>
<thead>
<tr>
<th>Year</th>
<th>Private</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>373</td>
<td>188</td>
<td>561</td>
</tr>
<tr>
<td>2010 (E)</td>
<td>978</td>
<td>577</td>
<td>1,555</td>
</tr>
</tbody>
</table>

*Private Sector created over 70% of the new beds, increasing its share of beds between 2002 and 2010*

**In-Patient admission rate, 2004**

- **Admissions per 100 population per year**
  - Private: 2.8
  - Public: 1.4

- **Consultations per 100 population per 15 days**
  - Private: 72%
  - Public: 28%

**Out-Patient consultation rate, 2004**

- **Consultations per 100 population per 15 days**
  - Private: 143.2
  - Public: 100%

*Private sector delivered 60-70% of the health services in India*
Delivery of Healthcare in India is still siloed

Large public sector healthcare delivery network, largely underutilised

Private healthcare is globally recognised for quality, low cost and innovative care models

However, the health systems (public, private, NGO) are working in silos, with minimal coordination
Some Thoughts

Enhancement of Healthcare “infrastructure”, “talent” and “Skills” to meet India’s growing needs will have its own gestation period.

At the same time benefits of progress in bringing latest protocol, procedure and technology remain locked up in certain quarters and have not percolated to smaller cities and rural India.

“Government, private sector and NGOs can work collaboratively to enable optimum utilization of existing assets and resources”
### What can we bring to the table

#### A New Spirit of Partnership

**Pooling of resources for a Healthier India**

1. Expertise
2. Technology
3. Clinical & Administrative protocols
4. Corporate Social Responsibility

---

**Working together can make 100,000 beds functional and 4.3 million more jobs**
Adoption of village by Private Sector Hospitals

Voluntarily...

**Proposed Activity to be performed by corporate hospitals in adopted village**

- **Prevention through sanitation and awareness**
  - Drinking water
  - Sewage and garbage disposal
  - Health awareness campaign in schools and general public
  - Sanitation

- **Primary care**
  - Mobile medical units
  - Telemedicine
  - Training of ASHA workers

- **Secondary care**
  - Depute Medical Resources on rotational basis to underserved areas (Anesthetists, visiting faculty to Govt. Medical Colleges)

**Impact**
- Communicable diseases like malaria, diarrheal, dysentery etc. could be reduced to a great extent
- Improve sex ratio
- Improves Maternal and Child Mortality ratio

Population 3700

Machhrauli Village

Gurgaon
The programme aims at improving health and education in identified villages with the support of corporate partners along the following 7 parameters:

- Drinking water, Sanitation, Roads
- Sewage and garbage disposal
- Health awareness campaign
- Build and upgrade schools
- Telemedicine
- Prevent vector-borne diseases
- Built necessary public utilities
Adoption of District Hospitals on PPP Models for optimum utilization of assets.

The models are already experimented in diagnostics, primary health centers, secondary care hospitals and large tertiary care set ups.

Government can also partner with private hospitals, diagnostic centers to utilize the specific services infrastructure (medical equipment & other support services).

…..What can we bring to the table
## Mobile health units for remote areas, managed and operated by private providers

1. **Provide Tertiary Care at reasonable cost for all sections of the population.**

2. **On a predetermined realistic cost plus basis**

   - Private sector will be involved in managing & operating mobile health units from District Hospitals
   - This will bring healthcare closer to patient, and ensures early detection and treatment of diseases

3. **Telemedicine & Tele radiology support from private healthcare providers**

   - Private hospitals to provide radiology department support to remote district hospitals for tele consultations
   - Specialist to consult and provide second opinion in district hospitals and community health centres
Better utilization of existing workforce to address shortfall.

Upgrading the quality of medical colleges, upgrading & bringing in innovative teaching methodologies by leveraging the high end service expertise of private sector and reduce the burden of creating additional infrastructure.

Address physician shortfall in rural areas by creating training and accreditation opportunities for the 3 lakh strong group of Rural Medical Practitioners.

Align nursing qualifications with the medical specialty they support and help strengthen career trajectory.

Attempt to integrate AYUSH Practitioners into the formal workforce.
Healthcare Sector Skill Council

A unique Initiative of National Skills Development Corporation (NSDC), Confederation of Indian Industry (CII) and leading Healthcare Service Providers

The key objective of the Council is to create a robust and vibrant eco-system for quality vocational education and skill development in Healthcare space in the country.

Nodal institution for skill development in Health Healthcare Sector Skill Council
Role of Healthcare Sector Skill Council

- Created National Occupational Standards for 24 Job roles of allied health profession.
- Launched 8 job roles with their course curriculum, training requirements and assessment standards provided to relevant stakeholders.
- Approximately 89 training institutes having 1000 training centres across India affiliated with HSSC.
Upskilling ASHA workers to function as frontline health workers

Healthcare Sector Skill Council (HSSC) could enhance the training & skill development module for ASHA workers:
- Private hospital providers can partner in developing evidence based practical modules for ASHA workers
- Community mobilization role of ASHA will be further expanded to manage health conditions and improve their effectiveness

Training areas
- Knowledge upgradation
- New born care
- Safe medication
- Community awareness on health conditions

Potential Impact
- Improved health outcomes
- Efficient referral process
- Increased health awareness in society
## Few Case Studies of Self Sustainable PPP Models (1/2)

<table>
<thead>
<tr>
<th>Name</th>
<th>Objective</th>
<th>Model</th>
<th>Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>B Braun Dialysis Centre PPP, Andhra Pradesh</td>
<td>Improving accessibility to dialysis care in the State</td>
<td>State sponsored health insurance scheme</td>
<td>PBL Population</td>
</tr>
<tr>
<td>Rajiv Aarogyasri Health Insurance Scheme, Andhra Pradesh</td>
<td>Enhancing the financial accessibility to healthcare</td>
<td>State sponsored health insurance scheme</td>
<td>BPL Population and enhances patient choice of care provider</td>
</tr>
<tr>
<td>Karuna Trust PPP, Karnataka</td>
<td>Management of Primary care centres in order to deliver essential health services to the rural population.</td>
<td>Govt. of Karnataka with Karuna trust to adopt an integrated approach for better management of PHCs and Sub-centres</td>
<td>Improving the health of the rural population through all aspects of preventive, promotive and curative care</td>
</tr>
</tbody>
</table>

...What can Private sector bring
### Few Case Studies of Self Sustainable PPP Models (2/2)

<table>
<thead>
<tr>
<th>Name</th>
<th>Objective</th>
<th>Model</th>
<th>Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving Accessibility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Akha Boat clinics, Assam</td>
<td>Bringing healthcare closer to the patient through outreach activities</td>
<td>Government of Assam and NRHM</td>
<td>Health Services to the society, geographically secluded population residing on the Brahmaputra river islands</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Training and Skilling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of basic healthcare courses in school, Haryana and Himachal Pradesh</td>
<td>Introduction patient care assistant courses in schools in Haryana and Himachal Pradesh</td>
<td>HSSC PPP between NSDC and Confederation of Indian Industry</td>
<td>Vocational education and training for the allied health workforce in the country</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drive Against Diabetes (DAD) 2013</td>
<td>Creating awareness about diabetes and its prevention through large scale citizen screening programmes</td>
<td>CII and MCGM</td>
<td>One lakh individuals were tested for Diabetes</td>
</tr>
</tbody>
</table>
Together we can build a healthier India:

**340 Million** more people will have **Access** to quality healthcare in next 5 years

**4.3 Million** additional **Employment** will be generated in next 5 years

**141 Billion** INR the country will save, by preventing DAILY loss due to **Heart disease, Stroke and Diabetes**
## Contents

1. **INTRODUCTION**

2. **JOINING THE DOTS FOR DELIVERING HEALTHCARE TO INDIA**

3. **WE CAN START WORKING TOGETHER**

4. **LOOKING TO THE LEADERSHIP**
We can start working together

1. Identify the areas, where private sector can complement Government efforts in achieving “Health Assurance”

2. Provide pilot sites for PPP models in District Hospital. Extend the successful models to more areas by creating funding provision for such Programmes

3. Mobilize private providers across country to participate in public education, awareness and preventive activities

4. Increase Post Graduate medical seats on a priority basis

5. Introduce policy and regulatory reforms in medical education including relaxation and minimum requirements for infrastructure etc. for enabling the setting up of medical colleges by the private sector
Looking to the Leadership for

1. An all-encompassing Vision of future demand should guide the vision and roadmap for Indian health system

2. A stewardship role as a “Primary Provider” or “Primary Payer”

3. Orchestrating the envisioning process such that it is inclusive. Institute mechanisms for constructive and transparent dialogue between the Public and Private Sector at the early stage of journey

4. Focus on efficiency, especially better utilization

5. Architecting the regulatory framework for the healthcare sector
Polio eradication demonstrated how the private & public sector can work together for disease free India
HEALTH ASSURANCE FOR ALL
LEVERAGING THE POWER OF A BILLION

Presentation to
Hon’ble Prime Minister of India

January 2015

Proposed by CII Working Group on Accessibility
Inspiration

Leveraging the power of the population to provide access to communication

- 915 Mn subscribers
- 886 Mn Mobile phones
- Teledensity: 74%
- India's telecommunication network is the second largest in the world, with one of the lowest call tariffs
- World's third-largest Internet user-base.
Our Idea

• Comprehensive Health assurance for all
• Standardized healthcare benefits for every Indian citizen not covered by a mandated scheme
• Learning from and Leveraging existing successful health financing and Insurance models
• Leveraging power of “pooling” of risks and resources for an economical and efficient healthcare delivery through health insurance
Rationale

• Government has successfully funded National and State health insurance schemes through insurance companies
• These schemes are evolving and now cover more categories of people and disease but only covers hospitalization
• Evaluations have shown that these schemes have reduced Out of Pocket Expenditure (OOPE) on Health and improved access to health
• There is a need to learn from RSBY and State level schemes and develop a National Health Insurance schemes for all citizens of country
• This National Health Insurance Scheme will also drive towards standardization, treatment protocols, Quality and outcomes
• The Proposed system will be sustainable as it will be built on the strength of both public and private sectors
CII Proposal

• “Composite” and “Hybrid” model of National Health Assurance that is efficient and affordable

• Major aim
  – Basic and essential NHA Package consisting of primary, secondary and tertiary care
  – Strengthen preventive, promotive and primary health care – (Core focus of Government and public health system)
  – Utilize health Insurance mechanism for providing secondary care and selected tertiary care through an acceptable defined packages with both Public and Private health care providers
NHA Package Delivery

Preventive & Primary Service
- Antenatal care
- Immunization
- Screening for specific diseases
- Ambulance services
- Outpatient Care
- Counselling
- Delivery

Promotive Service
- Safe drinking water
- Nutrition services
- IEC services
- Tobacco control
- Sanitation
- Counselling
- Anti-vector measures

Curative Service
- Secondary care services
- Tertiary care services
- Emergency services
- Follow-up Care
- Chronic Care

Government

Insurance
Why Insurance Route?

