Affordable and accessible healthcare
The east India journey
India has made rapid strides in the avenue of healthcare. Along with substantial progress in improving health indices, government reforms and innovative initiatives introduced under the National Rural Health Mission (NRHM) have resulted in states reporting significant improvements in key health indicators such as institutional deliveries, outpatient cases, full immunisation, availability of diagnostic as well as family welfare services and disease control programmes. Key drivers such as economic growth and rapid urbanisation are bringing in the expected transition to the sector in the country. Shifting demographics, increasing affordability towards quality healthcare services, changes in the morbidity pattern with the growing trend of degenerative and lifestyle diseases and the increasing penetration of health insurance are other such changes. Clearly, mammoth opportunities exist within the sector, which when tapped, can lead to unprecedented yields in the long-term.

On the other hand, the healthcare landscape in India is also a breeding ground for a slew of challenges, which has led to the country lagging behind many of its peer nations, as far healthcare outcomes are concerned.

**Triple burden of communicable, non-communicable and newer diseases:** India is currently undergoing a demographic transition which reflects both quantitative as well as qualitative changes in the population profile. This has led to the triple burden of communicable, non-communicable diseases and newer diseases. The country continues to combat against communicable diseases such as malaria, along with tuberculosis (TB), cholera, and plague, HIV, V cholera 139, hepatitis C virus. Non-communicable diseases are doubling in their incidence as well as prevalence in the country. Coronary artery disease, diabetes, renal failures, stroke and cancer are on a rise due to factors such as hypertension, metabolic syndrome and stress. In addition to this, new disease threats have emerged in the form of avian influenza, H1N1, etc. Over the next 15 years, non-communicable diseases are likely to constitute nearly half of the distribution of the total disease burden, thus posing a serious future threat to the health of the Indian population.

**Death burden due to diseases**

<table>
<thead>
<tr>
<th>Year</th>
<th>USA</th>
<th>Mexico</th>
<th>China</th>
<th>Brazil</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>28,575</td>
<td>15,090</td>
<td>14,266</td>
<td>15,378</td>
<td>20,721</td>
</tr>
<tr>
<td>1990</td>
<td>15,090</td>
<td>14,266</td>
<td>15,378</td>
<td>20,721</td>
<td>11,021</td>
</tr>
</tbody>
</table>

**Disability adjusted life year rates**


**High out-of-pocket spend:** Health expenditure in India is largely driven by private spending, namely, the out-of-pocket (OOP) route, with public funds constituting an insufficient share of the total pie. Despite several government initiatives in social protection, such as the Employees’ State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS), only around one-fourth of the population is covered by some form of public health insurance. Though several efforts, such as the NRHM, the Janani Suraksha Yojana, and the Rashtriya Swasthya Bima Yojana, have been initiated over the past few years in order to provide equitable healthcare to Indians, such programmes alone cannot accomplish the goal of universal health coverage (UHC).

**Urban-rural divide:** There are considerable gaps between the rural and urban areas of India, with respect to disease morbidity as well as mortality. Urban areas today have four times more health workers per 1,000 population than their rural counterparts. Moreover, 42% of health workers in the rural areas identifying themselves as allopathic doctors actually, have no medical training as compared to 15% in the urban areas. Compounding these disparities is an urban bias in healthcare financing. For example, almost 30% of public health expenditure (both from the centre as well as states) is allocated to urban allopathic services while rural centers receive less than 12% of this share.
Differences across states: Disparities persist at the state level as well. On the one hand, states such as Tamil Nadu and Kerala are regarded as role models in healthcare systems, while on the other hand, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh, have not been performing well. The landscape of the Indian healthcare sector also differs in terms of the number of beds, manpower, corporate facilities, consumer behaviour, etc. across various states. The southern part of India is termed as the healthcare hub, with a large concentration of healthcare facilities as well as larger average size of hospitals. In west India, the states of Maharashtra and Gujarat have incorporated a robust healthcare infrastructure, while the state of Madhya Pradesh is still developing in this avenue. As against other zones, the eastern region of India is way behind in terms of healthcare infrastructure and corporatisation. However, the utilisation of private nursing homes is one of the highest, as this region has few larger private hospitals. North India and some parts of east India are witnessing a high growth in terms of upcoming medical colleges, since the doctors per bed ratio is the lowest in these regions.