• Insurance route has been successful for aggregation of population and providers
• Insurance companies are well positioned to drive standards and quality of health care services.
• There is a vast experience (both human and systems) through RSBY and other schemes
• Insurance companies have business interest to keep the cost low by reducing frauds and abuses
• The insurance route is economical due of competitive lower premium, efficiencies and economies of scale
• Insurance companies can bring best global experiences bringing efficiency better healthcare delivery
## Base Package Under Universal Health Assurance

<table>
<thead>
<tr>
<th></th>
<th>Primary</th>
<th>Secondary Care</th>
<th>Tertiary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>Provided / arranged by government</td>
<td>Rs. 60,000 per year</td>
<td>Rs. 200,000 per year</td>
</tr>
<tr>
<td><strong>Package</strong></td>
<td>For Secondary Care</td>
<td>For Tertiary Care</td>
<td></td>
</tr>
<tr>
<td><strong>Conditions covered</strong></td>
<td>Hospitalisation and defined day care surgeries</td>
<td>Select critical care procedures</td>
<td></td>
</tr>
<tr>
<td><strong>Enrolment Unit</strong></td>
<td>Family</td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td><strong>Size of Family</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Payment</strong></td>
<td>Package Rates</td>
<td>Package Rates</td>
<td></td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>Mostly Govt. facilities</td>
<td>Both Public and Private</td>
<td>Both Public and Private</td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td>2 day pre and 7 day post hospitalisation</td>
<td>5 day pre hospitalisation and Separate packages for Follow up care</td>
<td></td>
</tr>
</tbody>
</table>
## Financial Estimates for Secondary & Tertiary Care Hospitalization

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of People to be Covered</strong></td>
<td>100 crore</td>
</tr>
<tr>
<td><strong>Number of people to be subsidised by the Government</strong></td>
<td>50 crore</td>
</tr>
<tr>
<td><strong>Benefit Package Per Family Per Year</strong></td>
<td>Rs. 60,000 for secondary care + Rs. 200,000 for tertiary care</td>
</tr>
<tr>
<td><strong>Premium per family</strong></td>
<td>Rs. 400 - 600 for secondary care ~ 500 + Rs. 300 – 500 for tertiary care ~ Rs 400 Total – Rs. 900 per family</td>
</tr>
<tr>
<td><strong>Total Premium Estimated to be paid by Government for 50 crore persons</strong></td>
<td>Rs. 9,000 crore</td>
</tr>
</tbody>
</table>

- The assumption is that 80% of families will be targeted by Universal Health Insurance Scheme
- **For non-poor people they will pay premium from their pocket and no subsidy will be given and they can purchase on a voluntary basis**
Advantages of Hybrid Model

• Better & ongoing monitoring of health outcomes
• Rational and necessary use of higher care through gate keeping mechanism and referral system.
• Pooled purchasing and lower costs due to aggregation of demand
• Leverage operational capabilities of Insurance industry to drive standards, quality & protocols
• Harmonization of disparate schemes and covers.
• Sustainable as it builds on the mutual strengths of government and private sector.
Recommendations

• Setting up of National Health Assurance Agency:
  – Should have representatives from various Ministries, industry bodies and professionals
  – Coordination with different insurance schemes of the government
  – Provide guidance and knowledge to State Governments
  – Coordination between IRDA and National Health Regulator
  – Coordination for a centralised database of beneficiaries covered with UHC

• Governance and Regulations:
  – Implement Clinical Establishment Act

• Advisable for IRDA to set up Health Insurance Authority under its wing
Thanks

“Harness the Power of the billion” to dramatically improve access and standards of care to the entire population

Proposal by CII Health care Assurance Team
DRAFT NATIONAL HEALTH POLICY 2015
CII SUBMISSIONS

Annexure III
Healthcare Sector in India - Challenges

• No standardization & uniformity in education system for allied healthcare space

• Lack of competency and mobility

• Paucity of Skilled & Quality Manpower

• Needs to address this issue......

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Availability per 1000</th>
<th>India</th>
<th>China</th>
<th>US</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>0.6</td>
<td>1.06</td>
<td>2.56</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>0.8</td>
<td>1.05</td>
<td>9.37</td>
<td>12.12</td>
<td></td>
</tr>
<tr>
<td>Midwives</td>
<td>0.47</td>
<td>0.03</td>
<td>-</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>0.06</td>
<td>0.11</td>
<td>1.63</td>
<td>1.01</td>
<td></td>
</tr>
<tr>
<td>Lab Technicians</td>
<td>0.02</td>
<td>0.16</td>
<td>2.15</td>
<td>0.34</td>
<td></td>
</tr>
</tbody>
</table>
SKILL GAP → Creation of HSSC

HEALTHCARE SECTOR SKILL COUNCIL [HSSC]

Total Supply: 2,83,378
Total Demand: 65,48,754
Demand Supply Gap: 62,65,376

*Report from PHFI- Existing Skill Gaps in Allied Health, 2012
Healthcare Sector Skill Council
A unique Initiative of National Skills Development Corporation (NSDC), Confederation of Indian Industry (CII) and leading Healthcare Service Providers

The key objective of the Council is to create a robust and vibrant eco-system for quality vocational education and skill development in Healthcare space in the country.

Nodal institution for skill development in Health
Healthcare Sector Skill Council
Role of Healthcare Sector Skill Council

- Development of National Occupational Standards
- Development / Alignment of Appropriate Courses & Curriculum to NOS
- Accreditation & Affiliation of Training Institutes
- Assessment & Certification for Trainees
- Placement Support
- Partnerships

Healthcare Sector Skill Council
Evolution of HSSC

- Founder Member from Healthcare Organization (HCO) constituted Governing Council representing Public and private HCOs, medical equipment & device manufacturers.
Process of Development of NOS

- Extensive deliberations with Healthcare service organizations done for
  - Market Survey & Functional Analysis (70+covering organizations)
  - Development of QP-NOS
  - Validation of QP-NOS

- NOS developed for 27 job roles

- Names of select organizations that participated:
  AIIMS, AFMC, Apollo, Amity, Astron Hospital, Catholic Health Association, Citizen Hospital, CMC Vellore, Fortis, HM&IR, IGNOU, Indian Dental Nursing, J&J, KIMS, LIHS, Manipal Hospitals, Max, NH, NABH, NHRC, NIHFW, Paras Hospital, St Stephens Hospital, Sitaram Bhartia, Nova Medical, Woodland Hospital, Vasan Eye Care.
Process of Development of Curriculum

- Curriculum Approval committees comprising of experts from industry are constituted.
- More than 45 experts are involved in the these committees
- Reviewing curriculum for 14 job roles
- Validation from larger industry group
More than 80 training providers are affiliated with 900 skill centers across the country.

95 are in process for affiliation.

Regular review done for improving the process of affiliation involving experts from industry.

Technical Committee comprising of experts from Industry ensuring Continuous Quality improvement.
Assessment & Certification for Trainees

- Assessment are conducted PAN India, HSSC on board is having 5 Accredited Assessing body to facilitate numerous assessments nationwide.

- Assessment done by the experts from the industry. Pool of around 180 oriented assessor

- Total Enrollment - 30000 ; Assessment done – 29600

- Pass percentage of around 65%

- In addition 5000 assessment carried out in government schools of Himachal Pradesh and Haryana
Industry Endorsement for HSSC

- Apollo Hospital Group
- Fortis Healthcare Ltd.
- Medanta – The Medicity
- Max Healthcare Ltd
- Dr. L.H Hiranandani Hospital
- B M Birla Heart Research Centre
- Johnson & Johnson Medical India
- Bausch & Lomb
- K G Hospital & Post Graduate Medical Institute
- Kerala Institute of Medical Sciences
- Siemens Limited
- Global Hospitals
- Narayana Hrudalaya Institute of Cardiac Sciences
- Paras Hospitals
- Ruby Hall Clinic
- Amity Foundation

- Santokba Durlabhji Memorial Hospital
- BD India
- Religare Enterprises Ltd
- Tyco Healthcare India
- Nova Medical Center Pvt. Ltd
- Kovai Medical Center and hospital Limited
- Sitaram Bhartia Institute of Science and Research
- VYAGON
- Ayur Vaid Hospitals
- Medived Innovations Pvt. Ltd
- Sintex International Limited
- Covidien
- Wipro GE Healthcare
- NIHFW
- NABH, QCI
<table>
<thead>
<tr>
<th>Sl.no</th>
<th>Name of HCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mеданта</td>
</tr>
<tr>
<td>2.</td>
<td>UргиСХре</td>
</tr>
<tr>
<td>3.</td>
<td>Ума Санивини</td>
</tr>
<tr>
<td>4.</td>
<td>Саровдая</td>
</tr>
<tr>
<td>5.</td>
<td>Киран Севая-санстран</td>
</tr>
<tr>
<td>6.</td>
<td>Vivo healthCare Pvt. Ltd.</td>
</tr>
<tr>
<td>7.</td>
<td>Капоор амбуланс</td>
</tr>
<tr>
<td>8.</td>
<td>Columbia Asia Hospital</td>
</tr>
<tr>
<td>9.</td>
<td>Balaji Hospital, Barmar</td>
</tr>
<tr>
<td>10.</td>
<td>Rajasthan Hospital</td>
</tr>
<tr>
<td>11.</td>
<td>Вишвас hospital</td>
</tr>
<tr>
<td>12.</td>
<td>Balaji Hospital, Barmar</td>
</tr>
<tr>
<td>13.</td>
<td>102 ambulance</td>
</tr>
<tr>
<td>14.</td>
<td>Artemis Hospital</td>
</tr>
<tr>
<td>15.</td>
<td>Paras Hospital</td>
</tr>
<tr>
<td>16.</td>
<td>Jaypee Ambulance</td>
</tr>
<tr>
<td>17.</td>
<td>Columbia Asia Hospital</td>
</tr>
<tr>
<td>18.</td>
<td>Bl Kapoor</td>
</tr>
<tr>
<td>19.</td>
<td>Vимханс</td>
</tr>
<tr>
<td>20.</td>
<td>Max superspeciality hospital</td>
</tr>
<tr>
<td>21.</td>
<td>Max ambulance services</td>
</tr>
<tr>
<td>22.</td>
<td>Fortis Noida</td>
</tr>
<tr>
<td>23.</td>
<td></td>
</tr>
</tbody>
</table>

General Duty Assistant placed in Paras Hospital, Noida, UP.
# List of organization where trainees placed

<table>
<thead>
<tr>
<th>S. No</th>
<th>Name of HCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>SUMAN HOSPITAL</td>
</tr>
<tr>
<td>25</td>
<td>LOTHARA DIAGNOSTIC</td>
</tr>
<tr>
<td>26</td>
<td>SOBITI NEURO AND SUPER SPECILALITY HOSPITAL</td>
</tr>
<tr>
<td>27</td>
<td>PREET HOSPITAL</td>
</tr>
<tr>
<td>28</td>
<td>AVASTHI BONE AND JOINT CLINIC</td>
</tr>
<tr>
<td>29</td>
<td>NATIONAL DIAGNOSTIC CLINIC</td>
</tr>
<tr>
<td>30</td>
<td>LABORATORY</td>
</tr>
<tr>
<td>31</td>
<td>MUNJAL DIAGNOSTIC</td>
</tr>
<tr>
<td>32</td>
<td>GREWAL NURSING HOME</td>
</tr>
<tr>
<td>33</td>
<td>KIRAN HOSPITAL</td>
</tr>
<tr>
<td>34</td>
<td>SHILPEY NURSING HOME</td>
</tr>
<tr>
<td>35</td>
<td>DEEP HOSPITAL, MODEL TOWN</td>
</tr>
<tr>
<td>36</td>
<td>PORTEA HOME MEDICAL CARE</td>
</tr>
<tr>
<td>37</td>
<td>VAMSHI HOSPITAL</td>
</tr>
<tr>
<td>38</td>
<td>YELLOW HOME CARE</td>
</tr>
<tr>
<td>39</td>
<td>OXYGEN HOSPITAL</td>
</tr>
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<td>40</td>
<td>SAHYOG HOSPITAL</td>
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<td>RUBIN HOSPITAL</td>
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<td>42</td>
<td>MULE HOSPITAL</td>
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<tr>
<td>43</td>
<td>LIFESUPPORTERS INSTITUTE OF HEALTH SCIENCES</td>
</tr>
<tr>
<td>44</td>
<td>YASHODA HOSPITAL</td>
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</tbody>
</table>

GDA placed at Yashoda Hospital, Ghaziabad

Copy of Offer letter
## List of organization where trainees placed

<table>
<thead>
<tr>
<th>Sl.no</th>
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<tbody>
<tr>
<td>44.</td>
<td>MATA ROOP RANI HOSPITAL</td>
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<tr>
<td>45.</td>
<td>GANGA RAM HOSPITAL</td>
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<tr>
<td>46.</td>
<td>DR. CHADDA NURSING HOME</td>
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<tr>
<td>47.</td>
<td>BALAJI HOSPITAL</td>
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<tr>
<td>48.</td>
<td>HOME HEALTH RENTAL &amp; HOME CARE SERVICES</td>
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<tr>
<td>49.</td>
<td>AMARLEELA HOSPITAL</td>
</tr>
<tr>
<td>50.</td>
<td>SANTOSH PHYSIOTHERAPY &amp; SKIN CLINIC</td>
</tr>
<tr>
<td>51.</td>
<td>DR. CHADDA NURSING HOME</td>
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<tr>
<td>52.</td>
<td>ZIQITZA HEALTH CARE LTD.</td>
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<tr>
<td>53.</td>
<td>PRINCE ALY KHAN HOSPITAL</td>
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<td>54.</td>
<td>GRACE HOSPITAL</td>
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<td>55.</td>
<td>DIVYA DRISHTI EYE CARE CENTRE</td>
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<td>56.</td>
<td>NEW PRAVIN HOSPITAL</td>
</tr>
<tr>
<td>57.</td>
<td>KOKILABEN DHIRUBHAI AMBANI HOSPITAL &amp; MEDICAL RESEARCH INSTITUTE</td>
</tr>
</tbody>
</table>

General Duty Assistant being handed over appointment letter by placement co-ordinator, Apollo Hospital, Hyderabad
KEY milestones of HSSC

• Created NOS for 27 Job roles of allied health profession

• Launched 7 job roles with their course curriculum, training requirements and assessment standards provided to relevant stakeholders. Soon to open Dietician Assistant, Cardiac Care Assistant, Phlebotomy etc.

• Approximately 80 training institutes having 900 training centres across India affiliated with HSSC

• Accreditation Board set up for development of accreditation standards at par with International Standards and accrediting the training providers through robust Accreditation process.

• 5 Assessing Bodies accredited by HSSC for facilitating third party assessment of trainees/training institutes

• 38 members ranging from nursing homes to super-specialty hospitals

• Register of HSSC certified allied health professionals*
Swach Bharat

- Introduction of Skill courses in schools under State Boards & CBSE inculcating good hygiene practices to students of 9th to 12th standard. For HSSC job role, waste management is an integral part of the skills being imparted to trainees which also contributes to the objective of this mission.

Make In India

- Skilled manpower would play a major role in success of Make in India programme. HSSC is facilitating training & skilling of professionals that would be required for medical equipment & device manufacturers in the country
Going Forward…

Enhance Collaboration with states

- With Orissa Government for their Ambulance Services- EMT B, Discussion on CATS (Delhi)
- MoU with School Boards of Government of Haryana, Himachal Pradesh & Punjab – UK and Rajasthan next
- MoU with State Skill Development Missions of UP & Punjab
- Tie Up with Universities – Symbiosis & Pune University – more to be added

Mutual recognition / Mapping of Indian standards / Development of transnational standards

- Partnered with Australia Healthcare Skill Council for development of trans-national standards for mutual recognition of training and certification
- Partnership with more countries and international universities leading development of transnational NOSs and mutual acceptance of standards
Going Forward…

- Create new NOSs as per industry needs & requirements

- Provide Placement Support to trainees

- Advocacy for
  - Recognition of HSSC certified people by government, Employment Exchange and other standard bodies.

  - Inclusion of HSSC certification as one parameter for human resource standards for accreditation by NABH & NABL

  - Awarding government tenders and work to organization that have min. 70% or more of their workforce certified
Thank you
DRAFT NATIONAL HEALTH POLICY 2015
CII SUBMISSIONS
Annexure IV
INSIGHTS FROM MULTI STAKEHOLDER CONSULTATION
MANAGEMENT AND CARE OF DIABETES IN INDIA

A Joint Initiative of
INSIGHTS FROM MULTI STAKEHOLDER CONSULTATION
MANAGEMENT AND CARE OF DIABETES IN INDIA

A Joint Initiative of

Confederation of Indian Industry

Lilly
Disclaimer: The white paper has been generated in public interest for the well being of the society. The national NCD summit and the development of this white paper have been funded by Eli Lilly and Company. Lilly was not involved in the creation of the content. This white paper shall in no way be considered as a substitute to any personalized advice of HCPs on the disease state of an individual.

Note: All maps used in the report are only for illustrative purpose and not as per scale.
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Diabetes has become one of the leading public health issues in the country. The Government of India has a strong commitment to tackle this challenge through the National Program on Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) programme. A strong need was felt to understand the enablers and barriers at the State level with regard to the implementation of this ambitious National program. The Confederation of Indian Industry in partnership with Eli Lilly has taken a lead in creating platforms at the State and the National levels for cross learning and facilitating a dialogue amongst multi stakeholder groups towards strengthening the implementation of the existing Government policies around NCDs with focus on Diabetes.

This National White Paper is intended to encapsulate some of the best practices and the suggestions from a diverse range of experts engaged in the public health with a keen interest in the NCDs domain. The recommendations in this report will be useful while the NPCDCS programme is all set to expand in the country and strengthen the Diabetes component of the program in particular. The recommendations included herein are derived from the experience and knowledge of professionals who have been working in the field of Non Communicable Diseases for many years and thus reflect on the real-life situations in the field.

CII is confident that this report would be a useful tool in the hands of policy makers, program managers, healthcare providers and other agencies working in the field of Non Communicable Diseases. This report can serve as a ready reckoner for planning and implementing diabetes management interventions.

CII would also like to thank all the partners for their efforts in analyzing and collating the proceedings of the State level consultations and drafting this White Paper. CII would like to specially thank Eli Lilly and Company for their partnership and guidance which has facilitated in creating a pioneering and much needed platform for knowledge sharing on NCDs in the country and exploring possibilities for private sector engagement to complement ongoing government initiatives.

CII is committed to join this partnership paradigm and would like to express sincere gratitude to the Government officials from Ministry of Health and Family Welfare, State Departments of Health, Nodal Officers for NCD, members of the Scientific Committee and Indian Council of Medical Research for their invaluable inputs and suggestions towards development of this report. It would not have been possible to prepare this report without the rich inputs from our industry partners, non-governmental organizations and the academia.
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EXECUTIVE SUMMARY

India is a vast, heterogeneous country with an approximate population of 1.1 billion people, a complex socio-economic milieu, and immense diversity in culture, dialects and customs. Indian health system is also multifaceted, with differing public and privately-funded health infrastructure, catering to the diverse needs and demands. These factors together necessitate the need for having locally relevant, specific and evidence-based policy options. This also underscores the importance of generating a robust, representative evidence base that documents the disease burden, vulnerable population groups and disease determinants.

India is also going through a demographic transition wherein approximately 67% of the population is in the economically productive age-group (15-65 years) and thus predisposed to development of non-communicable diseases. This transition is compounded by the fact that there is a rapid rate of urbanization occurring in India with an annual increase of almost 2.4%. The migratory population (moving from rural to urban areas) is especially prone to non-communicable diseases like Diabetes.