Talent and skill gap: Shortage of skilled talent is the single biggest bottleneck affecting the growth of the sector as well as the creation of healthcare access in India. The last decade (2000-10) saw an increase in physicians from 0.55 per 1,000 population to a mere 0.65 per 1,000 population. This puts India behind China which has 1.3 beds per 1,000 population as per the WHO benchmark of 2.5 per 1,000 population. Despite the scarcity of medical personnel, the problem of under-utilisation persists within the system. Also, around 50% of the existing medical workforce does not practise within the formal healthcare structural system. Paucity in talent can also be attributed to the uneven distribution of medical colleges in India. Presently, the southern region of India has the largest concentration of medical colleges, followed by west India. The eastern part of India on the other hand, has the least number of medical colleges.
Access to quality healthcare: Testing times

There exists a direct correlation between the economic prosperity of a country and the quality of its healthcare services. Greater coverage and better quality of healthcare at all levels, right from the primary to the tertiary level is an essential prerequisite for improving the quality of life of the population at large, which in turn, eventually affects the economic growth of the country. And to achieve this, an adequate volume of quality workforce is required.

In India, access to quality healthcare is perhaps the biggest challenge and continues to hinder the country’s progress and development. Today, it lags behind the developed nations of the western world as well as other comparable developing nations, in terms of healthcare infrastructure and services. There are approximately 0.9 beds per 1,000 persons in India. The country also lags behind other comparable developing nations such as Brazil and China with 2.4 and 3.0 beds per 1,000 persons respectively. Similarly, in terms of the availability of medical personnel, India has only 0.6 doctors per 1,000 persons as compared to 1.7 per 1,000 in Brazil and 1.4 in China.

Given this scenario, investments to the tune of around 80 billion USD are required to make up for this back-log. It is estimated that even to increase the availability of hospital beds to 1.7 per 1,000 persons from its current level, an addition of a million or more new beds, backed by substantial financial investments, is required.

Need for skilled human resources

The availability of trained workforce is a prerequisite to the growth of the sector. To achieve this, an adequate number and quality of healthcare personnel, possessing various skills are required. For any healthcare delivery set-up, besides doctors and nurses, paramedical workforce is crucial. As the importance of technology grows into the sector, the role of paramedics becomes vital in the effective delivery of quality healthcare.

Over time, the government has been able to improve the health condition of the population by formulating various national healthcare plans as well as programmes. However, major constraints in the implementation of these programmes and schemes have been in the realm of physical infrastructure, workforce and other support facilities.

<table>
<thead>
<tr>
<th>Parameter (per 1000)</th>
<th>Global average</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>1.23</td>
<td>0.6</td>
</tr>
<tr>
<td>Nurses</td>
<td>2.56</td>
<td>0.8</td>
</tr>
<tr>
<td>Dentists</td>
<td>0.29</td>
<td>0.06</td>
</tr>
<tr>
<td>Midwives</td>
<td>NA</td>
<td>0.47</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0.4</td>
<td>0.56</td>
</tr>
<tr>
<td>Community health workers</td>
<td>NA</td>
<td>0.05</td>
</tr>
<tr>
<td>Laboratory health workers</td>
<td>0.3</td>
<td>&lt; 1</td>
</tr>
</tbody>
</table>

Source: World Health Organisation

Global average

Hospital beds per thousand population

Source: NCMH report, 2005
Affordable and accessible healthcare: The east India journey

The gap between the demand and supply of human resources at various levels of healthcare is wide, and where available, the patient-provider interactions are beset with numerous problems, in addition to long waiting periods (opportunity cost) for consultation or treatment. The system lacks a real and working process of monitoring, evaluation, and feedback.

Also, the gap between the demand and supply of medical professionals can be attributed to the uneven distribution of medical colleges in the country. To meet the global average of 1.3 physicians and 2.56 nurses per 1,000 population in coming 15 years, India needs to open 600 medical colleges (100 seats per college) and 1,500 nursing colleges (60 seats per college) on an immediate basis.