By 2030, India's diabetes burden is expected to cross the 100 million mark. Considering the rising burden of non-communicable diseases and existing risk factors, Government of India initiated the integrated National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). The program attempts to create a wider knowledge base in the community for effective prevention, detection, referral and treatment strategies through convergence with the ongoing interventions and other national programs.

The objective of conducting round-table discussions and developing this whitepaper was to identify and assess the strengths, gaps, opportunities and the best practices pertaining to policies for managing Diabetes in India. This white-paper is an outcome of series of 5 state round-table discussions and scores of in-depth interviews with several stakeholders from within and outside the Government, working on Diabetes management. The round-table discussions identified and highlighted some of the broader infrastructure, financing and workforce issues and suggested specific solutions for overcoming those constraints.

The research and this whitepaper clearly demonstrate the fact that each state has its own strengths, weaknesses and priorities which differ from other states in many ways. Over the last two years, Diabetes management interventions under NPCDCS have reached more than 17.6 million patients, but with the incidence still going up, it is essential to scale-up the effective interventions. The Government’ plans to scale up the response to
the Diabetes epidemic by expanding the NPCDCS from 100 districts at present to cover all districts in the country during the 12th National Five Year Plan is appropriate and timely.

The national summit is an effort towards achieving the greater objective of establishing a platform for evidence based advocacy - using data for devising policy solutions for making India better prepared to tackle the challenge of increasing burden of diabetes. The summit features the united efforts of advocacy groups, academia, professional bodies, Government officials and agencies, public and private healthcare providers and healthcare industry partners, who have all come together to contribute to this initiative.

The round-table discussions and analysis of qualitative information was conducted in line with the strategic framework of NPCDCS and classified under the following five broad areas:

1. Prevention
2. Early detection (and screening)
3. Treatment
4. Training and Capacity Development
5. Monitoring, Surveillance and Evaluation

The discussions and analysis yielded the following key insights into each of the intervention areas:

1. Prevention: There is very limited awareness in the community regarding ways in which non communicable diseases can be prevented. Most of the messages are linked to treatment of the disease. It is essential to develop locally relevant messages around good dietary practices, exercise, ante-natal care, etc. Both inter-personal communication and mass-media modes should be used to disseminate the messages. There are several stakeholders in public and private sector already working on health issues. The activities of all the potential partners need to be synergized with the national program (NPCDCS) to have the maximum impact. Through appropriate messaging and reaching out with these messages to the community, it is possible to reduce the incidence of diabetes in the community.

2. Early detection (and screening): As much as we might desire, despite prevention there would be several new cases of diabetes in the community every year. As of now only 49% of the total cases get detected with the disease and many of these cases are detected after the onset of complications. This not only worsens the prognosis of the disease but also increases the cost of treatment. It is essential to detect every case of pre-diabetes and diabetes, early. Through the existing system of healthcare providers and health facilities, it is important to screen
Health facilities need to be equipped with essential diagnostic equipment ranging from Glucometer and Urine testing kits to auto-analyzers, as the need be. The community also needs to be made aware about the need and availability of screening facilities for diabetes. Integration of screening services amongst the existing healthcare providers and other national programs would go a long way in increasing the rate of detection and avoiding duplication of efforts.

3. Treatment: It is essential that every detected case of diabetes receives timely and appropriate treatment. Data suggests that out of the diagnosed cases, 15% do not receive any treatment at all, while there would be many more who receive inappropriate treatment. It is essential to have the key public health facilities well staffed with appropriately skilled and equipped manpower to provide access to treatment services. It is also vital to have and follow standard treatment protocols for disease management. Deficiencies in human resources could be mitigated through multi-skilling of healthcare providers, developing public private partnerships and increasing the availability of institutes for training of medical and paramedical healthcare providers. By strengthening diagnostic facilities and making affordable drugs available at the health facilities, it is possible to increase the uptake and compliance amongst diabetic patients. Strengthening supply chain for anti-diabetic drugs, developing linkages with community health insurance schemes and better counselling services could ensure higher compliance and lower rate of complications in people with diabetes.

4. Training and Capacity Development: In order to ensure that the healthcare services of optimum quality are being provided to the people with diabetes in India, it is important to have well trained manpower. Due to the rapid changes in treatment modalities and available options, capacity development starts from the first day of academic training and continues until the last day in service. Thus it is important that all healthcare providers be linked to an ongoing medical education process (CME), which provides them with the opportunities to stay updated on the treatment modalities for diabetes. The policy makers and program managers also need to be aware about the treatment modalities to enable them in taking appropriate policy and programmatic decisions pertaining to the interventions aimed at prevention and treatment of diabetes. Both in-person and virtual training platforms should be strengthened to create greater opportunities for capacity development. In
addition to training, it is essential for the program managers to be capacitated in terms of decision-making authority to effectively and efficiently run the program at state and district levels. Having the knowledge and the ability to take appropriate decisions could significantly strengthen the NPCDCS program in the country.

5. Monitoring, Surveillance and Evaluation:
While several monitoring and reporting systems exist, there is very limited programmatic use of these systems. A robust monitoring system can greatly help in making programmatic interventions more effective and efficient, while ensuring accountability of healthcare providers. It is possible to strengthen the monitoring system by integrating the multitude of reporting systems into one and having a mechanism of analyzing the data for program management purposes. An electronic medical records system linked to unique ID cards could potentially strengthen the disease management in the country. Quality assurance mechanisms like prescription audits, active disease surveillance and programmatic evaluations would significantly improve patient outcomes.

During the course of deliberations and consultations, many examples of effective, efficient and culturally relevant interventions were identified. These interventions could form the basis of establishing and scaling up relevant systems for prevention, early diagnosis, and treatment of Diabetes in India. While a lot of good policies exist and resources are made available, it is possible to improve the outputs of these policies through effective utilization of available resources. It is hoped that the outputs of this initiative would support the program in achieving ambitious outcomes for the states and the country.
BACKGROUND

Indian healthcare is undergoing a unique transition. The health system is undergoing systemic reforms through infusion of additional public funds as part of NRHM. There has been a significant reduction in infant and maternal mortality in the country over the past 10 years since NRHM was launched. Although it is difficult to singly attribute this reduction to the policy changes and reforms in the health system, the correlation is evident. While there is clear evidence of better control over common maternal and childhood illnesses through the efforts of the Government, there is an increasing incidence of non-communicable diseases (NCD) in the country. The National Program for Cancer, Diabetes, Cardiovascular Diseases and Stroke launched by the Ministry of Health and Family welfare is a visible and important testament to the fact that the Government is cognizant of the issue. Government of India has developed a strategy for implementing the program as part of the 12th National five-year plan. This strategy includes the following:

- **Thrust on health promotion**
- Screening for diabetes and hypertension to be continued
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- Thrust on health promotion
- Screening for diabetes and hypertension to be continued
- PHCs to be included under the program
- Screening of common cancers (oral, breast and cervical) at CHC and above
- Cardiac Care unit / Intensive Care Unit (ICU) in at least 25% district hospitals, wherever feasible
- Linkages with Medical Colleges for mentoring the districts and to provide outreach and referral services
- Screening of diabetes and hypertension in urban slums in 33 cities of more than one million population
- Chemotherapy facilities in at least 25% of district hospitals, where ever feasible.
- Establishment of 20 State Cancer Institutes & 50 Tertiary Cancer Centres with augmented funding
- Government of India (GOI) and State share: 75: 25 90: 10 in North East and hilly states

By 2030, India’s diabetes burden is expected to cross the 100 million mark as against 87 million, which was the previous estimate. The country is also the largest contributor to...
regional mortality with 983,000 deaths caused due to diabetes in year 2012. Considering the rising burden of NCDs and common risk factors to major non-communicable diseases, the Government of India initiated an integrated National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). The focus of the program is on health promotion and prevention, strengthening of infrastructure including human resources, early diagnosis and management of disease and integration with the primary health care system through NCD cells at different levels for optimal operational synergies.

Given that close to 70% of India’s population lives in rural areas, there is a need to have strategies aimed at reaching out to the rural masses. There is a distinct possibility of having a high ratio of undiagnosed cases and also a higher than expected burden of diabetes in rural areas. There are also large disparities in human and infrastructural resource allocation between rural and urban areas which can lead to divergence in disease outcomes.

The NPCDCS thus also aims at the integration of NCD interventions with the NRHM framework for optimal utilization of resources for provision of seamless services to the beneficiaries in rural areas. Thus, the institutional linkages of NPCDCS at national, state and district level with the Health Societies, sharing administrative and financial structure of NRHM becomes crucial for NPCDCS. The NCD cells at various levels have been established to ensure this integration, implementation and supervision of the program activities related to NCDs. The program activities include health promotion, early diagnosis, treatment, referral and measurement of the outcomes.

Simultaneously, the program attempts to create a wider knowledge base in the community for effective prevention, detection, referrals and treatment strategies through convergence with the ongoing interventions of National Rural Health Mission (NRHM), National Tobacco Control Program (NTCP), and National Program for Health Care of Elderly (NPHCE) etc. Within the context of NCDs, there has been a substantial and noticeable increase in the disease burden of Diabetes in the country.


The burgeoning disease burden of Diabetes in the country prompted the Ministry of Health and Family welfare to identify and publish a set of guidelines and implementation measures for running the Diabetes management interventions under NPCDCS in the country. While the incidence of DM in the country is increasing, there has also been a rapid change and development in the disease treatment methods, available drugs and tools to improve disease management, patient compliance etc.

Considerable research needs to be conducted to develop and test tools for decision makers to use for improving health care efficiency (e.g., relative drivers of costs, best practices in efficient care delivery, feedback and reporting methods) for the NPCDCS program. To facilitate an evidence-based, participatory and transparent process for prioritizing measures, the Confederation Of Indian Industries (CII) and Eli Lilly and Company created a roadmap in consultation with the Scientific committee for engaging stakeholders for identifying effective program strategies.