**Distribution of medical colleges in India**

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It’s all about the money: Affordable healthcare for all

India’s tryst with a health insurance programme goes back to the early 1950s, when it launched the Employee State Insurance Scheme (ESIS) in 1952 and the Central Government Health Scheme (CGHS) in 1954. The country’s health insurance has undergone a tremendous change in the last three years, with the launch of several health insurance schemes, largely initiated by central and state governments alike. The country that had witnessed only three health insurance programmes until 2007 (ESIS, CGHS and the PHI), is now swamped by a plethora of insurance programmes, in less than three years.

Health insurance serves as a major impetus to the growth of the healthcare sector in India. In the past, the number of beneficiaries have grown from 75 million people in 2007 to around 300 million in 2010. Individuals with private insurance cover have grown at an annual growth rate of 44% from 2005 to 2010, and the total premium paid towards private insurance has grown at an annual growth rate of over 50% during the same period\(^1\).

Details of government health insurance schemes in 2010

<table>
<thead>
<tr>
<th>Scheme</th>
<th>ESIS</th>
<th>CGHS</th>
<th>Yeshaswini</th>
<th>Rajiv Aarogyasri</th>
<th>RSBY</th>
<th>Tamil Nadu Health Scheme</th>
<th>Vajpayee Aarogyasri</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area</strong></td>
<td>Pan-India</td>
<td>Pan-India</td>
<td>Karnataka</td>
<td>Andhra Pradesh</td>
<td>Pan-India</td>
<td>Tamil Nadu</td>
<td>Karnataka</td>
</tr>
<tr>
<td><strong>Beneficiaries (mn)</strong></td>
<td>55.4</td>
<td>3</td>
<td>3</td>
<td>70</td>
<td>70</td>
<td>36</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Enrolment unit</strong></td>
<td>Family</td>
<td>Family</td>
<td>Individual</td>
<td>Family</td>
<td>Family</td>
<td>Family</td>
<td>Family</td>
</tr>
<tr>
<td><strong>Max insurance coverage (USD)</strong></td>
<td>No limit</td>
<td>No limit</td>
<td>4,000</td>
<td>4,000 per family</td>
<td>600 per family</td>
<td>2,000 per family for 4 yrs</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Empanelled hospitals</strong></td>
<td>148 ESIS and 400 private</td>
<td>562 private</td>
<td>543 (30 government)</td>
<td>241 private, 97 government</td>
<td>8103 (2503 government)</td>
<td>692 (86 government)</td>
<td>94 (8 government)</td>
</tr>
<tr>
<td><strong>Expenditure (bn USD)</strong></td>
<td>0.40</td>
<td>0.32</td>
<td>0.01</td>
<td>0.22</td>
<td>0.10</td>
<td>0.10</td>
<td>None. Claim expenditure commenced in 2010-11</td>
</tr>
<tr>
<td><strong>Hospitalisations per year</strong></td>
<td>417,498</td>
<td>NA</td>
<td>66,749</td>
<td>322,723</td>
<td>400,000</td>
<td>153,410</td>
<td>3,738</td>
</tr>
</tbody>
</table>

Source: World Bank

\(^1\) IRDA
Growth of private insurance

The influx of private health insurance companies in recent years indicate the growing awareness and demand of having a health cover among patients. While members (persons with private insurance cover) have grown at a CAGR of 44% from 2005 to 2010, the total premium paid towards insurance has grown at a CAGR of over 50% during the same period.

Health insurance is an emerging segment and while it has considerably evolved, a lot remains unachieved. The market needs to be educated about health insurance and its offerings. All industries face segment-specific issues, and it is the same with the Indian health insurance sector as well, irrespective of whether it includes private or public players. There is a need to increase the penetration of health insurance in the semi-urban as well as rural areas, which is an obstacle in the growth of the segment. Health insurers need to expand their reach to Tier-II and Tier-III cities in order to bring more people under the health insurance cover. On the other hand, there is a scope for insurers to improve their offerings as well as services. The health insurance market has a huge potential for growth in India, considering the rise in medical costs and increase in awareness. Thus, the sector needs to constantly evolve to insure universal health coverage in India.
The east India diaries
A healthcare overview