This initiative was commissioned to examine what issues and challenges are being faced by the NPCDCS program at the national and state levels and to document best practices across different states. This report documents the process, deliberations, and results of the stakeholder consultations, in-depth interviews and structured surveys administered to key stakeholders.
OBJECTIVES OF THE INITIATIVE

To help facilitate an evidence-based and transparent process for prioritizing measures, the Confederation Of Indian Industries (CII) and Eli Lilly & Company (India) Pvt. Ltd established a partnership with the following broad objectives:

- Sensitization and capacity building of all state nodal officers across states on high level policies around NCDs.
- Exploring PPP opportunities and involvement of industries to complement the NCPCDCS that could be expanded through the CII network.
- Identifying potentially efficacious interventions and best practices that could be scaled up and aimed at reducing mortality and morbidity due to diabetes.
- Creating a roadmap in consultation with key thought leaders in the field for strengthening the policies drafted for prevention and treatment of DM in India.
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- Exploring PPP opportunities and involvement of industries to complement the NCPCDCS that could be expanded through the CII network.
METHODOLOGY AND DESIGN

This project is being organized in two phases. Two days “National NCD summit” in Delhi that has been preceded by state roundtables in selected 5 state capitals. Each roundtable is contemplated to be a brainstorming session with the participation from senior Government officials of NPCDCS, program officers, representatives of non-government organizations at state and district level. During the 2 days national summit the participants will deliberate on a wide range of topics on diabetes management, policy issues, best practices, health education needs, media and technology tools etc. This state report is an outcome of the process of intensive technical and programmatic deliberations held amongst the multitude of stakeholders involved in the process of preventing and treating Diabetes Mellitus in India.
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The process involved the following steps:

1. **Primary Research**: Administering structured questionnaires (quantitative assessment) for key stakeholders followed by thematic group discussions (qualitative research) around the issue as part of the state round-table discussions with the participation from Directors and Program officers of NCD program, representatives of non-government organizations and private sector.

2. **Secondary Research**: Review of existing data and information related to disease burden and prevention & treatment of DM in India.

3. **Triangulation of qualitative and quantitative primary data** with secondary data followed by policy analysis.

**National NCD summit-Modus**

- **Stage 1**: 5 Regional multi-stakeholders consultation (State Round Tables)
- **Stage 2**: Interviews with key individuals/institutions, Collation and analysis of the findings in form of state specific reports.
- **Stage 3**: National NCD summit (7-8th June)
- **Stage 4**: CII translates the recommendations into action with industry involvement for strengthening NCD initiatives in country.
METHODOLOGY AND DESIGN

INSIGHTS FROM MULTI STAKEHOLDER CONSULTATION: MANAGEMENT AND CARE OF DIABETES IN INDIA

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2. Secondary Research:
   - Review of existing data and information related to disease burden and prevention & treatment of DM.

3. Triangulation of qualitative and quantitative primary data with secondary data followed by policy analysis.

THE ROUNDTABLE DISCUSSIONS

National NCD summit - Modus

Stage 1
- 5 Regional multi stakeholders consultation (State Round Tables)

Stage 2
- Interviews with key individuals/institutions
- Collation and analysis of the findings in form of state specific reports

Stage 3
- National NCD summit (7-8th June)

Stage 4
- CII translates the recommendations into action with industry involvement for strengthening NCD initiatives in country reports.
Healthcare delivery model under NPCDCS (NCD Program)

3. Treatment strengthening - by ensuring availability of healthcare providers, logistics and supplies

4. Capacity development and training of healthcare providers for providing appropriate counselling, treatment and support

5. Monitoring and surveillance for improving quality of healthcare services for DM (Quality assurance and monitoring systems)

During the deliberations in the roundtable meeting, 1:1 interviews and surveys, the existing status of the program was assessed, strengths, issues and gaps identified and the way forward charted out. The key areas of intervention were classified (linked to the NPCDCS framework) as follows:

1. Prevention of disease - through community sensitization and outreach

2. Early diagnosis - through timely screening at community level
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1. **Prevention of disease - through community sensitization and outreach**

2. **Early Diagnosis -** through timely screening at community level

3. **Treatment strengthening** - by ensuring availability of Healthcare providers, logistics and supplies

4. **Capacity Development** and training of healthcare providers for providing appropriate counselling, treatment and support

5. **Monitoring and Surveillance** for improving Quality of Healthcare services for DM (Quality Assurance and Monitoring systems)

Healthcare delivery model under NPCDCS (NCD Program)
Multi-stakeholder dialogue and brainstorming

Participants’ profile (sector wise) consulted during state round table

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<td>Medical Institutions and Universities- IHMR, Fortis, Janana, JK Lon, Rajasthan Medical services Corporation, SMS College, AVUSH</td>
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NATIONAL SUMMIT FRAMEWORK
INSIGHTS FROM MULTI STAKEHOLDER CONSULTATION:
MANAGEMENT AND CARE OF DIABETES IN INDIA

NATIONAL SUMMIT FRAMEWORK

"Diabetes in India". As part of the state roundtables, key stakeholders identified and presented the strengths, weaknesses, opportunities and possible solutions for strengthening the prevention, diagnosis and treatment interventions in the state. These options and opportunities have been compiled together as part of the national summit framework.

The framework looks at the issue of Diabetes management in a continuum from prevention to treatment and follow-up linked in a matrix with potential solutions and its expected impact. Although increased financial allocation would generally lead to better health outcomes, it has to be coupled with effective and efficient strategies to ensure that we get the best patient outcomes in the given resources.

In our health system, healthcare providers viz. Doctors, Nurses, ANMs, Chemists, ASHAs and Aanganwadi workers are the key drivers of change. They form the interface between the community and the health system. Thus the whole framework of the report is focused on strengthening this interface through various interventions, leading to better patient outcomes and lower chances of health complications.

Expanding access to health is an important part of an overall strategy to achieve universal health coverage. India will need to make crucial decisions if access and financial protection in the context of health are to be expanded to cover the majority of the population. This initiative on "Strengthening Policies for Diabetes Care: Learning from Case Studies" explores the experiences of implementing NPCDCS across different states and in the country overall. The report delves upon the experience and the outcomes of the interventions in the states, as they developed strategy to provide optimal health coverage to people suffering from Diabetes. The report systematically analyzes and presents lessons learned from these states which should be useful for expanding and improving the Diabetes management initiatives in India, and for other countries working to fight this epidemic for providing basic health access.

There was a long felt need for a national forum on diabetes from a public health perspective. Together CII, Eli Lilly & Company and Ministry of Health & Family Welfare, Government of India joined hands to bring together learnings from seven states of India for all the stakeholders. This phase of primary and secondary research culminates into the "National Summit for Strengthening Policies for..."
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Research clearly indicates that countries, states, regions with greater means of health education and awareness have better health outcomes\(^1\). Giving the healthcare providers and policy makers the option to choose the best interventions leads to overall improvement in the healthcare outcomes of the community. In practice, however, finding the mechanism to make this happen is difficult. Ultimately, as in any system, the real value of choice comes from people having the right information to select the option that is superior. This framework endeavors to systematically present the available information and options for the policy makers and program managers.

The framework has been designed to be in synchrony with the NPCDCS strategy that aims to strengthen prevention, diagnosis, treatment and capacity aspects of the health system.

\(^1\) Source: [http://www.nber.org/digest/mar07/w12352.html](http://www.nber.org/digest/mar07/w12352.html)
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RECOMMENDATIONS
**Recommendations** based action plan (linked to NPCDCS Strategic Framework)

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- The private partners, development agencies and Government to synergize CSR and development activities to streamline them with the NPCDCS program.  
- “Diabetes Education Kiosks” should be set up jointly by the government and non-governmental partners to enable community in getting key health education messages closer to their homes. |
| - Limited involvement of community based groups | - PRI (Panchayati Raj Institutions), NGOs, CBOs and community forums like Ramayan Mandalis, Saas Bahu sammelans should be involved for providing health education regarding prevention, screening, early diagnosis and timely & appropriate treatment. |
While targeting the adolescents and children, health educators should reach out to school children through National Rural Health Mission’s School Health Program with messages pertaining to good dietary practices.

Health education to pregnant women could be provided at the outreach sites (MCHN days).

Awareness campaign to promote better dietary practices, ante-natal care and rest during last-trimester of pregnancy etc.

Have a directory of LBW babies to screen LBW babies at regular intervals for pre-diabetes.

Cross referrals from programs like RNTCP and NPCB can help identify cases early.

Non-diabetic but overweight and the high risk group people (having family history, having low birth weight) should be given a dietary plan, exercise advice and followed-up after 6 months.

Glucometers to be made available at all the sub centre level and PHCs.

A standardized screening system to have accurate linkages between different facilities.

Integration and collaboration with screening systems established in other national programs like RNTCP, NPCB, RCH, NACP.

Municipal corporations in the state often function as a separate system. There is a need to collaborate with the urban local bodies to synergize the health interventions being implemented by NPCDCS, Ministry of Health and Family Welfare and Urban Development.

System of urban dispensaries or health centres set up by urban local bodies to be equipped with screening tools and equipment.

No separate cadre that can be engaged for screening in urban areas.
### Recommendations

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<td>Deficiency in availability of Human resources at the facilities</td>
<td>Empanelment of senior doctors through associations, corporate and individually for tertiary care hospitals and peripheral centres for complications management.</td>
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**Issue**
- Verticality in the programs leading to artificial shortages in HR
- Limited diagnostic facilities

**Recommendations**
- Integrated approach to disease management, including integration of funding lines and reporting mechanisms.
- Realignment of roles and responsibilities of healthcare providers aimed at multi-skilling and holistic disease management.
- Continuum of care approach where a General Physician, an Ophthalmologist, an Endocrinologist, vascular surgeon neurologist work in tandem for treatment of DM.
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### Recommendations

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| **Ambiguous Policies** | - Clear policy on deputation, transfer & posting, promotions etc, which also has performance linked incentives tied to clear deliverables.  
- Clarity on roles and responsibilities of existing manpower, with clear delegation of funds, functions and functionaries  
- Need for greater flexibility for the state to re-align funding for locally relevant NCD activities and regional priorities, akin to NRHM flexi-pool. |
| **No cadre of diabetes counselors** | - A diabetes educators cadre to provide specialized counselling services at tertiary level  
- Diabetes educators or counsellors should be available on a toll free helpline for increasing compliance |
| **High out of pocket expenses due to lack of reimbursement mechanisms** | - An OPD based Insurance scheme for Non-communicable diseases like Diabetes.  
- The existing reimbursement systems like Rashtriya Swashtyha Bima Yojana (RSBY) cover only the hospitalization and not chronic illnesses like diabetes. There is a need to extend this to the out-patient care for DM, Hypertension to prevent subsequent expenditure on treating complications.  
- Drugs should be available, accessible and affordable at all levels of health system - the PHCs, CHCs, DHs and teaching centres. The free supply of medicines in the government medical college hospitals and tertiary care general hospitals needs to be streamlined. |
Doctors need to be provided with a protocol based guide for reference, appropriate training and CMEs to become confident and work away the fear of prescribing insulin.