The eastern region of India lags behind the rest of the country across key health indicators such as the infant mortality rate (IMR), the maternal mortality rate (MMR) and the longevity of the life span of an individual. Lack of skilled medical professionals as well as physical infrastructure, paucity of funds and other financial mechanisms, dearth of medical colleges and other educational institutions, lukewarm initiatives and policies by the government, are other pain points faced by this region. Access to high-end healthcare services is mainly concentrated in the urban areas, while the semi-urban and rural areas continue to face the challenge of low penetration of healthcare facilities. In most of the states within this region, healthcare services are primarily rendered by charity-run organisations, which again face an acute shortage of skilled manpower and basic infrastructural facilities. In order to strengthen and improvise upon their facilities as well as services, most of these hospitals are highly dependent on funds from benefactors and trustees, which are highly erratic in nature.

In such a scenario, patients have no other choice but to travel to other cities in order to avail and access healthcare facilities which might not always be the best-suited option. Also, there is a wide gap between the demand and supply of medical professionals in the region. This can be attributed to the fact that today, the eastern region has the least number of medical colleges in the country. Presently, it accounts for less than 14% of the total medical colleges in India.

Due to its uneven terrain and geographical topography, patients face myriad difficulties in availing transport options in the eastern region. Moreover, loss of earnings as a result of travel time can lead to treatments being deferred. This is especially true for patients suffering from chronic ailments.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>India</th>
<th>Bihar</th>
<th>Orissa</th>
<th>West Bengal</th>
<th>Chhattisgarh</th>
<th>Jharkhand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (in crore)</td>
<td>121</td>
<td>10.38</td>
<td>4.2</td>
<td>9.13</td>
<td>2.5</td>
<td>3.29</td>
</tr>
<tr>
<td>MMR (per lakh)</td>
<td>212</td>
<td>261</td>
<td>258</td>
<td>145</td>
<td>269</td>
<td>312</td>
</tr>
<tr>
<td>Institutional delivery (%)</td>
<td>78.5</td>
<td>27.7</td>
<td>80</td>
<td>49.27</td>
<td>34.9</td>
<td>17</td>
</tr>
<tr>
<td>IMR (per thousand)</td>
<td>50</td>
<td>52</td>
<td>65</td>
<td>33</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>Medical colleges</td>
<td>381</td>
<td>11</td>
<td>9</td>
<td>14</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Life expectancy (at birth)</td>
<td>65.5</td>
<td>61.6</td>
<td>59.6</td>
<td>64.9</td>
<td>61</td>
<td>61</td>
</tr>
</tbody>
</table>

Source: PwC Analysis, Family Welfare Statistics in India, Ministry of Health & Family Welfare and DLHS 3

Region at a glance

East India region
Despite the gloomy scenario, a number of positive developments have been observed in the healthcare sector in the north-eastern region of India. These include the following:

- Odisha has performed better than the national average in the avenue of institutional deliveries. Compared to other states, today it has the largest number of public healthcare facilities in the country.
- In West Bengal, improvement in critical indicators such as IMR as well as MMR was the fastest among all the states in the country. Infant mortality is must lower than the national average.
- Chhattisgarh was a pioneer to launch a cadre of rural medical assistants (RMA) a decade ago. By early January this year, in 18 districts of Chhattisgarh, 1,233 RMAs were posted in PHCs and health sub-centres, out of which 490 were women. The state had created 741 regular posts out of its own budget, in addition to the NRHM-funded contractual posts. Though 361 PHCs (managed by the ayurveda, yoga and naturopathy, unani, siddha and homeopathy or the AYUSH and the paramedical staff) did not have an MBBS doctor as of August 2008, today, all these centres have RMAs in place.
- Cites such as Kolkata and Bhubaneswar are among the fastest growing metros in the region, having in place ‘state of the art’ tertiary healthcare facilities.

The north-eastern region

In comparison to the rest of India, the healthcare sector in the north-eastern region is yet to garner enough steam, due to the lack of healthcare infrastructural facilities and an acute paucity of trained medical professionals. Other than the states of Assam and Manipur, the remaining states are yet to institute a single medical college to its credibility. A study suggests that based on three critical health indicators namely, the crude birth rate (CBR), crude death rate (CDR) and the IMR at two time-points namely, 2006 and 2010, it has been observed that the condition of all the north-eastern states, except for Assam and Meghalaya, is better than the national average, in both the rural and urban areas alike. The states of Manipur, Nagaland and Sikkim are way ahead of the national average as well as the other north-eastern states in all the three indicators. For Assam and Meghalaya, the healthcare scenario is better than the national average in case of CBR and CDR in the case of urban areas. However, for the rural areas, their condition is below the national average as well as the other north eastern states. In the case of IMR, the scenario for both the states is below the national average as well as the other north-eastern states, in both the rural and urban areas alike.

Given this scenario, rural healthcare needs to be an area of utmost precedence for any governmental social sector policy, especially the healthcare policy. The rural healthcare infrastructure, which is primarily run by SCs, PHCs and CHCs, has also witnessed a couple of developments. Between 2005 and 2011, for this region as a whole, the number of SCs has declined from 7,755 to 7,259 between 2005 and 2011. This is mainly due to the significant decline in the SCs in Assam and Arunachal Pradesh, whereas the number of SCs has increased in Tripura. Also, the decline in SCs in the region can be attributed to the fact that many have been upgraded to PHCs, evident from the fact that, the number of PHCs in the region have increased from 1,109 to 1,510 between 2005 and 2011. The number of CHCs has increased from 215 to 244 for the entire region during 2005-2011. Apart from significant progress made by Assam, Nagaland and Arunachal Pradesh in the avenue of PCHs and by Tripura in SCs, the remaining states in the region have not taken many initiatives with respect to the establishment of health centres, even after the implementation of the NRHM in 2005. Alongside the progress in health centres, facilities available in these centres constitute a critical aspect. In this regard, the condition of the north-eastern region has been deplorable.

As far as the availability of trained medical professionals are concerned, it has been observed that the states of Assam, Manipur, Sikkim and Tripura have a surplus of doctors in PHCs, while other states have been experiencing acute shortages. Similarly, Assam, Manipur, Meghalaya and Tripura have a surplus of pharmacists in PHCs and CHCs, whereas the remaining states, except for Arunachal Pradesh and Sikkim enjoy a surplus in nursing staff in PHCs and CHCs. The entire region faces an acute shortage of specialists and radiographers in CHCs. In addition to this, more than 75% of PHCs in Meghalaya and Mizoram and 69 % of PHCs in Nagaland have been functioning with only doctor, while for the other states the percentage of PHCs with only one doctor is less than the national average (62.18 %). The states of Manipur, Tripura and Assam are in a better position, with more than three doctors operating out of PHCs as compared to the rest of the country (6.89%).

The private sector is yet to etch its footprints in the region. According to the Economic Survey of India 2009-10, there are only 131 private hospitals in Assam. Other than the urban areas of Guwahati, Dibrugarah and Shillong, the remaining state capitals, district headquarters, major towns and cities of the region are deprived of adequate healthcare infrastructure. Patients therefore, have no other choice but to avail the facilities provided by public hospitals. The paying class of patients usually opt to travel to other cities such as Vellore, Chennai, Delhi, Kolkata and Patna, etc for tertiary level of care.

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\(^1\) Healthcare infrastructure-the sunrise industry in NE India, EPC World
\(^2\) Rural Health Infrastructures in the North-East India by Dilip Saikia and Kalyani Kangkana Das
\(^3\) Rural Health Infrastructures in the North-East India by Dilip Saikia and Kalyani Kangkana Das
\(^4\) Healthcare infrastructure-the sunrise industry in NE India, EPC World
Looking ahead, robust infrastructural facilities coupled with high-end technological services will be the cornerstones of growth for the industry. These will need to be backed by effective financial mechanisms as well as governmental reforms and policies.

The current scenario however presents a stark picture. Amongst the BRIC nations, India probably has the lowest health indicators. According to the WHO health statistics, in 2010, the country recorded one of the lowest rates of institutional delivery. This was predominantly due to the non-availability of hospital beds. Public expenditure in healthcare in many countries is above 40%, whereas in India, it is less than 30%. India has around 1.37 million hospital beds, that is, 1.1 bed per 1,000 population. To reach the world average of 2.6 beds per 1,000 population, India will need 1.7 million hospital beds.