Referral systems are weak at the peripheral level and there is a need for JSY-like referral transportation system for emergencies arising out of NCDs

Glucometers, Insulin and other supplies procurement and logistics management should be adequately budgeted and timely procurement initiated, keeping in view the lag time.

The industry stakeholders could provide better packaging for anti-diabetic drugs with clear indications, treatment modalities and compliance printed on the packaging

Training needs assessment during and after the recruitment of manpower, on NCDs.

Budgeting related to training to be in line with the training needs assessment of each state.

Integration of NCDs prevention and treatment in pre-service and in-service training

The training on NCDs should be made mandatory or; linked to career development opportunities.

Annual training calendars for each state should be developed in advance in consultation with the NCD cell and shared with all potential training institutes to ensure timely engagement.

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### Strategy 4) Capacity building of human resources (healthcare providers)

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|                                      | Budgeting related to training to be in line with the training needs assessment of each state.                                                  |
| Limited integration of training      | Integration of NCDs prevention and treatment in pre-service and in-service training  
|                                      | The training on NCDs should be made mandatory or; linked to career development opportunities.                                                  
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<td>Limited orientation regarding NCDs</td>
<td>Standardized orientation programs for NCD program management team, including Simple operational guidelines on fund utilization.</td>
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<td>Orientation training of policymakers on various prevention, treatment and complications management strategies for DM.</td>
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<td>Training of nursing staff as Diabetic educators and in using innovative tools like Diabetes Conversation Maps</td>
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<td>Chemists and pharmacists should be trained and sensitized about the need for providing literature, explaining the effects, side effects, importance of compliance and complications related to DM.</td>
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<td>Few opportunities of continuing medical education around DM</td>
<td>DM should be included regularly in the CME programs for doctors and nurses</td>
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<td>CMEs should focus on special indications like juvenile diabetes, gestational diabetes and complications management, with involvement of both public and private healthcare providers at primary, secondary and tertiary levels.</td>
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<td>To avoid treatment related complications and enhance patient outcomes, have uniformity in the treatment modalities throughout the country. This could be achieved through standard treatment guidelines for DM.</td>
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<td>Limited capacity of State/ National training institutes</td>
<td>Government could source-in or source-out trainings on NCD through partnerships with multitude of leading training institutes (public and private) like SHFW, NIHFW, Medical Colleges, Regional institutes and other autonomous public health bodies.</td>
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**Strategy 5) Surveillance, Monitoring & Evaluation**

- **Multiple MIS formats**
  - There are several stand-alone MIS in the health system which need to be standardized and integrated.
  - The MIS for NPCDCS should be mainstreamed with other cross-sectoral initiatives being carried out by Government and other development partners (like World Bank, USAID, FAO, WFP, UNICEF, WHO etc).
  - Engaging PRI (Panchayati Raj Institutions) members in community-based monitoring. The Village Health Committee (VHC) should form the link between the Healthcare providers and the community.

- **Limited disease surveillance systems**
  - A clinical registry of the people suffering from DM should be prepared. All the individuals seeking services from NPCDCS should be given health card with unique identity number to track treatment. Duplication of diagnostic tests leads to wastage. To avoid this medical history of the patient can be linked to the Aadhaar card (UID) on a medical record system.
  - A program surveillance unit to conduct performance audit and allocation of funds. Ensuring quality control by conducting frequent prescription audits to help in standardizing treatment practices and ensuring quality control towards ensuring patient satisfaction.
Insights from Multi Stakeholder Consultation: Management and Care of Diabetes in India

Recommendations

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LEARNING FROM STATE ROUNDTABLES

Chhattisgarh state is implementing the program in 3 districts (Raipur, Bilaspur and Jashpur). The Unique strength of Chhattisgarh lies in its largest trained network of ASHA (Mitanins) in the country. The stakeholders felt that “ASHA-Mitanins” across the state must be trained on basics of Diabetes and its related complications with the help of conversation maps and they can play meaningful role at community level in identification, prevention and referral of patients with non communicable diseases including Diabetes. It was felt that Mitanins should be empowered with technology and supported with incentives and performance linked rewards.

Healthy Lifestyle centers have been established in the state through EU commission’s financial support in Raipur and Bilaspur districts. There is a strong need for training of primary health functionaries. CME programs are very
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There is a strong need for training of primary health functionaries. CME programs are very
few in the state and there is a need to create awareness amongst doctors around Insulin therapy. There were many reported cases of Juvenile Diabetes from the state that require Insulin therapy.

Eli Lilly and Company designed a two-day training workshop in consultation with NCD Cell of Govt. of Chhattisgarh and covered the several topics on Diabetes management with focus on prevention, promotion and lifestyle modification. A batch of 15 trainees selected and nominated by the state NCD cell participated in the program. The participants felt that their knowledge level increased significantly after the two days program and they were much more confident to talk about Diabetes management at community level. Diabetes Conversation Map appeared as a very effective tool for community education. Being a pictorial map with limited text messages this could be effectively used with illiterate people as well.

It was felt that the State NPCDCS Guidelines need to be revisited to provide flexibility as per regional needs. Through this, flexible funds for needs like transportation, virtual help-lines, patient education etc could be addressed. Similarly, there is a need to have flexibility in hiring guidelines as the "ideally qualified" professionals are hard to find due to a significant scarcity of skilled professionals.
LEARNING FROM STATE ROUNDTABLES

West Bengal

**Strength**

- Strong efforts by Media channels in the state
  - Jagran's PEHEL Covered 93 districts in project states and conducted screening of 1, 14, 000 persons for diabetes with referral services through 360 degree approach.

- Behavior change that is required in the population is a challenge
  - Media, Community reach programs, Medical institutes and Govt. need to join hands for this.

- Great opportunity to build awareness using ICT programs, telemedicine in schools and workplaces.

**Weakness**

- High level of female illiteracy, lack of access to clean water, insanitary conditions, food insecurity, poor household caring practices, heavy work demand, and lack of fertility control, as well as low access to preventive and basic curative care is a challenge.

- Low awareness about treatment procedures.

- Current reimbursement policies and existing schemes in the state aren’t adequate looking at the growing incidence of the disease.

- Officials felt the need for redesigning of the NCD program with sufficient manpower, training and surveillance of the program.

**Opportunities**

- Diabetes to be around 9.05%. For scaling up screening initiatives procurement of equipments has started. State is looking at ways to augment the process of screening at the sub centre level.

- Due to the uniqueness of the State as far as the culture is concerned, it was understood that mediums of community sensitization should be mainstreamed with local modes of recreation, cultural exchanges and diet. The Government is therefore planning to involve song and drama

**Threat**

- Population currently being covered under NPCDCS is around 7,382,540. Around 10% of the population is being screened for Diabetes and the state has found the incidence of
divisions of Government of India and Radio/TV channels for IEC related activities. Building lifestyle change and awareness came up as the biggest challenge in West Bengal and can be considered as a major area for new interventions and partnerships.

While targeting the Adolescent age group, school interventions are important. It was felt that workplace interventions should be made mandatory for preventing non-communicable diseases like Diabetes, Hypertension, Cancer and Stroke.

Integration and collaboration for screening and treatment is important. Screening efforts in national programs like RNTCP, NPCB, RCH, NVBDCP and NACP should be integrated with NPCDCS. This will also synergize inputs towards infrastructure, manpower, technology, reporting mechanisms etc. Municipal corporations in the state do a lot of credible health work and should be partnered with for NCD interventions.

A huge workforce exists under ICDS Scheme (AWW) and under NRHM (ASHAs). These should be trained properly and should be empowered in identifying and educating about signs, symptoms and complications related to Diabetes.

Duplication of diagnostics and treatment leads to substantial wastage in the system. The Aadhaar card (UID) platform could form the basis of registration of a patient linked to an electronic medical record system. Retrieving the history, related tests, treatment regimen, state of compliance and status of the individual's disease can help do away with duplication and medical errors.

Media Channels like Jagran Pehel were quite forthcoming in aiding the cause by conducting school camps, helping build awareness through their columns and involve more and more stakeholders across the value chain.
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A huge workforce exists under ICDS Scheme (AWW) and under NRHM (ASHAs). These should be trained properly and should be empowered in identifying and educating about signs, symptoms and complications related to Diabetes.

Duplication of diagnostics and treatment leads to substantial wastage in the system. The Aadhaar card (UID) platform could form the basis of registration of a patient linked to an electronic medical record system. Retrieving the history, related tests, treatment regimen, state of compliance and status of the individual's disease can help do away with duplication and medical errors.

Media Channels like Jagran Pehel were quite forthcoming in aiding the cause by conducting school camps, helping build awareness through their columns and involve more and more stakeholders across the value chain.

High literacy, strong will to try and adapt to new solutions. Several volunteering bodies like Kutumbashree and trade unions functioning in the state already. No geographically distinct Urban-Rural divide that ensures uniform health coverage.

Public private partnerships have been successful in National TB (RNTCP) and other program- provides clarion recommendation to join hands with Private sector.

High teledensity in Kerala has provides opportunities to innovate more on ICT based solutions for building health delivery and access.

In the state of Kerala, there are total of 231 CHC, 835 PHC and 5144 sub-centres. The state has implemented the NPCDCS program in five districts and the state has appointed the staff necessary for each district. There are nodal officers appointed for each of the five districts. The state has also engaged DEO, Doctors, staff nurse, Physiotherapist and Dietician.

The State has piloted ehealth/mhealth initiatives in the state. Mobile-Health programs have been started by the Department of science and technology division of health for providing solutions for the doctors and the patients through SMS. Bulks SMS services, eSMS, 2-way interactive SMS and voice solutions through IVRS have been initiated. Some programs like DR SMS from the state made it to the Computer-World honors program.