In such a situation, conferring a full-fledged infrastructure status to the healthcare sector can open up new vistas. Benefits include the creation of employment opportunities within the sector, helping the nation cope with the burden of communicable and non-communicable diseases, thereby leading to significant contributions to the overall GDP growth. With an infrastructure status, the sector can avail a 10-year tax exemption as compared to the current five-year tax exemption for healthcare facilities. This will also enable the sector to avail government as well as infrastructure-oriented funding. The sector can thus utilise additional funds in the form of external commercial borrowings, forex reserves to meet capital requirements (supported by the Ministry of Finance and subject to an approval by the RBI) as well as of insurance and pension funds. With such a status, hospitals will now come under the purview of the minimum alternate tax (MAT). Currently, hospitals are covered under sections 80-IB (11B) and (11C). Hence, they do not incur any benefits as covered under section 115JB (which refers to MAT).

As a supplement to the above recommendations, a critical and quicker means to reach out to the patient population would be through leveraging technology. As India sees a growing supply of mHealth providers and given its lead in the global market in the mobile network, a large portion of the population’s health needs may be served through mHealth technologies. For instance, in most of the cases, patients flood medical facilities with minor illnesses, thus overcrowding the already over-burdened and lean infrastructure resources. The idea is to spread awareness to the masses for them to differentiate between ailments that are minor versus those that need greater medical attention. Organisations, government or private, may even consider a low budget tele-health centre that can be supported from big cities in the north-east, thus providing medical help and support remotely to places which are ill-connected otherwise.

Technopak analysis (WHO statistics 2010 of 0.9 beds per 1,000 population)
Examples of mHealth initiatives

India has a lot to learn from its African counterparts. Most of the African nations have undertaken a few of technological initiatives to take healthcare to the remote population. Some of these include the following:

- **Portable Eye Examination Kit (PEEK):** This is a smartphone mobile app that uses the phone’s camera in order to scan a patient’s eye for diseases such as cataracts. PEEK’s developers are currently testing their app in Kenya as well.

- **Skyscape Medical Resource app:** Apple Inc recently launched a video to promote this app, where a nurse is shown demonstrating the proper methods for breastfeeding.

- **Pharmasecure:** This is used by pharmaceutical companies in order to verify genuine serial number on medicine packs and strips. This is used to combat growing menace of counterfeit drugs.

- **Logistimo:** The government of Sudan uses this mobile app to manage the vaccine stock in southern Sudan.

The possibility of mHealth and tele-health operating out of the remote areas of the country has a huge potential, and till the time when large-scale infrastructural facilities will be set-up, these technological avenues may help address the health conditions of the eastern region of India, especially the north-eastern states.

Also, the government also needs to recognise healthcare as a priority sector. This will stimulate investments, enhance the viability of Tier-II, Tier-III cities as well as rural India. With priority status, sector estimates for the next five years suggest that investments apart from metros will be channelised to around 150 non-metro towns. This will mean an addition of almost 30,000 hospital beds, which will be 200 beds per town. Total investments made into the sector will be around 15,000 crore INR. This will also lead to the generation of direct employment to the tune of 1, 50,000 people and indirect employment to the tune of approximately 6,00,000 people into the sector.

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7 Towns above a population of three lakh
4 This is in addition to 62,000 beds added every year
6 Investment at 50 lakh INR per bed for an upgraded secondary care hospital
† Source: medcitynews
Notes
About CII

The Confederation of Indian Industry (CII) works to create and susta

in an environment conducive to the development of India, partnering industry, government, and civil society, through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organisation, playing a proactive role in India’s development process. Founded over 118 years ago, India’s premier business association has over 7,100 members, from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 90,000 enterprises from around 257 national and regional sectoral industry bodies.

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The CII theme for 2013-14 is Accelerating Economic Growth through Innovation, Transformation, Inclusion and Governance. Towards this, CII advocacy will accord top priority to stepping up the growth trajectory of the nation, while retaining a strong focus on accountability, transparency and measurement in the corporate and social eco-system, building a knowledge economy, and broad-basing development to help deliver the fruits of progress to all.

With 63 offices, including 10 Centres of Excellence, in India, and seven overseas offices in Australia, China, France, Singapore, South Africa, UK, and USA, as well as institutional partnerships with 224 counterpart organisations in 90 countries, CII serves as a reference point for Indian industry and the international business community.

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