On 6th April 2013, Government of Kerala announced launch of an year-long action plan to create awareness about the importance of
The state has issued guidelines for organizing screening camps in the state as per NPCDCS. Diagnostic kits for DM have been distributed to the sub-centres, PHCs and CHCs.

In spite of a free drug availability program for Diabetes, stock-outs in the supply of drugs emerged as an issue. Public private partnerships, involvement of all stakeholders was proposed as a solution to these issues.

Lessons can be drawn from Kudumbashree or the ASA initiatives that have contributed to strengthening health system and service deliver in the state.

For effective disease diagnosis, it was proposed that medical teaching centers should have facilities for conducting Insulin sensitivity test. Private clinics and hospitals should have designated diabetic screening labs. A mobile van/ lab having integrated colorimetric and glucometer screening methods could be useful for reaching out with screening services. These services should also reach the urban areas, which seem to have a high incidence of the disease but very limited service availability. Municipalities and in the major corporations should be involved in health education for Diabetes prevention in urban slums. There are of total 60 municipalities and 5 major corporations where no facility of screening is performed till now. It is proposed that the non-diabetic but overweight and the high risk group patients should be given dietary plan, physical exercise advice and periodic check-up calendar.

Existing reimbursement systems like RSBY covers only the acute illness and not chronic illnesses like diabetes. The services could be extended to the OPD/ Out-patient care for Diabetes and thereby prevent excessive expenditure on treatment of complications later.

The Amrutham Aarogyam program provides free medicine for diabetic and hypertensive patients through Kerala Medical Service Corporation Limited.

The state has selected and recruited state and district nodal officers, program assistants and finance officers at the state NCD cell level. At CHCs and District level hospitals more than 50% of the sanctioned staff has already been recruited.

Rajasthan has varied terrain ranging from sparsely populated desert areas to hilly and plain terrains. The state also has a significant migratory population. With a facility based system, providing continuum of care to such patients is a challenge. Low literacy and poverty compounds these challenges. For such conditions mobile medical units, remotely managed health education and awareness.

LEARNING FROM STATE ROUNDTABLES

Due to the high prevalence of DM and Hypertension in the state, NPCDCS is being implemented in 7 high focus districts: Bhilwara, Jodhpur, Jaisalmer, Sri Ganganagar, Bikaner, Barmer and Nagaur. Of the total of 17.6 million people being reached through NPCDCS interventions, 96,257 people have been screened for Diabetes till now out of which 13.81% people were found to be diabetic.

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Existing reimbursement systems like RSBY covers only the acute illness and not chronic illnesses like diabetes. The services could be extended to the OPD/Out-patient care for Diabetes and thereby prevent excessive expenditure on treatment of complications later.

**Strength**

- Free diagnostic tests for Diabetes
- Free Diabetes medication for all
- Presence of interested capable institutions (IIHMR, SIFW)
- Presence of active NGOs and international agencies (mainstreaming opportunities)

**Weakness**

- Geographic challenges: Desert and scattered population
- Nomadic population: difficult to reach and poor compliance
- Poor IT penetration and literacy restricted use of technology possible

**Opportunities**

- Possible integration in diabetes screening and awareness drive with existing programme (eligible couple survey, Mahila Arogya Samiti)
- Robust referral system: for patient management—high possibility
- Ayush therapies: Use of Kadam tree and camel milk in Diabetes management

**Threat**

As CHCs, PHCs are located in rural areas and Mukhya Mantri free medications scheme covers these establishments. Rural BPL may stay neglected. Increasing indulgence in Alcohol, smoking and other bad habits may complicate existing Diabetes and may increase the demand for tertiary care.

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Rajasthan has varied terrain ranging from sparsely populated desert areas to hilly and plain terrains. The state also has a significant migratory population. With a facility based system, providing continuum of care to such patients is a challenge. Low literacy and poverty compounds these challenges. For such conditions mobile medical units, remotely managed health education and awareness.
tools, single window for service provision of NCD, RCH, Immunization, TB, Malaria etc. should be established. For other areas where there is severe shortage of manpower and limited opportunities to hire or partner with private sector, building ICT platforms like telemedicine, GramSet should be explored. A systematic referral system needs to be introduced through which there could be a triage of patients those requiring advanced treatment and medications could be referred to higher facilities and treatment and medication at a subsidized price at tertiary care centres and medical colleges. Glycosylated Hemoglobin (HbA1C) tests and Microalbuminuria estimation should also be added to the list of free investigations. The state faced constraints in recruiting district level finance personnel and diabetes counselors. The biggest challenge initially for the program was mobilization of staff & placement of equipment in difficult to reach areas of the state.

The state initially faced issues with the allocation and thus utilization of the funds in early 2012, which was overcome through stronger operational guidelines and system strengthening. The unique achievement of the state is that 90% of financial expenses related to Diabetes management in terms of diagnostic tests and medications including insulin are being provided free of cost under the Chief Ministers Drug Scheme. Government of India has also provided Rs 1 lakh per BPL patient for treatment of NCDs which will be utilized for 500 BPL patients per district.

The Chemists/ pharmacists or the drug dispensing personnel need to be equipped with pictorial IEC material for health education related to the disease and medication. Pharmacists should educate the patients about the significance of dose modifications, compliance etc at regular intervals.

Monitoring and surveillance for improving quality of healthcare services can be strengthened through engagement of PRI (Panchayati Raj Institutions) members in community-based monitoring. The Village Health Committee (VHC) should form the link between the Healthcare providers and the community. The VHC would be responsible for working with the healthcare providers to ensure that the health plan is in harmony with the overall local needs. The performance incentives for healthcare providers could be linked to this community monitoring system.

90% of financial expenses related to Diabetes management in terms of diagnostic tests and medications including insulin are being provided free of cost under the Chief Ministers Drug Scheme. This is aimed to make treatment of diabetes affordable to the community.
Odisha

**Strength**
- Good progress in screening. Nearly 50% population is screened for Diabetes already.
- Good example of converging NPHCE with NPCDCS program at the District NCD cells.
- Considerable good number of health institutions in the state.

**Weakness**
- Geographically isolated terrains like hilly areas has problems with the availability of medicines.
- Resource availability is a problem - medicines, doctors, information etc.

**Opportunities**
- As Training instructors, material and program is a challenge there is an opportunity to design a structured program with PPP.
- As there is apathy to General Govt.
- Healthcare system, it is required that service providers are motivated and empowered by converging several national programs.

**Threat**
- Lack of voluntary health seeking behavior in the population is the biggest barrier.
- Till the time all the health institutions in the program implemented districts aren't covered in the program, implementation will be an issue.

Odisha extends and lies on the eastern coast of India. It has an area about 155,707 Sq Km. It is bounded by West Bengal in the north-east, Bihar in the north, Madhya Pradesh in the west, Andhra Pradesh in the south and the Bay of Bengal in the east. Odisha was the first state in the country to launch the National Program for prevention and control of cancer, diabetes, cardiovascular disease and stroke and National program for health care for elderly. Odisha was also the first State in the country to constitute State NCD Steering Committee under the Chairmanship of Health Secretary for the purpose. As per the 2012, MOHFW report the incidence of Diabetes in the state to be 9%. ICMR study shows that 8-12% population in urban areas and 6-8 % population in rural area are having diabetes. As per the latest statistics by the NCD nodal authority, population covered under NPCDCS is 55, 00,000. Target population for screening is around 27 ,00,000. 11.83 lacs has already been screened for...
Diabetes (42% of the total population). Around 82,862 people were identified as suffering from diabetes—which is around 7%.

In Odisha NCD clinics at DHQ hospitals in all 5 districts have started functioning in an integrated manner. Here the program got implemented in 5 districts i.e. Nuapada, Malkanagir, Koraput, Nawrangpur and Bolangir. Finance officer, program assistant and 2 DEOs (data entry operators) have joined the NCD cell already. Apart from NCD Cell Staff, there are 14 Staff Nurse, 8 Physiotherapist, 21 Counselors, 16 DEOs, 3 Care Coordinators, 1 Cytopathology Technician, 21 Rehabilitation Worker are recruited in different districts and 3 Hospital Attendants and 4 Sanitary Attendants are engaged by outsource agency. However, because of non-release of funds under salary component for staff of state NCD cell during 2011-2012 & 2012-2013 by GOI, recruitment of state program officer have been withheld.

Odisha is the first State to start submission of weekly report of screening hence weekly report of screening is being collected and submitted regularly to GOI. Glucometres and gluostrips have been saturated in 5 implementing districts. All 109 (Mobile Health Units) MHUs of 5 districts have been supplied Glucometer and strips. Health & FW Dept., Govt. of Odisha has released Rs. 51 lakh to districts from 20% State Share for procurement of drugs to give appropriate treatment of diabetes, hypertension, CVDs and Stroke and also for geriatric patients. Districts also procured drugs and supplied to CHC level.
SIKKIM, a small Himalayan State lying between 27 to 28 degrees North latitude and 88 to 89 degrees East longitude is the second smallest state in India. Amongst the hilly states like Himachal, J&K, Uttarakhand and Sikkim, Sikkim recorded the highest prevalence of diabetes at 14 percent in 2012 as per a study by the Ministry of Health. Sikkim has seen dramatic change in health scenario in recent years. The state has already initiated some of the activities for prevention and control of non-communicable disease (NCD) though Sikkim was not included in pilot phase with much effort pilot program was launched in the year 2009 for East Sikkim. In Sikkim the National Program for Cancer, Diabetes, Cardiovascular and Stroke (NPCDCS) program has started since 2011. As per the current status report provided by NPCDCS program head in Sikkim, around 16.5% population suffers from HRBS (high random blood sugar) and 19% from hypertension.

**SWOT Analysis**

**Strength**
- Good progress in screening. Through CATCH Sikkim program running a large number of population has already been screened (almost 95%)
- Good uptake of technology and automation of laboratories in the state. Bar coded health cards, electronic medical records have been maintained.
- Folk/traditional medicines are common in the state and can be a good module for PPP for diabetes Screening. Fold healers are working with several NGOs in the state.
- Telemedicine can have a huge play due to lack of tertiary care facilities in the state. The State can also partner with adjoining states health facilities.

**Weakness**
- Lack of tertiary care institutions in the state, so far Sikkim has just one big Medical institute.
- Unique health culture due to geographical barriers. The biggest barrier is identified as food habits and lifestyle. Rice is a staple diet.
- People take heavy meals in the morning and end up eating heavy dinner. Also, In such a case RBS (random blood sugar) mayn’t be the right methodology and may give false positive results.
- Lack of tertiary healthcare can prove as a barrier in providing follow up interventional care.

**Opportunities**
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- Lack of tertiary healthcare can prove as a barrier in providing follow up interventional care.
In Sikkim all manpower is recruited for the State NCD program and Medical specialists are made available at all the district hospitals by the NPCDCS cell. The Sikkim Government planned to provide additional support for treatment under NPCDCS. Diabetes retinopathy for all patients will start from the current year onwards. The State of Sikkim has come up with a unique program called CATCH Sikkim under the aegis of Chief Minister’s office which was launched in 2010. This path breaking initiative is aimed at providing comprehensive (Promotive, Preventive Curative and Rehabilitative) care with focus on Health Promotions and Prevention by doing Annual and periodical and Total (Head to foot) Health Checkup free of cost for all the citizens of Sikkim from village to State level. Diabetes is one of the main focus of the program. More than 5,13,797 people have been screened so far (around 95% of the population). Bar coded health cards are provided and the Government is maintaining computerized health data base for all the citizens.

The State in addition to training offered to NPCDCS staff, is coming up with training manuals for ASHA incorporating NCD, DMHP (District mental health program) etc. The State also plans to gain active involvement from Village Health, Sanitation and Nutrition Committee (VHSNC) as well in Diabetes management. The best practice shared was to render universal health coverage to people of Sikkim with the CATCH SIKKIM program funded by the Chief Minister. The State is involved in PPP with Sikkim Manipal institute of Medical sciences being the only medical institute present in Sikkim. The state felt the absence of many tertiary care and super specialty facilities in the state. Follow up facilities are setup at all PHCs related to Diabetes and other NCDs. The State plans to confirm all suspected cases, regular follow up and provide provision of improved care. The State is maintaining health records and automatic reporting of vitals happen through fully automatic biochemistry analyzers set up at district levels.
Maharashtra

**Strength**

- MCGM strong Diabetes programme can be replicated in other urban areas
- Presence of large number of interested NGOs, training institutions and Private sectors engaged in screening activities for Diabetes
- High scope of integration with ongoing Govt. and private efforts on Health
- Interested private/NGO sector waiting for Government EOI to join hands with Govt.

**Weakness**

- Non availability of free medication and insulin from Government
- Non availability of NCD staff in remote districts
- Limited service limits under programme
- Unplanned use of funds in the absence of standard treatment protocol may hamper
- Continued absence of partnership with Pvt. Sector and NGOs will have adverse impact

**Opportunities**

**Threat**

As per INDIAB 2011 study, 10.3% population in urban areas of Maharashtra is suffering from diabetes, whereas in rural areas the prevalence is 6.3%. Changing dietary patterns, lower physical activity and psychological stress contribute to this increase. The NPCDCS program in Maharashtra has been launched in 6 major districts namely- Amravati, Bhandara, Gadchiroli, Chanderpur, Wardha and Washim. The state has issued guidelines for organizing diabetes screening camps in the state. In Wardha and Washim approximately 90% of the vulnerable population has already been screened while in Amravati, Bhandara, Chandrapur and Gadchiroli, 20% of the population has undergone screening by outreach teams.

"Control Diabetes Act Now" campaign was initiated by MCGM (The Municipal Corporation of Greater Mumbai) in Nov 2011 which included establishment of 55 "Diabetes Clinics", through which 26,992 people were
screened, and 6,478 diabetes patients diagnosed. Presently 8,320 patients are on comprehensive treatment with regular follow-up. The campaign has also established linkages with Health posts & dispensaries. The state has also tied up with consultants & dieticians for providing weekly visits & referrals.

It was hard for the state initially to recruit manpower as per the guidelines due to scarcity of skilled health professionals available in the state. However, subsequently, the state recruited and filled-up all positions of district nodal officers, program assistants, finance officers and DEOs (data entry operators).

Lack of community awareness was a major constraint in the state. Self help groups that are driven by the community are a potent channel to inform, educate and engage communities. Women were identified as harbinger of “family based reforms”. Mass media campaigns appear to have a significant impact on household practices in the state.

For ensuring an increase in early diagnosis of diabetes in the community, cross referrals of DM patients from other national programs like RNTCP and NPCB can help identify cases early leading to early treatment and better prognosis for effective referral management.

There is a need to have a standard “risk assessment checklist” based on family history, symptoms, lifestyle score to rate predisposition to Diabetes in individuals. IDRS score can be used in resource poor settings to complement the screening process. State Guidelines related to NCD program need to be simplified to enable their translation into action. The guidelines, it was felt, need to promote creative solutions by providing flexibility and ability of revision in utilization mechanisms as per regional needs. Cross-sectoral linkages with departments like town planning, urban local bodies etc could lead to a healthy environment that promote more physical activity.

The state has pioneered in training of the NPCDCS staff for Diabetes and other NCDs. Training programs were conducted to train ANMs of all 6 focus districts for using glucometer. Nurses and Medical Officers were sensitized about NPCDCS & NPHCE programs and trained in providing palliative care.

Standard IEC material has been developed with the help of State IEC bureau, Pune and Tata Memorial Hospital along with NPCDCS officials. Though there are good training institutions available in the state, there is a lack of accreditation mechanisms for the programs and courses. It is essential that Government either outsources or partners with private or trust-based or other autonomous training institutions to create training manuals and enroll healthcare providers for ongoing training and capacitation. Pharmacists can act as health educators and can provide positive reinforcement regarding appropriate and regular treatment of diabetes to prevent complications. The state is working towards...
developing and disseminating standard treatment guidelines and protocols for management of diabetes.

There is a dire need to have mechanisms to collect, compile, collate and analyze data comprehensively. This system should be linked to both public and private institutions screening and treating DM.

For ensuring increased access, availability and affordability of services, it is required to reduce out of pocket expenditure on health. It is possible to do so using an OPD based insurance scheme for diseases like diabetes and CAD.

Chellaram Institute has established outreach program using Rural Mobile screening clinics. These clinics are equipped to test blood sugar levels and conduct foot and eye examinations for timely identification of complications due to uncontrolled DM. Through the initiative diabetes health education is being provided through documentaries and information leaflets in local language. The Clinics reach out to remote villages. The clinics also screen pregnant women, for gestational diabetes. Currently the clinics are being held in Junner, Ambegaon and Khed takulas (blocks) of Pune District. The Institute is also supporting research and CME Courses for Doctors, Paramedics, bio-chemists, technicians, dietitians, podiatrists, and pharmacists in areas related to diabetes. A regular Diabetic Health magazine is published for increasing awareness in the community.
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ASA</td>
<td>Athiyannoor Sreechitra Action</td>
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<td>ASHA</td>
<td>Accredited Social Health Activists</td>
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<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CII</td>
<td>Confederation of Indian Industries</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
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<tr>
<td>CVA</td>
<td>Cardio Vascular Accidents</td>
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<td>DEO</td>
<td>Data Entry Operators</td>
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<tr>
<td>DGHS</td>
<td>Directorate General of Health Services</td>
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<td>DM</td>
<td>Diabetes Mellitus</td>
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<tr>
<td>E.H.R</td>
<td>Electronic Health Records</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<tr>
<td>FOGSI</td>
<td>Federation of Obstetric and Gynaecological Societies of India</td>
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<td>GOI</td>
<td>Government of India</td>
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<td>IAP</td>
<td>Indian Academy of Pediatrics</td>
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<td>ICDS</td>
<td>Integrated Child Development Services Scheme</td>
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<td>ICMR</td>
<td>Indian Council of Medical Research</td>
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<td>ICT</td>
<td>Information and Communications Technology</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>ID</td>
<td>Identity Document</td>
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<tr>
<td>IDF</td>
<td>International Diabetes Federation</td>
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<td>IDRS</td>
<td>Indian Diabetes Risk Score</td>
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<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<tr>
<td>IMA</td>
<td>Indian Medical Association</td>
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<tr>
<td>INDIAB</td>
<td>India Diabetes (ICMR-INDIAB) Study</td>
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<td>INGOA</td>
<td>Indian Association of NGOs</td>
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<tr>
<td>IVRS</td>
<td>Interactive Voice Response System</td>
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<td>JSY</td>
<td>Janani Suraksha Yojana</td>
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<td>KMSCL</td>
<td>The Kerala Medical Services Corporation Limited</td>
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<td>LBW</td>
<td>Low Birth Weight</td>
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<td>MCGM</td>
<td>Municipal Corporation of Greater Mumbai</td>
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<tr>
<td>MCHN</td>
<td>Maternal and Child Health &amp; Nutrition (Day)</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MO</td>
<td>Medical Officer</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NCD</td>
<td>Non Communicable Diseases</td>
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<td>NIHFW</td>
<td>The National Institute of Health and Family Welfare</td>
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<td>NPCB</td>
<td>National Program for Control of Blindness</td>
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<tr>
<td>NPCDCS</td>
<td>National Program for Prevention and control of Cancer, Diabetes, Cardiovascular diseases &amp; Stroke</td>
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<tr>
<td>NPHCE</td>
<td>National Programme for the Health Care of the Elderly</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>NTCP</td>
<td>National Tobacco Control Programme</td>
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<tr>
<td>NVBDCP</td>
<td>National Vector Borne Disease Control Programme</td>
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LIST OF ABBREVIATIONS

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>OPD</td>
<td>Out Patient Department</td>
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<tr>
<td>OPPI</td>
<td>The Organisation of Pharmaceutical Producers of India</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>PRI</td>
<td>Panchayati Raj Institutions</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<tr>
<td>RNTCP</td>
<td>Revised National TB Control Program</td>
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<tr>
<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojana</td>
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<tr>
<td>SIHFW</td>
<td>State Institute of Health and Family Welfare</td>
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<td>SMS</td>
<td>Short Message Service</td>
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<td>SRS</td>
<td>Sample Registration System</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TV</td>
<td>Television</td>
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<tr>
<td>UID</td>
<td>Unique Identification</td>
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<tr>
<td>UNICEF</td>
<td>The United Nations Children's Fund</td>
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<tr>
<td>USAID</td>
<td>The United States Agency for International Development</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<tr>
<td>WFP</td>
<td>World Food Program</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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